Work Meaning Constructions by Lay Community Health Workers in an HIV/AIDS Palliative Care Setting: Community and Adult Education Perspectives

By

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A thesis submitted in fulfilment of the full requirements for the degree

PHILOSOPHIAE DOCTOR (EDUCATIONIS)

in

PSYCHOLOGY OF EDUCATION

in the

FACULTY OF EDUCATION

at the

UNIVERSITY OF JOHANNESBURG

SUPERVISOR: Professor J. Pillay

2015

DECLARATION

I, Bonita Bernice Visagie, declare that *Work Meaning Constructions by Lay Community Health Workers in an HIV/AIDS Palliative Care Setting: community and adult education perspectives.* This qualitative phenomenological research study is my own work, conducted under the supervision of Professor Jace Pillay. The sources and quotations applied in this research study are acknowledged and supported by a complete list of references. This is the first submission, and I confirm that it was, on no account, formerly submitted to any other tertiary institution for a degree.

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Bonita Bernice Visagie

ACKNOWLEDGEMENTS

This journey was made possible by the grace and mercy of our Lord and Saviour, Jesus Christ. I am grateful to the Father for guiding me throughout my life and allowing me to make a success of it, including the completion of this study. Any road travelled cannot be travelled successfully without help, assistance, encouragement and guidance from other people.

Thank you very much to the participants, stakeholders and management of the NGO who made this research study possible.

I would like to express my sincere gratitude to my supervisor, Professor Jace Pillay for his continuous support, patience, motivation, enthusiasm and immense knowledge. His tireless guidance had helped me to complete my study. I could not have been given a better supervisor and mentor for my study. Rojasperi Govindasamy, your smiles, encouragement and hospitality gave me hope when everything seemed hopeless to me.

In addition, I would like to thank the members of the doctoral committee: Dr E. Fritz, Dr H. Dunbar-Krige, Dr D. Magano, Prof. M. Poggenpoel and Prof. M. C. Myburgh for their insightful comments and difficult questions.

Thank you to Helen Holleman for the professional language editing of my study and for accommodating me at the last minute.

My family, friends and colleagues, thank you for your unconditional support and care. Vernita and LeVern, my daughters, for your continued encouragement, support, prayers and love. Gilberto, who could never understand why I was taking so long to finish my study, thank you for believing in me, and for your love, patience and understanding during the challenging years.

"Thank you" does not seem sufficient, but it comes from the heart and it is said with much appreciation, gratitude and respect to every person who supported and encouraged me throughout this study. I owe the completion of this study to several people who have knowingly and unknowingly helped me along this journey.

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LIST OF ACRONYMS AND ABBREVIATIONS

ABET	Adult Basic Education and Training
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ATR	Annual Training Report
BCT	Behavioural Couples Therapy
CBC	Community Based Care
CBHC	Community Based Health Care
CBO	Community Based Organisation
CHWs	Community Health Workers
CD	Compact Disc
ECDVT	European Centre for the Development of Vocational Training
DoL	Department of Labour
ETDPSETA	Education, Training and Development Practices SETA
EU	European Union
FET	Further Education and Training
GET	General Education and Training
H&WSETA	Health and Welfare Sector Education and Training Authority
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HRD	Human Resources Development
HRDSA	Human Resources Development Strategy South Africa
JC	Junior Certificate
LCHWs	Lay Community Health Workers
NDoH	National Department of Health
NGO	Non-Government Organisation
NPO	Non-Profit organisation
OECD	Organisation for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
SOP	Standard Operating Processes
TNA	Training Needs Analysis

ABSTRACT

Lay community health workers (LCHWs) have received increased attention in recent years as many global health programmes emphasise their potential for improving community health. As with many community organisations worldwide, particularly in South Africa, the number of people affected and infected with HIV/AIDS is increasing, directly affecting the palliative care needs of patients, their immediate families, orphans and vulnerable children (OVC). Many of the affected and infected patients, orphans and vulnerable children reach a stage where they can no longer care for themselves or their families, which is why palliative care community organisations are emerging and now becoming more responsible for providing the support and care needed. Lay community health workers have become a solution and community organisations make use of their services to provide constant palliative care to those in need of it in their local and surrounding communities. We, however, do not have any understanding of what happens in those palliative care community organisations, with the employees and volunteer workers, and what meaning they construct about the work they do. We need to understand how lay community health workers perceive their work, and their roles as carers in community organisations providing extensive palliative care to patients, orphans and vulnerable children. It is against this background that this research looks into how lay community health workers' construct work meaning about their roles as palliative carers in community organisations. This research focused specifically on lay community health workers from Bronkhorstspruit, working at a community organisation in Sizanani Village.

A qualitative research approach was used, from a social constructivist paradigm. The study employed a phenomenological case study design, and a single case study design was selected to address the research question. Community and adult education from a job-demands perspective served as the theoretical framework of the study. Data were collected using multiple sources, including twenty-five individual interviews, two focus groups with ten and eleven participants respectively, observation and document explication. Participants were purposefully selected and identified by the management from a purposive community organisation where the study was conducted. A total of nine men and thirty-seven women participated in this research study. Explication of data was conducted using inductive thematic processes. Three main themes emerged

from the findings: included knowledge needed by LCHWs, skills needed by LCHWs, and organisational challenges, with three sub-themes: lack of career pathing processes, lack of career guidance, and inadequate employment processes at this particular community organisation, such as *retention, succession planning, and promotion.*

The findings of the explication of data in the first two themes showed that lay community health workers needed specific knowledge and skills to provide adequate palliative care to the patients, orphans and vulnerable children for whom they cared. In theme three, the findings highlighted the community organisation's employment process challenges which affected how the lay community health workers could make meaning of their work as carers in their palliative care setting. As indicated by the findings, palliative care services clearly fall within the scale of high need in this community organisation, therefore, significant resources are needed to ensure education and training in the workplace and that momentum is retained to meet the knowledge and skill-resourcing needs of the lay community health workers. However, the capacity of these lay community health workers and the methods of their retention, succession planning and promotion are still skewed, indicating that diverse and innovative methods of incentives, training and support were required to ascertain how replicable they were. For that reason, a work resourcing needs framework, based on the two elements of the JD-R model, job-demands and job-resources, was developed to understand how lay community health workers construct work meaning in a palliative care environment. The framework is designed to be used by the community organisation involved in this study as well as by other community organisations who provide similar services.

The findings of this research have implications for theory, policy and practice. The main theoretical contribution offered is how the job-demands model could be used in the context of a similar study. Limitations and further study in the form of suggestions are all provided.

CHAPTER ONE: ORIENTATION TO THE STUDY

1.1 INTRODUCTION

In South Africa and in many parts of Africa, as well as the rest of the world, there is an increasing number of people who are HIV positive, and some who have full-blown AIDS. Families are not able to care for them anymore therefore palliative care centres are emerging which are responsible for providing the support and care that families cannot give. Simultaneously, we have an emerging problem with orphans and vulnerable children (OVC), because the parents have died. Organisations are now beginning to cater for both: the frail and the dying, as well as the children that have no adult supervision. This unfortunately, is going to be the reality in South Africa and the rest of Africa. There is obviously going to be a need for more organisations that provide such palliative care, as well as support for OVC. However, we do not know what exactly happens in those organisations and with the people that are employed there; what meaning they construct about their work; what they understand their work to be; the roles that they play and what relevance the work has in terms of them as lay community health workers. It is important to look at how these community organisations sustain themselves and their employees. There are many such community organisations, but in order to answer these questions, this particular study looked at a palliative care centre that is currently in such a situation: St Joseph's Care and Support Trust[1]. (St Joseph's)[2] is a non-government (NGO), non-profit (NPO) organisation based in the Kungwini local municipality of Bronkhorstspruit.

1.2 BACKGROUND AND RATIONALE OF THE STUDY

St Joseph's is situated in Sizanani Village, a small farming town 50 kilometres east of Pretoria, on the N4 highway to Witbank. It lies on the border between the Gauteng and Mpumalanga provinces. The NGO was formed in response to the needs created by HIV/AIDS and has been in existence since 1999. It remains the only organisation offering

[1] Permission granted to use actual name of the community organisation.
[2] The shorter version of the name of St Joseph's has been mainly used in this study.

comprehensive holistic palliative care service for all life-threatening illnesses in the region. Services are rendered by a team of highly committed, fully trained and experienced staff and volunteer workers. The hospice provides 24-hour palliative care services to persons diagnosed with life-threatening illnesses, with a particular focus on HIV/AIDS. Furthermore, it supports Government in the health-strengthening forum that aims to create clear lines of communication, to avoid service duplication and to enhance capacity building between the Government's Health Department and all Non-Governmental Organisations providing health services within Region 7 of the City of Tshwane. The Tshwane Metropolitan is one of the districts in the country chosen by the Government to pilot National Health Insurance, a health strategy to re-engineer Primary Health Care in Communities. St Joseph's has been chosen as one of the hospices in Bronkhorstspruit to operate a Health Post under the National Health Insurance programmes. The aim of selecting St Joseph's as one of the hospices was to reach the rural areas such as Sokhulumi and other surrounding farming areas that are underserved.

The Government's Department of Health has carried out two on-site trainings thus far, where eight of St Joseph's caregivers and another ten from the community were trained in how they will be operating. The number of caregivers is set to increase in the future and will cover communities in City of Tshwane Regions 5 and 7 (Gauteng) and Nkangala District (Mpumalanga). Each caregiver will be expected to reach 200 households and will be monitored by a professional nurse.

Based on the mandate of the palliative community-based health care programme, St Joseph's is responsible for providing comprehensive palliative care services to patients in their homes. The target clients are those patients who are not sick enough to require admission into the Hospice of St Joseph's and also those patients that have been discharged from the Hospice to recover fully at home. Community-based workers and the professional nurses conduct follow-up home visits in order to keep track of and monitor the progress of these patients. St Joseph's provides an all-inclusive service such as home visits, treatment adherence checks, health assessments and follow-ups, counselling and psycho-social

support, food parcels, assistance with the applications for grants, referral to other medical and social services, and funeral assistance where necessary.

OVC infected and affected by HIV/AIDS and their families are also included in St Joseph's holistic spiritual support services. These support interventions include statutory, educational, nutritional, economic and psychological support to ensure that these affected and infected children are able to cope with their day-to-day lives. Support groups are conducted for OVC and their foster parents to give them continuous psycho-social and spiritual support through individual counselling sessions and group sessions. The main thrust of the support groups is to create an enabling environment for children, child-care workers and foster parents to discuss issues and challenges relating to disclosure of children's status, present HIV/AIDS challenges and to provide solutions that will enable the OVC to live positively with the disease. At such meetings, OVC are taught how to cope with their situation and how to take their medicines correctly; foster parents are taught how to ensure that children adhere to their medication and how to deal with children when they feel stressed. St Joseph's fulfils the OVCs basic needs by feeding every child, clothing them and providing them with medical attention. These needs are met through nutritional, health and physiological support on a daily basis in the form of food parcels and cooked meals at community centres.

One of the community development objectives is that St Joseph's staff and volunteers are involved with the community by way of development initiatives to help alleviate poverty in the communities. These activities include home, school and communal vegetable gardens. The home vegetable garden project remains a viable and lucrative project as it assists with nutritional support and it acts as an income-generating opportunity when there is a surplus harvest. Community development coordinators render agriculture training to the community members.

St Joseph's Care and Support Trust operates in twelve communities, and three of these community centres cater for OVC. The staff and volunteers employed at St Joseph's come from the community and consist of a team of community health-care workers, nurses,

administrative employees, volunteer workers, caregivers. Each of these groups of people plays a vital role in enabling the organisation to contribute to the health and wellbeing of the surrounding communities. By providing Antiretroviral Treatment (ART), St Joseph's has secured the economic survival of families; the breadwinner of the family can stay healthy and thus work for longer and the ART programme has had a positive impact on the structure of the surrounding communities.

That is why, from an organisational level, I looked at the demands of the participants' particular jobs, which introduced the job-demands theory. I also looked into what would be expected from the participants in terms of competencies and abilities and their coping mechanisms, because they deal with dying people and vulnerable children. These situations most definitely have a psychological impact on the staff and volunteers of St Joseph's. Hence, it is critical to understand the meaning St Joseph's participants construct of their jobs, with research to back it up.

My concern is based on the fact that if these organisations do not have proper management and a better understanding of the people they are employing, or those people who are already in their employ, irrespective of whether it is on a voluntary basis or as fulltime employees, the sustainability of this organisation is be questionable. Yet, the need for more of these types of organisations will increase and such issues can create problems in terms of how support is provided. I therefore build my main argument around the fact that this is the future, and therefore, emphasis should be placed on the sustainability of these organisations in order to continue providing the support and care they are currently providing. The sustainability of these organisations is critical in terms of the support and care that will be giving to a multitude of people, whether they are infected or affected, whether they are adults or vulnerable children.

I researched this particular NGO and all the employees, from the ground level up to management level, to explore the meaning they construct about their work and how they deal with the stressful situation where they find themselves caring for dying people, sick people, watching OVC battling to survive on their own which must have psychological

impacts on the caregivers. It is imperative to determine what kind of support they need and what meanings they construct about the actual jobs that they do. I therefore looked at the situation on a personal and individual level (in terms of the participants themselves), and at the organisational level in terms of what will be needed. To assist this study, and because the participants are adults, I looked at adult education, and because the research is focused on community, I also looked at community education. From a community and educational perspective in terms of their needs, it is important to understand how the lay community health workers (LCHWs) construct meaning of their work in their palliative setting.

The primary purpose of my study was to explore and describe the manner in which a group of LCHWs from a South African community organisation construct meaning of work in an HIV/AIDS palliative care setting from a community and adult education perspective. Secondly, I aimed to use the findings of this study to create a framework that could further enhance the work meaning of LCHWs in their unique palliative care setting. Research in this area could provide critical insights into aspects such as sustainability of community health organisations; strengths, aspirations, expertise of lay community health workers, and future prospects of patients, OVC lives which are often painfully affected by HIV/AIDS.

1.3 AIM OF THE STUDY AND RESEARCH QUESTIONS

The main aim of this study was to determine the work meaning construction by lay community health workers (LCHWs) in an HIV/AIDS palliative care setting in their roles as carers. Based on the findings, the second aim was to provide a framework that could further enhance the work meaning of lay community health workers.

1.4 THEORETICAL PLACEMENT OF THIS RESEARCH

This research study is about work meaning constructions by adult LCHWs, between the ages of 18 to 65 years, both male and female. These groups of LCHWs are all employed by St Joseph's, which provides comprehensive palliative care to patients, OVC in their community. Community organisations such as St Joseph's play a critical role in the health-

care service, assisting in prolonging the lives of patients with life-threatening illnesses, and other diseases. In the following section, I use literature and theory to substantiate why community organisations, whether in South Africa, Africa, or in the rest of world, have an important function to fulfil. In addition, I provide a theoretical perspective on community and adult education, looking at it from a job-demands viewpoint.

1.4.1 Role of community organisations in an HIV/AIDS palliative care settings

Universally HIV/AIDS has placed a huge strain on the health sector, resulting in new care needs and a crisis in health services. The United Nations Educational, Scientific and Cultural Organisation (UNESCO) (2002) stated that, in less than two decades, HIV/AIDS has been transformed from a medical curiosity to an international emergency. Both scientific and non-scientific literature indicate the vast and escalating impact of HIV/AIDS on communities, with reference to the people that are infected with HIV/AIDS, including those affected directly or indirectly, and by the growing number of people dying or incapacitated by the disease. Community involvement is increasingly identified as a critical enabler of effective AIDS response (Rodrigueqz-Garcia, Bonnel, N'Jie, Olivier, Pascual, & Wodon, 2011; Schwartländer, Stover, Hallett, Atun, Avila, Gouws & Padian, 2011). Historically, all cultures have systems of natural helpers who provide community members with social support and advice. Given that the South African government regards dealing with the illness as a community-based matter (Gow & Desmond, 2002), it is important to determine how South African community non-government organisations (NGOs) are responding to HIV/AIDS through the roles of lay community health workers (LCHWs) who render comprehensive palliative care to local communities.

South Africa has one of the fastest growing rates of HIV infection and is experiencing one of the most powerful and probably the largest HIV/AIDS illness worldwide. Based on the *Statistics South Africa: Statistical release – Mid-year population estimates* (2013), the estimated overall HIV prevalence rate is approximately 10%, and the total number of people living with HIV was estimated at 5.26 million in 2013. Statistics like these emphasise the powerful impact on HIV/AIDS. The social and economic effects of this

illness are complex and potentially shocking to families, communities and economies. For that reason, the vast impact of HIV/AIDS requires people to work together to address the international, national, regional and local challenges collaboratively (Department of Economic and Social Affairs of the United Nations, 2000a; Barolsky, 2003; Smart, 2003b; International HIV/AIDS Alliance, 2001). According to Ogden, Esim and Grown (2006), one of the key system-wide effects of large new investments in the HIV/AIDS response in South Africa and elsewhere has been the growth of lay community health workers' involvement in the health system and, related to this, the emergence of a complex and diverse new economy of care at the boundaries of the formal health and social welfare systems. In the context of general health worker shortages, community members have taken on care roles where care is not available; community-based organisations have sprung up to advocate and support people living with HIV/AIDS through new cadres of counsellors and peer supporters; and non-governmental organisations have formed care and support networks which make use of different groups of lay personnel. This mobilisation of non-professionals has catered for new forms of service provision within health facilities, but has also led to a shift of care from a fragile formal health system to household and communities. According to Blecher, Day, Dove, and Cairns, (2009), community-based services are an established and growing part of district health system budgets, and there are virtually no primary health care clinics in South Africa operating without the help of lay community health workers, either facility-based or providing home-based care within its catchment area.

In the absence of conclusive evidence concerning the relationship between health outcomes and the number of human resources (HR) available for health care, it is clear that qualified and motivated human resources are essential for adequate health service provision, but also that human resource shortages have now reached critical levels in certain areas. The World Health Report (2006) has given another important boost to the global agenda of Human Resources for Health (HRH).

Determinants of poor performance of workers can be influenced in a variety of ways, using various methods at different levels in the health system. The World Health Report of 2006

describes three levers that influence workforce performance: job-related interventions that focus on individual occupations, support-system-related interventions, and interventions that create an enabling environment and focus on managerial culture and organisational arrangements (WHO, 2006).

In general, the purpose of training and development programmes serves to improve employee and organisational capabilities. Organisations are expected to manage four resources: money, equipment, information, and people. By investing in improving the knowledge and skills of its employees, organisations benefit when the investment is returned in the form of more productive and effective employees. As indicated by Ospina, Godsoe and Schall (2002, p. 30), "Leadership is a process of meaning making in a community." By constructing this common meaning and direction to shape change efforts, this study will enable St Joseph's and the LCHWs to align their efforts and create an upward spiral of the organisation's increasing assets.

Jackson (2002) described two approaches – the hard and soft approaches – explaining that some cultural assumptions underlie human resource management with regard to developing employees. According to Korean (2000), in order to strengthen the loyalty of employees, organisations should take on a more systematic approach by sharing information and experiences, which will promote their human capacity building and sustain productivity in the workplace. Studies have shown that at hospital level, lower nurse-to-patient rations lead to more complications and poorer patient outcomes (Aiken in Duffield & O'Brien-Pallas, 2003). Staff shortages are seen in a negative light, because they affect the motivation of the remaining staff as they increase workloads, causing more stress and increasing the risk of more staff leaving or being absent from work. In light of the latter, the role of LCHWs in organisations is discussed next.

1.4.2 Role of lay community health workers (LCHWs) in community organisations

According to Joseph, Rigodon, Cancedda *et al.*, (2012), LCHWs play an important role in the provision of HIV/AIDS services, ranging from translation, adherence counselling, palliative care, voluntary counselling, testing, and the distribution of medication.

LCHWs have re-emerged as a significant phenomenon in health systems, largely in response to new funding for disease-specific programmes and in the context of health worker shortages. These teams of workers have become essential players in the provision of health care and form part of a broader mobilisation of communities and non-governmental participation in the health system, precipitated in Sub-Saharan Africa (SSA) by the HIV epidemic. In general, LCHWs assume multiple roles and still perform adequately, but require training and support, and a balance between generalist and specialist roles (Schneider & Lehmann, 2010). The Committee on a National Strategy for AIDS (CNSA), where home-based care for the United States of America originated in 1986, described the system of AIDS care in terms of three components known as hospital care, out-patient care, and community-based care. These components are identified as follows:

Hospitals are where diagnosis and in-patient therapy, happens as well as discharge planning to integrate patients with out-patient and community agencies. **Out-patient services** refer to the medical management of patients with AIDS-related complex (ARC) or AIDS which is ideally delivered through dedicated AIDS clinics, together with counselling and health education. **Community-based care** occurs at a patient's home to support or replace hospital-based care. This type of care includes medication management, palliative care, and social support (Committee on a National Strategy for AIDS, 1986). Home-based care programmes originated in North America and Europe when it became clear that hospital care was too expensive, and that family and other carers found it difficult to cope on their own with the demanding nature of caring for people living with HIV/AIDS (Spier & Edwards, 1990).

The Committee on a National Strategy for AIDS (1986, p. 101) concluded that:

> "If the care of these patients is to be both comprehensive and cost effective, it must be conducted, as much as possible, with hospitalisation only when necessary. The various requirements for the care of patients with asymptomatic HIV infection, ARC or AIDS (i.e. community-based care, out-patient care, and hospitalisation) should carefully be coordinated."

Previous studies highlighted the negative impacts of the burden of care (Campbell & Foulis, 2004). These highlights include burnout (Lindsey, Hirschfeld & Tlou, 2003), impaired physical health (Akintola, 2006), emotional distress (Kipp, Nkosi, Laing, *et al.* 2006), family breakdown (Thomas, 2006), the destruction of household economies and the lack of social support (Robson, 2006). This list is, however, not exhaustive. There is a dire need to strengthen local networks to support community health workers (Robson, 2000). Thomas (2006, p.3186) emphasises the need for "locally appropriate initiatives" to support carers. Strong links between formal and informal health care systems are required to enhance the treatment of HIV/AIDS related illnesses (Harding & Higginson, 2005).

There is an understanding that lay community health worker/carer programmes strive to improve access to care. As the interface between health systems and communities, these carers provide outreach services and help households to overcome barriers to care, barriers such as, lack of access to transport, clean water, sanitation and nutrition, which relate to the social determinates of health. While there is growing evidence that lay community health workers/carers can help to improve certain health outcomes (Lewin, Dick, Pond *et. al*., 2005), research suggests that community health programmes often fail because of lack of support, knowledge and skills (Gilson, Doherty, Loewenson & Francis, 2007).

1.4.3 Community and adult education from a job-demands (JD-R model) perspective

The job demands-resources (JD-R) model consists of two main elements: first, the job demands, which refer to the physical or emotional stressors in the roles of employees. These demands include time pressure, a heavy workload, a stressful working environment, role ambiguity, emotional labour, and poor relationships (Bakker, Demerouti, & Schaufeli, 2005). The second element is the job resources, also referred to as job positives, which are seen by Bakker, Hakanen, Demerouti, Xanthopoulou (2007) as the physical, social, or organisational factors that help one achieve goals, and reduce stress. They include autonomy, strong work relationships, opportunities for advancement, coaching and mentoring, and learning and development. As pointed out in the JD-R model, when job demands are high and job resources/positives are low, stress and burnout appear to be a common experience for employees. Conversely, good job resources/positives have the potential to offset the effects of extreme job demands, and to motivate and engage employees. I found the JD-R model to be the most appropriate model to use as the main theoretical framework in this study. The categories of job demands and job resources were particularly valuable to this study because they included job characteristics that were commonly encountered across various jobs, but specifically and uniquely at St Joseph's Care and Support Trust, the community organisation where the LCHWs (participants) work. The JD-R model allowed the inclusion of job-specific aspects according to the context St Joseph's and its LCHWs. In addition, at the core of the JD-R model, lies the assumption that various job characteristics may influence the functioning of LCHWs (Bakker & Demerouti, 2007), which is an ideal way to obtain a better understanding of how they construct meaning of their work.

Job-demands: The participants in this study work in particular jobs at St Joseph's and, based on the demands of these jobs, one would expect them to have the required knowledge, skills and competencies to perform their duties. Those demands require them to have the relevant knowledge, skills and ability in order to cope in their very stressful situations on a daily basis as they deal with people who are dying or who are on the point

of dying, and with vulnerable children. These situations are likely to have a psychological impact on the carers. A large number of research studies in the job-demands-resources model have shown job stress and burnout and their psychological effect on employees in general, which is why it is so critical to understand the meaning that the participants in this study construct in their work situations. In this study the concept of 'meaning of work' has a somewhat more existential quality, as it describes the subjective sense that workers make of their work tasks (cf. Wrzesniewski, 2003). Based on the views of Pratt and Ashford (2003), individuals experience meaning at work when the work roles and work context are considered purposeful and significant, thereby affirming central aspects of individual identity. These authors describe meaningfulness as an "on-going, day-by-day, constantly unfolding phenomenon, not an end-state that is once-and-for-all resolved" (p. 313). According to Wrzesniewski (2003), meaningful work fulfils individual needs for purpose, values, efficacy, and self-worth, and hence the experience of meaning at work also contributes to individual well-being. This view is also shared by Arnold, Turner, Barling, *et al*. (2007). Hence, following the Job Demands Resources Model (JD-R model) developed by Arnold Bakker and Evangelia Demerouti in 2006, it can be expected that a positive psychological work environment in, for example, a balance between job demands and job resources, would be associated with experiences of positive work-related affect. Furthermore, high levels of positive affective organisational commitment and experiences of meaning at work can thus be understood as concurrent experiences of work-related positive affect that, in turn, will have a bearing on the quality of the working life of LCHWs (Arnold *et al*, 2007). In following their model, it is to be expected that experiences of positive affect in the workplace will be associated with the overall well-being of individual LCHW in this study. The development of this model served as an alternative to existing models of employee well-being according to these researchers. It is their view that other models addressed only a limited number of variables, and did not apply to all people or job industries. Bakker and Demerouti's model include a wide range of demands and resources/job positives that could fit any occupation and industry.

In the following section, I briefly discuss community and adult education from a job-demands perspective as it forms part of the theoretical framework of this research.

Community and adult education play an important role in the LCHWs' (participants') search for constructing meaning of their work. Firstly, St Joseph's is a community organisation, situated in a community, and provides holistic palliative care to various communities. Secondly, the LCHWs responsible for providing the palliative care services are all adult workers. I therefore found it essential to bring in the community and adult education perspectives, because they had bearing on the participants in relation to the research questions.

Community education: In this study, I regard community and adult education as an important aspect that requires on-going attention by organisations, because it can positively build the LCHWs competencies. According to Bratton (2001), the defining feature of a successful organisation has become the ability of the organisation to change and continually reinvent itself. Therefore, for organisations such as St Joseph's to remain successful, they must invent and maintain processes, through continual review, evaluation and change, and the ability to learn faster than their competitors. Searle (2001) states that flexible workers, structures, pay, and learning are assumed to ensure organisational competiveness. Participants at St Joseph's are within that category of workers that is assumed to take personal responsibility for adapting to the organisation's changing needs through the enhancement of needed skills (Searle, 2001). Thus, this change in the way organisations structure themselves has led to changes in the characteristics of employees within these organisations. However, Farrell (2000) identifies two forms of employees: the traditional employee who works under a manager, and the professional, independent human being who demonstrates discipline, a characteristic style of thinking, the right temperament, self-motivation, sincerity, enthusiasm, and tenacity. For this reason, education is viewed as a critical, necessary element for this new employee. Falk and Millar (2002) suggest the idea of the portfolio employee, and describe this type of employee as one who has a multitude (portfolio) of skills which are transferable over a multitude of workplaces and contexts within workplaces (Falk & Miller, 2002). In addition, Hamilton and Barton (2000) point out that a consequence of transferable skills is a heightened need for multiple literacies and numeracies. Thus, the skills and abilities that are theorised as making up human resources, according to the standard definition, as the "knowledge, skills,

competencies, and attributes embodied in individuals that facilitate the creation of personal, social and economic well-being" (OECD, 2001, p.18) can only be brought into being for the benefit of the collective, through social means (Balatti & Falk, 2002). Belatti and Falk (2002) argue that learning in a society is accessed through social wealth. Social interactions draw on the identity and knowledge resources of the people involved, and at the same time, build these resources (Balatti, et al, 2004). Hence, knowledge resources are derived where "the interactions draw on the resource of common understandings related to knowledge of community, personal, individual and collective information which is drawn from sources internal and external to the community" (Falk & Kilpatrick, 2000, p.99).

Community education is characterised by the integrated involvement of people of all ages, use of community learning resources, and research to bring about community change and recognition that people can learn through, with and from each other to create a better world (Akande, 2007). This author further indicates that community education aims to facilitate collective problem-solving by community members by equipping them with the knowledge to facilitate, and through promoting citizen participation and shared decision-making (Akande, 2007). In the case of St Joseph's and the participants, the mode of delivery of community education varied according to the target audience and level of need within the communities they serve. Tomison (2000) indicates that, at the local community level, information packages, resource centres and community development programmes are common and, at the individual level, education is often delivered through training programmes targeted at adults with particular professional or social roles, for example, parents, teachers or mandated notifiers. Community education is a form of non-formal education, where for example, educational activities for the participants at St Joseph's are carried on outside the framework of the formal school system to provide selected types of learning to particular sub-groups in the community at large. Anyanwa (2002), corroborated by Ezimah (2004), is of the view that the non-formal nature of operational strategies can be a determining factor in the objectives of community education.

Adult education: Green, Preston, and Sabates (2003) give an overview of the place of adult education in social movements over the centuries. Simon (1969, cited in Green, Preston, &

Sabates, 2003) states that while, in the 19th century, dominant groups viewed education as a force for social order, the subordinate groups looked to education as a means of critical awareness, raising consciousness, and forging solidarity among progressive groups. At present, Green, Preston, and Sabates (2003) view the dominant policy discourse as about community renewal and social inclusion via the labour market as opposed to social cohesion and social solidarity. These authors claim that there has been a shift from the view of the macro-collective perspective to that of the role of education in shaping social outcomes through the individual (Green, Preston, & Sabates, 2003). Based on the view that investment in education and training has benefits both for individual and for the society and/or workplace through the combination of human and social capital, the knowledge economy era has harnessed the concept of the learning organisation. Edwards and Usher (2001) mention that, in the knowledge economy discourse, organisations are required to become flexible in terms of managing their knowledge, which must continually change to keep up with or keep ahead of competitors. According to Gorard (2003), lifelong learning through the establishment of a learning organisation is the means by which this competitiveness can be achieved, and it is largely seen as an economic imperative.

Apart from government participation in organising and financing adult education programmes in developing countries, non-governmental organisations have contributed immensely to furthering adult education in Africa (Barode, 2011). There are numerous national community organisations which serve the interest of each country in eradicating illiteracy and furthering the course of learning and research in adult education. Being close to the grassroots and flexible in their approaches allows community organisations to propose tailor-made education systems that are not only a reality, but serious and valid. Barode (2011) further asserts that community organisations have succeeded in bringing into the education movement significant groups of learners around the world who are excluded from education or stay away from the formal system because it does not correspond to their learning needs and expectations.

The roles of community organisations and those of LCHWs in an HIV/AIDS palliative care setting, and the theoretical framework which includes the JD-R model and community

and adult education, are core concepts underpinning this research as illustrated in Figure 1.1.

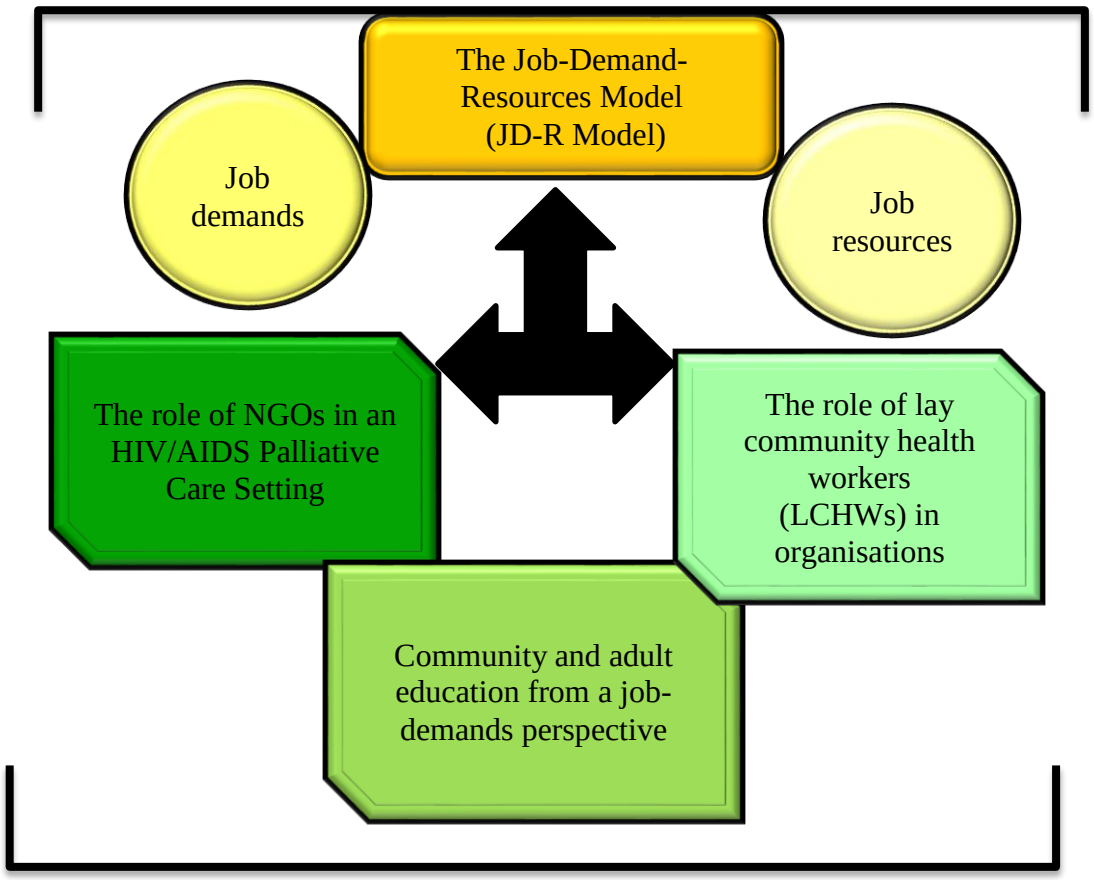

Figure 1.1: Core concepts underpinning this research

In the next section I explain the research methodology I followed.

1.5 RESEARCH METHODOLOGY

I found it appropriate to use a qualitative phenomenological approach, because it is a creative way of studying the world of the participants in the study (Edwards, 2001). The aim of using this approach was to obtain a sound understanding of the participants' description, perspectives, interpretation of and meaning about their work in their roles as carers (Leedy & Ormrod, 2001; Willis, 2001 & Giorgi, 2008). What makes this approach so suitable for this investigation, is that the perceptions and experiences of the participants

are socially constructed (Goulding, 2004; Aspers, 2004). Therefore, by remaining in this constructivist realm, the aim was to understand the perceptions that LCHWs have about their work (Lather, 2006), simply because they constructed the reality in their minds as individuals, and they described it according to their own understanding and experiences. Further, the phenomenological approach steered this investigation into focusing on the first-hand experiences described by the participants about their work roles (Denscombe, 2004).

In an attempt to become familiar with, and to understand the context of the participants, the use of an intrinsic case was deemed appropriate for this investigation. As a single case, it created a platform to gain an understanding of the particulars of the participants and the organisation where they worked as a bounded system, rather than what it represents (Stake, 1995). Through the application of the qualitative case study method, I was able to develop a relationship with the participants. The continuous interaction between the participants facilitated a transactional method of inquiry, creating a climate in which I could develop personal interaction with the case. Despite the relations developed through interaction, I endeavoured to bracket any personal past knowledge and any other theoretical knowledge that might prejudice the investigation of this research (Giorgi, 2003).

The qualitative approach enabled me to explore the participants and the organisation where they were working in their real-life, contemporary setting as a single case (Creswell, 2013b). This exploration happened over a period of eight months, through detailed, in-depth data collection, which included different sources of information. As indicated by Denzin and Lincoln (2011a, p.5), the qualitative research approach is an ‘inherent multi-method’. In this study, then, different qualitative data collection methods were used specifically for social relations, aimed at describing, making sense of, interpreting or reconstructing the relations in terms of the values that the participants in this investigation attached to them. The nature of this qualitative research methodology as indicated by Aveyard and Neale (2009), mandated the application of an inductive form of reasoning to develop concepts, insights, understanding from the patterns in the data, through descriptions and behaviours after the collection process. By applying this form of

methodology, I focused on identifying patterns, categories, themes and sub-themes that emerged from the data (Grinnell & Unrau, 2008). Throughout the data collection process, I collected and captured data based purely on the experiences of the participants, and continuously strove not to lose the rich descriptions of their experiences. I made concerted efforts to retain the essence of the expressions of the participants (Greeff, 2005).

1.5.1 Selection of participants

The participants in this study are the lay community health workers at the organisation who are responsible for the supply and delivery of the essential palliative care as mentioned above. The staff complement consist mainly of people with limited resources; in total they number 46, a total of nine men and 37 women, between the ages of 12 and 65 (it including orphans and vulnerable children). A prediction suggests that by 2015, there will possibly be about 3 million children who would have lost one or both parents (UNAIDS, 2002). All participants were identified by the organisation, and from the different projects within the organisation. These participants were selected because they were in a position to provide rich data to answer the research questions, through their direct connection and familiarity with the organisation as lay community health workers (McBurney, 2001).

1.5.2 Data collection

Prior to the inception of the study, me and the management of St Joseph's engaged in two meetings to discuss the processes and procedure to follow with data collection and to minimise interruptions to staff members' daily duties. At the outset, I identified possible problems and concepts which I discussed with the participants as a form of showing commitment to collaboration in knowledge generation, as indicated by Nieuwenhuys (2005), and also as a way for them to reflect on their experiences. I discussed the different data collection methods with the participants in order to find the most suitable methods that complemented the work meaning in their roles as carers. The data collection methods in this study consisted of individual interviews, focus group discussions, and documentary explication. These are discussed in greater detail in Chapter Three.

Interviews consisted of open-ended questions about the understanding LCHWs have of their work, their perceptions of their work roles, and also the perspective from the organisations about their work, well-being, training and development in their roles as carers.

I conducted 25 in-depth individual interviews. In Chapter Three the profiles of the participants who were interviewed are provided. According to McMillan and Schumacher (2001, p.42), an "in-depth interview merely extends and formalises conversation and is often characterised as a conversation with a goal". In the individual in-depth interviews, I was able to focus on each participant, in the hope that the in-depth setting would create an environment in which to address their complex experiences, and at the same time, provide an opportunity to investigate their individual perspectives regarding their lack of knowledge and skills in relation to their work in the community.

In addition, I conducted two focus group discussions to create further a friendly environment that encouraged the free flow of ideas from the participants. The focus group members included volunteers, project leaders and home-based care workers from St Joseph's various projects. Focus group interviews were conducted until data saturation was achieved. Through the focus group interview discussions, I explored and to gained insight into the views and experiences of the participants, and created a comfortable and welcoming environment for the participants to feel at ease and be free to participate in the group discussions (Litoselliti, 2003).

1.5.3 Documentation

I reviewed the documentation made available by the organisation with the intention of employing relevant content, relating to the main research. According to Yin (2003, p.87), "for case studies, the most important use of documents is to corroborate and augment evidence from other sources". In this study, I used the documents that were provided by St Joseph's Care and Support Trust and included their Annual Reports from 2008–2013, the

Executive Summary, and Training Plan. These documents are discussed in detail in Chapter Four.

1.5.4 Explication of data

Explication of data process focussed on the detailed descriptions provided by the participants from the 25 individual interviews, followed by the two focus group interviews. The collected data were reduced into themes through a process of coding and condensing codes; all data were presented in the form of figures, tables and discussions (Creswell, 2007). Documentation included the existing training plan (which provided details of the participants' training programme), executive summary (which emphasised the training and development endeavours the organisation incorporated into its mission and vision statements), and the annual reports from 2008–2013 (discussions and reports on participants' employment, training and development programmes and achievements).

The verbatim accounts emerging from the individual, focus group interviews and document explication assisted me in categorising data according to the identified main themes. Repetition of categories and themes was conducted which cautioned me against possible bias and, at the same time, supported the strength of the occurring patterns (Grinnell & Unrau, 2005). I followed a continuous process of identifying relevantly explicit themes through elimination of redundant data: explicit themes were sorted according to appropriately constructed categories (Ginnell & Unrau, 2005). The final explication process focussed on a comparison of the different themes and the identification of variations and connectedness between them. I linked the interpretation to the descriptions given by the participants during the individual and focus group interview sessions, including documentation to develop an understanding of the work meaning constructions by lay community health workers in a HIV/AIDS palliative care setting.

1.5.5 Trustworthiness

This study was framed within a constructivist paradigm, which automatically structured my line of thinking in terms of the trustworthiness. I was interested in the lived experiences of the LCHWs and followed Streubert-Speziale's (2007) view which specifies that "the goal of rigor in qualitative research is to accurately represent study participants' experiences" (p. 49). I applied confirmability according to the understanding of Polit, Beck and Hungler (2006) and used the documentation as a paper trail to support my decisions, thinking and methods applied in this study (Streubert-Speziale, 2007). In order to enhance the credibility of this study, I employed the suggestions of Polit, Beck and Hungler (2006) and Streubert-Speziale (2007) of using multiple sources of data and methods, which I discussed mutually with the participants in order to arrive at the findings (triangulation). Member checking was conducted and I also discussed, clarified, and confirmed the findings with the participants to ensure that their voices were heard. Peer examination, through colleagues, an independent coder, and my supervisor, of the initial findings and the inferred categories was conducted to support the credibility of this research study. The trustworthiness is discussed in further detail in Chapter Three.

1.6 ETHICAL CONSIDERATIONS

I adhered to the ethics as prescribed by the Ethics Committee in the University's Faculty of Education, in order to confirm the validity and authenticity of the study. Participation was voluntary and written consent from each participant was obtained before the interviewing process. All the participants were notified during the initial briefing session that the interviews would be audio-recorded, and no objections were received from them. I assured participants that the information they shared would remain confidential and that they had the freedom to withdraw from the study at any time they wished without incurring any penalties. During the briefing session at St Joseph's, the participants were informed that the results would be published as part of the research (McLeod, 1999).

In order to protect the confidentiality of the information obtained from the participants, the audio-recordings, transcriptions and other data were kept in a secure environment and as part of ensuring that the ethical issues were addressed, I only engaged with LCHWs after the identification of the themes from the raw data, to ensure that the findings revealed exactly what the participants said and not merely my interpretation (Oliver, 2003; Cohen, Manion & Morrison, 2001; Hayes, 2000). Chapter Three presents a fuller discussion of the ethical guidelines adhered to in this study.

1.7 CONCEPT CLARIFICATION

I provides operational definitions of terms and core concepts used. Based on the context of this study, the following relevant concepts are clarified, in alphabetical order:

An **adult** is described as a "grown-up person" according to the *Collins Webster's Dictionary* (2007, p.7). Merriam and Brocket (2007), on the other hand, define adulthood as a stage of life. In the South African context, in terms of the law, adulthood is defined by a person's age, which is 18 years and over. Bjorklund and Bee (2008) describe the adult stage as "emerging adulthood (when adolescence is ending) to the end of life" (2008, p.4). In this study, the **LCHW**s were adults who assumed responsibility of certain social, psychological and, to an extent, economic positions as required from them as adults, based on their different cultures and their communities. The above-mentioned roles are also referred to by Bjorklund and Bee (2008) as dimensions that affect learning; they also state that "age was just a number" (p.13), and that adulthood includes the following dimensions that affect learning:

- Chronological age represents the literal number of years that an adult has lived;
- Biological or functional age refers to the physical condition of adult learners;
- Psychological age refers to the adult learners' developmental maturity, and;
- Social age refers to the adult learners' perception of their roles and expectations at any given point in their lives (Bjorklund and Bee, 2008, p.13)

Taking into consideration the above dimensions, I am mindful that the different measures of age of the LCHWs of St Joseph's might also have impacted on their individual desires, need for, and ability to pursue any learning offered.

According to Taylor, Marienau, and Fiddler (2000, p.4), **adult learners** participate in many types of formal and informal education activities that they hope will help them function effectively in the changing world around them, and sometimes, as indicated by Mott (2000), adult learners' focus is specifically aimed at reaching self-actualisation to add value to their personal and recreational lives. In this study, training and career guidance development of the LCHWs was considered in terms of building an accurate understanding of their learning differences to construct meaning in their work, based upon their diverse backgrounds and cultural differences. These adults have many other responsibilities or life tasks; adults have the ability to work and learn, and simultaneously, are in a position to make an economic contribution (Crawford, 2004). One can reason from the above explanation that the adult learners (participants) in this study were simultaneously learners and workers. Not all their time was devoted to schooling or educational events, but there were other roles in their society that they needed to perform, such as members of staff, volunteer worker (employee), parent, foster parent, grandparent, community leader and member of the wider community of Bronkhorstspruit, as well as family member.

Career is viewed as a mobility path within a single organisation, a pattern of work-related experiences that spans the course of a person's life (Greenhaus, Callanan & Godshalk, 2000).

In the context of this study, **career adaptability** refers to the readiness to cope with predictable and unpredictable adjustments prompted by changes in work and working conditions, and is applicable to all stages of the individual's life-span (Savickas, 2009).

Career guidance is the systematic process by which an individual discovers and explores personal characteristics in order to make a career-related decision (Maree & Ebersöhn, 2002). This findings of this study were envisaged as part of the process through which

possible recommendations might provide guidelines to LCHW workers to plan and make decisions about their work and learning.

Career path refers to the growth of the employee in an organisation that provides them with a type of career service for career progression and possible future job opportunities as he or she grows and develops within the organisation (Bohlander, Snell & Sherman, 2001). In this study, the term 'career path' is seen as a line of advancement or sequence of jobs in an occupational field within St Joseph's that a LCHW worker could follow in order to achieve his or her personal and career goals. Career paths could aid the LCHWs in developing their personal career strategies and construct meaning of their work. In many organisations, career paths are being designed for employees by acquainting them with the possibilities for job rotation and/or job movement, along with job descriptions. The latter is confirmed by Bohlander *et al.* (2001, p.279) in their statement that "promotion is an assignment to a higher job level within organisations".

Strong and Vorwerk, (2001, p.4) define **coaching** as "a way of ensuring that learning reaches the workplace and translates into a benefit of the organisation". In the context of this study and in the training and development process, coaching is viewed as a form of training to develop the ability and experiences of LCHWs of St Joseph's by giving them systematically planned and progressively more stretching tasks to perform, combined with continuous assessment and support.

In this study, the term **community** refers to St Joseph's Care and Support Trust. A community is a group of people living in a particular local area, having ethnic, cultural or religious characteristics in common (Bartle, 2010).

Community health worker: In this study a community health worker is regarded as any individual person who carries out functions related to health-care delivery; provides psycho-social support; is trained in specific ways in the context of the intervention; and has no formal professional or paraprofessional certificated or degreed tertiary education (Lewin, *et al.,* 2005).

Formal and informal learning is defined by Cedefop (2009) in the following summary:

Formal learning occurs in an organised and structured environment, for instance at work, training centres, or educational institutions, and is explicitly designed in terms of objectives, time and resources. It is an intentional act stemming from the learner's perspective, which may lead to an accredited and recognised qualification.

Informal learning is embedded in planned activities which are not always explicitly designed as learning in terms of objectives, learning time and learning support. It is mostly an unintentional event, from the learner's point of view. In the context of this study, informal learning indicates that learning is the result of LCHWs' daily activities related to their work, family or leisure. It was not seen as organised or structured in terms of objectives, time or learning support, and was mostly unintentional.

In the context of this study, **lay community health workers** are the participants who perform functions related to health-care delivery, are trained in some way in the context of HIV/AIDS intervention, but who have no formal professional or paraprofessional certificate or tertiary education degree (Lewin, 2005).

Learning is defined as "the process whereby individuals acquire knowledge, skills and attitudes through experience, reflection, study or instruction" (Pinnington & Edwards, 2000, p.185).

A **mentor** is most commonly seen as an experienced, wise person who has the trust of a protégé, and who guides the protégé through an extended period of learning (Strong & Vorwerk, 2001 p.9). In the context of this study, mentoring served the same purpose.

Susan Ayers (2011) defines **on-the-job training** as occurring while a person is actually working at a business or workplace. This type of training can be facilitated by a manager, a supervisor or even by another employee who knows the job well enough to teach it. On-

the-job training is viewed as cost-effective and helps the employee learn the specific business.

"**Retention** is the action of keeping something rather than losing it or stopping it" (*Oxford Advanced Learner's Dictionary*, 2010, p.1262). In the context of this study, it refers explicitly to the retention of the LCHWs.

"**Service** is a system that provides the public needs, organised by the government or by a private company" (*Oxford Advanced Lerner's Dictionary*, 2010, p. 1349). The role of *service* as it applies to this study is described by Best (2011, p.7) as: "There is simultaneously a growing demand to take a more holistic (systematic) approach to how commercial businesses and non-commercial organisations operate, and to ensure greater accountability and governance in terms of their cultural, environmental, political and social impact". The service that participants in this study render is palliative care and psycho-social support to the patients, orphans and vulnerable children at St Josephs.

"**Succession planning** is the process of training and preparing employees in a company or an organisation so that there will always be someone to replace, for example, a senior manager who leaves" (*Oxford Advanced Learner's Dictionary*, 2010, p. 1491). In the context of this study, the purpose of succession planning is to ensure continuity of the organisation's performance and its sustainability. It is carried out to ensure that, should key employees leave, the organisation could continue to fulfil its goals and carry out day-to-day operations with minimal disruption, and it could help to facilitate a smooth leadership transition.

As defined in the *Oxford Advanced Learner's Dictionary* (2010, p.1586), "**training** is the process of learning the skills that you need to do a job" which suggests that training is directed towards agreed standards or objectives. These are sometimes called 'learning outcomes': what people are expected to learn from training. Training usually involves participation, an indication that a person being trained has an active role in the training process, rather than a passive role. Training is further described as a process organised to

transform attitudes, knowledge or skills behaviour through learning experience to attain good performance in an activity or range of activities. In the context of this study the term 'training' refers to the training needed by or provided to LCHWs at St Joseph's to perform their duties more effectively, so increasing personal growth that could lead to job satisfaction.

In this study, the terms **workers**, **LCHWs, employees** and **participants** were used frequently and interchangeably, as generally used and understood by the participants.

1.8 OUTLINE OF REASEARCH STUDY

The chapters in this research study have been organised in the following manner:

Chapter One: Orientation of the study

The first chapter serves as the blueprint of this thesis, and provides the background, purpose, research problem and aims of the study. It also introduces the research design and methodology, and explains the theoretical placement of this study. The trustworthiness, as well as the ethical considerations, are also highlighted. This is followed by the concept clarification, an outline of the entire study, and a summary of Chapter One.

Chapter Two: Literature review

Chapter Two focuses on relevant international and national literature consulted, in reference to the roles that community organisations and lay community health workers (LCHWs) play in palliative care, as well as the support provided to orphans and vulnerable children affected and infected with HIV/AIDS; also to ascertain how these community organisations function on a daily basis. A job-demands theoretical perspective is used to understand community and adult education within the context of this study.

Chapter Three: Research design and methodology

In Chapter Three, a detailed explanation of the research design and methodology of the qualitative phenomenological approach is provided, together with a description of the methodological process of data collection (sampling and bracketing), and explication and interpretation thereof. An in-depth discussion on the trustworthiness, triangulation and ethical considerations of the study is presented.

Chapter Four: Presentation of findings

This chapter presents the findings, explication and discussion of the findings. The findings are presented according to the main themes and sub-themes that emerged during the data explication process.

Chapter Five:Discussion of the findings

Research findings are discussed and compared to existing and new literature as presented in Chapter Two with the intention of connecting them to the current theoretical framework, designs and paradigms as part of reaching conclusions regarding the participants' constructed meaning of their roles as carers.

Chapter Six: Work resourcing needs framework

Based on the findings, this chapter suggests a framework for St Joseph's to use as a guiding tool in addressing their work challenges.

Chapter Seven: Contributions, limitations and suggestions

The research study concludes with Chapter Seven which includes the contributions, limitations and suggestions, based on the findings and the literature review.

1.9 SUMMARY OF CHAPTER

Chapter one provided an overview of the research study, contextualising the need for this specific research to contribute to the community health knowledge base, more specifically to lay community health workers in South Africa from marginalised groups. In the next chapter, specific, relevant, related international and national literature consulted about the roles of community organisations and LCHWs in organisations, community and adult education in terms of the job demands is discussed in detail.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter I focus on the LCHWs and the services that they provide, and the organisations where they work, and consider the sustainability of those organisations. Since I have focused on adults, I look at community and adult education, because it relates to the participants. For this chapter I consulted literature that would support and enhance an understanding of the construction of work meaning for LCHWs in community organisations. Firstly, I consulted literature about general perspectives of work meaning constructions of LCHWs in their various roles worldwide, followed by the essence of palliative care nationwide, and finally, the sustainability of community organisations. Thereafter, my focus moves to literature on the JD-R model to review the theoretical perspectives about job demands and job resources in terms of palliative care. Reference is also made to personal resources, work meaning, positive meaning at work through job crafting, work engagement job hindrances and challenges, motivation and organisational involvement. Literature about community and adult education perspectives was reviewed to add more value to the theoretical perspective. Within each sub-section, the contextual effects were discussed as a unit, then linked specifically to the LCHWs and St Joseph's. Finally, I focus on aspects of the JD-R model, community and adult education perspectives within the theoretical framework as a critical view of the job demands, job resources, community and adult education that underpins the construction of work meaning of LCHWs in community organisations.

2.2 General perspectives of work meaning constructions of LCHWs in their various roles, worldwide

Internationally, lay community health workers are a well-known phenomenon, the only difference being in their titles, which may differ from country to country. However, based on the literature, their job functions are interrelated. Internationally, LCHWs are recognised for the critical role they play in community organisations as service providers,

according to the following authors: Kipp, Kabagambe and Konde-Lule (2002) indicate that lay community health workers are widely used as lay counsellors. Similarly, the Health Resources and Services Administration (HRSA) Community Health Workers National Workforce study, (2007), states that LCHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counselling and guidance on health behaviours, advocate for individual and community health needs, and provide some direct services, such as first aid and blood pressure screening. In this study, the LCHWs also provide informal counselling, guidance, translation and interpretation on health behaviours in the communities they serve, as well as psycho-social support to orphans and vulnerable children in Bronkhorstspruit. Andrews, Weyers, and Heath (2004), who explore the roles and effectiveness of community health workers in research with ethnic minority women in the United States of America, found that, despite varying roles and functions, evidence indicates that community health workers are effective in increasing access to health services, increasing knowledge, and promoting behavioural change among ethnic minority women. These authors suggest that other advantages of using community health workers are to provide social support and culturally competent cost-effective care. According to Serpell (2011, p.200):

> …the promotion of health is universally endorsed across nations as a priority goal of progressive social change. The dramatic advances achieved by bio-medical science over the past two centuries have generated a powerful body of knowledge for the treatment and prevention of many diseases that cause widespread suffering in Africa. The primary health-care declaration of the World Health Organisation (WHO) (2000) emphasises that much of that knowledge can be effectively applied by laypersons rather than relying on specialised services from technically trained professionals.

The umbrella term ‘Community Health Worker’ (CHW) embraces a variety of community health aides who are selected, trained and work in the communities from which they come. Community health workers include the most generic type of community-based workers,

including groups such as village health workers (VHWs), community resources persons (CRPs) or home-based carers (HBC), lay community health workers, (LCHWs), lay health workers, carers and volunteers, to name but a few. These types of community health workers carry out one or more functions related to health-care delivery, are trained in some way in the context of the intervention, but usually have no formal professional or paraprofessional certificated or degreed tertiary education, and can be involved in either paid or voluntary care. Chen (2004) and Filippi (2006) say that this team of health workers may be able to play an important role in achieving the Millennium Development Goals for Health. However, in a meta-study conducted by Lewin, Dick, Zwarenstein, Aja, van Wyk and Bosch-Capblanch (2005) on lay health workers in the United States and around the world, the authors report that the best practices for community health recruitment and training, and delegating tasks to them remain unclear due to insufficient research. Literature also highlights variations in training and preparation, roles and responsibilities, and controversy associated with using lay community health workers. A study conducted to describe the profile of LCHWs in Peru reported that the majority were men with limited education who worked voluntarily. They were young high school graduates, but there was a high drop-out rate among them; in contrast, traditional healers and birth attendants were older and not prone to drop out. At community level, the health promoters were the most visible LCHWs as Brown, Malca, Zumaran and Miranda (2006) indicate. This observation was confirmed in a study conducted by Lehmann and Sanders (2007) who reported that the majority of health promoters in Peru are male and that they skew the gender equality in community leadership positions. From this, one can infer that lay community health workers work in other occupations, across various sectors, but LCHWs feature only in the health sector.

Conferences like Alma Ata (1978), Ottawa (1986) and Jakarta (1996) declared the importance of community participation to improve health conditions, as Minkler and Wallerstein (2003) explain. Van Ginneken, Levin and Berridge (2010) report that the more technical focus of current lay community health worker programmes under-utilises available human resources in South Africa, which previously had a much wider social and health impact. Since the Alma-Ata Conference in 1978 restated the goal of health for all

by the year of 2000, health service delivery programmes promoting the primary health-care approach using LCHWs have been established in many developing countries. These programmes should improve the cost-effectiveness of health-care systems by reaching large numbers of previously underserved people with high-impact basic services at low cost (Walker & Jan, 2005). Reaching out into homes and the community to promote healing and wellness as an integral part of health practice, is regarded as ancient health-care practice, according to Treadwell (2003). Although there is wide variation in the types of CHWs and the forms taken by their programmes, these international experiences give rise to a set of core debates on the role of CHWs in health systems, and highlight common problems associated with their management. In the United States of America (USA), community health workers were used in the Community Health Intervention Program (CHIP) in Virginia to enhance the quality of care for children, and to ensure contact and referral of sick children, which can be an ongoing process (Cash, 2004). A systematic review was conducted to categorise and describe intervention models, involving CHWs, which aimed to improve case management of sick children at household and community levels (Winch, Gilroy, Wolfheim, *et al.,* 2005). These authors identify seven intervention models and classify them according to the roles of the CHWs and families in assessment and treatment of children, a system of referral to the nearest health facility, and location in the community of drug stock. Winch, *et al.* (2005) suggest that choices are made about what responsibilities were realistic to assign to CHWs.

The findings of a CHW programme conducted in Iran report that trust-based relationships with rural communities, selfless motivation to serve rural people, and sound health knowledge and skills are the most important factors in facilitating successful implementation of a CHW programme (Javanparast, Baum, Labonte & Sanders, 2011). Dick, Clark, van Zyl, *et al.* (2007, p. 388) reported increased personal self-confidence with LCHWs as they gained expertise in the health field. They commented on the LCHW as a ‘role model’ in the community. In Mumbai, a study was conducted in the urban slum areas with female peer facilitators in a community-based maternal and new-born health intervention clinic, about their role perceptions and experiences regarding the birth and wellbeing of babies. These LCHWs were called ‘sakhis’ and the ‘sakhis’ shared knowledge

and experiences of pregnancy, childbirth and care-seeking behaviour with their peers. They visited homes, offered advice, and accompanied women to health facilities. They were required to provide information and were seen as a source of knowledge. These tasks brought positive changes in self-esteem and their confidence increased (Alcock, More, Patel, *et al.,* 2009). Similarly, a study conducted in the United Kingdom, found that community advisers are used as part of a Community Education Training Programme that provides smoking cessation support. These community advisors are available to encourage, motivate and counsel the group of smokers on a regular basis. Kai and Drinkwater (2004) are of the opinion that the advantages of community advisors is to empower members of the communities in transferable skills of group work, and thus build the community resources. In yet another case, according to Saad-Harfouche, Jandorf, Gage, *et al.* (2011), LCHWs are currently used as community advisors to promote community health education programmes and are trained beforehand in the knowledge on breast and cervical cancer. Han, Lee, Kim and Kim (2009) support this study with their results from a study they conducted about LCHW intervention that increased awareness on the prevention of breast cancer in non-adherent treatment by Korean women. Partnership between a hospital and community-based organisation with 'promotoras' appeared to be effective in providing chronic-disease self-management education in an urban community in Korea (Deitrick, Paxton, Rivera, *et al.,* 2010).

Another study conducted in Costa Rica and India, using rural health workers for specific interventions on the nutritional status of pregnant and lactating women (Taylor & Jinabhai, 2001), found that LCHWs engaged in community nutrition activities are promoted as a cost-effective human resource for reaching underserved groups. Alamo, Wabwire-Mangen, Kenneth, Sunday, Laga and Colebunders (2012) indicate that staff and volunteer workers provide enabling health-care services to help families and caregivers navigate a fragmented health-care system and create a connection between the medical system and the wider contexts of community members. The United States Agency for International Development (USAID) (2012) states that, based on international experience, community health workers should have definite responsibilities: be receptive to the needs of communities and be well-supported by the other health services and any non-governmental

organisations (NGOs) working with them. As indicated by Kipp, Kabagambe and Konde-Lule (2002), community health workers are widely used as lay counsellors. As mentioned above, LCHWs offer a wide variety of services, among them interpreting, translating, providing culturally appropriate health education and information, assisting with the care they need, giving informal counselling and guidance on health, advocating for individual and community health needs, and providing direct services, such as first aid and blood pressure screening. (Health Resources and Services Administration (HRSA) Community Health Workers National Workforce study, 2007).

Nationally, there is no literature on lay community workers in education, most of the literature deals with lay community health workers in the health sector. Taking into account that the LCHWs in this study work in the health sector and face skill-resourcing needs which are directly related to adult education and workplace learning, I found it appropriate to focus on literature of work meaning construction in this sector in the absence of information on lay community workers in the education sector. However, literature of other sectors that are searching for meaning and recognition in the workplace, which I found to be close to work meaning construction in the context of this study, is briefly discussed in the next sections.

One of the foci of the Department of Social Development is developing community caregivers with the ability to address the needs of and care for orphaned and vulnerable children, and to bring together community caregivers in health and social development sectors by 2006, to approximately 62,445 (NDoH, 2006b). In 2002, the national government announced the year to encourage, strengthen and promote community volunteers across all sectors. The idea of having volunteers affects the discourse on community caregivers in the health sector, but on the other hand, the presence of lay health workers, such as the participants in this study, also impacts discourse on community-ready models for placing volunteers in other related sectors. The National Department of Health (NDoH, 2006b), reported on a census conducted that nine social sector community worker categories were counted, namely: community development workers, community development practitioners, mid-level worker, community caregivers, community health

workers, child and youth care workers, youth workers, probation officers or community service officers, and early childhood development practitioners. The lay community health workers in this study are recognised by the names 'community health workers', 'community caregivers', 'child and youth care workers' and 'early childhood development practitioners'. Daniels, van Zyl, Clarke, *et al.* (2004) confirm this in saying that LCHWs serve a critical function in the communities in which they work, often providing a service to the most marginalised poor communities, where none might otherwise have been available. LCHWs perceive their roles as being experienced in their training and having the qualities and skills that they need, such as advocacy, interpersonal effectiveness, availability and willingness to help, relationships based on trust, and appropriate health care skills. van Ginneken, Levin and Berridge (2010) report that the more technical focus of current community health worker programmes under-utilises available human resources in South Africa, which previously had a much wider social and health impact. As stated by Cufino-Svitone, Garfield and Vasconcelos (2000), these lay health workers are also sometimes engaged in services regarding contraceptives, promoting cancer screening, encouraging water and sanitation improvement, screening and follow-up treatment for locally endemic diseases, screening and follow-up for chronic diseases, and death and birth notification.

A report from the Regional Development Profile Cape Winelands District (2011), shows that a total of 525 community health workers are deployed in the district, and that the staff is overworked and cannot meet the service demands. Community-based service is provided by non-profit and non-governmental organisations and only some are subsidised by provincial government. As a result of the burden of disease and the socio-economic circumstances of patients in rural areas, the formal health care service needs to be expanded to make use of LCHWs to provide care to the community members that cannot be reached by nurses. Another study conducted in the province of KwaZulu Natal makes it clear that LCHWs are responsible for improving and educating the community members on nutritional aspects (Taylor & Jinabhai, 2001). They promote the use of locally available food, encourage the development of food gardens, and emphasise the benefits of improved sanitation and hygiene to prevent disease. Researchers found that using community health

workers in promoting development in the community was in keeping with the tradition of rural communities working together and supporting each other (Taylor & Jinabhai, 2001). In the same study, the authors also found that community workers were mostly women who lived in areas where they understood the local concerns and constraints of that area (Taylor & Jinabhai, 2001). LCHWs continue to focus on their role in community development and on bridging the gap between the community and formal health services (Lehmann & Sanders, 2007). According to "The guide for community health workers" a *nomphilo* is the word used for a "women of love, health and care" which is what the community health workers are called in KwaZulu Natal. Their training was based on this guide and included needs assessments and referral; informing people about health problems; developing health education, and special events for projects like AIDS; starting vegetable gardens; visiting and caring the sick, old, and disabled; empowering individuals, families and communities by sharing knowledge and skills, information and resources (Clarke, Dick, Knight, *et al.,* 2003, p.11). As indicated by Herman (2011), as natural helpers, LCHWs play an important role in connecting public and primary care to the communities that they serve. The natural helper roles, which include trust, rapport, understanding and the ability to communicate with the community, take on an increased significance. Therefore, the LCHWs provide structured links between the community, the patient and the health-care system. Kennedy, Milton and Bundred (2008) were of the opinion that LCHWs improved the quality of health-care by educating health-care providers about the community health-care needs and enabling patients to foster self-efficacy. These programmes strengthen local economies by linking families to much-needed services and mobilising communities to seek resources to meet their health needs.

A study conducted by Barnard (2003) describes a home-based care intervention in Ingwavuma, established to address the problems faced by AIDS patients in rural areas. The carers were chosen by the community and received their training at a hospice, doing a month's practical at the local hospital. They were then placed in teams to work in their neighbourhoods. They travelled by bicycle or on foot to do home-care visits to AIDS patients. The author is of the opinion that the programme works well, but that the home-carers experience stress, because of all the orphans that they cannot give over to orphan

organisations. A study on specific interventions with LCHWs to address problems in caring for children found that primary health care for children in remote underserved communities, using LCHWs, is possible and feasible (Rennert & Koop, 2009). A home-based care intervention was initiated by the South African Hospice Association in response to the HIV/AIDS epidemic. A curriculum was developed to train community health workers in rural, peri-urban and urban areas to take part in home-based care projects for people living with AIDS. Training took 58 days and theory and practical was integrated to teach lay health workers to show commitment to render holistic care; show respect for the dignity and uniqueness of people living with HIV/AIDS; provide the relevant basic home nursing skills in order to alleviate pain and suffering; provide knowledge and caring skills in all diverse areas pertaining to HIV/AIDS, tuberculosis and sexually transmitted diseases; provide basic education and information to people living with AIDS and their families (Duma & Cameron, 2002). Ingram, Reinschmidt, Schachter, *et al.* (2012) state that community health workers work with clients, groups, other CHWs and community leaders to address health issues, for instance, chronic disease prevention and health care access. LCHWs were used in Swaziland for direct observation of a short treatment course called Directly Observed Treatment, Short-Courses (DOTS) in which community health workers and family members observed that patients with tuberculosis took their treatment daily. No significant differences in the cure and completion rates were found between DOTS by community health workers or DOTS by family members (Wright, Manigault & Black, 2004). In the Boland Western Cape, South Africa, a different outcome was observed. A cluster randomised control trial was carried out to evaluate the effects of LCHWs on tuberculosis control among permanent farm dwellers in an area with a high tuberculosis rate. The conclusion was that LCHWs were able to improve successful tuberculosis treatment rates among adults' new-smear positive tuberculosis patients in a well-established health service, despite the reduction of treatment series (Clark, *et al.,* 2005). Dick (2001) describes the same intervention of LCHWs on farms in the Boland areas. He indicates that the LCHWs also treat minor ailments and act as important links between employees, farm management and health services. It was found that the system was successful if LCHWs are supervised and supported. Furthermore, the programmes had a snowball effect in the sense that TB action committees were formed, capacity-building

events were held, recreational activities were carried out and health promotion activities for women, men and youth developed.

According to Sengwana and Puoane (2004), community health workers' role as key agents in improving health has been widely documented. Based on their understanding of the social environment, they are able to work closely with women to enhance active patient participation, thus helping to reduce the prevalence of hypertension and assist in the workload in primary health care facilities where it is essential that LCHWs have the correct knowledge of the disease and do not spread wrong beliefs. In order for the roles of LCHWs to be well grounded, it is important for those roles to be linked to the goals of the community programmes to which they are affiliated. According to Nemcek and Sabattier (2003), such goals consist of three interrelated goals for the use of LCHWs in the community, known as the 'therapeutic alliance': stronger relations between health-care professionals and lay persons in the community; improved appropriate health-care utilisation, which can cut costs with early access, prompt diagnoses and treatment, greater use of primary care providers and fewer urgent care units; and reduced health risks as a result of educating the community about prevention, early diagnosis and treatment. These goals are interdependent and, to achieve maximum effectiveness, it is important to incorporate them into the training the LCHWs, ensuring that the roles and organisational programme goals forms a unit.

In another study conducted in the Free State, South Africa, the community health workers were trained as single-purpose workers, such as lay counsellors, home-based carers of DOTS support. The results showed a shifting of tasks from professionals to community health workers; patients presenting with social problems; nurses who were positive about the community health worker's role as mediator between family and the community. This was an empowering role that served as a bridge between the patient/community and the health system (Schneider, Hlophe & van Rensburg, 2008). LCHWs provide the ideal bridge between the community and the health sector; however, experience in numerous countries has demonstrated that the top priority must be given to understanding and tackling the problems raised by attempting to achieve this bridging function in practice, a

function that is regarded as an extension of health services and an agent for educational and developmental change. Nemcek and Sabattier (2003) point out that the main need is to restore and resurrect socially and economically shattered community organisations so that they can make better use of available lay community health workers. The widespread difficulty in achieving the undoubted potential of this category of workers does not originate from medical or other technical problems, but from organisational and management issues. The positive and unique benefits of lay community health workers should be emphasised and they should not simply be used because there are not enough trained professionals. According to Nemcek and Sabattier (2003), the under-utilisation of lay community health workers exists because of the lack of understanding of the LCHW concept and a dearth of evaluation literature on LCHWs.

In South Africa, the Department of Health (DoH) relies on non-governmental and non-profit organisations (NGOs and NPOs) to deliver community-based services. These services provided by the NGOs and NPOs are financially supported by the state or international donors. As a result, NGOs and NPOs have gained expertise in administration and community health work. Overseeing community-based health initiatives is difficult work that requires continuous training, supervision, coaching and mentorship. In order for community health worker programmes to run effectively, it is important to draw on the skills and knowledge of NGOs and NPOs (Equal Treatment Magazine, 2011). Equal Treatment Magazine (2011) also documents that community health workers in South Africa can help shape a fairer, more affordable health system, but in order to do this, they need support and resources. Gow and Desmond (2002) indicate that the South African government manages the HIV/AIDS epidemic and other life-threatening illnesses as a community-based concern. For these reasons, various projects and programmes have been employed to care for the needs of people infected or affected by HIV/AIDS and other life-threatening illnesses. The focus of these initiatives is on toughening and sustaining the position of families, extended families and caregivers to nurture children; motivating, equipping and assisting community-based organisations; developing the ability of children and young people to sustain their own needs; making sure that government develops suitable policies, and securing social grants for orphans and vulnerable child. In addition,

it is important to foster an understanding of the importance of building an environment that supports communities infected with and affected by the HIV/AIDS epidemic (Smart, 2003a; Gow & Desmond, 2002; Mugabe, Stirling, & Whiteside, 2002). This brings us to the role of LCHWs, as discussed in the next section.

Studies found that, as part of overcoming the challenges imposed by the scale of the HIV/AIDS epidemic, community-based, decentralised HIV services have been used in many regions where health-care resources are limited (Schneider & Lehmann (2010). Eriksen, Mujinja, Warsame, et al, 2010 defines community-based care as care that "the consumer can access nearest to home, and which encourages participation by people, responds to the needs of people, encourages traditional community life, and creates responsibilities" The idea of using lay community health workers was integrated into primary healthcare reform in the 1970s, based on a study done by Izugbare, Ezeh and Fotso (2009). Furthermore, and according to Lees, Kielmann, Cataldo and Gitau-Mburu (2012), during the 1990s, community-based care programmes that addressed various aspects of the HIV/AIDS continuum of care, such as testing, counselling services, medical and social support were introduced in countries affected by the epidemic.

LCHWs serve as the main link between members of a community in South Africa and the health-care and social services systems in general. The core functions of their duties are based on the prevention of HIV/AIDS and other life-threatening diseases, and minimising the impact of existing diseases through providing holistic palliative care and psycho-social support; sharing information through adult learning; coordinating community education; taking in patients, orphans and vulnerable children, and providing orientation and outreach services. The group of LCHW studied in this research are indigenous to the communities in and around Bronkhorstspruit. Based on their ethnic, cultural, linguistic, socio-economic and experiential characteristics, they are in a position to bridge possible gaps in language, culture, economic position and education, thus placing them in a position to connect the diverse patients, orphans and vulnerable children affiliated to St Joseph's with the health care and psycho-social support they need (American Public Health Association (APHA), 2012).

It is evident from the literature consulted that we do not have work meaning constructions for LCHWs in the educational development areas of the health-care sector. Community organisations have not yet focused their attention on construction of work meaning for LCHWs, which is why it was important to conduct this research study.

2.3 The essence of palliative care nationwide

Nationwide palliative care is seen as an essential part of treatment, and such treatment, while not curative, prolongs life for considerable periods of time and restores quality of life (Harding, 2004). The objective of palliative care is to achieve the best possible quality of life for patients and their families. Brennan (2007) however, observed that global progress in developing palliative care across the world fluctuates. WHO (2014) defines palliative care as a medical speciality that addresses physical, psychological, social, legal and spiritual domains of care by an interdisciplinary team of professional and lay health care providers. Harding, Foley, and Connor, *et al.* (2012) report that most of the health workers have little or no knowledge of the functions or practices in palliative care, but that does not include LCHWs. The spectrum of LCHW programmes varies across countries in their objectives, rollout and management; their larger penetration and sustainability are more easily observed in the public sectors (Lewin, Dick, Pond, *et al* 2005). According to Willaert (2005), there is currently no national standard for community health workers or professional certification, and most of them receive on-the-job training tailored to the specific programme with which the LCHWs are hired to work. It has been suggested that a community's perception of community health workers' knowledge, skills and ability to assist communities with their health needs is crucial in inspiring respect and acceptance of their services (Jaskiewicz & Tulenko, 2012). In their roles as facilitators, community health workers require a diverse range of skills which includes communication skills, as part of facilitation includes communicating with the patients, OVC. By implication, it is expected that community health workers know how to guide and support patients, OVC. According to Keene (2000), the increased demands to support and provide such information may result in lay community health workers not being able to meet those expectations, because they lack the required capabilities.

There are some aspects of palliative care that relate to the earlier course of the illness, in conjunction with other treatment (WHO, 1990). The World Health Organisation and the Joint United Nations Programme on AIDS (UNAIDS) also regard palliative care as an essential activity for care and support (WHO & UNAIDS, 2000). The full scope of palliative care is seen as improving the quality of life of patients and their families facing life-threatening illnesses through preventing and relieving suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (UNAIDS, 2000). There are existing models of palliative care approaches in developing countries and some of these were initially developed to respond to the needs of people with cancer and subsequently have expanded to include people with HIV/AIDS, and other models which have developed palliative care processes as part of their response to the HIV epidemic. In Africa, for example, palliative care was initiated by the African Palliative Care Association (APCA) and well-supported by funders such as The Diana, Princess of Wales Memorial Fund, World Health Organisation (WHO – Africa Project on Palliative Care) and the Open Society Foundation International Palliative Care Initiative (IPCI), which all contributed to the progress of integrating palliative care into the main health-care service of some countries worldwide, but in particular, in Africa (WPCA, 2011). There is an understanding that palliative care focuses on relieving suffering of any kind and on maximising the quality of life of patients and their families (Harding, 2005b, WHO 2013), and is widely considered a human right (Brennan, 2007; Gwyther, 2009). However, it is rarely accessible in resource-limited settings (Connor, 2012; Farmer, 2010; Harding 2005a; Lamas, 2012; Uwimana, 2007), for multiple related factors, including lack of opioid availability, lack of training, and decentralisation of key services from the central hospital level to the health centres or patient's home. According to Dix (2012), the way palliative care is delivered shows many of the skills, knowledge and attitudes necessary to improve and support health systems and patient care. She adds that the skill of effectively managing pain and symptoms, combined with attention to psycho-social issues, improving the health status and well-being of patients across all domains were also important skills. In addition, the way palliative care teams operate in multi-disciplinary teams, focusing on spreading skills and shared care, is increasingly acknowledged as an effective way of managing the care of patients.

In Africa, the Hospice movement has developed and is expanding in a few countries, including South Africa, Uganda and Zimbabwe. The functions of the Hospice movement, initially established in the United Kingdom, were developed in these projects to care for people with HIV/AIDS. The outreach includes home care, treatment to relieve pain, psychological and spiritual support of affected people. Established organisations such as Hospice Uganda and Hospice South Africa (HASA) are able to provide training in palliative care to help increase the local capacity in implementing palliative care projects. These hospices, in common with other similar hospice projects, care for people with HIV/AIDS. Other projects such as The AIDS Support Organisations (TASO) in Uganda, The Mildmay Centre for AIDS Palliative care in Uganda, the Ministry of Health/NGO Home Care Programme Government NGO in Cambodia, and the Ndola Diocese Home Care Programme in Zambia, amongst others, have been established in response to the HIV/AIDS epidemic. Links between the two models are necessary to ensure that optimum care is made available to those who need it, and that the experiences from different angles are shared. Good referral systems, especially where projects focus on different aspects of palliative care, are also essential (Lucas, 2002). A study was carried out in the Kalabo district in Zambia to determine the factors contributing to the low performance of community health workers. The results showed that it was the irregular and unreliable supply of drugs and the selection of the wrong people to be trained as CHWs that made the programmes unsuccessful (Stekelenburg, Kyanamina & Wolfers, (2003). These researchers suggested that the programme should be rehabilitated, but they also found that the community support and supervision was inadequate. Palliative care is a relatively new discipline in Africa and its development is hampered by the fact that the concept of pain management is not integrated into health-care systems. Only four of fifty-three countries have integrated palliative care into health-care policy or used it as part of a strategic plan focusing on cancer treatment. These countries are Kenya, South Africa, Tanzania, and Uganda, while Rwanda and Swaziland have taken a different approach by developing stand-alone national palliative care policies (Mwangi-Powell (2011).

The following examples illustrate how palliative care works with, adds value to and supports the health-care system by enhancing the care of people with life-limiting illnesses. In Kenya, palliative care services began 20 years ago with the development of Nairobi

Hospice. Training initiatives included the development of a national palliative care training curriculum, the integration of palliative care into the medical and nursing curriculum; the provision of specialist training; and the use of essential medications. Despite these developments, coverage of palliative care provision remains stretched. However, there is now strong leadership in palliative care, coupled with commitment from the Ministry of Health to support palliative care services (Dix & Ross-Gakava, 2012). Malawi, on the other hand, began palliative care services over 10 years ago. Since the launch, there has been strong, dedicated leadership and strong support from the Ministry of Health through the office of home-based and palliative care. However, despite these developments, coverage for palliative care provision across the country remains poor in many parts, and access to essential medications can be a challenge (Dix & Ross-Gakava, 2012). In both Kenya and Malawi, volunteers and staff tried to meet basic needs with small gifts of household essentials, but there was a frequent recognition, particularly from the volunteers, that patients required more than they were able to deliver. For all the programmes, patient needs constantly exceed the resources available and all programmes recognise that the more care they deliver, the more demands they receive.

The Hospice Palliative Care Association (HPCA) in South Africa provides palliative care services to patients who have life-threatening illnesses, and who live with their families. A greater part of the HPCA's work is to assist its members, spread across the nine provinces, to provide quality palliative care to paediatric and adult patients. Mataka (2010) believes that children with life-limiting diseases should get the best possible treatment and care, and access to palliative care from diagnosis onwards is essential. Therefore, the holistic approach of palliative care ensures that the child's developmental and emotional, as well as medical needs, are met.

Looking at St Joseph's, I realised that more and more organisations like St Joseph's will be needed in the future, because of the continuous spread of the HIV/AIDS epidemic, resulting in the on-going need for palliative care. The epidemic makes it difficult for families to cope with caring for their children, and with family and friends who are dying. It is obvious that more community organisations will have to help bear the huge burden of

care caused by the HIV/AIDS epidemic. It raises a further concern about whether these community organisations will be able to provide the palliative care services on a continuous basis: are they sustainable in terms of what they do? In order to understand these questions, my focus is on this particular organisation – St Joseph's – because it has been in operation for so many years, and has been providing holistic palliative care to people, OVC who are infected and affected with HIV/AIDS. I see St Joseph's as the ideal organisation at which to conduct this study, particularly in terms of understanding how the LCHWs construct meaning of their work in their palliative care environment.

Because St Joseph's is the community organisation responsible for providing holistic palliative care to patients, orphans and vulnerable children, I regard it important to know how it is managed, the actual services it provides, and what type of support it offers to its employees. St Joseph's organisational processes and commitment will play a critical role in its sustainability. In the following section, therefore, I examine issues of sustainability and, in particular, what happens at St Joseph's in terms of its employees' growth, development, retention, succession planning and promotion, all of which are aspects in the organisation's sustainability.

2.4 Sustainability of community organisations

In the context of this study, the importance of the sustainability of community organisations goes without saying. The well-being and livelihood of the LCHWs in this study are heavily dependent on the continuous existence of St Joseph's as their employer. This section explores how community organisations manage to sustain themselves in terms of how they function, how they conduct their daily operations, and how they support their employees.

This journey of exploration begins with a research study the International Research Institute, 2002 conducted on behalf of Te Puni Kokiri, which found that overarching indicators of success for community organisations include a policy that provides a stable, yet flexible funding environment, and collaborative relationships with other organisations and agencies to ensure that providers are not competing with one another within

competitive funding and policy regimes. This research supports initiatives that foster greater collaboration and coordination in policy development processes, and supports opportunities that place primacy on driven development priorities (International Research Institute, 2002). In addition, the International Research Institute (2002), makes it clear that another key aspect of effective interventions that support and nurture sustainable community development is that community values are respected and upheld. On the other hand, Ife (2002) maintains that communities know their own issues and through the course of community development processes will, hopefully, be able to resolve their own problems. He cautions that public sector agencies often pass over local skills and grounded local knowledge in favour of outside expertise. Likewise, the temptation is to use what had been successfully used before in different contexts. Eketone (2006) asserts that using a process approach that respects the community's ability to find their own solutions is the most effective approach. However, Ife (2002) cautions that by being outcomes-focused, many programmes of community development are condemned to irrelevance or failure. Instead, for interventions to be effective in supporting and cultivating sustainability, public sector agencies need to listen to communities and value the knowledge, wisdom and expertise of local people. Ife (2002) reiterates that the public sector needs to trust that the community knows what it wants, and trust the process rather than the outcome. With regard to relationships in community organisational sustainability, Ife (2003) claims that strong and resilient community organisations are clear in their purpose and have transparent philosophical values and a collective approach across the community. In the same vein, Bryant (2006, p. 5) says that because of the strength of their relationships, the 'associational life' of the community is valued as important. Associational life refers to the culture nurtured with strength-based community organisations that empowers people who are members of the community to take control of their own lives, taking responsibility for their own needs and managing their own welfare, resources and direction. Bryant (2006) cautions that relationships must be built through participation and a philosophy of working 'with' rather than 'for' community members. Another aspect of successful innovative strength-based communities is that they have people who are key community stakeholders who lead by example in setting a sustainable agenda (Connelly, Roseland, & Markey, 2008). The authors also state that these organisations are often pragmatic rather than

'ideologically purist' and are content to apply the 'pretty good solution' and use their knowledge to link community problems with sustainable solutions (Connelly, Roseland & Markey, 2008, pp. 9–10). According to Bhattacharyya (2004), the purpose of community development is to create and sustain a satisfying life. Loomis (2002), Ife (2002), Bhattacharyya (2004) and Bradlow (2007) view sustainability as the means to an end of promoting change from unsustainable practices to benefit present and future generations. In contrast to the abovementioned positives about sustainability in community organisations, Bullen (2007) discusses community development models and ideas but does not provide any information about concepts of sustainability and how those in the community and voluntary sector might achieve this. He defines how the different models of community development might operate at the overlap between the community and government sectors, but with no analysis of the ways that different models might best serve either sector. On the same note, Murphy and Cauchi (2002) focus on what prevents groups from being sustainable rather on what makes them sustainable.

According to McKenzie (2004), social sustainability is much harder to quantify. He argues that any indicators or measures are often developed within the context of the organisation or local community being studied and so its usefulness for comparative study is limited or questionable. He also suggests that, in most instances, local communities and organisations work towards achieving a certain level of social sustainability rather than an end goal. McKenzie (2004) claims that social sustainability is a positive condition and process within communities. From the literature it was clear how community organisations manage to survive, including the type of funding, sponsors and financial assistance they receive. It is evident, according to the literature, that organisations such as St Joseph's do not close down because of funding issues, despite the fact that they have to generate funds to keep operating. Because St Joseph's is a community organisation, it mainly generates its own income, so it is important to understand how it sustains itself. Based on the literature, it is clear that St Joseph's, like other community organisations, sustains itself by the funding they have, the type of people they employ, and the kind of services they provide to the community.

The purpose of the following section is to understand how work meaning is constructed by LCHWs in terms of their work as palliative carers, by using the job demands and job resources as predictors, and including the perspective of community and adult education. In order to find out what is actually happening in organisations based on the above, I am locating the discussion in a particular theoretical framework: the job-demands perspective, which is ideal in understanding what happens in the context of this study. The reason for choosing this particular framework is that the job-demands-resource model (JD-R model) has been one of the leading frameworks in explaining the effects of job characteristics on employees' health and well-being (Bakker & Demerouti, 2007). The JD-R model is flexible in its specification of demands and resources, and it can be applied across all occupational groups. It further proposes that employee well-being is related to a wide range of workplace variables that can be conceptualised as either job demands, such as the physical, social, or organisational aspects of the job that require sustained physical or psychological effort; or job resources, such as personal growth, learning and development, irrespective of the occupational context under study (Bakker, Demerouti, & Schaufeli, 2003; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001).

2.5 THE JOB-DEMANDS-RESOURCES MODEL (JD-R model)

The JD-R model has been identified as one of the developed and theorised models as a tool to explain job demands, based on the assumption that specific occupations are characterised by specific structures of job demands and job resources (Demerouti *et al.*, 2001). Specific job demands and job resource components can be related to this study because they can be used to predict certain behaviours in workers such as stress, burnout and work engagement, and consequently organisational performance (Bakker *et al.*, 2007). The JD-R model does not require a matching of the job demands with the job resources in its specification as is needed in the Demand Induced Strain Compensation (DISC) model (cf. Bakker, Hakanen, Demerouti, & Xanthopoulou, 2007; de Jonge & Dormann, 2003). Emotional work load is shown to be more prevalent in specific occupations, such as the teaching, nursing and health-care sectors, but basically absent in others (cf. Bakker & Demerouti, 2007). The JD-R model is capable of including in itself various demands and resources (Demerouti *et al.*,

2001); it can therefore be adapted by researchers to fit the context under investigation, for example, to specify any applicable demands and resources desired (Llorens, Bakker Schaufeli, & Salanova, 2006).

Job-demands: Job demands refer to those physical, psychological, social, or organisational aspects of the job that require sustainable physical and/or psychological (cognitive and emotional) effort or skills, and are therefore associated with certain physiological costs. Meijman and Mulder (1998) indicate that high work pressure, an unfavourable physical environment, and emotionally demanding interactions with clients could be regarded as job demands. They also state that although job demands are not necessarily negative, they may turn into job stressors when meeting those demands requires high effort from which the employee has not adequately recovered. The LCHWs in their palliative care setting are exposed to high job demands involving extensive and intensive psycho-social support to patients, OVC on a daily basis.

Excessive job demand levels are often referred to as 'role overload' (Carlson & Kasur, 2000). As stated by Boyar, Carr, Mosely *et al.*, (2007), role overload is generally defined as having too much work to do, which can result in negative affective reactions by individuals experiencing these demand pressures. In a South African context, a study of primary educators in the North West Province revealed that if high job demands are experienced without sufficient job resources to cope with these demands, burnout develops, which in turn, can result in physical and/or psychological ill health (Montgomery, Mostert, & Jackson, 2005). Having a demanding, unstable job, and achieving at a high level without being offered any promotion prospects, is an example of a stressful imbalance (de Jonge, Bosma, Peter *et al.,* 2000). Schaufeli and Bakker (2004) emphasise that both organisational and individual resources, such as social support and perceived control, may lower job demands and thereby also reduce stress, burnout and possible negative health consequences. These authors indicate that resources can also contribute to intrinsic motivation, leading to growth, learning and development of employees. LCHWs at St Joseph's do not have a specific role as palliative carers, their roles vary on a daily basis

between being a lay counsellor, auxiliary worker, foster parent to OVCs and treatment adherence facilitators to patients and OVCs.

Job-resources: Bakker and Demerouti (2007), Lu, Siu, Spector *et al.* (2009) specify that job resources are located at the level of the organisation at large (for example: pay, career opportunities, family-friendly policies, job security), the level of interpersonal and social relations (supervisor and co-worker support, team spirit), the level of the organisation of work (role clarity), and at the task level (knowledge and skill variety, task identity, task significance, autonomy, performance feedback). Employees differentiate between support from the organisation and the support they receive from their co-workers and their supervisors (Allen, 2001; Jahn, Thompson & Kopelman, 2003; Self, Holt, & Schaninger, 2005; Thompson, Beauvais, & Lyness (1999), defined work-family culture as, "the shared assumptions, beliefs and values regarding to the extent to which an organisation supports and values the integration of employees' work and family lives" (p. 349). As indicated by Dikkers, Geurts, den Dulk *et al.* (2007; 2004), work support is regarded as one of the main issues of the work-family culture. These authors further define work support as the extent to which the organisation, direct supervisors and co-workers are perceived to be supportive of the integration of employees' work and private lives and the utilisation of work family arrangements. The above aspects covered by the literature are relevant to the LCHWs at St Joseph's in their roles as palliative carers, as well as employees of this organisation.

The accumulation of social resources at work is associated with positive feelings about one's career, such as the degree of flexibility and support in the workplace (Friedman & Greenhaus, 2000). Allen (2001) and Behson (2002) indicate that a supportive work family culture, such as support from the organisation, direct supervisors and co-workers, could simply make the organisation a more pleasant place to work, which can affect employees' well-being positively and can be interpreted by employees that the organisation takes care of their well-being. Hobfoll (2002) is of the view that resource gain, in turn and in itself, has only a modest effect, but acquires its saliency in the context of resource loss. This, therefore, implies that resources gain their motivational potential particularly when employees are confronted with high job demands. A study conducted by Billings, Folkman,

Acree *et al.*, (2000) reveals that men who were care-giving for AIDS patients and used social support coping maintained their positive emotional status under conditions of stress, and consequently experienced fewer physical symptoms, thus supporting the importance of resource gain in the context of loss. Also, Bakker and Demerouti (2006) found that job resources particularly influence work engagement when teachers are confronted with high levels of pupil misconduct.

Personal resources: It is generally assumed that employees' functioning is determined not only by situational factors such as job demands and job resources, but also by individual characteristics (Kanfer, Chen & Pritchard, 2008). As indicated by Hackman and Oldham (1976), the job characteristics model, for instance, considered employees' critical psychological states to mediate the association between job characteristics and outcomes, whereas their growth need, strength and skills were expected to moderate this association. The JD-R model considers individual factors mainly as personal resources, such as mental and emotional competence, self-efficacy, organisational-based self-esteem and optimism (Prieto, Salanova, Martinez, & Schaufeli, 2008; Xanthopoulou, Bakker, Demerouti & Schaufeli, 2007). In line with this assumption, personal resources such as self-efficacy and hope have been found to relate negatively to job demands such as emotional dissonance and positively to job resources such as social support (Karatepe & Olugbade, 2009; Xanthopoulou, Bakker, Demerouti, *et al.*, 2007). Personal resources are also thought to moderate, and more specifically to attenuate, the health-impairing impact of job demands, much as job resources do. Therefore, in this regard, self-esteem and optimism have been shown to weaken the association of job demands, such as time pressure, and psychological distress (Mäkikangas & Kinnunen, 2003).

Work meaning: The concept of the meaning of work refers to an individual's beliefs, values, and attitudes about the outcomes of work and the functions or purposes that work serves in life (Brief & Nord, 1990; Chalofsky, 2003). Brief and Nord (1990) made it clear in their work that the conceptualisation of work meaning has taken many forms, resulting in a fragmented literature. To clarify this fragmented literature of work meaning, Robertson (1990) identified three categories of work meaning. These categories are: work centrality,

which addresses the priority of work relative to other life interests (Dubin, 1956); work values, consisting of relatively enduring ideals for work behaviours and outcomes (Dawes, 1991); and work orientation, which attends to the purposes that work serves in an individual's life for the experience of meaning. Historically work has had diverse meanings. Work plays a significant role in most individuals' lives, but the psychological meaning of work varies across individuals. As a result of the implications of work meaning for individual and organisational outcomes, researchers (Dik & Duffy, 2009; Hall & Chandler, 2005) have called for more studies investigating meaning within the work environment. For instance, organisational commitment is used as an outcome that may be negatively influenced by work engagement through the health impairment process, or positively influenced by work engagement through the motivation process. Organisational commitment has been defined as "a strong belief in and acceptance of the organisation's goals and values, a willingness to exert considerable effort on behalf of the organisation, and a definite desire to maintain organisational membership" (Porter, Steers, Mowday, & Boulian, 1974, p. 604). According to other researchers, it has been convincingly demonstrated that burnout is related to poor organizational commitment (Schaufeli & Buunk, 2003), whereas Meyer and Allen (1991) provide evidence to suggest that commitment is associated with positive organisational behaviour, including organisation citizenship, a concept that is close to work engagement. In addition, negative relationships have been found between organisational commitment and job demands, and positive relationships with job resources (Mathieu & Zajac, 1990).

Positive meaning at work through job crafting: Wrzesniewski, LoBuglio, Dutton and Berg (2013) are of the view that the design of a job is deeply consequential for employees' psychological experiences at work. These authors explain that jobs are collections of tasks and relationships that are grouped together and assigned to an individual. Job crafting has emerged as a theoretical approach that expands perspectives on job design to include pro-active changes that employees make to their own jobs (Wrzesniewski & Dutton, 2001). They further define job crafting as "the physical and cognitive changes individuals make in the task or relational boundaries of their work" (Wrzesniewski & Dutton, 2001, p. 179). By altering tasks and relational boundaries, employees can change the social and task

components of their job and experience different types of meaning of the work and themselves; from the most routine tasks, to the most complex jobs, and from the lowest to the highest levels of an organisation (Berg, Wrzesniewski & Dutton, 2010). The potential for job crafting to alter the ways in which employees define the meaning of their work and their work identities is relevant across a broad range of job situations (Berg, Wrzesniewski & Dutton, 2010). Berg, Grant, and Johnson (2010) found that job crafting has positive effects on employees' degree of psychological well-being, as well as on work engagement and performance.

Work engagement: In spite of the fact that research on work engagement is successful, there are still many lessons to be learned about engagement. Even though most authors use the three-dimensional model of Schaufeli and Bakker (2004) that includes vigour, dedication, and absorption, some authors argue that the definitions should include a behavioural dimension (Macey, Schneider, Barbera & Young 2009). As an extension of this view, Schaufeli, Salanova, González-Roma *et al.* (2002) define engagement as the positive, fulfilling, work-related state of mind that is characterised by vigour, dedication and absorption.

Generally, there is no universal definition on employee engagement. In the academic literature, employee engagement was conceptualised by Kahn (1990) as "the harnessing of organisation members' in their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performance" (p.694). In essence, a working definition of employee engagement includes both employees' psychology about their work and workplace, and the resulting behaviour of that employee in the workplace. As an example of this working definition, Kahn (1990) indicates that engaged employees are physically involved in the tasks, whether alone or with others; cognitively engaged employees' are concerned about the organisation, its leaders and working conditions, and display their thinking and feelings, their beliefs and values in their ways of working and service. The Institution of Employee Studies (IES), which is the centre of research and consultancy in human resource issues, investigated 10 000 employees in 14 organisations and defined engagement as "a positive attitude held by the

employees towards the organisation and its values". An engaged employee is therefore aware of business contexts, and works with colleagues to improve performance within the job for the benefit of the organisation. Therefore, the organisation must work to nurture, maintain and grow engagement, which requires a two-way relationship between employer and employee" (Robinson, Perryman & Hayday, 2004 p. IX). Work engagement has often been studied in the context of the JD-R model, and such studies show that job resources are positively associated with work engagement and may even predict engagement in the long-term, according to Hakanen, Schaufeli and Ahola (2008b), Mauno, Kinunen and Ruokolainen (2007). Recent research also shows that job resources and work engagement may mutually predict each other over time (Hakanen, Perhoniemi & Toppinen-Tanner (2008a). Maslach, Schaufeli and Leiter (2001) argue that job engagement can be seen as the opposite of job burnout, and is characterised by high levels of energy, involvement in work, and a sense of personal efficacy at work. These authors see job burnout and job engagement as opposite ends of a single continuum, rather than as two separate dimensions. However, Schaufeli *et al.* (2002) are of the opinion that job engagement and job burnout should be conceptualised and assessed as two independent, but correlated, constructs. These authors argue that engagement at work is characterised by vigour, dedication, and absorption, and provide evidence through structural equation modelling for constructs of burnout and engagement. According to Shirom (2004), of these three dimensions – vigour, dedication, and absorption – dedication is considered to be broadly conceptualised because its meaning overlaps with identification, work-based identity and job involvement. Bakker & Demerouti (2008, p. 210) state that dedication refers to "being strongly involved in one's work and experiencing a sense of significance, enthusiasm, and challenge". Dedication is characterised by Mauno, Kinnunen & Ruokolainen (2006) as a strong psychological involvement in one's work, feeling a sense of significance and enthusiasm, being inspired and proud, and viewing work as a challenge. This dimension of work engagement shares some conceptual similarity with the more traditional concept of job involvement, which has been defined as the degree to which employees psychologically relate to their job and to the work performed therein.

Another explanation of engagement by Harter, Schmidt and Keyes (2003) defines employee engagement as "a combination of cognitive and emotional antecedent variables in the workplace" (p. 206). These authors propose that employee engagement is best assessed by a diverse set of 12 items addressing such factors as knowing what is expected at work, and having fellow employees who are committed to doing quality work. Despite the argument of these authors that these variables are the background of employee engagement, no evidence is presented to show how these variables contribute to an independent assessment of engagement. Previous work engagement studies have tested the JD-R model, which is partly an extension of Karasek's Demand-Control model (DMC) (Karasek, 1979). According to the DMC, job stress is particularly caused by the combination of high job demands (specifically work overload and time pressure) and low job control. It is therefore clear that the DMC focuses only on one type of job resource (job control). However, according to the JD-R model, the category of job resources may include not only job control, but also supervisor and colleague support, opportunities for professional development, feedback and appreciation, positive client contacts, job security, social and innovative climate, and many other resources, depending on the work situation and the work context. The importance of specific job resources may change in different organisational contexts and situations, and to a certain extent, some job resources may perhaps compensate for the lack of other resources. Thus, the JD-R model, which includes both job resources and job demands, offers a realistic, positive, dynamic, and practical approach to developing work sites (Bakker & Demerouti, 2007; Hakanen, Bakker, & Schaufeli, 2006). Recent research has found that engaged employees care for their own engagement by shaping their work environments, thereby not only making full use of their job resources, but also creating their own resources to remain engaged (Bakker, Demerouti & Xanthopoulou, 2011).

However, the JD-R model does not explain any mechanisms that translate resources or demands into engagement, including work meaning. It was for these reasons that van den Broeck, Vansteenkiste, de Witte, and Lens (2008) developed and validated a model derived from self-determination theory to re-dress this shortfall. These authors argue and show that job resources enable individuals to fulfil their key fundamental needs – autonomy,

competence, and relationships. When these needs are fulfilled, engagement is more likely to increase, and thus motivation fares well because individuals can engage in roles that align with their inclinations, and depletion of energy dissipates because problems do not have to be side-stepped. In contrast to engagement, according to Hallberg and Schaufeli (2006), disengagement has been found to be associated more with health issues, such as depressive symptoms and physical problems, which may affect employee well-being. Disengaged employees, according to Sundaray (2011), are seen as sleepwalking through their workday; they pass the working time without energy or passion. They do not work productively with their managers and co-workers. Some employees who are actively disengaged are busy acting out their unhappiness; rather than just being unhappy, they undermine what their engaged co-workers have accomplished. A conclusive, compelling relationship between engagement and profitability through higher productivity, sales, customer satisfaction, and employee retention was established by Hewitt Associates (2005). Many research results have shown a statistical relationship between engagement and productivity, profitability, employee retention, safety, and customer satisfaction, according to Buckingham and Coffman (1999), and Coffman and Gonzalez-Molina (2002). Hence, there are many definitions where engagement is referred to as attitude, as indicated by Northcraft and Neale (1996). These authors point out that commitment is an attitude reflecting an employee's loyalty to the organisation, and an ongoing process through which organisation members express their concern for the organisation and its continued success and wellbeing. Similarly, Saks (2006) explains engagement as the degree to which an individual is attentive and absorbed in the performance of his/her roles.

Harter, Schmidt and Hayes (2002) are of the opinion that engaged employees will have less intention to leave the organisation; rather, they will actively advocate the organisational culture and its external image, and strive to drive high customer satisfaction. It is critical to drive employee engagement, not only for retaining the services of employees, but also for improved organisational performance (Greenberg, 2004). According to Britt (1999, 2003b) and Britt and Bliese (2003), job engagement is defined as feeling responsible for and committed to superior job performance, so that job performance matters to the individual. As a further elaboration on employee work

performance, Tuomi, Ilmarinen, Jahkola, *et al.* (1998) suggest that job satisfaction usually refers to the personal perception of the whole work situation including work itself, social relations and supervisory behaviour.

As an example of the link between job demands and job strain, the influential demand-control model (DMC) of Karasek (1979, 1998) indicates that job strain is particularly caused by the combination of high job demands, specifically with regard to work overload, time pressure and low job control. The author adds that the working individual's control over his or her tasks and his or her conduct during the working day (Karasek, 1979) also contribute to job strain. Despite the fact that Karasek's (1979) empirical test demand-control model has primarily focused on work overload and time pressure as indicators of job demands, and skill discretion and decision latitude as indicators of job control, the author also includes role conflict in his original job demands measure, and states that:

> The goal in constructing the scale of job demands is to measure the psychological stressors involved in accomplishing the work load, stressors related to unexpected tasks, and stressors of job-related personal conflict (Karasek, 1979, p. 291).

In essence, it can be understood that Karasek acknowledges the relevance of a wider range of job demands and resources. Nonetheless, most studies on the demand-control and the effort-reward imbalance models have been restricted to a given and limited set of independent variables that may not be relevant for all job positions (Bakker & Demerouti, 2006). However, based on the job-demands-resources model job characteristics, even though every occupation may have its own specific risk factors associated with job stress, these factors can be classified in two general categories: job demands and job resources, thus creating an all-embracing model that may be applied to various occupational settings, regardless of the particular demands and resources involved (Bakker & Demerouti, 2006).

Job hindrances and challenges: According to Folkman and Lazarus (1985), when confronted with job demands, employees feel a lack of control, they experience negative emotions, and as a result, tend to adopt an emotion-focused coping style. These demands

elicit negative emotions, thus interfering with employees' work goal achievement and well-being. For this reason, these job demands have been labelled as job hindrances and they include work characteristics such as role ambiguity, job insecurity, constraints and interpersonal conflict (Cavanaugh, Boswell, Roehling & Boudreau, 2000; Lepine, Podsakoff & Lepine, 2005). The difference between hindrances and job challenges is built on Selye's (1956) distinction between positive and negative feelings of stress, referred to as 'eustress' and 'distress', respectively. Eustress and distress both activate individuals. However, unlike eustress which involves feelings of being challenged and which may contribute to better achievement, distress disturbs individuals' balance in a negative way and prompts negative emotions. Selye (1956) further states that eustress represents a positive motivating force, which might elicit problem-focused coping, involvement, and even achievement. Distress, on the other hand, is likely to result in avoidance behaviour and withdrawal from the task at hand.

Motivation is regarded as a critical matter for organisations and employees, as Pinder (2008) indicates. Motivation is further substantiated by Kanfer, Chen and Pritchard (2008), who point out that, in the globalised economy, where knowledge and commodities are widely spread, workers' motivation might be a critical resource to increase an organisation's productivity. According to Hakanen, Bakker and Schaufeli (2006), in the motivational process, job resources are known to influence employee well-being intrinsically by fostering employee growth, learning and development, or extrinsically by helping an employee to achieve his or her work goals. Confirmation comes from other authors who state that the self-determination theory provides support for this motivational process (Deci, Vallerand, Pelletier & Ryan, 1991). This theory further postulates that if the need for competence, relatedness and autonomy (or self-determination) is met in any social context, it enhances well-being and increases commitment. It is clear, therefore, that job resources play an important role in promoting work engagement, work meaning, organisational commitment, and in achieving employee well-being. In addition, de Lange, de Witte and Notelaers (2008) point out that job resources are considered to be critical for employee retention, in that low work engagement, low job autonomy and low departmental

resources are predictors of employees' leaving their organisations and transferring to other organisations.

Organisational involvement: A social exchange perspective as described by Blau (1964), van Knippenberg, van Dick and Tavares (2007) is usually based on the principle that a relationship between the LCHWs and the organisation where they are working is built on a transaction of effort and commitment for the benefits of receiving a salary, recognition, and organisational support. One can say that an employee and employer relationship is managed through a formal employment contractual agreement and a psychological contract agreement. However, van Knippenberg *et al.* (2007) state that a social exchange is judged to be one of quality when employee inputs into the relationship, such as work, time and effort, are on a par with or equivalent to the benefits, such as salary, promotion and recognition that the employee receives from the relationship. This opinion is supported by Rousseau (1998, p. 222), who points out that individuals become more motivated to maintain the relationship, "boundaries between the self and other" are blurred, and deep structure identification is able to develop. The JD-R model explains how employees' working conditions influence their work meaning construction and commitment to the organisation through various independent processes. This model further assumes that job demands and job resources suggest two different processes, such as the motivational process in which job resources stimulate employees' motivation to foster engagement and organisational commitment, and the health impairment process in which high job demands deplete employees' mental and physical resources leading to job burnout and ultimately to health problems (Demerouti & Bakker, 2011).

In the following section, community education perspectives are examined. St Joseph's is the ideal organisation in which to conduct this research because of its location. As a community-based organisation, all its operations take place within the community, and, I introduce a community education perspective, because St Joseph's palliative care services are of such a nature, that it cannot work independently of the community, thus, the community is educated about palliative care activities on an on-going basis.

2.6 COMMUNITY EDUCATION PERSPECTIVES

Community education as it applies to this study, as well as to everywhere else in the world, should enable individuals and communities to make real changes to their lives through community action and community-based learning. Community learning and development should incorporate the best practices undertaken in the fields of community education; it is also- an approach which enables organisations to work with communities and provide access to their involvement in learning, action and decision-making (Scottish Executive, 2004).

Community education: The Irish National Association of Adult Education (AONTAS), Community Education Network defines community education as:

> A process of personal and community transformation, empowerment, challenge, social change and collective responsiveness. It is community-led, reflecting and valuing the lived experiences of individuals and their community. Through its ethos and holistic approach, community education builds the capacity of groups to engage in developing a social teaching and learning process that is creative, participative and needs-based. Community education is grounded on principles of justice, equality and inclusiveness. It differs from general adult education provision in its political and radical methodologies (AONTAS, 2015).

Community education refers to adult education and learning, generally outside the formal education sector, and aims to enhance learning, empower people and contribute to society. It further promotes personalised learning and flexibility within the learning group, and at the same time, regards participants involved as equal partners in identifying needs, designing and implementing programmes, and adapting them on a continuous basis (AONTAS, 2015).

Akande (2007) says that community education aims to facilitate collective problem solving by equipping community members with the knowledge to facilitate action, and through promoting citizen participation among those who reside in a particular locality or

geographic region, as well as among people who are connected through common characteristics or interest, or through cultural and historical heritage. There have been a wide array of community education efforts for the prevention of child maltreatment in Australia, according to Tomison (2000), and these range from personalised or group programmes to universal mass media awareness-raising campaigns. These efforts can be viewed through a public health lens as primary, secondary or tertiary interventions. In addition, these efforts can be seen in a socio-ecological framework that takes into account interconnected systems that contribute to child safety and wellbeing. These efforts are designed to inform target audiences and most often require voluntary involvement, with the target audience referred to here as described by Abound and Singla (2012):

> "…knowing one's audience is critical. Being aware of all the influences on the current state of affairs will help create realistic expectations about how much change is possible, and the barriers to address. Furthermore, the application of communication theories depends on an understanding of how willing and able the audience is to process the change message. Specifically, the message must be coined in a more entertaining way if the audience is less willing and able."

The Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA) (2010) identified that parents receive multiple and sometimes conflicting messages about parenting and child development. Anyanwu (2002) is of the view that community education is not a new phenomenon of human living, for instance, in Nigeria, people have been practicing indigenous community education since before the arrival of the early missionaries and colonial administrators. Anyanwu (2002) further holds that, through the philosophy of participation, the integration of the whole society can be greatly enhanced and sustained. Crowther (2011, p.15) defines the broader vision of education as:

> What is needed is a vision of education which makes a vital contribution to a humane, democratic and socially just society as well as a thriving and sustainable economic life. (Crowther, 2011, p.15)

The European Centre for the Development of Vocational Training (Cedefop) is an agency of the European Commission which provides information, explication and research on education and training systems across EU member states. Though the focus may be on vocational education and training, the work of Cedefop informs further education and training and is relevant to community education. Cedefop describes the non-market benefit as follows:

> For individuals, non-market benefits are commonly measured by positive psychological effects on individuals' motivation or attitudes, such as increasing self-esteem and self-confidence, especially among unemployed people (Cedefop, 2013a, p. 26).

Colardyn and Bjornavold (2004) document much of the thinking and rationale underpinning the EU's policy on recognising informal and non-formal learning. The validation of this kind of learning is very closely related to the Lisbon agenda of a knowledge-based economy which places lifelong learning at the centre of competitiveness, employability, individual fulfilment and self-development. This overarching vision is thus informed by the following recognition:

> The purpose is to make visible the entire scope of knowledge and experience held by an individual, irrespective of the context where the learning originally took place. For an employer it is a question of human resource management, for individuals, a question of having the full range of skills and competences valued, and for society, a question of making full use of existing knowledge and experience. (Colardyn & Bjornavold, 2004, p. 69).

In this study, community education through learning and development describes a way of working with supporting communities. St Joseph's should therefore see community education, learning and development as central to social capital. According to the Scottish Executive (2004), a way of working with communities to increase the knowledge, skills, confidence, networks and resources that employees, such as the LCHWs, needs to tackle

work and personal challenges and also to grasp developmental opportunities as they are presented. The aim of community organisations, such as St Joseph's, should be an inherent desire for community learning and development to bring together the best of what has been done under the banners of community education to help individual LCHWs and communities to address real issues in their working and personal lives through community action and community-based learning (Scottish Executive, 2004). By building community capacity, St Joseph's seems to be located at the heart of influencing its employees and people in the communities, enabling them to develop the confidence, understanding and skills required to influence decision making and service delivery in their daily operations. The Scottish Executive's statement on community regeneration makes clear the importance of community learning and development in building skills and confidence in disadvantaged communities to promote social inclusion (Scottish Executive, 2004). In addition, community education has clearly identifiable outcomes, such as improvements in the effectiveness, range and joint working of community organisations; increased confidence and motivation of excluded people, and improved core skills, allowing individuals whose previous experience of education has been negative to tackle important issues in their lives (Scottish Executive, 2004).

My focus in the following section is on literature about adult education. All the LCHWs at St Joseph's are adults, in particular the group that I worked with. Hence, adult education is critical in terms of understanding all aspects of palliative care service processes at St Joseph's.

2.7 ADULT EDUCATION PERSPECTIVE

Adult education: In this study, raising standards of achievement in learning for adults through community-based lifelong learning opportunities, and incorporating the core knowledge and skills of literacy, numeracy, communications, working with other people, problem-solving and information sharing can be seen as an important link between St Joseph's, the LCHWs and the community at large. Belatti and Falk (2002) are of the view that learning in a society is accessed through social capital. The skills and abilities that are

theorised as making up 'human capital' (a standard definition being the "knowledge, skills, competencies, and attributes embodied in individuals that facilitate the creation of personal, social and economic well-being" (OECD, 2001, p.18) can only be brought into being for the benefit of the collective, through social means. Social interactions draw on the identity and knowledge resources of the people involved at the same time as building these resources (Belatti, Gargano, Goldman *et al.*, 2004). Knowledge resources are derived where "the interactions draw on the resource of common understanding related to knowledge of community, personal, individual and collective information which is drawn from sources internal and external to the community" (Falk & Kilpatrick, 2000, p.99).

In a study undertaken by Falk (2001a), interviews were conducted with 15 adult literacy programme participants, who felt that improving their functional literacy skills (human capital) were the core need for improving their chances in life, to better themselves, and to attain employment. However, Falk (2001a) explains employment is not necessarily forthcoming upon achieving these skills, which can lead to disillusionment. He also states that the social interactions and ties between people that are built on trust, are as important for effective learning (and potentially further goal achievement) as the knowledge resources themselves. In another paper, Falk (2001b) states that learning to trust is essential to being able to learn as it bridges a fundamental gap for adult learners. Instead of withdrawing into themselves, adult learners will attend an education programme. Therefore, aspects of social capital must be valued as important and built into the programmes on offer, to increase the chance of achieving employment goals. An adult education programme that is successful would have to include the development of trust, confidence, and supportive networks among and between the adult learners, alongside the provision of learning (Falk, 2001b).

As indicated by Berryman (1994, p. iii), "employers train the trainable" and train mainly their more educated employees (this practice was also found to be the case in an analysis of the New Zealand International Adult Literacy Survey data sample (Cullinan, Arnold, Noble, & Sligo, 2004). Work-sponsored training increases employees' productivity and thus their earning, more than training in post-compulsory education (when the effects of

educations are controlled). Therefore, workplace learning is an important way in which both employers and workers adapted to change in the work environment, says Berryman (1994). In a survey that Gorard (2003) conducted, he states that, while employers are aware that the skills of their employees are very important to their businesses, those employees that were part-time, of lower status, and less qualified than others, received very little training that was generalised or non-task-specific. Informal tacit learning that occurs, and learning that happens on the job and is not explicitly planned, may not be considered learning from the dominant centre viewpoint. In a related argument about workplace learning, Billett (2002a; 2002b) says that widening the definition of learning and lifelong learning provides an opportunity to include those instances where knowledge is passed from worker to worker under informal and tacit circumstances.

Bloomer and Hodkinson (2000) point out the importance of the social context in that learning is a participatory act, within which social practices, knowledge, skills, and meaning are created and transformed (akin to situated learning theory). This situated learning theory outlines an ongoing process in which social interactions and practices lead to a new conceptualisation or transformation of knowledge (learning). It is however, argued that learning is not purely a reaction to external situations, or a construction of an individual's mind, but an interaction of the two.

Learning can affect the shaping of an individual's character, as Preston and Feinstein (2004) show in their study of the effects of learning on attitude formulation: "mechanisms through which adult education affects one attitude may be different from those which affect another" (p. 6). Bloomer and Hodkinson (2000) on the other hand, posit the idea of a 'learning career' as a response to life-long learning policies. They argue that if lifelong learning is a central concern for policy makers, then understanding how learning changes throughout the life span is important. A learning career is therefore defined as "a career of events, activities and meanings, and the making and remaking of meanings through those activities and events, and it is a career of relationships and the constant making and remaking of relationships, including relationships between position and disposition" (p. 590). There is a temporal element at the heart of this and Bloom and Hodkinson (2000)

outline it as the changes to dispositions within the learning career of an individual. There are also changes to personal identity, and transformations in a learning career can take many forms which are influenced not only by the habitus and the contexts within which the habitus has developed, but the contexts within which the individual is located at the time of the transformation.

It is argued that individuals control their own learning (either consciously or otherwise) through a sophisticated filter system that protects previous understandings and the individual identity that has been constructed from these (Illeris, 2003). In addition, Illeris (2003) argues for a more all-encompassing definition of learning, based on a structure of learning which involves two integrated processes and three dimensions, which two processes consist of:

1. Interaction processes between learners and their surroundings (both social and cultural) which are dependent on time and locality factors.
2. Inner mental acquisition and elaboration processes. These processes are mostly genetic in nature and include the cognitive (knowledge and skills) aspects as well as an emotional aspect (motivation and attitude).

The three integrated dimensions of this model include:

1. Cognitive, where knowledge, skills, understanding, meanings, and functionality are developed.
2. Emotional, where patterns of emotion, motivation, attitudes, sensitivity, and mental balance are developed.
3. Social-societal, where the potential for empathy, communication, and co-operation are developed.

Billet (200a) provides guided learning strategies as a means by which to achieve vocational knowledge in workplaces. Guided learning at work takes place through engagement in everyday work tasks, and the direct guidance of co-workers, and also indirect guidance from co-workers and the workplace itself. These strategies are claimed to enhance both the

individual's autonomy and progression, as well as the ability to conduct routine and unique work-place tasks. Guidance by co-workers can mean direct on-the-job teaching of specific tasks, and indirect guidance can mean observation of co-workers, mentoring, coaching, etc. Schribner (1985, cited in Billett. 2001a) claims that vocational knowledge is part of social and cultural practices. Both direct and indirect guidance assist learners to access and construct socially developed vocational practices (Billett, 2001a). In addition, three levels of guided learning are proposed by Billet (2001a) to enhance learning at work, which could form a structure for workplaces to use to develop vocational learning with their new employees. In the first place, organisations must ensure that access to direct and indirect guidance is intentionally organised around everyday activities. Secondly, a pathway plan that incorporates activities of increasing complexity and a means of evaluating progress is suggested in order to provide a structured means to developing workers' vocational knowledge. Guided learning through more experienced co-workers should take the form of modelling, coaching, questioning, and other strategies, and this should be combined with a proposed third level: guided learning for transfer, not just across tasks in the workplace, but also across settings (Billett, 1999, cited in Billett, 2001a).

Billett (2001a) outlines some limits to learning in the workplace which include: learning (either knowledge or practices) that is inappropriate, but reinforced by the workplace; barriers to access and guidance for developing workplace practice; having to learn knowledge that is not accessible in the workplace and the lack of expertise or experience required to develop this knowledge, such as ideas that employer-sponsored training builds on already assumed developed fundamental skills; and the reluctance of workers to participate in learning in the workplace. Billett (2001a) is of the view that the ability to engage in workplace activities and access the guidance on offer, is mediated by the interaction between the individual and the social sources. Furthermore, Billett (2001a) maintains that the concept of workplace affordances, which are the opportunities given to learn and perform tasks alongside the invitational qualities of the workplace, are shaped by workplace hierarchies, group affiliations, personal relationships, cliques, and cultural practices. Gorard (2003) states that while individual workers react to the workplace affordances and opportunities that are offered to them (or not offered as the case may be),

it is important to acknowledge that individual workers contribute to the construction of these affordances and opportunities, which are likely to be a product of dominant workplace discourses or ways of reading them by more experienced workers. Gorard (2003) adds that it is not constructive to define the worker merely as an individual and the workplace as providing the structure or context, as both individual and work-place construct, and are constructed by, each other.

2.8 SUMMATION OF THE JD-R MODEL

Looking at this particular model in terms of the context of this study and based on the literature, I am of the view that there are certain demands, and there are certain resources needed for LCHWs to perform their duties well. The literature addresses job resources, work meaning, positive meaning at work through job-crafting, work engagement, job hindrances and challenges, motivation and organisational involvement. Much of the literature consulted focusses on the JD-R model in the health sector; but irrespective of the job, the JD-R model posits that any job has certain demands, and any job needs to have certain resources for people to do their jobs better in various occupations. LCHWs who are working in palliative care situations have certain job demands: they must know the patients, orphans and vulnerable children, and they must be able to tolerate circumstances that includes working with the sick, frail and dying. Taking into consideration what these people need in terms of job demands, for example, their work is very stressful. In addition, LCHWs need particular resources to perform their duties better, and looking at what resources are needed for LCHWs from the literature consulted, there is a gap in the context of this particular study, but it is clear that there are job demands and resource needs. These are what I investigate further in this study.

2.9 SUMMARY OF CHAPTER

In this chapter I situated my study within the framework of existing literature. I commenced the chapter by discussing general perspectives about work meaning constructions of lay community health workers, internationally and nationally. This was followed by a

discussion on the theoretical framework, the JD-R model and its elements, job demands and job resources. The theoretical framework was discussed in relation to employee work engagement and well-being, taking into consideration the following: community and adult education, job demands, job resources, personal resources, work meaning, positive meaning at work through job crafting, work engagement, job hindrances and challenges, motivation and organisational involvement.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

In this chapter, I provide a thorough discussion of the research design and methodology which could enhance our understanding of work meaning constructions by lay community health workers in an HIV/AIDS palliative care setting. A qualitative phenomenological research approach is discussed. The phenomenological approach provides an in-depth understanding of the lived experiences of the work meaning constructions by the participants. In addition, the social constructivist paradigm is discussed to explore how the LCHWs construct the reality of their context. A discussion on a case study design follows to inform the study's research methodology.

3.2 METHOD USED

I selected a qualitative research methodology for this study. The qualitative research approach implies that I collect data in a real-world setting which is field focused, working inductively. By grounding this study in the qualitative phenomenological approach, I focused on the work meaning constructions of the LCHWs, with the outcome being a process rather than a product. I aimed to obtain insight and provide in-depth, rich descriptions of naturally occurring phenomena or lived-experiences about work meaning in natural situations, making sense of and interpreting that which I am studying in terms of the meaning that is ascribed to it by the LCHWs and not as predetermined or controlled by myself. Through the endeavour of qualitative research, I aimed to develop an understanding of the manner in which reality (the world) was constructed by each LCHW in a specific social setting, in terms of symbols, structures and social roles familiar to them. Qualitative techniques provided an opportunity to share in the views and understandings of the participants in this study and to explore the manner in which they give meaning to their life-worlds, themselves and others (Sterk & Elifson, 2004; Woods, 2003; Patton, 2002; Mayan, 2001; McLeod, 2001; Denzin & Lincoln, 2000).

The decision to approach the research qualitatively was primarily guided by its nature in terms of the research questions and the purpose of this research study. This is a phenomenological study that will enable me to look into the lived experiences of the LCHWs at St Joseph's (Schumacher, 2010). I wanted to explore and focus on the processes, meaning-giving patterns, as well as structural characteristics of a particular community in order to address the research questions. For those reasons, I support the view of Flick, Von Kardoff and Steinke (2004, p.3), who describe this process as:

> It [qualitative research] rather makes use of the unusual, of the deviant and unexpected as a source of insight and a mirror whose reflection makes the unknown perceptible in the known, and the known perceptible in the unknown, thereby opening up further possibilities of (self-) recognition.

I undertook this research study to contribute to the limited specific literature on work meaning for lay community health workers, using the Job-demands-resources model, as well as the knowledge base relating community and adult education to the lay community health workers' role in an HIV/AIDS palliative care setting in relation to work meaning. The role of the organisation was also explored.

3.3 PARADIGM EMPLOYED

In this study, I used the social constructivist paradigm, because I was interested in finding out how the participants construct the reality about their situation. This investigation aimed to gain understanding of the lived experiences and personal worlds of the participants, in terms of their perceptions and interpretations about work meaning in their work context, at the same time acknowledging that I am a co-creator of meaning in this study. I regard the social constructivist paradigm as a joint process, with different situations and effects being researched by various role players, such as the participants, myself, and St Joseph's. Above and beyond data, interpretations and results are embedded in contexts and persons other than myself. I acted as an instrument in the research process (as the researcher); I entered the research field with a set of ideas or blueprint of concepts, values and methods, based on my unique and specific history, background, gender and race which are some of the

determining factors with regard to my personal view on reality (Chambers, 2000; Patton, 2002; Denzin & Lincoln, 2000).

The decision to employ a social constructivist paradigm was related to the aim of this study, which focusses on a deep understanding of the personal perceptions and views of the lay community health workers of a particular organisation with regard to work meaning. Conducting this study from a social constructivist paradigm, allowed me to interact with the participants in their natural environment. I attempted to understand the participants in terms of their personal experiences, perspectives, definitions and perceptions of their everyday lives, within the unique contexts in which they operate and against their unique backgrounds. I adhered to Chambers' (2003) recommendation not to enter the research field as a professional outsider, believing that I have the answers, as I might be influenced by my own methods, values, beliefs and attitudes, thereby preventing me from learning from the LCHWs and the communities in which they served. I furthermore recognised, in this study, that a significant number of the participants were also outsiders, in the true sense of the word, in the communities where they served; however, I believed that they could share expert insight, based on their knowledge and daily involvement in the community. The same principles applied to the explication of data where I (as other researchers) may be likely to believe myself to be an expert, so denying the abilities and creativity of the people (participants in this study) who actually understand the reality in question.

Certain underlying philosophical beliefs or assumptions, which are ontological, epistemological and methodological, guided the research approach, actions, search for meaning, and understanding of reality, not only as a support to gain knowledge, but to understand the relationship between reality and research. In following a constructivist paradigm, the nature and content can be deemed to be the reality that was researched (the perspectives of lay community health workers of work meaning in their roles as carers in an HIV/AIDS palliative care setting) as multiple, personal and internal by nature (ontological assumption). In this study, the ontological assumption relates to the nature of reality and its characteristics, in which I support the idea of multiple realities and will thus report on these by exploring multiple forms of evidence from different participants'

perspectives and their experiences (Creswell, 2012). I deem this specific reality as one consisting of the LCHWs' personal experiences of their external world, therefore I aimed to reflect their perceptions in the findings of this research. As such, direct responses of the participants were included in the discussion of the emerging themes in Chapter Four, reflecting the voices of the participants and providing a trail of evidence. In terms of my epistemological assumptions, I took an interactional stand point and, as part of narrowing the distance between myself and the reality that I researched, I interacted and worked in partnership with the participants on a continuous basis, spent extended time in the field, and strove to obtain an emic perspective throughout (Lincoln & Guba, 2003; Terre Blanch & Durrheim, 2002; Cohen *et al*, 2001; Crabtree & Miller, 1999; Creswell, 1998).

I was fully aware that my research was value-laden and biased. Regardless of attempts made to report authentically on the perceptions of the participants, my interpretations cannot be regarded as being completely free of my personal voice, because I am a coloured woman, Afrikaans-speaking, conducting research in a black community of mixed African languages, and with people with resourcing needs. With reference to the rhetorical assumption, it was more appropriate to employ a first-person and somewhat informal, yet academic writing style in this study, mainly for the reader to hear my voice. For the methodological assumption, I selected inductive research methods for data collection, explication and interpretation. I continuously relied on interactions and the personal relationship between the participants and myself. I was always flexible about the choices I made, and continually reviewed the methodology where necessary (Lincoln & Guba, 2003; Terre Blanch & Durrheim, 2002; Cohen *et al*, 2001; Crabtree & Miller, 1999; Creswell, 1998).

3.4 RESEARCH DESIGN

I selected a case study design, applying phenomenological principles. Phenomenologists, in contrast to positivists, believe that I cannot be detached from my own presuppositions and that I should not pretend otherwise (Hammersley, 2000). Phenomenological research mainly makes use of unstructured interviews as a method of data collection (Polit & Beck,

2001), specifically because I do not have enough knowledge about the phenomenon under investigation. In this study, as it relates to the participants, phenomenological research allowed me to ask the participants to describe their experiences as they perceive them in their work situation at St Joseph's, and this process of sharing their experiences is conducted through the interview processes, as discussed under data collection. Applying the phenomenological method to this qualitative research, enabled me to focus specifically on identifying the inherent and actual meaning of the participants' construction of work meaning (Langdridge, 2007).

Although the phenomenological method is the most suitable for this study, I am cautioned by Freeman (2011), who asserts that understanding cannot be conveyed as a fixing of meaning but rather, how the meaning is generated and transformed. Throughout this study, I consciously set aside my personal beliefs about the participants' construction of work meaning, and made every attempt, on a continuous basis, not to allow my prior knowledge about the phenomenon under investigation to interfere (Carpenter, 2007).

3.4.1 Case study design

Case study design is a complementary and collaborative partner to the phenomenological research study. I applied the case study design, because case study research has a level of flexibility and it "explores a real-life, contemporary bounded system (a case) through detailed, in-depth data collection involving multiple sources of information…and reports a case description and case themes" (Creswell, 2013b).

As indicated by Yin (2009), this is a case study, because it involves one organisation. In the context of this study, the aim was to obtain a deep understanding, not just generalisable knowledge, of the perceptions of the LCHWs working at a specific community organisation within **a particular context** (providing palliative care to patients, orphans and vulnerable children living with HIV/AIDS), **environment** (based in the Kungwini local municipality of Bronkhorstspruit) **and timeframe** (June 2011 to October 2014). I chose purposive sampling, because it describes the specific method of involving particular

identified participants: for the purpose of this study, LCHWs at St Joseph's in their HIV/AIDS palliative care setting, to help co-construct work meaning based on their experience and perspectives.

I gained access to the organisation through a gatekeeper, as advised by Bogdan and Biklen (2003, pp. 76, 78) that official permission to conduct a study may "be sabotaged by the subjects", requiring that "permission will have to be sought and cooperation gained as you move out into new territories and meet new people". In this instance the gatekeeper was a director of one of the community projects in Bronkhorstspruit who had family members that worked as LCHWs. An important function of the gatekeeper was, as Neuman (2000) cautions, to influence to some extent the course of the research unfolding by, for example, steering me to look into areas where participants may want to use the interviews to complain about the organisation's working conditions. My interest was always in the training and development of lay people with skill-resourcing needs, which was why I selected an organisation through which I could reach the LCHWs. I therefore relied on typical case sampling to identify the case. The community and organisation where I conducted this research study was an example of a typical average community in that province, meeting the criteria that it had to be a rural community faced with work challenges as palliative carers for people affected and infected with HIV/AIDS.

3.4.2 Sampling

After receiving permission from the Board Members of St Joseph's to access the premises, I purposefully sampled participants from the complete staff complement in the organisation. All selected participants were considered relevant to the topic and possessed specific information about the phenomenon of interest, which was about work meaning construction in their HIV/AIDS palliative care setting. I realised that the participants in this study represent only a small section of the LCHWs to whom the study might possibly apply, and therefore aimed to select participants who were reasonably typical of the larger groups of LCHWs that I focused on, being South African citizens, working in HIV/AIDS palliative care organisations. Following Henning, van Rensburg and Smit (2004), these

desirable participants, representing a theoretical population, are seen as spokespersons for the topic for this study, but are, however, not representative of a group of LCHWs as the findings may not be generalised. I purposefully selected a sample size of forty-six participants that included project leaders, volunteers from each project, all section heads, and permanent employees. Participants were selected from each occupational level, as illustrated in Figure 3.1 below. The levels ranged from the most senior position (Director of the community organisation) to the lowest position of a general worker, namely a cleaner. There were only nine male LCHWs at this community organisation and they all participated in this research study.

After determining the primary participants in the study, the sampling process was conducted according to Durrheim (2002, p.44) in which "decisions about which people, settings, events, behaviours and/or social processes to observe" were considered. Details and timetables about the individual and focus group interviews were drawn up by the community organisation's training and development manager, to ensure that there was no interference with their daily duty schedules and the community organisation's objectives. I had to work according to the dates, times and venues provided by the NGO. This arrangement made access to the participants easier, because it was unanimously agreed between the Board Members, participants and me. I discussed accessibility with the participants with regard to their responses during the interviews, because it was necessary that they open in their responses, especially with regard to the sensitive areas about their work associated with HIV/AIDS patients, orphans and vulnerable children, and that they were able to communicate their perceptions, whether they were able to speak English or communicate through an interpreter (Henning *et al.*, 2004; Patton, 2002). In addition, I requested their permission to voice-record the interviews with the participants. Prior to the interviews, a special simulation interview was arranged for the participants who were not familiar with the voice recorder so they could experience the interview situation. I rewound the interview session and played the voice recorder for the participants to listen; there were not many questions for clarity, and most of the participants were fascinated to hear themselves. Participants were presented with the opportunity to agree to the voice recordings or not to agree. All were in favour of having their interview sessions voice-

recorded. Written consent forms were received (refer to Appendix 3, p. 262) from all those who agreed with their content, and who ended up being participants.

From the first meeting, I focused on initiating and establishing a good rapport with the participants because sound relationships encouraged voluntary participation, particularly with regard to the discussion of the content, which is sensitive by nature. Throughout my interaction (from the beginning of the research study), I showed respect, humility, patience, friendliness and interest in the participants. I listened attentively to what they had to say, without interrupting and maintained a welcoming, professional approach and warm body language. The participants were constantly encouraged and affirmed during the interview. Regular updates on the progress of the process were provided during our scheduled feedback meetings (Chambers, 2004; Grant & Shillito, 1998; Absalom & Mwayaya, 1997; White & Taket, 1997; Chambers, 1996; Chambers & Guijt 1995).

A total of forty-six interviews, consisting of twenty-five individual interviews, and two focus groups, one group of ten and the other a group of eleven participants, were conducted. The individual interviews were initially set for half an hour per participant, although a few lasted an hour, for those participants who spoke slowly. Other participants required interpretation and this also lengthened the individual interview sessions. The interviewing process was spread over five weeks and was completed only after data saturation had been achieved, that is, approximately eight weeks later. The following Figure 3.1 illustrates the selection of participants.

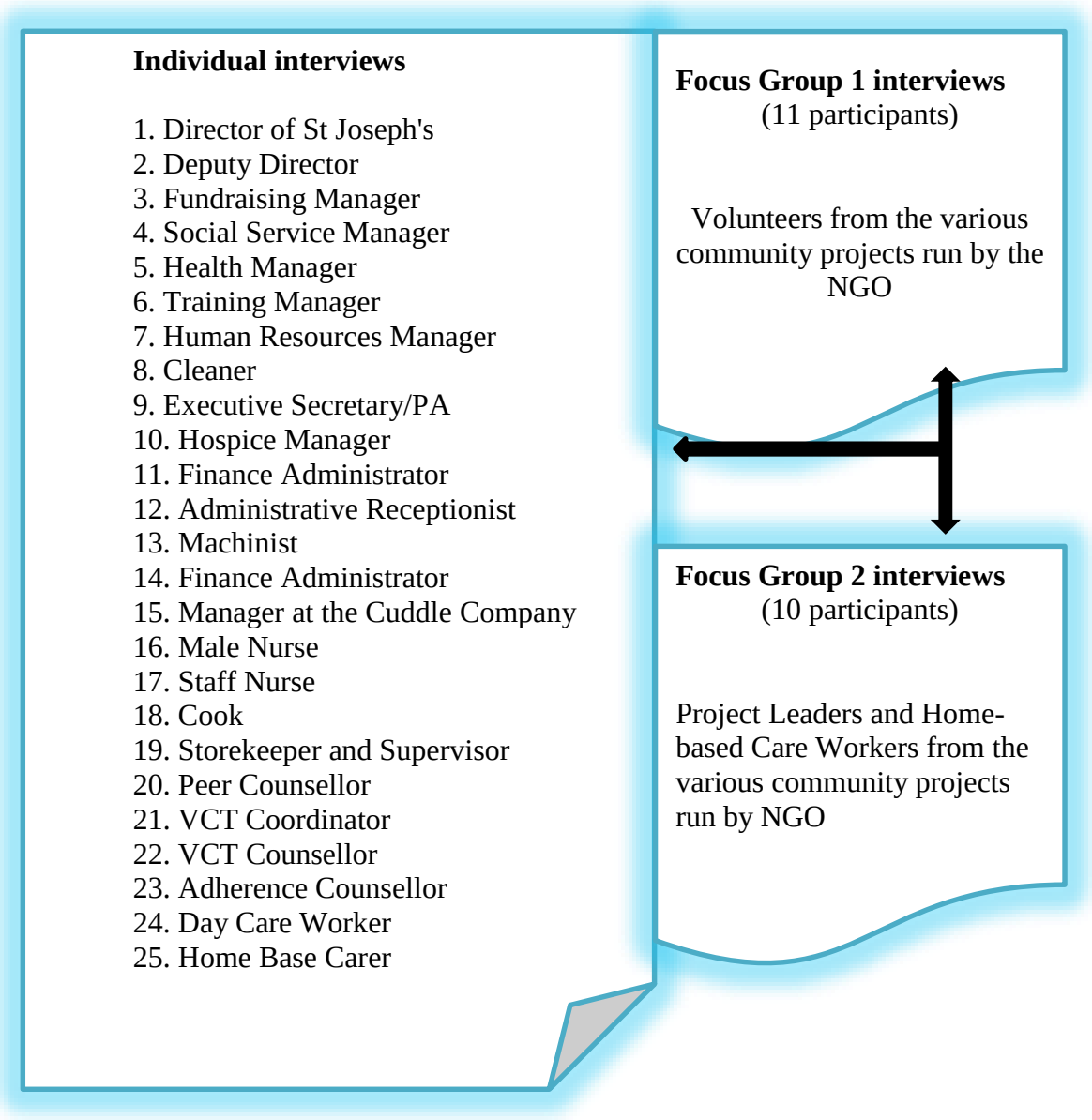

Figure 3.1: List of participants in this study

3.5 DATA COLLECTION

I employed multiple data collection methods for this qualitative research study, which consisted of individual and focus group interviews, observations and document explication. These multiple data collections are discussed in the following section.

3.5.1 Individual interviews

I conducted unstructured interviews, posing open-ended questions to the participants (Morse & Richards, 2002). Participants were interviewed to elicit their perceptions and experiences about work meaning in their roles as carers in their HIV/AIDS palliative care setting. The same process of unstructured interviews was conducted with the management of the NGO, namely the director, finance, training and human resources managers. The aim was to establish the organisation's vision, goal, funding resources and their training needs and challenges. Data collected from the director specifically covered the service delivery and objective protocol, to highlight the vision/mission of the organisation in relation to the work done by the participants.

Twenty-five in-depth individual, phenomenological, unstructured interviews were conducted to gain a deeper understanding of the participants' experiences and perceptions of their work meaning in their roles as carers and specifically, in relation to the lay community health workers (Munhall, 2007). The interviews were based on the view that qualitative interviewing is an interactive process of meaning-making for the participants. Therefore, during the individual interviews, participants were encouraged to talk freely about their daily lives, specifically with reference to work meaning. In conducting the individual interviews in this manner, I was able to gain a deeper insight into the LCHWs challenges, customs, practices and responses to their role as carers in the HIV/AIDS palliative care environment (Baker, 2004; Holstein & Gubbrium, 2004; Miller & Glassner, 2004; Babbie & Mouton, 2001; Kvale, 1996; Mascarenhas, 1990).

This method of data collection fits in well with the JD-R framework of this study, in particular the social constructivist paradigm, in that participants construct their own meaning through reflecting on their experiences. As indicated by Giorgi (2009, p. 122): "What one seeks from a research interview in phenomenological research is as complete a description as possible of the experience that a participant has lived through."

3.5.2 Focus group interviews

The interviewing process of the following two chosen focus groups provided me with multi-faceted responses from the participants:

a) Volunteer workers and home-based care workers from the various community projects run by the NGO; eleven in total, all female.

b) Project leaders from all the community projects run by the NGO, comprising ten participants, one male and nine female.

In the focus group interviews, the participants could share their varied, unique experiences freely, with encouragement and support for those who needed it.

Focus group interviews, as described by Denscombe (2010), have three characteristics: 1) the sessions have focus and the discussion is based on the experience of the topic of which all participants have knowledge; 2) the interaction within the group is a means of eliciting information; and 3) my role is to facilitate the group discussion and not to lead it. According to Cohen, Manion and Morrison (2000, p.288), "it is from the interaction of the group that the data emerge" because "the participants interact with each other rather than the interviewer, such that the views of the participants can emerge – the participants', rather than my agenda can predominate". The interviewer's role is that of a facilitator, moderator, monitor and recorder of the group interaction, rather than interviewer (Krueger, 2003; Punch, 2005). I based all follow-up questions on the replies from the participants, as I did in previously conducted interviews, allowing me to elaborate on perceptions shared by the participants and themes that emerged (Baker, 2004; Holstein & Gubbrium, 2004; Miller & Glassner, 2004; Patton, 2002; Wengraf, 2002; Babbie & Mouton, 2001; May, 2001; Breakwell, 2000; Kvale, 1996).

I focused on unstructured, open-ended questions, such as: *Can you please describe, in as much detail as possible, a situation in which you experienced being a lay counsellor to an*

orphan or vulnerable child who lost a parent as a result of HIV/AIDS? I also ensured that particular questions were phrased in a clear and understandable manner. Thereafter, I asked questions only for clarification or elaboration. One probing question for example, would be: *What are the challenges you are faced with during such lay counselling sessions?* At all times in these focus groups, I aimed at responding in a neutral way, relying on a good rapport between the participants and myself. I consciously avoided leading and bias questions, in order to gain insight into the perceptions of the participants without predicting their points of view in terms of pre-set categories, or contaminating their responses.

I further employed active listening as a way of encouraging broad discussions, to gain more detailed responses. I continuously took up the role of being sensitive, listening and more understanding, not only to what the participants said, but also to what they communicated on a non-verbal level, relying on thorough observation. Whenever necessary, I was quiet to allow the participants sufficient time to formulate answers, or for any other reason they required more time. During the individual and focus group interviews I paid special attention to the experiences shared by the LCHWs with skill-resourcing needs (Kitzinger, 1995).

3.5.3 Observations

Observations made in individual and focus groups formed an essential part of the research study. During the interviews, these observations enabled me to validate what was heard and provided me with some natural setting experiences regarding the participants' work and educational context. I was very aware that I was observing across cultures, and, guarded against my personal observation bias to avoid overly or incorrectly interpreting non-verbal communication, such as body language. According to Thomas (2003), direct observation has the advantage of getting the information from natural or unplanned events. On entering the premises of the organisation, my unplanned observation process began, using senses as depicted in Figure 3.2. I noted how the participants interacted with each other formally and informally during their working sessions and listened without interference or participation, to how they communicated verbally and non-verbally with

one another. As far as possible, I observed and noted my interactions with each participant during the individual and focus group interviews. Based on the phenomenon under investigation, the construction of work meaning, which was a sensitive topic, and I observed the expressive movements of the participants during the interviews (Babbie & Mouton, 2007). These observations included looking at concerns that presented difficulties to participants as well as those parts of the interviews to which they could relate comfortably. During the interview breaks, I used the time to make notes of my personal observations and also recorded observations made outside the interview sessions, such as the interactions of the participants with the patients, orphans and vulnerable children, co-workers, supervisors and managers. These observations provided some 'natural-setting' experiences regarding the participants' roles in terms of work meaning whilst on duty.

As indicated by Denscombe (2010), my observations during the visits to St Joseph's, where I slept over for the duration of one week, can be characterised as direct field work within the participants' natural (palliative care) working environment. I was able to observe how supper was prepared in the kitchen and served to patients and OVC in the hospice. During the mornings, I observed how all the day and night staff and volunteers gathered in the staff room, to start their day with a Bible verse and a prayer before going about their daily duties, all in their natural work settings. I relied on relaxed, unassuming observation to gain insight into the context and setting of the research field, with regard to aspects such as the environment, community, families and caregivers in the community where the organisation was situated (Chambers, 2004; Reddy, 2003; Patton, 2002, Shah, 1995; Jijiga, 1994).

During the project site visits, when no interviews were scheduled, I visited the feeding schemes, vegetable gardens, and some of the drop-in centres. There I was able to observe how LCHWs assisted OVC with their homework received from school. I also observed how some of the older women participants showed younger women how to plant vegetables. At the hospice, I was able to observe how participants fed those patients who were unable to feed themselves. In this environment, I was able to understand and capture the setting within which the participants interacted, and also discovered responses and behaviours which were not captured in their interview responses. I observed how the

vegetable gardens were managed and the produce was used to cook and supply the communities with some of the vegetables that were harvested. At one of the community projects known as the *Cuddle Company*, I was able to observe how on-the-job training was conducted amongst staff, and the role of supervisors and manager as coaches.

I documented all observations in the form of field notes, wherever appropriate. I observed external physical aspects, such as resources in the work stations, working circumstances and facilities and employees' physical health conditions. I observed how the participants worked as individuals or as teams, their interactions with each other, as well as their interactions with the patients for whom they cared. Specific attention was given to movement, in the form of participants' posture, body language, facial expressions and eye movements. Attention was also paid to language behaviour, with particular focus on topics of discussion, stuttering or difficulty in expressing themselves fully in English, which was also a barrier, based on the language differences between the participants and myself. An important opportunity for me was when I could observe time duration in terms of the length that participants spent in their work and how they went about their daily duties. I was fortunate to observe participants' feelings, in instances where they expressed their emotions non-verbally. Importantly, and throughout the observation process, I was consciously observing myself, my background and approach to the field, as well as my interaction with the participants, by means of on-going self-refection (Chambers, 2004; Reddy, 2003; Patton, 2002; Babbie & Mouton, 2001; Fox, 1998). I was able to gain insight into the actual working environments in which participants fulfilled their daily tasks and captured their live visual data. I was in a position to observe the participants interacting with the patients in their own time and space, allowing me insight into their life-worlds, according to Emmison (2004). This process of observation is called direct observation of the social contexts of participants. In the context of this study, I regarded observation as an important part of entering the organisation as an outsider, and became engaged in observing the participants sharing their lives, existing knowledge and skills about their roles as carers who interact daily with HIV/AIDS patients. For the duration of this observation process, I was able to learn from these observed experiences of the participants. I observed by making use of my senses as described in Figure 3.3 below:

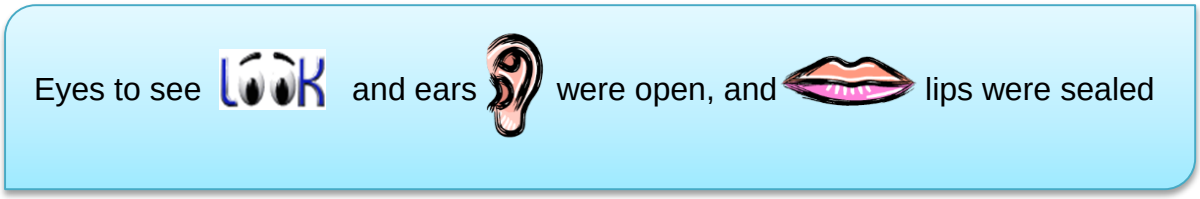

Figure 3.2: Observation through the application of senses

All observations were recorded in the form of observation notes, according to the description provided by Merriam (1998, p.104) that "the more complete the recording, the easier it is to analyse the data". The focus was on observing the interactions of the participants with each other, without any interpretation (Taylor & Bodgan, in Merriam, 1998, p.105). I used non-participant observation in order to enter the social system of the participants to observe their events, activities, and interactions with the aim of gaining a direct understanding of them whilst working in their natural setting at St Joseph's (Mills, Durepos & Wiebe, 2010). It was a valuable technique, and involved extended immersion in the life of the staff, volunteers and beneficiaries of St Joseph's Care and Support Trust at each site and project as part of discerning their habits and thoughts, and to deciphering the social structure that bound them together (Van Manen & Schein, 1979). Figure 3.3 (below) depicts the process of observations followed.

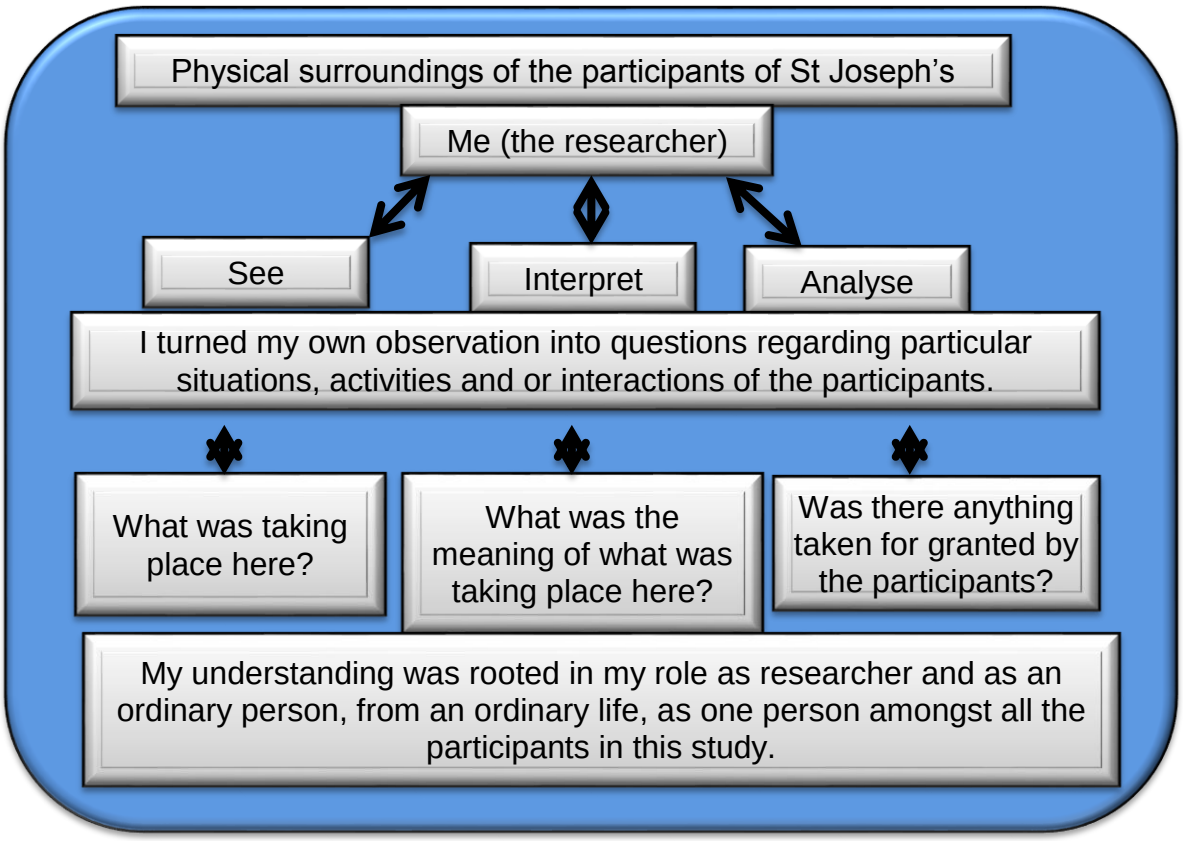

Figure 3.3: Process of observations

3.5.4 Documentation

The documents used by me in this study included St Joseph's Annual Reports from 2008-2013, their executive summary, and their training plan (refer to Appendices 10, 11, 12, pp. 285-321). These documents were made available by St Joseph's to enable me to compare and identify possible gaps during process of explication of the data. According to the explanation given by Punch (2005), documentary data, whether quantitative or qualitative, can be used in case studies in conjunction with other instruments. The documentation as an additional data collection method was used to corroborate and augment evidence from other sources. The documents were examined from different angles as part of enriching knowledge and understanding about the participants' experiences with the aim of

understanding what meaning they construct about the work in palliative care. These documents provided information about St Joseph's vision/mission, recruitment and selection processes, training and development, as well as the organisation's overall objectives and goals.

Data storage, which included all the audio recordings, field notes and filing of hard copy documentation, interviews transcriptions were stored electronically on multiple hard drives.

The following section explains the explication of data

3.6 EXPLICATION OF DATA

I intentionally used explication of data in this research study instead of analysis as Hycner cautions that 'analysis' has dangerous connotations for phenomenology. The "term [analysis] usually means a 'breaking into parts' and therefore often means a loss of the whole phenomenon… [whereas 'explication' implies an]…investigation of the constituents of a phenomenon while keeping the context of the whole" (1999, p. 161). I aimed at providing evocative descriptions of human actions, behavioural intentions and experiences as lived by the participants in their real life worlds. The themes from the study could therefore be seen as structures of experiences and offer a thick description of the phenomena (van Manen, 1997, as cited in Ajjawi *et al.*, 2007).

3.6.1 Bracketing and phenomenological reduction

In this study, bracketing provided a useful methodological device to demonstrate the validity of the study. According to Carpenter (2007), this is a methodological device of phenomenological inquiry that requires deliberate putting aside of one's belief about the phenomenon under investigation, or what one already knows about the subject prior to and throughout the phenomenological investigation. I did not know any of the participants, and

was unfamiliar with St Joseph's. I was therefore unaware of the possible challenges they were faced with prior to the formal commencement of this study.

According to Parahoo (2006), personal knowledge hinders the ability to research a topic thoroughly when we unconsciously bring assumptions about it into the research process. In order to limit or avoid any bias, regular engagements with the participants were initially used to work out practical strategies to facilitate bracketing. These bracketing strategies were addressed before conducting the data collection, explication and literature review, as part of the mental preparation of employing the phenomenological research method. Before choosing the research paradigm, the supervisor helped me to put aside personal knowledge. This attitude was upheld throughout the research study, maintaining interest and curiosity about the research question, and maintaining the core focus on the participants' experiences.

Polit, Beck and Hungler (2001), emphasise that bracketing allows one to confront the interview data in pure form; it is a process of separating out or removing any knowledge I have about the phenomenon of interest, so that the remaining information reflects what was said by the participants. Impartiality was maintained during the collection of data, with personal experiences of employment conditions according to the Basic Conditions of Employment Amendment Act (2013) being bracketed. For example, participants reported that there was discrimination and inequalities with regard to their permanently employment on the payroll of St Joseph's. It was sensitively explained to them that these were issues that needed to be brought to the attention of the management team in a different forum and that this study had to focus on their training and career guidance experiences. In another instance, they described their struggles and their need for money and social grants, and again this was managed in a sensitive and understanding manner. The phenomenological bracketing procedure further helped them ascertain and understand whether their responses to any of the interview questions needed to be corrected, and to ensure that there was no misinterpretation of the collected data.

3.6.2 Delineating units of meaning

I employed inductive thematic explication or pattern explication, often associated with a case study design (Creswell, 1998). In order to make sense of the raw data, my focus was on working with large amounts of detailed qualitative information, identifying core meanings in terms of themes, patterns, categories and interrelationships, and on working inductively. This made it possible to summarise and systematise the data, by placing specific sections of the data within the wider context of other gathered data (Henning *et al.*, 2004; Wilkinson, 2003; Patton, 2002; Mayan, 2001; Mouton, 2001; Ryan & Bernard, 2000; Creswell, 1998). The explication of data processing began at the initial stage of data collection and provided new insights and guidance on where to go, whilst the follow-up stages served to deepen insights. These later stages also confirmed or contested patterns that emerged (Smith & Osborn, 2003; Mayan, 2001; Morse, 1999). This study involved repeated visits to St Joseph's project sites in order to generate and collect data, with periods of explication of data and further planning in between.

During the data collection phase, all interviews were audio-recorded, after which, each one was manually transcribed. There were twenty-five individual interview transcripts and two sets of focus group interview transcripts. I listened repeatedly to the audio recordings and also read and re-read the interview transcripts to immerse myself in the data collected (van Manen, 1994), as well as reflecting on the context each day an interview took place. By immersing myself in the data, I was able to engage with the meaning of the texts, and thereby obtain a sense and preliminary interpretation of the texts, which facilitated the coding. I examined the raw data collected and worked with the texts that consisted of the transcripts and field notes, in order to become familiar with the texts, to obtain a general idea of what might be found, and to develop manageable classification systems or categories for coding. These were continuously discussed with my supervisor. Once I was fully acquainted with the raw data, generating open coding codes became much simpler. I started with brief notes in the margins during the initial reading, which served as the initial sorting process. Raw data were organised in such a way that possible topics, identified related themes, patterns, similarities and differences emerged, which later needed to be

named and listed. I employed member-checking in this study, and the participants were presented with the preliminary findings in terms of emerging categories, themes, and sub-themes, using the same terminology used by the participants. In line with Henning *et al.* (2004), Smith and Osborn (2003), Patton (2002), Terre Blanche and Kelly (2002), Creswell (1998), Webber and Ison (1995), Miles and Huberman (1994), the participants were given an opportunity to confirm themes, suggest corrections, elaborate or clarify where needed, thus encouraging further discussions on the already-created data base.

As soon as I completed the identification of possible themes, the initial phase, independent explication of data was also conducted before handing it to my supervisor for checking. I read through the data several times in order to start with the systematic formal coding process. I identified and organised principles of underlying data and re-arranged possible themes and categories continuously. Again I read and re-read the raw data until I reached saturation. Data was then sorted and coded, and thereafter, I grouped the codes into suitable categories under appropriate headings. This category formulation stage required me to develop a classification system in terms of families of themes that consisted of sub-themes, which resulted in an interpretation based on my views and on information that I had acquired from relevant literature, such as the annual reports from St Joseph's. On the odd occasion, I gained new insight, upon which I had to regroup codes. It became force of habit to continually identify relationships between the categories in order to identify emerging thematic patterns and develop analytical frameworks, thereby transforming my initial notes into phases that could capture the essence of what had been established. At times it was necessary for me to revisit identified categories, codes and even raw data. Once I had identified the emerging themes, I listed them in order to elaborate by identifying possible connections. I consciously focused on the refined nuances of meaning, attempting to make sense of the connections between themes and provide an interpretation of the lessons learned (reaching so-called assertions, as defined by Creswell, 1998). I made a concerted effort during the entire data explication process to reflect constantly on my personal involvement and influence on the results, looking for and explaining any contradictions. I purposefully referred back to the raw texts to ensure that the structure and identified themes and sub-themes accurately reflected the words and meanings of the participants (Henning

et al., 2004; Smith & Osborn, 2003; Terre Blanche & Kelly, 2002; Creswell, 1998; Mertens, 1998; Miles & Huberman, 1994).

The term used to name a category or theme was taken from the responses given by the participants, and created because it represented some common event and imagery from them during the data collection process. The aim was also to ensure that the "conceptual name or label suggested by the context in which an event was located" (Strauss & Corbin, 1998, p.106) linked according to its relatedness. Each individual interview and audio-recording was labelled P1 (participant 1) to P25 (participant 25), and the first focus group interview audio-recordings were labelled FG1p1 (Focus Group 1, participants 1 to 11), whilst the second focus group audio-recordings were labelled FG2p1 to 10 for easy identification and reference.

3.6.3 Explication of individual interviews

All the interviews were conducted in English. Where required, the interpreter assisted with the translation for those participants who could not articulate themselves clearly in English. A few months were spent reading and re-reading the transcriptions to become immersed in the data during this intensive reading process (Burns & Grove, 2001). After completing identification of the initial possible themes, I read through the data for a second time, in order to start systematically with the formal coding process. All the transcriptions were thoroughly read a number of times, followed by a rigorous data induction process. Meaningful units were articulated and transformed into psychological expression and finally synthesised into themes and sub-themes. Interviews were tape-recorded and transcribed verbatim (refer to Appendices 9a).

3.6.4 Explication of focus group interviews

All interviews were explicated individually, including the two focus groups. Common patterns were shared in particular instances, often by identifying essential categories and themes, because this was a case study (Polit & Beck, 2004). On the other hand, in a

phenomenological investigation it is not critical to generate general trends or patterns for the purpose of generalisations, since the experiences of one participant are as important as the collective experiences of all (Burns & Grove, 2001).

In this study, in particular for the individual and focus group interview explication, six principles were adopted which included the complete transcribing process for all interviews, reading the individual transcriptions of the entire interviews, data reduction, determining meaning of units from raw data, articulating and transforming meaning units into psychological expression, and synthesising all transformed meaning units obtained from the raw data during the explication process. The audio-recordings of each interview were listened to several times to obtain the essence of the descriptions given by the participants, after which they were read and re-read a number of times (minimum of four) to obtain an understanding and suitable meaning of their responses. Throughout the listening and reading process of the interview audio-recordings and transcriptions, openness toward the responses was maintained, consciously and continuously avoiding bias and presuppositions. This process helped with objectivity and avoided influencing or tainting the research process.

3.6.5 Observations explication

Explication of the observation notes taken during the data collection process was performed in a meticulous manner as part of the process of recalling data. The explication from the observations stemmed from the notes I had written during the non-participant observation activities as indicated in 3.5.3. Throughout my interactions with the LCHWs, as a participant and non-participant observer, I had opportunities to observe them as they engaged in their daily project activities, without being noticed. I also had opportunities to observe them during activities where I could be involved, such as the feeding schemes. Here I observed the interaction between the LCHWs and the OVC as they served the food and no communication took place, except when the OVC received the plate of food and said, “Thank you”. During a counselling session, I was able to observe how LCHWs found it difficult to relate to some of the patients who failed to adhere to their antiretroviral

treatment; some patients would just cry, whilst others became aggressive and threw the water and tablet out; others would just nod their heads, showing no emotion or expression on their faces LCHWs helped OVC with their homework after feeding them, and I was able to observe the social differences among the OVC, and how some of them lacked the confidence to answer questions when asked. It was also obvious, during the daily visits to the hospice, how LCHWs were unable to communicate with some of the patients, because an interpreter was always called for assistance. I further observed during the trauma and bereavement counselling session with patients and OVC that LCHWs demonstrated difficulty in talking to those affected. Some of the LCHWs would leave the room without saying a word to the people who had lost a loved one; at times both the LCHW and the OVC or the patient were in tears.

3.6.6 Document explication

I read all the annual reports that covered areas where groups of LCHWs worked on the organisation's mission and vision statement. I also read minutes of meetings, newsletters and annual reports that St Joseph's provided me. In order to get a real understanding of what was happening in their working environment, reading these documents served as a reflection of the participants' lived experiences, because this was how their daily experiences were recorded. These documents also allowed me to highlight and pursue possible contradictions in the evidence that emerged from the results, based on any inconsistencies between the data cleared in the documents and the interviews, and in my observations of the participants. Documentation, or the physical evidence (artefacts) used in this study were St Joseph's Annual Reports 2008–2013 (refer to Appendix 11, p. 315), Executive Summary of St Joseph's (refer to Appendix 10, p. 285), and their Training Plan (refer to Appendix 12, p. 321).

In addition, the explication of the documentation was partially done prior to conducting the interviews with the participants. By using this document explication angle, my understanding and perspective about work meaning construction in relation to the participants' existing knowledge and skills about their roles in an HIV/AIDS palliative care

setting, were further enriched. This document explication method enabled me to identify and highlight contradictions and inconsistencies between the data cleared in the documents, and the content of the interviews conducted with the participants. According to Yin (2003, p.87), "For case studies, the most important use of documents was to corroborate and augment evidence from other sources". I applied this guideline in this study.

3.6.7 Triangulation

Different data collection methods, sources and participants were used as part of the triangulation process. With regard to triangulation of data, Janesick (2000, p.392) proposes the use of the term 'crystallization' in qualitative research, as this concept "recognises the many facets of any given approach to the social world as a fact of life". Triangulation in this study relied on multiple perspectives, involving various methods, participants and sources, aimed at clarifying meaning and obtaining a deeper understanding of the data. Triangulation was used to compare data collected through multi-methods, such as interviewing (individual and focus groups), audio-recordings, observation and document explication, and to collect and report multiple viewpoints from different participants, in various ways (Patton, 2002). The information obtained from the individual and focus group interviews was compared with observations made during the interview process, and afterwards matched to the documentation supplied by St Joseph's, which included their training plan and executive summary.

3.7 TRUSTWORTHINESS

In order to meet the criteria of trustworthiness, I relied on critical self-awareness, not regarding myself as the expert, but being open to listening, learning and facilitating rather than to speaking, teaching and controlling the participants in this study (Chambers, 2003). The presentation of samples of raw data in the appendices, including samples of the explication as it progressed, and the member-checking process, allowed participants to verify their quotes and correct any misinterpretations. According to Patton (2002), the observation notes served as a tool for me to reflect upon any potential bias and to discuss

these with the supervisor. Methodological triangulation allowed for consideration of the data from different sides.

I attempted to enhance methodological coherence by selecting data collection and explication methods that would best address the research questions in this study. The selected paradigm, context, purpose of this research study, research design and data collection strategies support one another and correspond logically. The notion of trustworthiness captures the idea of the neutrality of findings and/or decisions within the research process.

The following section outlines the four strategies: *credibility, dependability, transferability and confirmability* as part of enhancing the trustworthiness illustrated in Table 3.1.

3.7.1 Credibility

Credibility implies a feeling of confidence in the observations, data interpretation and conclusions that I used in this study. These were supported by the raw data and matched with the descriptions given by the participants. Answers to the questions were related to the extent of the findings, their truthfulness and whether the trail of evidence was believable. Most importantly, credibility relates to professional integrity, intellectual rigor and methodological capability (Lincoln & Guba, 2003; Patton, 2002; Mayan, 2001; Seale, 2000; Creswell, 1998; Fox, 1998; Mertens, 1998).

Continuous engagement and observation, together with triangulation, made it possible "that credible findings will be produced" (Lincoln & Guba, 1985, p.301). The individual and focus group interviews held with the participants increased the amount of time spent with them through the data collection process, which made the findings more credible (Seidman, 2006). My on-going interaction and involvement with the participants during their daily activities encouraged them to open up by interacting and speaking more freely when I was with them, and this also strengthened the credibility of the study (Lincoln & Guba, 1985).

Member-checking tested my findings and interpretations with the participants from which the data originated (Lincoln & Guba, 1985; Merriam, 2002). Applying member-checking to the feedback received from the participants was important in testing the accuracy of the explication of data, due to the phenomenological nature of the study. Lincoln and Guba (1985, p.314) regard member-checks as "the most useful technique" for establishing credibility.

3.7.2 Dependability

Dependability, according to Guba and Lincoln (cited in Mertens, 2005), is the qualitative parallel to reliability or stability in quantitative studies over time. In this study, dependability implies a certain degree of consistency with regard to the measuring instrument, in this case, I, the researcher, when conducting a qualitative study. According to Holloway (2005), dependability is related to consistency of findings, which if repeated in a similar context with the same participants would be evidence of consistency. To ensure dependability or consistency in this study, I explained the concepts and theories behind the study, my position with regard to the LCHWs and St Joseph's being studied, the basis for selecting the participants and a description of them, and the social context from which I collected the data. I discussed the research methods applied in this study in full; the extent to which data was accounted for was ensured through extensive literature contextualisation and by aligning the data to existing theoretical frameworks underpinning this study. A full description of the research methodology was provided through an audit trail that helped in explaining the process of this study (Lincoln & Guba, 1985; Merriam, 2002).

3.7.3 Transferability

According to Byrne (2001), *transferability* is used to judge the extent to which the findings of a study can be applied to other contexts, whilst for Polit and Hungler (1991, p.645) *generalisation* is the "degree to which findings can be generalised from the study sample to the entire population". A serious allegation levied against the qualitative inquiry method is its inability to generalise the findings from such research (Cohen, Manion & Morrison,

2000; Hardy & Bryman, 2004; Punch, 2005), mostly because of the small samples involved (Hamel, Dufour & Fortin, 1993; Yin, 1994) and because such studies are often difficult to replicate (Myers, 2000). Having said this, Myers (2000) argues that partial generalisation may be possible to similar populations; however, it should not be the primary concern of qualitative research because the knowledge transferability in this research study was significant in its own right, and the challenges related to sampling and generalisation have limited relevance to the aims of this study. The intention of this study is an in-depth understanding of the concerns raised.

The focus of this study was on St Joseph's Care and Support Trust only and all the projects that it was running. Therefore, it involved purposively selected participants whose voices did not represent the wider community of Bronkhorstspruit. The results and findings cannot be generalised or applied to other settings. However, the proposed skill framework may apply to other community projects although it would require some customisation according to their specific needs and requirements. In order for other researchers to use the findings appropriately in similar settings or contexts, rich and detailed descriptions of the context and background of St Joseph's and the process throughout this research study have been provided (Kelly, 2002a; Janesick, 2000; Seale, 2000; Mertens, 1998). Transferability was addressed through immersion in the data and providing rich and thick descriptions of the data and findings to strengthen the credibility of this study (Merriam, 2002).

3.7.4 Confirmability

Confirmability, according to Morse and Field (1996), refers to the manner in which the research findings are established as the actual product of the participants' description of information, being the outcome of the conditions under which the research study was conducted, and not the result of my preconceived ideas. Confirmability, demands neutrality that indicates no bias in the findings (Krefting, 1991). I entered the research field with the possibility of personal subjectivity, personal biases and prejudices, which are often present in descriptive phenomenological research studies. Thus, from the outset of this study, it was necessary to clarify any issue that might arise with participants on a regular basis.

Constantly guarding against her own biases, I focussed and interpreted the data as provided by the participants to ensure confirmable results and conclusions at the end of the study (Patton, 2002; Seale, 2000). Participants were involved during the explication of data and interpretation processes, when I reflected preliminary interpretations to them to obtain their views, clarification or additional comments.

My supervisor also assisted in ensuring that the interpretations and conclusions were supported by the data and an audit trail was included, which is evident in the description of interpretations and research processes employed, in order to reach the required conclusions as suggested by Babbie and Mouton (2001), Seale (2000), Fox (1998), and Mertens (1998).

Table 3.1: Strategies employed to ensure trustworthiness of the study

STRATEGY	CRITERIA	APPLICABILITY TO THIS STUDY
Credibility	Prolonged engagement and extensive field work	Extensive field visits over a period of four years; numerous months working on the raw data from the transcribed interviews.
	Reflexivity and research bias	Document observations used to describe the context and environment. Reflection on personal experiences, feelings, competencies and bias regarding the research study.
	Data triangulation	Twenty-five individual phenomenological in-depth interviews conducted; two focus groups, consisting of ten and eleven participants respectively.
	Member-checking	Repeated verification of emerging themes based on data collection and preliminary explication with the participants. After each interview, interview sessions summarised for the participants to correct or clarify any misinterpreted or misunderstood descriptions.
	Peer review	A doctoral candidate from another tertiary institution assisted in reviewing the data and research process.
	Authority of the researcher	Experienced human resources practitioner, extensive knowledge of and exposure in interviewing.

Table 3.1 (continues) Strategies employed to ensure trustworthiness of the study

STRATEGY	CRITERIA	APPLICABILITY TO THIS STUDY
Dependability	Audit trail	The research methodology fully described. Examples and evidence of observation notes, raw data, explication of data and interpretations provided to serve as an audit trail.
Transferability	Sample Dense description	Purposive sampling method was applied in this study. Complete description of phenomenological research methods given; verbatim quotations from collected data provided. Providing a dense description of data will help other researchers apply it in similar contexts.
Confirmability	Confirmability audit	From the outset, clarification given of any issue that might arise with participants. Constantly aware of own bias, I strove to obtain confirmable results and conclusions (Patton, 2002; Seale, 2000).

3.8 MY ROLE AS RESEARCHER

In this study, my role was distinctly that of the researcher. When I entered the research field, I was aware of the differences in backgrounds between myself and the participants, therefore, I constantly reflected on the potential influence of my status on the knowledge and meaning that took shape. I paid extensive attention to interactions with the participants, to gain insight into their views. During these interactions, I actively took a stance to be understanding, sensitive and, at the same time, maintain a distinct balance between getting too involved (with the implied danger of subjectivity and influencing judgment) and being already involved (which might have harmed relationships and inhibited understanding). I thus practiced empathetic neutrality. I was responsible for the content presented in the thesis, and therefore had to ensure that the representation of what transpired and what I found in the study was factual and true.

Merriam (1998) believes the importance of the researcher in qualitative research cannot be over-emphasised, as s/he is the primary instrument for data collection and explication, as was the case in this study. As a human resources practitioner, specialising in recruitment and selection of prospective employees, I consciously did not enter the study process wearing that hat, because personal bias would complicate the process.

As a way of avoiding the role of judge, I observed and recorded the events as they transpired during the research process by adopting the 'participant-as-observer' and 'observer-as-participant' method. The qualities of *Ubuntu*, human kindness or humanity to others, which is a core element found in relationships and interactions in the human resources working environment, enabled me to build a basis of good rapport, understanding and communication with the participants. My main focus was the perceptions and contributions of the participants, and I attended to their voices throughout, supporting those voices with my field notes and observations. I then derived meaning from an understanding of the phenomenon under investigation in the participants' own terms (emic approach). I went to the extent of swopping roles, (whereby, I was the interviewee and the participants were the interviewers) with the participants in an attempt to understand their practices and

perspectives (Henning *et al.*, 2004; Kelly, 2002b; Babbie & Mouton, 2001; Denzin & Lincoln, 2000).

Miles and Huberman (1994, p.201) suggest that the essence of credibility is the unique authority of the researcher, the "I was there element". In this study, I entered the research field as someone coming from a background different from that of the participants, and was therefore very mindful of possible personal influences on the knowledge and meaning that took shape in the interview processes. This is in line with Kelly's (2002b) proposal that interpretivist studies employ both an insider and outsider perspective. Throughout this investigation, I networked with the director of St Joseph's, the training and development manager, my supervisor, and the participants to keep them up to date with my visits to St Joseph's and my contact with the participants. I had to reflect continually on who I was, and on all the assumptions, biases and values I had when entering the research field. I relied on an interpreter to overcome language barriers, and I tried not to speak on behalf of any of the participants. I managed to focus on my research and area of enquiry and endeavoured to remain focused and not to allow my investigation to move beyond the research focus area.

3.9 ETHICAL CONSIDERATIONS

Ethical principles are based on respect for human beings and their experiences, and in research they serve to safeguard the dignity, rights, safety and wellbeing of each participant (Creswell, 1998). The study remained within the bounds of research ethics in that no participant was subjected to any harmful environment or circumstance (Schurink, 2005). I was sensitive to moral issues, as "each stage in the research sequence, may be a potential source of ethical problems…" (Cohen, Manion & Morrison, 2000. p.49).

The following steps were taken:

i. Written requests were made to the Ethics Committee of the University of Johannesburg, and the Board Members of St Joseph's to conduct the research. Permission and accessibility was granted by both bodies (refer to Appendix 1, p. 259).
ii. The research purpose was explained, as well as the method to be used to collect data, which was the interview process. Participants' consented to audio-recorded interviews (refer to Appendix 3, p. 262). The recording helped ensure that all information was correctly presented in the report.
iii. Participation was voluntary and each participant was given the freedom to withdraw from the research process at any time they felt they needed to and without being penalised. No names were mentioned anywhere in any report, and data were kept safely in a locked cabinet. They will be destroyed two years after publication, or after five years if no publications emanate from the study.
iv. I am an experienced human resources practitioner who ensured that interviews were arranged when it was convenient for the participants. Debriefing happened on request from certain participants. An African woman human resources officer from St Joseph's, who volunteered to be the interpreter, assisted with translation when required. She translated and interpreted interviews when LCHWs were unable to express themselves in Afrikaans or English. The human resources officer also helped with interpretation during the debriefing sessions.
v. Feedback was given to St Joseph's in the form of a report, made accessible and available to all participants upon request. Further feedback will be given to project managers, training and human resources and other members of the management team at St Joseph's once the study is completed. An oral feedback session was to be coordinated by St Joseph's for all participants after completion of the research study.
vi. Each participant was approached through an introductory interview session to obtain their completed and signed consent forms. The collected consent forms were

signed by my supervisor and the information will be made available in a scanned format on a compact disc.

vii. The research purpose was explained to the participants during the introductory meeting at the beginning of the initial phase. The interview methods and the time slots for each participant and focus group were clarified.

viii. *Confidentiality*, according to Polit and Hungler (1999), means that no information that a participant divulges is made public or available to others. In this study, the confidentiality procedure was explained in detail to the participants at the outset of the research process, prior to receiving their signed consent forms.

ix. The *anonymity* of a person or an institution is protected by making it impossible to link aspects of data to a specific person or institution, as confirmed by LoBiondo-Wood and Harber (2002, p.273): "confidentiality and anonymity are guaranteed by ensuring that data obtained are used in such a way that no one other than me and my supervisor knows the sources". All the participants were assured, in writing that their identities, as well as the interview data collected from them, would not be made public without their approval. However, they were all informed at the beginning of the study that the data might be available in a printed format after the completion of the study.

3.10 CRITERION OF AUTHENTICITY

The genuineness of this qualitative study was determined in terms of impartiality and implied ontological and tactical authenticity (Lincoln & Guba, 2003; Mertens, 1998). The ontological authenticity was obtained by the participants' views and description of their experiences in their life-worlds that became enriched as the study progressed, resulting in a clear understanding of the overall need for St Joseph's to have a well-planned training and career guidance strategy in place. The techniques and strategies applied and described above strengthened the credibility, transferability, dependability, and confirmability of the findings of this research study, which contributed to an overall increased trustworthiness. (See Table 3.1 above)

The phenomenological research design contributed toward the truth of this research study. I bracketed myself consciously in order to understand perspectives of the participants interviewed and the phenomenon which was investigated in this research study, that "the focus [was] on an insider perspective" (Mouton & Marais, 1990, p. 70).

Audio-recordings were made of each interview and again, I bracketed myself during the transcription of the interview to further contribute to truth. Thereafter, the participants received a copy of the texts to ensure that it reflected their perspectives regarding the phenomenon that was investigated. A further attempt to meet the authenticity of a qualitative study, according to Lincoln and Guba (2003); Mertens (1998), is determined in terms of fairness and implies ontological, catalytic and tactical authenticity. In order for me to meet this criterion, I included a range of different perspectives (realities) and contributions obtained during this investigation. I reported on contradictions and conflicting values, which allowed me to stick to the criterion of fairness. Ontological authenticity was obtained by the participants' views and experiences of their life-worlds becoming more enriched as the investigation progressed, resulting in a better understanding of their roles as carers in working in an HIV/AIDS palliative care environment. As a way of further enhancing ontological authenticity and reporting on changes in the constructions of participants, member-checking was used in this investigation together with an audit trail.

Impartiality and implied ontological and tactical authenticity (Lincoln & Guba, 2003; Mertens, 1998) determined the genuineness of this qualitative study. The ontological authenticity was obtained by the participants' views and description of their experiences in their life-worlds that became enriched as the study progressed, and resulted in a clear understanding of the overall need for St Joseph's to have a well-planned training and career guidance strategy in place.

The techniques and strategies applied and described in the aforementioned sections strengthened the credibility, transferability, dependability, and confirmability of the findings of this research study, and contributed to an overall increased trustworthiness, as outlined in Table 3.1 above.

3.11 SUMMARY OF CHAPTER

This chapter consists of a description of the research design and methodology applied. The different methodological concepts and techniques were explained, and the chapter covered the qualitative research approach, paradigm, and the design. Research methodology was outlined, describing the processes of sample selection, data collection and the explication of data. Ethical issues that affected the process of this study were elaborated. Specific reference was made to trustworthiness, and particular reference to the four main strategies of credibility, transferability, dependability and confirmability, as well as the triangulation and authenticity of this research study. In Chapter Four the results are discussed in detail.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents a discussion of the explication of collected data as described in Chapter Three, followed by transcripts of the experiences shared by the participants through the individual and focus group interviews, observations made by me, and the documentation obtained from St Joseph's, which included the executive summary of St Joseph's, Annual Reports 2008-2013, and the training plan. The discussion is structured according to the three main themes, as illustrated in Figure 4.2, namely, knowledge needed by LCHWs, skills to be acquired to work more efficiently, and organisational challenges. I discuss the themes that emerged during thematic explication of the raw data. Verbatim responses were used to enrich the discussions.

The findings were based on the lived experiences and perceptions of the participants about how they make meaning of their work in their HIV/AIDS palliative care setting. A general case study data process consisted of individual and focus group interviews. Data were collected in a fieldwork context, in the natural setting of the participants, which was mainly at the premises of St Joseph's and at the various community project sites where participants operate in and around Bronkhorstspruit. I gathered the data through twenty-five individual interviews, two focus group interviews, one group presenting ten project leaders and the other presenting eleven volunteer workers (see Figure 3.2). Qualitative interviewing was applied to explore the participants' lived experiences and perceptions of their roles as carers in an HIV/AIDS palliative care environment. I had no prior contact with any of the participants until the inception of the formal interview process.

According to Richards and Morse (2007, p.37), linking the labelled data "leads you from the data to the idea and from the idea to all the data pertaining to that idea". Thus, phrases and sentences used by the participants were linked to the relevant identified categories and numbered next to each emergent category as explained. The transcripts were compiled according to the example provided in Table 4.1 below.

Table 4.1: Visual description of transcript labelling

Individual and focus group transcript labelling examples (voice of the participants)
P1 = participant 1
FG1p1 = Focus Group 1, Participant 1 (1–10)
FG2p1 = Focus Group 2, Participant 1 (1–11)

The following extracts depict how the coding process was conducted. An example of the raw data that were manually coded into emergent categories is presented in Appendix 8, p. 268.

The full transcripts are available on a compact disc.

HOW DO YOU THINK YOU WILL REALLY BE ABLE TO IDENTIFY WHEN PEOPLE ARE FROM GRASS ROOT LEVEL, TAKING INTO CONSIDERATION THAT ST. JOSEPH'S FOCUS IS BASICALLY MORE FOCUSED ON THE PEOPLE WHO ARE ALREADY QUALIFIED? ...

Staff with skill resourcing needs

No, not really already qualified because when you look at the courses which are offered, there are people who are just from the grass roots. I wouldn't term those already qualified; they would have had 1 or 2 or 3 weeks of a workshop here and there. So they are not really qualified and they still need improvement.

Training needs

It is not worth marketing the thing; we do not expect people to come with certain enquiries, are you referring this? People should know which and the people see that we are offering this.

AND WHO IS OUR TARGET MARKET OUT THERE? AS YOU SAID EARLIER IT IS THE ONES WHO CAN AFFORD IT. ...

Training courses and programmes

This is on the beneficiaries but because of the target market in terms of where we get funding ... I think we had to sign papers that came to us last week. Then they were saying that we were offering this thing of training of home based carers, workers, we are looking for someone. But then we said that these people don't know that we are offering this, we can do this. That's when we pulled ... do this. Then they said we had been advertising for this and nobody knew. So that's when they gave us the idea that maybe we are now going to do the training. In other words, what I am trying to point out is that our marketing ... is ... That is one thing which we will need to put up if we had to set it up separately, nicely.

Training marketing

... CAREER PATH, NEAR THE END.

Career management

It never ends because right now I am still studying. Sometimes I get bored and I study when I am bored. I am doing my CIMA exams but when I look at those examinations, those qualifications, I don't see how I can use them here. The place is too small for me to use those things.

Career guidance

Career pathing

SO WHAT ARE YOU SAYING? YOU ARE IN THE WRONG PROFESSION?

Career pathing

No, I am in the right profession. I enjoy my profession. What I am saying is – I don't know how to explain this. I think the only thing which remains now is, if I were going to have my way, is to streamline the operations of this place. That is the only thing.

Figure 4.1: Example of Coding Process

4.2 OVERVIEW OF THEMES

This section presents the data as obtained from participants through the individual and focus group interviews, observations and document explication. The results are presented in terms of the emergent themes and sub-themes; the discussions are supported by the responses received from the participants and presented verbatim.

4.3 PRESENTATION OF FINDINGS

The focus of this study was to show how the LCHWs in this study construct meaning of their work as carers in their HIV/AIDS palliative care setting. Meaning constructions were related to their perceptions about the knowledge and skills required in their jobs as well as their perceptions about St Joseph's. In relation to the focus of this study, and based on the findings, it is clear that: (i) there is meaning construction in terms of knowledge, (ii) there is meaning construction in terms of skills, (iii) and there is meaning construction in terms of organisational challenges. The three main themes are discussed, as shown in Figure 4.2, each according to their respective sub-themes[3].

It is clear, according to the findings, the meaning participants construct is that they actually feel ill-equipped and that they do not have the necessary knowledge and skills to work efficiently, as discussed in the first two themes: knowledge and skills needed by the LCHWs.

[3] Only theme three had sub-themes.

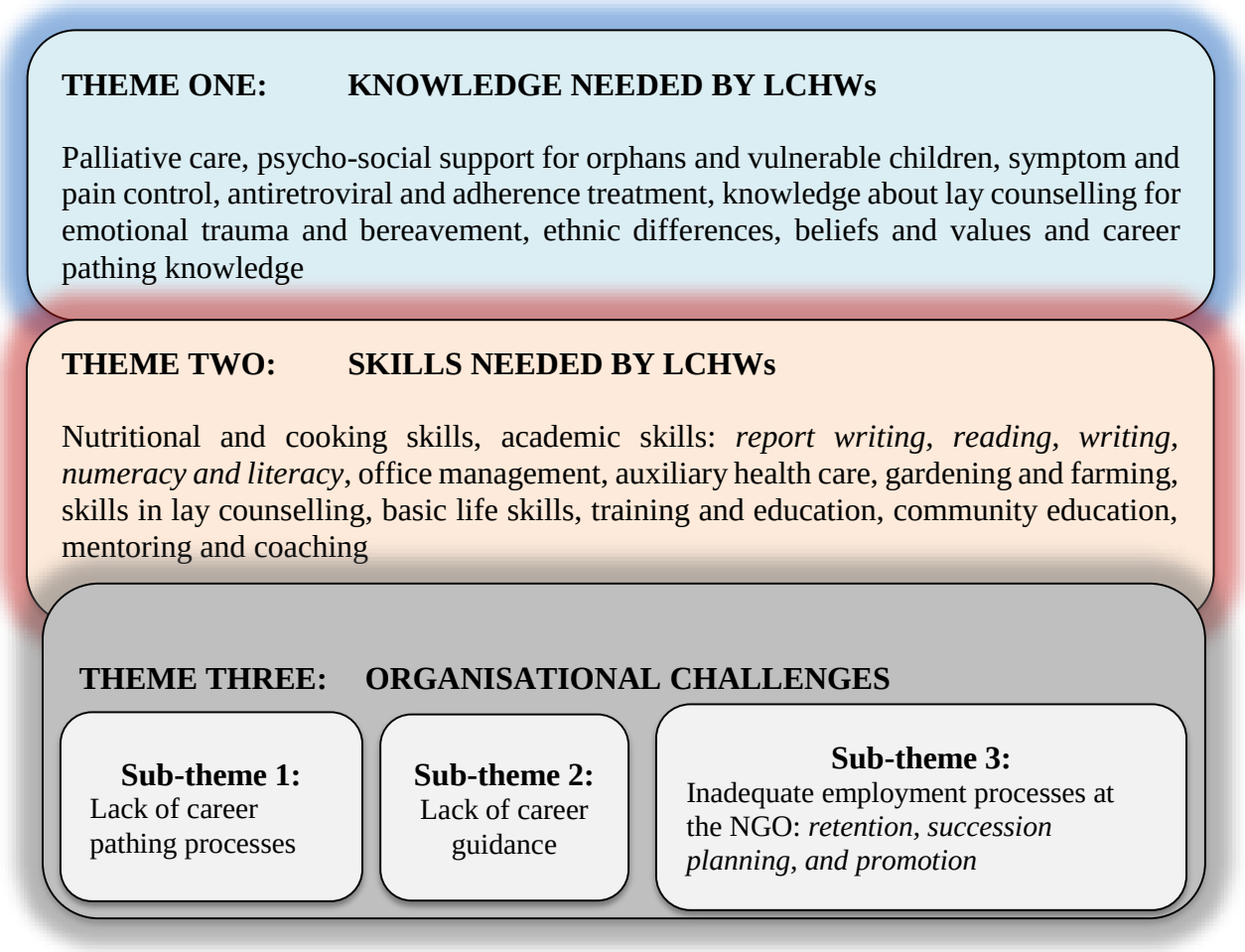

Figure 4.2: Presentation of themes and sub-themes

4.3.1 Theme one: Knowledge needed by LCHWs

In terms of meaning construction, the first meaning that LCHWs construct from their work situation is that they do not have the necessary knowledge, or adequate knowledge, to be able to function optimally.

There are particular aspects of knowledge that the participants pointed out, namely:

1) They needed knowledge in terms of palliative care itself.
2) They needed knowledge of psycho-social support for orphans and vulnerable children.

3) They needed knowledge on how to assist patients, orphans and vulnerable children with symptom and pain control.
4) They needed knowledge to help patients, orphans and vulnerable children to adhere to antiretroviral treatment (ARVs).
5) They needed knowledge to provide lay counselling for dealing with emotional trauma and bereavement.
6) They needed knowledge to handle the ethnic differences in their groups, including their different beliefs and values with regard to their career pathing knowledge.

In terms of the knowledge issues raised, evidence to substantiate these claims is captured in the following verbatim discussion:

Palliative care: LCHWs at St Joseph's are responsible for all palliative care, and are expected to consult with the patients, to whom they explain the options that they have about specific treatment for illnesses. However, they felt that they did not have in-depth understanding of what palliative care is all about, as confirmed by a participant: *"Very few people have an idea what palliative care really is about" (P23).* One of the participants mentioned that training in palliative care would enhance their understanding: *"But we haven't developed a course to do palliative care, understanding on that level of home-based care and child carers" (P24).* This was supported by P2, who pointed out the following: *"If a patient comes, what is expected of me, what do I do before I call the doctor, I must do something so that when the doctor comes at least he must see I have done one, two, and three, and then he can continue from there – we should observe the doctor."* In addition to needing training in palliative care, participants mentioned that it was important for people to know about HIV/AIDS, in order to have a better understanding of palliative care. This was explained by a participant: "*I also maintain there is a whole lot of AIDS education going out there. But there is very little that the people understand of it. The rural people are not educated people. We must start from the bottom again; educate them about your body, what is the immune system." (FG2p11)*[4].

[4] All participants' responses were verbatim quotes, with grammatical errors retained.

P24 gave a detailed description of how she found knowledge and information sharing important for people in the community who were involved in palliative care: *"We've got some clinics, government clinics, but we do have some people who may be lacking knowledge about this disease which is very high in our community and people are killed by this disease. If our community can get that information or get people who have knowledge about HIV and everything, being educated in nursing and everything, we will be fine."*

Palliative care includes home support and assistance to families in distress with respite care to caregivers. One of the participant's expressed one way of support: *"We are not training people because they are HIV infected; we are training people to look after people who are HIV infected" (FG2p10).* One of the participants was not happy about the manner in which operations were managed in the Hospice: *"We cannot operate in the same way we have been operating five years ago, by saying Hospice" (FG1p9).* The following opinion was provided by P25: *"People need knowledge to deal with HIV status and treatment"*.

Patients in need of palliative care were placed at the Hospice of St Joseph's, and cared for. This statement was corroborated by St Joseph's Annual Reports 2008-2013, stipulating that the Hospice provide institutional palliative care, which included symptom and pain control as well as psycho-social support to adults and children. Participants regarded nursing as a scarce skill at St Joseph: *"We don't have a lot of nurses trained in palliative care at this level" (FG2p8).* It was observed during visits to the Hospice how many of the LCHWs workers found it difficult to move the bodies of the terminally ill patients from side to side when they needed to be washed, fed or required any other physical attendance. Most of the time there was only one nurse on duty and it was not easy to assist all the LCHWs with the challenges they encountered. Their sad, and unhappy faces and slow walking demonstrated that they were uncomfortable during those processes.

Psycho-social support for orphans and vulnerable children: Psycho-social support is regarded as an important area in the work of LCHWs. In their view, psycho-social support addresses the ongoing psychological and social problems of HIV/AIDS infected and

affected individuals at St Joseph's. They acknowledge their responsibility, which involves care and support to orphans, vulnerable children, families and communities, as highlighted in the following supporting statements: P18 viewed psycho-social support to orphans and vulnerable children as: *"In the… district we've got two orphans and vulnerable children (OVC) programmes for Saint Joseph's. It is getting the help from Saint Joseph's, so right now it belongs to Saint Joseph's but it was meant for orphans and vulnerable children; we are doing psycho-social support, which is when you make the child grow up, you teach her the life skills and then you make her to talk about death."* Another participant specified how they actually take care of orphans and vulnerable children as part of their daily psycho-social support duties: *"We cook for them, twenty-two of those children they come to the feeding scheme and then we do homework supervision and then after the homework supervision we do social support" (FG1p6).* The following participant described another category of people who benefit from the psycho-social support provided: *"Beneficiaries are the people who are beneficiaries from our organisation, so you find that mammas have passed away and then the child will be our beneficiary" (FG2p1).*

The importance of psycho-social support was also supported in the document explication in which the compliance of the home-based care programmes with the South African Department of Health Standards was described, and the care covered by psycho-social support was highlighted (St Joseph's Annual Reports, 2008-2013.

Apart from providing psycho-social support to the orphans and vulnerable children, participants made it clear that they needed additional knowledge and understanding of other ways to provide adequate counselling during their psycho-social support sessions to those OVCs: *"I started there with the loving of the kids, without any knowledge but a loving of kids" (P2).* The next participant explained her need for knowledge: *"I want to be trained more, to know more about children; it is only for the love of children and I have not yet trained" (P13).* One of the participant's views was expressed as follows: *"When it comes to child-care people don't really understand what child-care really means" (FG1p4).* Another participant how she needed knowledge in psycho-social support for children: *"How to manage the mind of a child" (P22).* The following participant said: "*We visit the*

family and see that families also get the right information on how to treat orphan and vulnerable children, because it is not an easy task to deal with these children on a daily basis" (P3). The above was confirmed by an observation I made during one of the field visits. She noted the body language (sighing, frowning and shrugging of shoulders) of the volunteer workers who found it difficult to console an orphan child that was crying. According to the document explication, the importance of psycho-social support at St Joseph's was also highlighted in their Annual Reports 2008-2013.

*Symptom and pain control**:*** The participants provide quality care and comprehensive support to the dying patients, thus it is important for them to know about symptom and pain control to provide the necessary care, love and empathy: *"We are feeding the patients, bathing the patients, changing the linen and things like that" (P1).* Another participant who needs to know how to react in times of emergency, described the following: *"If maybe a patient is very, very sick, I must try to phone here; I must try to book her here at St Joseph's, and maybe she is very sick or she is dehydrated, I know what to give her" (P6).* During day visits to the Hospice, I observed how LCHWs were actively running around trying to ensure that all patients were comfortable, eating properly and escorting those who could walk to the bathroom. It was clear from the observations that LCHWs were stressed and some showed forms of panic during those periods.

Antiretroviral and adherence treatment: Successful antiretroviral treatment depends on sustaining high rates of adherence. However, the participants were faced with the challenge of not having the required knowledge to make treatment more accessible by creating a supportive environment for the patients. This was confirmed by P25 who said: *"People need knowledge and skills to deal with HIV status and treatment" (P25).* One of the participants, who is also infected by HIV/AIDS, said: *"To help the people to help the sick people, like me, I am HIV positive and that's why I like to be close to those people". (FG2p10).* The importance of adherence treatments was highlighted: *"Others are good with adherence, others are not good with visiting, and we needed those people who can excel in adherence" (P23).* The documents analysed, St Joseph's Annual Reports 2008-2013, confirmed that LCHWs conduct home visits to ensure that children do not default on

their treatment. These home visits added to the participants' need for knowledge about HIV/AIDS. However, one of the participants pointed out that some of the patients were not willing to go the extra mile for their treatment: *"So we have allocated days to do that and we do give treatment to those who are willing to take it locally. Most of the time the patients complain that they are not able to come here because this area is very awkward to reach" (P8).* During the field visits to one of the projects, a participant struggled to explain to one of the patients why it was important for him to eat, and what the purpose of healthy eating meant for him in his condition.

Knowledge about lay counselling for emotional trauma and bereavement: The participants at St Joseph's were responsible for lay counselling as an additional support method, usually carried out in an unstructured manner, generally run alongside professional counselling sessions. However, this was not the standard practice at St Joseph's, where LCHWs conducted lay counselling sessions without the appropriate counselling guidance knowledge. P5 indicated: *"I think the other two counsellors need more counselling on… because they are good in visiting but not …for the patients to take medication."* One participant's idea for knowledge needed in counselling was based on her understanding and ignorance about how to address death as a sensitive matter: *"We are doing psycho-social support, you teach her life skills and then you make her to talk about death" (P3).* During outreach programme visits, I observed how difficult it was for LCHWs to console grieving children. It was not always possible to stop the children crying, and a few volunteers shrugged their shoulders and said at the same time, *"I don't know what to do now"*, as a sign of giving up hope on the grieving children. The document explication (Annual Reports 2008-2013) showed clearly that bereavement counselling was identified as an important part of the support activities of the NGO.

Ethnic differences, beliefs and values: The LCHWs of St Joseph's were all from different places, backgrounds and beliefs. Their work requires them to work together for the same organisational goals, in spite of their various languages, behaviour and perceptions. One of the main challenges they faced was managing diversity in their workplace; as individuals, they demonstrated an inability to be themselves at work or engage fully as part of their

respective teams in their various community projects. They were noticeably aware of their differences, however, and it appeared that they needed a deeper understanding of how to manage and deal with people from different race groups, backgrounds and ethnicity in a more sensitive manner. These factors were visible in their interaction, communication and behaviour towards each other, as expressed in the following statement by one of the participants: *"The psychologists that you get are those who speak English and Afrikaans and so they are talking Sotho and … so that is why I decided to study psychology so that I can be the first psychologist at the NGO to talk Sotho. If you conduct a session with a child and then you need somebody to interpret it is not a session, it is not effective anymore" (FG1p9).* Another participant shared her belief: *"I like when you support people spiritually" (P18).* The following participant described her understanding as: *"It is very rural so for people there to survive, it is by the grace of God" (P20),* and another interpretation and understanding of diversity was given: *"God gave them more sun and He gave them more time but the sun is the reason because they work slowly" (P25).* The following participant described her understanding of diversity: *"They see themselves as little bit as brothers and sisters" (P15),* and another said: *"…there are people who are just from the grass roots" (FG1p1).* The document explication obtained from St Joseph's demonstrated that there was a formal value system in place, which was also confirmed in their Statement of Intent. These values included: "Christ-centeredness, love and care, confidentiality, quality and dignity, respect for human life, reliability and honesty, commitment, compassion, non-judgmental attitude, patience, non-discrimination, responsibility, accountability and teamwork" (Annual Reports 2008-2013).

LCHWs of St Joseph's are diverse with varying and different cultural influences. The way they socialise and work, and their cultural beliefs must be dealt with sensitively and respectfully. In one of the focus group interviews the following participant explained her belief: *"The hospice started because people needed a place to die" (FG2p5).* In this instance cultural beliefs can be used positively as they encompass the spirit of *Ubuntu*, for example, caring for one another, supporting and helping where necessary. It becomes more challenging, however, when cultural beliefs or socialisation reinforce a negative stereotype, as indicated by the following participants: *"This is very confidential because it is personal;*

when I went to school my father didn't want to send a girl to school like the boys. My brother went for boarding school and he wanted me to be at home. It is a tradition, but it was actually changing, but my father remained with it for some reason…" (P16). "Males are much needed in child-care, so I still need to go to the other six projects where the boys are located in order to talk with them and then where they can get information on how to behave as young men" (FG1p8). This participant described his interpretation about why knowledge about culture was important: *"I don't think it is a matter of qualifications, but it is a matter of being a human being, to understand other people and to learn from other people's culture" (FG1p6).* One of the other participants said: *"Girls speak easily and girls are cleverer than boys" (FG2p6).* A second participant added: *"When I went to school my father didn't want to send a girl to school like the boys" (P2).* During the field visit sessions, and individual and focus group interviews, I observed that most of the participants could not speak all the languages used at St Joseph's and they found it difficult to communicate with each other and with the patients, orphans and vulnerable children. Throughout the data gathering process, I observed how LCHWs continually acted as interpreters for one another.

4.3.2 Theme two: Skills needed by LCHWs

The second meaning construction around the work situation is that LCHWs feel they do not have the necessary skills to do the job competently. They highlighted the following specific skills: nutrition and cooking, report writing, communication, academic work, reading and writing, numeracy and literacy, office administration, ancillary health care, parenting, gardening and farming, and lay counselling skills. The following section gives evidence from the participants' lived experience in terms of their skill issues.

Nutrition and cooking skills: LCHWs are responsible for providing a healthy nutritional diet to terminally-ill patients on a daily basis. Patients need to eat regularly and their diets should have nutritional value to improve their condition. The challenges found here were directly related to the lack of skills in nutritional cooking and the lack of communication skills about nutrition that would encourage diet-related behavioural changes in patients. The following participant described her understanding of a formal nutritionist and cook as:

"There was a lady who was doing the basic Dietician, not the professional one" (P15). In support, another participant highlighted the following: *"Professional Chef and like hotel management and industrial chef…like you cook for old people" (P18).* Another participant described her cooking responsibility in the following manner: *"I am cook…I cook for the patients" (P5)*. Observation showed there were no special ways or methods used by those responsible for the cooking, and no dietary plan or a nutritional checklist against which they planned their daily cooking. All the vegetables were cut up on tables placed outside, and anyone could turn up and help with the peeling, without washing their hands. It was clear from the observations that the cooks did not follow any dietary programmes or menus, and all the food was cooked in the same manner with the menus remaining the same for weeks. The food that was prepared consisted mainly of pap and gravy, or rice, without meat.

Academic skills: In the context of St Joseph's, academic skills include reading, writing, numeracy and literacy. LCHWs who worked in the projects needed to have reading and writing skills because they need to complete handwritten reports, and fill in personal detail forms of patients, orphans and vulnerable children. The lack of reading and writing was perceived as a challenge, as an observation made during field visits at one project showed, when the volunteer was unable to read the medicine bottle and was not sure how many teaspoons of cough medicine she needed to give the child. She had to ask one of her colleagues to read the label and count the teaspoons. This observation was confirmed in the following statement made by a participant: *"To be honest there are no way you can survive in child-care without having studied" (FG1p9).* A similar view came from another participant: "*Yes, you have to be able to read and write what you are doing because you also have to give reports" (FG2p3).* The following participant explained: *"The ones that are low skilled, they are illiterate within this organisation and even outside" (FG2p2).* A participant from the focus group was very vocal, as indicated in the following comment: *"You know in our area we are not skilled learners, we are not very learned people, because there are many people who are uneducated" (FG1p10).* I further observed explicitly that none of the LCHWs with skill-resourcing needs used a pen and paper to present their reports to their supervisors; all their reporting done verbally.

Office management: The project could not exist without administrative, financial and secretarial employees and as a donor-funded NGO, St Joseph's needs to have administrative support staff members who could manage the office and keep it sustainable at a different level. Therefore, the identified office skills needed were viewed as an important area of office management for most of the participants. This was substantiated by one of the participants: *"I am just thinking of our little switchboard lady, with excellent potential, excellent material, wonderful little girl, beautiful personality. She just needs that extra to get her into a secretarial position" (P10).* Another participant expressed her view: *"I am happy to do my work but maybe the skills that I need most is financial management, because I don't have any skills on that. I am doing it without any degree or diploma" (P13).* The following need was also articulated: *"I feel that fundraising is also marketing and communication, so I am using the qualification that I have" (FG2p6).* From an observation made during a field visit to St Joseph's Head Office, it was clear that some of the participants found it challenging to juggle their duties. For example, the receptionist was unsure whether she should attend to the visitors at the door, or pay attention to the ringing switchboard.

Auxiliary health care: Caring for patients, orphans and vulnerable children and their families for whom cure is no longer an option is a reality which the participants faced on a regular basis at St Joseph's. As auxiliary health-care workers, they were expected to have basic patient care skills, such as conveying simple messages, dispensing non-prescription medicines and providing nutritional advice to patients, which they lacked. This lack was verified in the following statement: *"We would like for our staff to improve their health-care skills and one of the areas that we feel that we lagging back on is training in the area of health. Not training within the company, training out of the company" (FG2p5).* One of the participants was determined to acquire those skills: *"Actually I would need a bursary that would help me get inside of nursing, not just the basics and I have a diploma for that" (P17).* The next participant shared a different view altogether: *"There is Social Auxiliary work, they are like Nursing Assistants and they assist the Social Workers. So it enables those that didn't have high marks in Matric, but they can be career guided to Social work as they grow in the profession. So maybe those are started" (FG1p2).* Participants

identified more areas in which they needed skills: *"For those people who needed to be trained on social auxiliary, ancillary, home nursing, ECD – all that training – I think it will benefit them" (FG2p7).* Another participant highlighted the following: *"The enrolled nurse is one of the people, as much as she is an enrolled nurse, she functions like a professional nurse; that's how good she is" (FG2p10).* In support, another participant said: *"We don't have a lot of nurses trained in palliative care at this level" (FG2p8).* This participant motivated for more training: *"Well I would say we will need community development workers, professional ones, nurses and childcare workers, project, managers, fundraisers, administrators and counsellors" (P16).*

Gardening and farming: The garden and farming projects at St Joseph's were regarded as very important by many of the participants, for different reasons. According to St Joseph's Annual Reports 2008-2013, the garden and farming projects at St Joseph's provided food for the feeding schemes, orphans and vulnerable children, and patients of St Joseph's. It was also seen as creating jobs, providing career development in agriculture and a sustainable project for vulnerable families. The observations made during informal interactions with the participants and site visits verify this. I visited the garden projects and learned about vegetable planting processes, and how the proceeds were used to feed the patients, orphans and vulnerable children, and to sustain families and feeding schemes of St Joseph's. Feedback was received from the project workers during informal interaction and site visits. In the following statement, one of the participants provided his view about the importance of gardening and farming: *"I also know that a lot of farmers are the old people who are involved in farming and then a lot of youngsters are not involved in farming. So it is also an opportunity for youngsters to become involved and they have to know that food comes from Mother Earth. Therefore, children have to learn, it could be a professional career for them" (P14)*. One of the other participants gave the following perspective: *"That is why* our *aims and goals are to see the garden producing and giving an income for the feeding scheme" (P16)*. The gardens were managed by the women, and a few of the older men. It was evident that the young beneficiaries of St Joseph's have no interest in the garden projects, as confirmed during an informal conversation between two adolescent orphans and vulnerable boys and their project leader. When asked why they did

not join the team, the boys laughed and said that it was not their type of job. One of the participants validated this observation in her statement: *"…youngsters are not involved in farming" (FG2p10),* and it was backed up in a statement made by the following participant: *"…farmers are the old people" (FG2p11).* Further awareness of the need for gardening and farming was pointed out by the following participant: *"For us the garden is very important and that is why we try to link the gardens with the drop-in centres, but unfortunately some of my colleagues don't see the garden as important" (FG1p7).* Another participant agreed: *"We have a huge garden where we plant vegetable to support the other seven feeding schemes" (FG1p2).*

Skills in lay counselling: In their respective roles as lay counsellors, the participants are responsible for educating the patients, orphans and vulnerable children and providing emotional support. They are active in areas such as trauma, HIV/AIDS and other life-threatening illnesses, and have been recognised at St Joseph's for their important contributions to pre- and post-test counselling. However, these counselling sessions are conducted without the necessary lay counselling skills, self-awareness and proper insight, as the participants' statements reflect. One described counselling events and exposure: *"We go to different ones. Like when there is an event, maybe the municipality or government is doing some programmes in the community, we do go there and give some counselling, do some behavioural couples therapy (BCT), telling people about HIV/AIDS, counsel them and then they get the knowledge about HIV" (P11).* Another participant stated: *"We did outreach, basic counselling, to prisons and everywhere at schools, thereafter they gave me the job to do adherence education on antiretroviral treatment" (P7).* One of the other participants explained her understanding about counselling in the following way: *"Because I am just looking at my age and I say I am old now, I am getting tired or something like that, it means that this counselling is alright for me" (P1).* The following participant expressed the need for counselling skills: *"Maybe they should be trained on counselling and interacting with the families" (FG1p5),* which another emphasised: *"I think they need more counselling skills" (FGp3).* Lay counselling was viewed by some of the LCHWs as essential because, as workers, they also needed debriefing sessions in order to cope. The following participant explained: *"So they need to develop how to face challenges, they*

suffer from burnout, they suffer from stress and depression" (P11). In the following statement, the participant explained the place in which they needed to conduct counselling to people: "*At one particular lay counselling session held at one of the feeding schemes one of the children was informed that her mother passed away "(P16).* I observed how one of the volunteer workers took the child to the corner of the kitchen and started talking about HIV/AIDS and the discussion was so intense, the expression on the child's face indicated that the counselling process administered was not really helping much, the child became quiet and just stared at the wall, and the volunteer worker left her there.

Basic life skills, training and education: Participants identified basic life skills, training and education as important areas for their personal and career development which needed attention. From the first focus group discussion as well as from individual interviews, it was clear that the people with skill-resourcing needs were very keen to be trained, as described in their own words. One of the participants said: *"Just the basic training people appreciated so much, it is that amazing" (FG1p6).* In another instance a participant indicated: *"I think they will firstly, because they don't know how to write their names, they will need to go to adult basic education and training (ABET) and then after that they can do like housekeeping courses and cooking courses" (FG2p4).* Another participant made the following comment: *"…we have a lot of home-based carers and most of them have a very low level of education" (FG2p7).* On the other hand, there were participants with a higher level of education, such as senior primary and secondary levels, who also identified the need for basic skills and education training. This was clear from a statement made by the following participant: *"At this moment I don't have standard 10" (P19).* Another participant pointed out her level of education in the following statement: *"The highest grade is Grade 11" (P22).* One of the participants pointed out that there were other avenues for people to receive education and training, as follows: *"When you look at the people who want to finish their matric, they come mostly under our social welfare thing" (FG2p3).* One participant interpreted the importance of basic life skills for community members like this: *"As I said, here in Bronkhorstspruit the level of education is very low. You know what makes me cry? I can go with you to the Automatic Teller Machine (ATM) and I can tell you that there will be five people who don't know how to use that ATM and they've got a card"*

(FGp8). A different perspective about the need for basic life skills came from the next participant: *"Perhaps skills that help to do things that are needed in a household, sewing and handicrafts. These things perhaps for young adults could be a step to help them in their own lives and if they go better and better they can have a little income from it" (P14).* The following participant said: "*Basically our product requires sewing, cutting and basic skills" (FG2p2).* A very different experience and understanding of basic training and education was described by the following participant: *"We've got some cleaners who have said can't they do level 1, the lowest level, if it keeps them in line, a better standing. They would never go to level 4 because they haven't got the capacity and one of them is illiterate, she can just sign her name" (P7).* In support of this statement, the following participant said: *"I think we can start by National Qualifications Framework (NQF) level 4, maybe the introductory course first and then NQF level 5 then level 6" (P1).*

People from other organisations were referred to St Joseph's to participate in studies that taught them how the LCHWs provided their services to the communities they served. It was evident from the way they performed certain tasks that not all the LCHWs had been exposed to basic training. One of the cleaners said informally that she had not received any skills training during the site visits. A request for formal training was also raised by one participant during a focus group discussion, who explained: *"The only area that I think people can improve on is those who are not formally qualified. Probably, if somebody knows the project management skills but they are not formally qualified at it and they are probably good at what they do; and to give them a formal education even those who are not formally educated" (FG1p5).*

Community education skills: The participants identified the need for St Joseph's to nurture the learning environment in the communities they served because, in their view, it provided learning opportunities for all community members. There was a strong belief among the LCHWs about community education to enable people to develop skills that would improve their lives. Some of these factors were pointed out by the participants, as the following statement makes clear: *"Community development trains people to make a living…community is hands-on-training from poverty alleviation, to help people to help*

others" (P15). Another participant felt it was important to involve community members in the farming and gardening projects as a way of contributing to community development in their province: "*If you go out into the area and you talk to people about planting you can learn from them*" (P4). St Joseph's Annual Reports 2008-2013, made reference to patients who had been referred to the home-based care programmes so that the community health care workers, who were trained as adherence monitors, could take care of them in a domestic setting, with the help of the communities and their families.

The Annual Reports showed that St Joseph's provided skills development and training to foster parents who wished to start their own businesses in support of their community development initiatives. In addition, the document explication indicated that St Joseph's was accredited by the Council for Health Care Accreditation of Southern Africa (COHSASA), which signified the standards of quality services rendered (Annual Report, 2008, p.3). According to additional document explication, St Joseph's aims to empower and develop the community. In their view, community development occurs through the placement of programmers and projects that could improve the quality of life of people infected or affected by HIV/AIDS, by helping them to become self-sufficient (Annual Report, April 2008–March 2009, p.21).

Mentoring skills: The participants mentored each other in a lay fashion through sharing information about their work and teaching fellow workers how to perform tasks they were unable to perform. The challenge in this mentorship application process indicated the need for mentoring skills. Participants from the individual and focus group interviews described their experience and perceptions in various ways, as indicated below. P12's view was that: *"It is constant training and mentoring, there has to be mentoring in any profession"* A different view was pointed out by the following participant: *"He started when the project started and I don't know how things were done then but he is one of the people with potential that was never brought up by whoever was mentoring him then. So it is something that I have just started and he was a little bit scared but we will say he can do it, he can do it because he is good. Now he says that he is good and at first there was also that bit of resistance, he says it on his own that he is glad I have taught him so much. He has been*

here for so many years…for example now there was a workshop in Durban on Phlebotomy and to find that people who need to draw blood don't have to be doctors or nurses and he is doing that, he is drawing blood" (FG2p4). Another participant's view was: *"Actually I haven't been on any training so they just taught me here what I didn't know, my supervisors taught me about child and youth care work" (P2).*

The document explication makes it clear that St Joseph's assists different community-based organisations by mentoring them (St Joseph's Annual Reports, 2008-2013). The documents also mention patients referred to the home-based care programmes so that the community health-care workers, who were trained as adherence monitors, could take care of them in a domestic setting with the help of communities and their families (Annual Reports, 2008-2013). It was observed that, when there were no interview sessions during informal project visits, the participants acted as mentors to their fellow workers. They used their hands and bodies to demonstrate different tasks to those participants who seemed to have difficulty in executing their tasks.

Coaching skills: The participants at St Joseph's practise coaching on an informal basis as a way of learning new tasks and teaching other participants in their respective community projects. They perceived it as a supportive way to improve their work performance. Participants acknowledged the difference their informal coaching practice made in their work environment, and highlighted the support received and provided amongst their fellow workers in a positive spirit. However, it is clear that this informal coaching practice needs to be acknowledged and recognised as an acceptable work practice by St Joseph's. P24 explained how his supervisor coached him: *"He is always pushing me; he is motivating me a lot, I can't explain how much I have learned from him"* Similarly, another participant said: *"I was learning a lot from them" (P7).* Adding to that, another participant pointed out: *"My supervisor taught me about child and youth care" (P2).* In one of St Joseph's community projects, the Cuddle Company, where a stuffed animal ('ZEB') is manufactured, coaching practice is used as a training method to teach working skills. A participant explained how she learned new skills through the coaching: *"Most of the people didn't have machine skills but now we have trained them to be machinists" (P3).* A similar

experience was shared by the following participant: *"I did get training here at the Cuddle Company; they trained me on those machines" (P5).* The informal manner in which coaching was applied at St Joseph's was described by this participant: *"I also know that a lot of farmers are the old people who are involved in farming… and then a lot of youngsters are not involved…therefore, children have to learn" (P14).* Observations made in all the projects visited during site visits, showed that coaching was used in the daily duties between colleagues on the same level, and between managers, supervisors and subordinates. They showed each other in how to perform certain tasks, and in some instances, encouraged others to persevere when tasks became too much and the workload too heavy.

I noted how coaching was applied in the work context to teach and encourage LCHWs to perform new tasks or improve on existing ones. Participants are in the habit of teaching each other, and they describe it as on-the-job training. There are no inductions, therefore; participants take it upon themselves to have coaching practice where new and existing employees can be assisted. This approach was confirmed in a statement made by the following participant: *"I will show the person step-by-step" (P17).* Another said: *"We teach them" (P25),* and another indicated: *"They knew nothing; I knew nothing and we taught each other as we went along" (P19).* The following participant explained her understanding and experience of coaching in the workplace: *"When I arrived here I had never done minutes…the managers were great because one or two of them knew how to actual do them and helped me a lot" (P5).* Similarly, one participant described his experiences: *"He is always pushing me; he is motivating me a lot. I can't explain how much I have learned from him" (P24).*

4.3.3 Theme three: Organisational challenges

With regard to the third meaning construct, the participants pointed out the following distinct meanings that they constructed about the organisation (St Joseph's) they work at:

1) St Joseph's did not do enough for them in terms of their career pathing processes.
2) They feel that they lack career guidance.

3) There are no proper policies in terms of retention, succession-planning, and promotion.

These are the organisational challenges participants referred to, and in the following section, the actual (verbatim) statements are discussed.

4.3.3.1 Lack of career pathing processes

LCHWs are inspired to be the best workers by finding a place in St Joseph's where they can express excellence and contribute to the goals of the organisation, a platform yet to be developed. They came across as being unfamiliar with the term 'career pathing' in relation to their day-to-day jobs. A career development programme at St Joseph's seems to be the missing link, as observed during the interview sessions. Their non-verbal communication responses about career pathing indicated that they did not understand its meaning (when a question was directed to them, they would just stare at me, but no response), and many participants confused 'career path' and 'a job' in some of the informal discussions. A few pointed out that they needed to study before they could have a career path. This observation was supported by the following participant's experience: *"I am not doing my career presently…but I love my job very much, I am a supervisor in the workshop" (P13).* One of the participants in Focus Group One stated: *"Some of them they do home base care but they don't like home base care; they would like to be social workers" (FG1p3).* Another participant mentioned: *"Most of us want to do social work to help the kids" (P4)*, and the next participant said: *"I don't want to change my career, but maybe it will push me because now I have a lot of responsibilities" (P13).* These views were corroborated by the document explication that social service, psycho-social and spiritual support were the main career path opportunities offered to LCHWs at St Joseph's. Career paths provide a holistic, high-quality, sustainable health-care and social service to orphans and vulnerable children and their families in disadvantaged communities, most of whom were affected by HIV/AIDS (refer to Annual Reports 2008-2013), available on a Compact Disc. In Focus Group Two, a participant said: *"Most of them want to do nursing; one did nursing and the next thing he wanted to do social auxiliary" (FG2p10).* During the individual and focus group interview

session most of the participants could not engage meaningfully in the discussion regarding career guidance, and many of the participants did not respond at all. The documentary explication indicated that there was no career guidance on St Joseph's exiting training plan, and more specifically, for the volunteer workers (refer to Appendix 12, p. 321). This was backed up by the following response: *"When I say where your strength is, what we can develop you into, where is your weak side I found that most of the staff have no self-knowledge" (p22).* Another participant's view was: *"I must know what I am good at…better acceptance of self, negative self, image all over very much so" (P24).* The view of the next participant corroborated the above statement: *"The next part will depend on them, on where their passion is and then we can look from there what are they good at and what they like. Then by evaluating them we can see what they want to do, what they want as their career path" (P21).* A participant, who believed that she was not part of the career decision process in her career path, said: *"So they actually stimulate people to get into a profession though mine wasn't chosen, I never wanted to be a nurse, I wanted to be a doctor but unfortunately I couldn't" (P20).*

Career pathing knowledge: Participants in this study were tasked with the responsibility of delivering basic health care to the patients, orphans and vulnerable children in the communities in and around Bronkhorstspruit. There were inconsistencies in the quality of service they provided which directly related to their job descriptions, inconsistencies related to unstructured career paths which, if redressed, could improve their performance as community health workers. This view found support in the following statement made by a participant: *"I am not doing my career presently" (P22).* Another participant described her career path in relation to other commitments, as follows: *"Even if I don't want to change my career, but maybe it will push me because now I have a lot of responsibility, I have to take care of my baby" (P25).* The following participant indicated the confusion felt by participants, which highlighted that knowledge and understanding of career pathing was necessary: *"Some of them they do home base care, but they don't like home base care; they would like to be social workers" (FG1p3).* The Annual Reports 2008-2013 are silent on career pathing strategies for the LCHWs, with no information on their personal views about their job descriptions or roles, or on their levels of occupational stress.

During field visits, the way some participants acted or simply detached themselves from a stressful situation showed that they were confused about their duties. This behavioural pattern was noticeable amongst many participants who perceived it as a level of job stress.

4.3.3.2 Lack of career guidance

Career guidance in the context of this study was geared mainly to help participants deal with work and life challenges, and to create an environment in which they had the freedom to adjust to their individual challenges within their respective and often unsolicited career paths. The need for immediate, useful and suitable information on career guidance was clear from their interactions with each other in their different project settings. During the individual and focus group interview sessions, I observed that most of the participants could not engage meaningfully in the discussions regarding career guidance, whilst a number of them did not respond in any way during these informal discussions. However, other participants indicated that they faced some challenges, but that they had no money to improve their careers. The latter was confirmed in the following statement made by one participant who said: *"You cannot offer something, no matter how good it is, if you offer something which people do not want and even though they want it, are they able to pay for it" (FG2p3).* In support of this statement, the following participant mentioned: *"Actually I would need a bursary that would help me get inside of nursing, not just basics and I have a diploma" (P17).* The document explication revealed that there was no career guidance in St Joseph's existing training plan, more specifically for the volunteer workers (refer to Appendix 11, p. 315). The observation and document explication were further corroborated by the statement made by the following participant: *"So what I think would be a good idea is that there will be a career plan, starting with the volunteers in the communities to see where one can grow to become a child-care worker and maybe then after that they can become a project leader; but they have a picture of how they can develop themselves" (FG2p5).*

One of the other participants felt that: *"Career guidance person for now will be an idea because I feel a lot of people are confused" (P13).* As a professionally trained person, the

view of the next participant also pointed out the need for career guidance: *"I don't know if I like to study, I did a Communications Degree and I did my Honours in Marketing. I feel that fundraising is also marketing and communication, so I am using the qualification that I have" (FG2p6).* The following view came from a participant who indicated: *"I was unemployed and then when I started to get better, I was working at security but did not have enough money to further my studies until I was employed at the NGO. So then I started to see that Matric was needed. What I have now is only that Junior Certificate (JC)" (P23).* These statements were corroborated by the following participant: *"I think career guidance can be very helpful" (P2).* The view of this participant was: *"So, for me what is more important is the day of orientation, to make a learner understand before they go into the qualification. The learner must know what the qualification is all about, where would this qualification take me, does the qualification talk to me as my character, my personality?" (FG2p4).*

In the next example, the participant made her request known in the following way: *"I think if I can get just training to take me forward because I am just stuck to cleaning, I'd like to be like others, maybe to make something different" (P25).* This participant described the need for direction as: *"…they want to grab whatever course that you say is available. If you ask the person how they think it is going to help them as a person, because you need to look at yourself like that. I feel a lot of people are confused" (FG2p2).* One of the participants was specific in what was needed: "*I want to do psychology; I want to help a person that is what I want to do" (P12)*, and another emphasised direction in career guidance: *"I started cooking in the kitchen for the ones who are going to school, when I was cooking I felt it was not my place, my place is with the small children…and I told them I was interested in day-care" (P22).* The following participant made the point: *"I had to come to a point where I really wanted to study something, but I don't know what" (P3).* The following participant indicated her need for career guidance in the following manner: *"Maybe I am not ambitious. I need someone to guide me so that I can go there" (P24).* The following statement makes it clear that career guidance and motivation was needed by LCHWs who were professionally qualified: *"Sometimes I get bored and I study when I am bored I am doing my Chartered Management Accountant (CIMA) exams but when I look*

at those examinations, those qualifications, I don't see how I can use them here – this place is too small for me to use" (FG2p4). According to the documentary explication, career guidance was provided to external children who visited St Joseph's, but there was no mention of career guidance offered to any of the participants in this study (summarised in the Annual Reports 2008-2013).

Responses during data collection showed that participants did not know the meaning of career guidance, which was also evident from the manner in which they reacted and responded when asked about their future plans; one could infer that they did not know about or understand career guidance. This was also demonstrated by their silence when they were not certain how to answer, and many of the participants came across as being confused when I asked about their careers, career paths and where they saw themselves in the next five years. All St Joseph's documents analysed for this study were silent on career guidance for LCHWs, but did mention the grades 9, 10, 11 and 12 children who visit St Joseph's drop-in centres through social services and for whom they provide career guidance (2009, p.14).

4.3.3.3 Inadequate employment processes at St Joseph's: retention, succession planning and promotion

In this section I discusses the three employment processes as interpreted by the participants, with each concept discussed in more detail.

Retention: The sudden departure of approximately seven LCHWs within a period of two and a half months can create a void in the employment structure of St Joseph's if no succession plan is in place. As a result of such a departure, that specific skill, knowledge and experience can be difficult to replace. In this context, retention strategies at St Joseph's are critical. This was also supported in one of the focus group discussions, in which a participant viewed her understanding of retention as follows: *"People are being trained here already but after they have trained they leave, and if you have a good follow-up plan for after that year where they can even grow into new positions, there might be a chance*

that you keep them and that you keep the circle running" (FG1p9). Another participant gave her opinion: *"I think if people are staying longer in their place because they had certain training and they become more responsible for what they are doing or more engaged to what they are doing and they see that they can develop within a company, it becomes more stable for investors" (FG1p6).* Other views were raised, and one participant indicated: *"We don't have a problem with retention with the lowly educated one, they don't leave, very few, we can't employ all those that we train, they must find employment" (P23*).

A different view came from the following participant: *"Professional nurses and social workers are being enticed by everybody. They get good packages and then we are an NGO, we are donor funded so it is so difficult to compete with others, more especially international organisations" (P9).* This finding is corroborated in St Joseph's Annual Report (2008, p.3) document explication, indicated that well-trained staff had left and were working in leading positions in other organisations. The document explication further revealed that St Joseph's focussed on the retention of high calibre staff (Annual Reports, 2008-2013).

Succession planning: Participants realised that St Joseph's business objectives must include the identification of critical positions, competencies and the implementation of succession plans. The challenges they foresaw were how this strategic approach could ensure that the necessary talent, knowledge and skills were made available to all participants. One participant mentioned: *"We can't employ all those that we train, they must find employment" (P3).* A different view came from another participant, who indicated: *"I just had that feeling where I have been studying a long time and I need to move" (FG1p1).* The following participant made the point: *"Then they will see that even if you could be a home-based carer today, but come five years' time you could be a professional nurse and if you want to be something else you will be a professional person at that moment" (FG1p2),* and this statement confirmed that there was no succession plan in some of the projects: *"We don't have a plan for the next ten years" (P23)*. According to documents analysed, St Joseph's Annual Reports 2008-2013 were silent on succession planning processes, only referring to the external replacement of the previous director.

During a visit to the human resources department, I observed, whilst scanning the noticeboards and training plans, that succession planning did not feature, and the term was not used during many discussions held with the human resources manager about succession planning.

Promotion: The absence of formal promotion structures at St Joseph's seemed to have a negative effect on the retention of LCHWs, as demonstrated by the participants. The need for a promotion plan came from participants in different ways as indicated in the following discussion. Participants from individual and focus group discussions indicated that there was room for promotion within St Joseph's, upward or lateral moves between projects. One participant explained promotion processes as follows: *"... (Name) has resigned, she is jumping for greener pastures all over the show, and she is a young career woman" (P20).* The following observation was made by one of the participants: *"That is how we lost two of our staff, I have been here two years and five months now and this is our third health service manager, because they come much more marketable" (P16).* The following participant described her situation: *"So I started there and maybe they saw that I am a good manager in finances and I can understand, so I started there and just grew" (P3).* In this statement, the participant emphasised that: *"When you are not qualified, just a volunteer, you will stay a volunteer for ten years, so there is no space for you to grow" (FG1p3).* According to observations during informal interactions with the LCHWs, and during the formal interviewing process, the prospects of promotion within St Joseph's were not specifically raised; however, when they were, it was evident in the body language of many of the participants that they were dissatisfied. In all the Annual Reports reviewed (2008–2013), the document explication was unclear clear about promotion policies and processes for LCHWs at St Joseph's.

It was evident from the findings that the participants constructed negative experiences in terms of their challenges at work.

4.4 SUMMARY OF CHAPTER

This chapter presented a report on the findings obtained during the data collection process of this research study, based on the lived experiences of the participants. The results were discussed as three main themes, followed by their related sub-themes, in terms of meaning constructed by the participants with regard to their work at St Joseph's. The explication was informed by the raw data and the actual voices of the LCHWs, taken from the transcriptions obtained through the phenomenological individual and focus group interviews held with them. The explication also included documentation provided by St Joseph's. In Chapter Five, the discussion of the findings is presented in relation to the literature review and theoretical focus of the study.

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1 INTRODUCTION

In this chapter I discuss the findings on how the participants constructed meaning of their work, based on their lived experiences. The meanings that they constructed were based on the knowledge and skills they needed, and also what these specific knowledge and skills were in terms of their work as carers in their palliative care setting. I focused on what St Joseph's was doing about the knowledge and skills gaps in relation to what the participants needed the organisation to do and linked it to the literature and theory in the following discussion.

5.2 KNOWLEDGE NEEDED BY LCHWS

The research findings indicated that the participants highlight the fact that they lacked the required knowledge about **palliative care** which they need to provide the health-care service and support to the patients in the community (see Section 4.3.1). This finding was supported by the work of authors such as Goodyear, Ames-Oliver and Russell (2006) who state that commitment, motivation, knowledge, and skills make an incredible difference in an organisation. Having to work without adequate palliative care knowledge, according to the job-demands, can only add to the existing stress. I found it commendable that the participants could work for many years with limited or no knowledge, and that many of the participants could persevere under these circumstances, because it was the only job they knew and they needed to hold on to it. The findings also revealed that the participants felt that it was not possible for them to provide effective health-care services to the patients and OVC if they lacked knowledge in palliative care, which forms the core of the health promotion services from St Joseph's to the various communities within Bronkhorstspruit. This finding relates to what Harding (2004) states, that palliative care is seen as an essential part of treatment and such treatment, while not curative, prolongs life for a considerable period of time and restores quality of life. The fact that the participants were compelled to work without the required knowledge in palliative care makes it more challenging for St

Joseph's, and their lack of knowledge could be detrimental to the survival of the organisation. This finding is confirmed by Kanfer, Chen and Pritchard (2008) who see the lack of resources, with specific reference to motivation as a resource in relation to participants' knowledge, lies in the global economy, where knowledge and commodities are widely spread, and workers' motivation might be a critical resource to increase an organisation's productivity. In a narrative review, Hutala and Parzefall (2007) argue that work-related resources influence employee innovativeness and creativity from a work engagement perspective. These authors also indicate that, whereas a certain level of stimulation such as job demands is beneficial, too high a level of challenge may turn into a stressor and subsequently lead to burnout and hinder innovativeness. This point was also made by the Department of Social Development in the establishment of its own category of community caregivers in health and social development (NDoH, 2006b). Cognisance has to be taken of the fact that the people with skill-resourcing needs (participants) were the workers who actually provided the palliative care to the patients on a regular basis and who, despite their lack of knowledge, persevered to improve the lives of those community members who were affected and infected. Participants' wellbeing in the motivational process, is further emphasised by Hakanen *et al.* (2006), in that job resources are known to influence employee well-being intrinsically by helping an employee to achieve his or her work goals. The problematic aspect is that their contribution was not positively recognised by St Joseph's. The knowledge and skills needs identified by the participants to care better for the patients is also emphasised by WHO (2000), who indicate that much of bio-medical knowledge generated over the past two centuries can effectively be applied by laypersons (LCHWs), rather than relying on specialised services by technically trained professionals. The LCHWs' need for knowledge and skills can be related to hindrance job stressors which are defined as job demands or work circumstances that involve excessive or undesirable constraints that interfere with or inhibit an individual's ability to achieve valued goals (Podsakoff *et al.*, 2007). I find it strange that St Joseph's, as such a highly recognised community organisation identified by the NDoH as an important community intervention programme to assist in alleviating the HIV/AIDS burden through their provision of holistic palliative care to patients and OVC, could overlook the lack of knowledge identified in the findings of this study, a lack which could be seen as a hindrance for the LCHWs. According

to Podsakoff *et al.*, (2007), examples of hindrance job demands are role conflict, role overload, or role ambiguity, and these job stressors may be harmful.

The majority of the participants worked with terminally ill patients and OVC with limited knowledge about palliative care. WHO (2014), defines palliative care as a medical speciality that addresses physical, psycho-social, social, legal and spiritual domains of care through an interdisciplinary team of professional and lay care providers. It is significant that the people with skill-resourcing needs, such as the LCHWs (participants) were able to provide psycho-social support to both levels (adult and child), despite their lack of knowledge and understanding in that area of their work, as indicated by the findings.

Because participants do not have the required knowledge about palliative care, they cannot adequately educate and support the patients and their families' self-management and care within the communities. There is a need for community education and training. The finding is similar to the statement made by Jaskiewicz and Tulenko (2012), who said it has been suggested that a community's perception of community health workers' knowledge, skills and ability to assist communities' with their health needs is crucial in inspiring respect and acceptance of their services. Furthermore, the need for training and development identified by the participants is crucial, as confirmed by the Health Resources and Services Administration (HRSA) Community Health Workers National Workforce Study (2007), who state that community health workers offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counselling and guidance on health behaviours, advocate for individual and community health needs, provide some direct services such as first aid, and blood pressure screening. In this study, I was convinced that the training need for knowledge about palliative care was justifiable, and that St Joseph's should regard the results of this study as an encouragement to provide purposefully and continuously the necessary training for all participants because, according to Phillips (1996), the purpose of providing training is ultimately to improve their capabilities and those of St Joseph's. Under the present circumstances, it is inappropriate for St Joseph's to allow the participants

to be responsible for administering palliative care treatment to the patients and OVC with their inadequate palliative care knowledge.

The LCHWs in this study made it known that the **psycho-social support** for patients and OVC at St Joseph's covers a large area of their daily responsibilities, across a diverse group of people with different cultures, who need special attention. Gakuba and Passini (2011) supplement this line of thinking by reporting that family, peers and the community can be involved in the psycho-social support of the vulnerable child. The psycho-social support given to patients and OVC at St Joseph's was relevant to the needs of the adult patients for whom they cared. In line with the findings, the primary health-care declaration of the Alma Ata of 1978 in WHO (2000) states that much of the bio-medical sciences knowledge for the treatment and prevention of many diseases can be effectively applied by laypersons rather than relying on specialised services by technically trained professionals.

As a result, there is a critical need for St Joseph's to introduce and implement community and adult education programmes because, as Burkey (1996) indicates, these will help the adult participants acquire the holistic knowledge needed in palliative care to help curb the explosive statistics and, at the same time, make a difference in their own lives and in the lives of the people of the community. As Yin (2005) indicates, St Joseph's does not have a learning infrastructure for its own LCHWs to acquire the knowledge needed on HIV/AIDS to provide effective palliative care, and should therefore incorporate the principles of adult learning whereby the unique attributes of the LCHWs could be utilized (Yin, 2005).

The National Department of Health (NDoH, 2006b) purposefully developed its own type of community caregivers to attend to the needs of orphaned and vulnerable children, combining some of the community caregivers in the health and social development sectors. Based on the findings, it was clear that St Joseph's did not acknowledge the contribution of the people with skill-resourcing needs (LCHWs) in their respective roles of providing psycho-social support to the patients, as they were continually expected to work with limited or no knowledge. Cautioning against such practice, Winch, *et al.*, (2005) points out

that choices are made about what responsibilities were realistic to assign to community health workers. The psycho-social support work provided by these participants is also concerned with working collectively with the communities toward positive social change, inclusion and equality, and community education was another area that required the attention at St Joseph's, as revealed in the findings. Using community education, St Joseph's could create an environment that provides learning for staff and volunteers, including the community; however, community education was currently focused on the community rather than on the participants. The need for LCHWs is an international concern, and forms part of the Department of Social Development's focus, to develop community caregivers with the ability to address the needs and care for OVC, which is part of the responsibility of the participants in this study.

Apart from the palliative care and psycho-social support to OVC, the findings revealed that participants were also responsible for the **symptom and pain control** of terminally ill patients as well as those affected and infected with HIV/AIDS. According to the National Department of Health (NDoH, 2003), lay-workers such as the participants in this study, are also part of the Comprehensive Care, Management and Treatment Programme that governs antiretroviral access. The findings show that participants lacked self-confidence and indicated that they needed more informed knowledge about managing the symptom and pain control of the patients at St Joseph's; if such training were not provided, it could worsen the state of self-efficacy. According to Chen, Gully and Eden (2001), self-efficacy as it relates to the participants in this study, refers to their individual perceptions about their ability to meet demands in a broad array of contexts. These authors indicated that the accumulation of successes, as well as persistent positive experiences, augment general self-efficacy. The participants cared for very ill patients on a daily basis where they were required to witness their suffering and, in certain cases, to face the death of patients they were caring for. This suffering and death impacted negatively on their work performance and affected their already low self-efficacy levels. The job-demands perspective, in particular personal resources, focuses on mainly personal resources, such as mental and emotional competence, self-efficacy, organisational-based self-esteem, and optimism (Prieto, *et al.,* 2008; Xanthopoulou *et al.,* 2007). The importance of the role of LCHWs

(participants) in this study, their need for knowledge, and skills to be more efficient have been identified in a study conducted by Andrews *et al.*, (2004) who explore the effectiveness of community health workers in their research with ethnic minority women in the United State of America. Their study found that, despite the varying roles and functions, evidence indicates that community health workers are effective in increasing access to health services, increasing knowledge, and promoting behavioural change among ethnic minority women. It is clear that St Joseph's does not recognise the value of the LCHWs in their contribution to the service of the organisation in maintaining its sustainability, the organisation's focus is mainly on academic qualified staff.

In an attempt to deal with the HIV/AIDS epidemic in an effective and integrated manner (Birdsall & Kelly, 2005; Gow & Desmond, 2002; South African Department of Social Development, 2002), state responses have generally centred on social development, education and welfare. Based on this initiative, and on endeavours driven by government, NGOs and community projects, HIV/AIDS and other life-threatening illnesses have an impact on all South Africans and the need for continual health-care services to affected and infected people remains crucial. In order for the NGO to contribute successfully to such interventions, it needs to equip and capacitate its LCHWs with the required **knowledge and skills about HIV/AIDS** to enable them to work more effectively and to render efficient palliative care and psycho-social support services to the community members in and around Bronkhorstspruit. Lehmann and Sanders (2007) reaffirm the role of community health workers in their statement that community health workers continue to focus on their role in community development and on bridging the gap between the community and formal health-care services. In support of the roles of community health workers, Herman (2011) refers to them as natural helpers, who play an important role in connecting public and primary care to the communities that they serve. He explains that the roles of community health workers, as a natural helpers, include trust, rapport, understanding and the ability to communicate with the community; roles which take on an increased significance. This statement is also connected to job-demands; Bakker and Demerouti (2008) point out that dedicated employees are strongly involved in their work and that they experience a sense of significance, enthusiasm, and challenge.

Although the focus in community projects, such as St Joseph's, is on the health and social well-being of community members affected and infected by HIV/AIDS, it was clear that the people with skill-resourcing needs (participants) had been marginalised in the education and learning quest of St Joseph's. This raises a deep concern about the roles and wellbeing of LCHWs who have been at St. Joseph's for many years, as confirmed by Bahal, Swanson and Earner (1992), who mention that there are more than 600,000 extension or lay workers, comprising administrative staff, subject-matter specialists, fieldworkers, and multi-purpose unidentified people working as LCHWs. Similarly, Walt (1988) indicated that the deployment of lay community health workers is not a new occurrence in South Africa or internally; since the 1978 Alma Declaration on Primary Health Care (PHC), community health workers have been encouraged and have become a part of many developing countries' health systems. In my view, this raises the question: Why are we still faced with LCHWs who are working whilst they have serious skill-resourcing needs? There was no indication in this study that provision was made to educate and train the participants who would address the community's health needs and concerns. The document explication, training plan and annual reports of St Joseph's do not address the adult learning and community training needs, according to those people with skill-resourcing needs or the participants in this study. An important point about the symptom and pain control functions of the participants was how comfortable they were when they had to deal with the patients' cultural attitudes towards death and dying, with different religions and faiths, and their concern about how to improve relationships across cultures within the health-care environment of St Joseph's. Bandura (2000) pointed out that although people's perception of and adaptation to environments is variable depending on their levels of person resources, these resource levels are cultivated by environmental factors. Studies suggest that under demanding work conditions (skills resourcing needs), optimistic employees reported lower levels of mental distress than their less optimistic colleagues, and employees with high levels of personal resources have greater mastery that helps them to deal more effectively with demanding conditions, which in turn, prevents them from negative outcomes, such as exhaustion (Mäkikangas & Kinnunen, 2003).

The participants in this study emphasised the importance of a sustainable and continuous application process of antiretroviral and adherence treatment for all the patients of St Joseph's and surrounding areas. This approach is consistent with the research findings of Tindyebwa, Kayita, Musoke, Eley, Nduati, Coovadia, Bobart, Mbori-Ngacha & Kieffer (2004) who emphasise that people infected with HIV/AIDS living in communities with limited resources, have limited access to basic HIV/AIDS supportive care – even antiretroviral treatment. According to the results obtained in this study, the participants found it challenging to provide adequate antiretroviral and adherence treatment to the patients because they lacked the knowledge of how to administer the treatment to the patients. I was mindful that the participants needed to acquire knowledge of antiretroviral and adherence treatment because the antiretroviral medication both prolongs the lives of parents who are dying from HIV/AIDS, and decreases the number of OVC. Findings by Luthans *et al.* (2006) support the finding of this study, showing that a resourceful work environment activates employees' psychological capital and that the existence of job resources may activate personal resources and this, in turn, may result in positive psychological and organisational outcomes.

According to Steyn *et al.* (2006), community health workers have been recognised as an indispensable extension of workers who are involved in antiretroviral services. In this sense, the participants played a significant role in saving lives of those affected and infected with HIV/AIDS through their services in adherence treatment. However, it was evident that the roles of the LCHWs were not perceived in the positive light Steyn *et al.* mention. If this had been the case, then the findings would not have revealed such a high need for knowledge in palliative care, psycho-social support, symptom and pain control, as well as in antiretroviral adherence, among other treatments not mentioned. AONTAS (2002) emphasises that community education and learning is rooted in a process of empowerment, social justice, change, challenge, respect and collective consciousness.

From an African perspective, the effects of illnesses and failure extend beyond the individual to the family, the community, and then ultimately to the nation, with the emphasis on the importance of health which lies within education (Brannen, 2011). In this

regard, I feel that community education plays a role in imparting this specific knowledge needed by the participants about palliative care; a process which was currently non-existent at St Joseph's. It has to be borne in mind that the training needed by the participants in this study requires active participation from their side, the community members and St Joseph's to produce individuals with the capacity to provide support to the people living with HIV/AIDS who are on antiretroviral treatment. This training would build on each participant's past knowledge and experience which could then be used to advantage in their willingness to accomplish learning tasks. The application of this study to the adult learning and community education principle is supported by Belzer (2004), according to whom community education, through a community-based programme, aims to help adult learners meet their personal, self-identified goals while empowering them to bring about social change. From the view of an African theorist, the purpose and goals of education could be greatly enhanced if students and teachers had a clear understanding of the value of education.

With regard to HIV/AIDS, the LCHWs indicated an urgent need for in-depth knowledge and **training in lay counselling** for traumatised patients, and bereaved and vulnerable children. Although the LCHWs regarded themselves as people with skill-resourcing needs, they were still responsible for the day-to-day counselling care of the patients and children. Kipp, Kabagambe and Konde-Lule (2002) confirm that community health workers are widely used as lay-counsellors. However, these challenges were intensified by a lack of knowledge of lay counselling in cases of emotional trauma and bereavement, which is needed daily for those people affected or infected by HIV/AIDS and other life-threatening illnesses. It is clear that, at times, the participants were personally traumatised during lay counselling sessions, and needed both counselling and support. This finding is recognised in the work of Richter, Manegold and Pather (2004), Smart (2003b), Clacherty and associates (2002) who found that those who care for the sick also sometimes find themselves in need of care and support. In contrast to their finding, I observed that the participants, despite their need for knowledge in lay counselling, often ignored their own need for counselling in their commitment to supporting those who were emotionally traumatised or bereaved.

According to the literature, and viewed from an African perspective, counselling is about helping people and children to deal with life's challenges, to adjust to difficult changes, to facilitate effective expressions of their emotions, to develop an understanding of those emotions and guiding the child in the development of personal solutions to challenges (Gakuba & Passini, 2011). I view lay counselling, as described by these authors, as relevant to the situation and context of the participants, including the orphans and vulnerable children to whom the LCHWs provide holistic psycho-social support. The LCHWs at St Joseph's were responsible for the lay counselling of patients and OVC, and yet they were not competent to provide such support because they lacked knowledge in lay counselling. The self-efficacy of the participants, then, was influenced by their own inability to provide effective lay counselling as part of their daily duties, by the oversight from St Joseph's about their lack of knowledge in lay counselling and by the absence of proper lay counselling training for adult community health workers. This type of situation contributes to poor quality of care as the LCHWs do not have the basic and/or acquired knowledge and skills to perform the duties.

Ethnicity and culture were important in the findings. The participants referred to various differences in terms of ethnic groups, personalities, cognitive behaviour and St Joseph's organisational function. They recognised the individual differences and respected them in their own way. However, the findings clearly show that they needed knowledge about how to deal with the differences of race, ethnicity, gender, religious and political beliefs, sexual orientation, socio-economic status, class and education background, age and physical abilities within the context of their day-to-day duties and interaction with the patients, orphans and vulnerable children.

According to African theorists, Sall and Nsamenang (2011), diversity has been superimposed on the cultural orientation of ethnic varieties, which indicate that every nation should have its own political style, religion, ethnic map and linguistic consideration. This view correlates with the context in which the LCHWs found themselves, the difference being that the participants could not choose which patients and OVC to care for, because it was part of their community health service to deal with this diversity. An

awareness of gender inequality in the workplace was pointed out, in particular the lack of interest from male workers in community projects at St Joseph's. Diversity training for the participants is a good way to develop awareness and to increase their knowledge and sensitivity to diversity issues.

LCHWs pointed out that diversity played a significant role in their line of work, and they faced challenges of language which affected their communication. The language as a barrier, was also recognised in the work of Lent, Steven, Brown and Hackett (2002), as the perceptions of each LCHW and within their individual abilities to manage or cope with certain and less-than-ideal situations. St Joseph's does not set the tone in improving diversity and inclusiveness amongst the participants, because St Joseph's showed that the communication channels were neither open nor free, so there were few opportunities for LCHWs to discuss issues relating to diversity. An inclusive environment at St Joseph's requires individual diversity awareness knowledge as well as effective organisational systems to support diversity in the organisation, but this knowledge was not clearly visible and not part of community education principles and practices that specifically involved LCHWs.

There were striking similarities between diversity and culture identified in theme one regarding knowledge needed by LCHWs. Although part of a team, LCHWs worked with the same patients and OVC, however, these LCHWs came from different cultures. Meeting this need to understand different cultures could create a platform for participants to learn about cultural differences and bring them closer to the patients and OVC, enabling them to see how much they have in common as human beings. This finding correlates with a suggestion made by Banks (1997) to establish an authentic unity amongst people that has moral authority and at the same time creates moral, civic, and just communities in which citizens from diverse racial, ethnic, and cultural communities participate and to which they commit. The lack of knowledge in assessing and responding to differences in values, beliefs, and health behaviours amongst the diverse participants at St Joseph's could have a negative impact on their interpersonal skills and affect their service delivery. In this regard, literature from an African perspective as indicated by Sall and Nsamenang, 2011, who

perceived values and attitudes of LCHWs with regard to their education must be recognised. As people with skill-resourcing needs, LCHWs need knowledge of cultural awareness, and of sensitivity and competence behaviours, because the concepts of health, illness, suffering and care had a different meaning for each of them. These differences affected their self-efficacy beliefs because they were unsure how to manage cultural differences. According to Bandura's (1990) theory, the findings in this research study indicate that social constraints and inadequate resources obstruct academic performance. Self-efficacy may exceed actual performance because it is not so much a matter that the participant does not know what to do, but that he or she is unable to do what he/she knows he/she can do. Other authors, such as Ali and Saunders (2006), support this line of thinking by suggesting that social cognitive career theory can explain the career development processes of minority and underserved groups (relevant to the participants in this study, based on their identified environment) where cultural characteristics of specific environments are captured. In this study, the participants were not subjected to the social cognitive career theory, as suggested by the authors in the above statement.

5.3 SKILLS NEEDED BY LCHWS

This theme addresses all the skills needed by the LCHWs and here I want to discuss what the skills say about their ideas of work as identified in Section 4.3.2. The discussion includes all the specific skills identified in the findings, such as: nutrition and cooking, academic work, office management, auxiliary health care, gardening and farming, basic life skills, training and education, community education, mentoring and coaching. These are discussed collectively.

The LCHWs indicated the need to have **professional skills in providing nutritional meals** for the patients, in particular cooking skills. It was clear from the findings that meal preparation at St Joseph's was not structured, and the LCHWs responsible for the cooking created their own menus and prepared meals as they saw fit, based on the ingredients that were available. During the study, I observed how the food was prepared, including the food parcels St Joseph's provides to the OVC from their feeding scheme centres. The menus did

not seem to change for a number of days. It was not clear from the findings how the food was funded, but the fact that St Joseph's is surrounded by poverty-stricken communities, could be a contributory factor to food being prepared in the way it was at St Joseph's. The identification of specific skills, such as nutrition and cooking, needed by the participants to feed orphans and vulnerable children, ties in with the findings from a specific study conducted by Rennert and Koop (2009) who reported that interventions with CHWs to address problems in caring for children found that primary health care for children in remote underserved communities using CHWs is possible and feasible.

The LCHWs worked in the different community projects, without the basic academic skills in reading, writing, numeracy and literacy, which are important requirements in their respective jobs. Despite their limitations, they continued to provide care and services for the patients and OVC. The Tertiary Education Commission (TEC) (2008) is of the opinion that improving workforce literacy, language and numeracy skills works best if the learning is in a context that is relevant to the learner, for example, existing workplace training. Therefore, the identified skills that emanate from the findings need attention and require a structured approach, as suggested in the work of Fidishun (2000), who proposes the following process as a guideline: setting up a graded learning programme, developing rapport with adult learners, showing interest, leading the adult learner toward inquiry, reviewing and acknowledging the adult leaners' goals, providing regular constructive and specific feedback, providing tasks that interest adult learners, and acknowledging their preferred learning styles. The LCHWs provide an extensive health service to the patients and OVC through St Joseph's where they work, which is why, as people with skill-resourcing needs, they cannot be ignored. The value of the work done by LCHWs is supported by the views of Kennedy, *et al.* (2008) who points out that CHWs improve the quality of health care, by educating the community through the providence of health-care, and enabling patients to foster self-efficacy.. .

In this study, it was clear that not all the LCHWs worked in the community projects; some of the LCHWs were based in the office and were responsible for the day-to-day running of the office administration, finance, marketing and general administration, which required a

specific level of skills for them to perform satisfactorily in their respective jobs. Based on the results of this study, I support the idea of Yin (2005) who indicates the following methods of learning that could be applied to this study to accommodate the participants' skills and needs. In order to foster learning in adult organisations, the approach adopted should focus on problem-based learning which builds communication and interpersonal skills, and situated learning, which targets specific technical skills that can be directly related to the field of work. Studies conducted by Fidishun, (2000) describe how organisations should engage with adult learners in their expectations of learning and provide them with choices. With regard to the different skills needs of the participants, there was no individual engagement with the LCHWs about their learning expectations, with the option to make their own choices about their learning processes.

As community health workers, LCHWs identified the need to be **trained and qualified in auxiliary health-care**, especially in view of the fact that St Joseph's has a limited number of qualified social workers and nurses to mentor and coach LCHWs auxiliary health-care. LCHWs indicated the need for training outside St Joseph's premises, because they viewed such training as being recognised and accredited, which is not the case with training conducted on the premises. From the findings of this study, it was evident that LCHWs were ready to engage in structured self-directed learning. However, training facilitators do not automatically apply adult learning theory, as suggested by the aforementioned authors, unless they themselves understand the principles of the theory. As adult learners, these participants demonstrated that they were internally motivated and self-directed; this finding supports the work of Fidishun (2000) who encourages training facilitators to develop rapport with adult learners, show interest, review and acknowledge their goals, and provide them with constant and constructive feedback.

The **garden and farming projects** were regarded as very important projects at St Joseph's because they formed part of the promotion of sustainable development through partnerships with the rural community in and around Bronkhorstspruit. In addition to sustainable development, I noted that the garden and farming projects were a means to an end for many families at St Joseph's who could not buy food, but lived off the proceeds

from their food gardens. In a study conducted in KwaZulu Natal, Clark *et al.* (2003, p.11) reported that the training of community health workers was based on *The Guide for Community Health Workers* which included needs assessments and referrals; groups talking about health problems; development of health education and special events for projects, such as starting vegetable gardens. What stood out in the findings of this study was getting the adult males and young boys involved in the gardening and farming projects. They were unwilling to participate in the gardening and farming projects, because they lacked interest in community work, and in the garden and farming projects in particular. I was aware that, based on the context of this study, culture must be recognised and understood, and that the adult males and young boys need to be respected for their non-participation; however, training in the garden and farming projects is still regarded as a need at St Joseph's. This finding was consistent with the findings of Gibbons and Shoffner (2004), who indicated that the impact of gender and culture would likely be more individualised.

The results of this study showed that the need to have basic life skills, training and education was a major factor in the enhancement of the participants' work performance. The findings highlighted the fact that the people with skill-resourcing needs did not focus on their needs for basic life skills, training and education, their focus was on getting the job done. Their needs for basic life skills, training and education were crucial for LCHWs for their work meaning construction. By identifying the basic skills, training and education needs to improve their competencies in their work, the LCHWs indicated that they were ready to learn and were open to development within the organisation. The importance of readiness to learn is supported by the findings of studies by Hart (1991) and Good (1997), in which adults decide for themselves what is important to be learned, and function best in a collaborative environment as active participants in the training process. All the skills identified by the participants as necessary were an indication that, as adult community health workers, they were ready and motivated to embark on their adult learning journey as a sign that they also wanted to positively promote the image of St Joseph's as their employer. This trend to gain new skills concurred with the findings of a study conducted by Goodyear, Ames-Oliver and Russell (2006), on human assets that drive business

success. The study indicated that the stronger the workers, the stronger the organisation. The dedication, motivation, knowledge, and skill sets of individuals make a great difference in the organisation. The participants in this study with skill-resourcing needs had been driving the success of St Joseph's, as is evident in the ongoing sustainability of the organisation, based on the work conducted by these participants.

This study has been centred around the theoretical perspective of the job-demands-resources model (JD-R model), work meaning constructions by the participants based on their individual beliefs, values, and attitudes about outcomes of work and the functions or purposes that work serves for them (Brief & Nord, 1990; Chalofsky, 2003). The JD-R model has been identified as one of the models developed and theorised as a tool to explain working conditions which contribute largely to the meaning participants give to their work. This statement is in line with a statement made by Dawes (1991), who suggests that work orientation attends to the purposes that work serves in an individual's life for the experience of meaning. Yeo (2005), too, acknowledges that organisational learning requires both individual and organisational competence, and organisational culture to work, which may require effort to attain a high level of commitment, trust, and understanding amongst LCHWs. These statements about work meaning and training and development for the individual, supported by the organisation, tie in with Porter, *et al*. (1974) who maintain that organisational commitment has been defined as a strong belief in and acceptance of the organisation's goals and values, a willingness to exert considerable effort on behalf the organisation, and definite aspiration to maintain an organisation's membership through training and development of its employees. However, I did not obtain results relating to the role and commitment from an organisational perspective regarding training and career guidance in particular for the participants with skill resourcing needs, and relied on information based on the document explication, which highlighted the focus of training. That focus was on the community rather than on the LCHWs who were the people with skill-resourcing needs. The JD-R model considers psycho-social work conditions, particular job demands such as workload and emotional demands as significant predictors of an employee health erosion pathway. Coping with chronic job demands leads to an erosion of the LCHWs energy reserve; in turn, this leads to negative responses such as

psychological distress, and in the longer term, other health problems (Schaufeli & Bakker, 2004). The findings suggest that there is a lack of commitment from St Joseph's, which could lead to burnout of the employees, because they are characterised in this study as people with skill-resourcing needs. Meyer and Allen (1991) point out that commitment is associated with positive organisational behaviour, including organisational citizenship, a concept that is close to work engagements. Studies conducted by Mathieu and Zajac (1990) showed that negative relationships occur between organisational commitment, and job-demands and job-resources.

It was clear from the findings that community engagement formed part of the daily activities and interactions of the participants, thus the need for community education about HIV/AIDS was in line with the findings of research conducted by the WHO that proposed training community health workers as a core idea in its AIDS and health workforce plan (WHO, 2006). This massive training of community-based workers was identified as a quick win for achieving the Millennium Development Goals (MDGS, UN Millennium Projects 2005, cited in Abbatt, 2005). In this study, I recognised the health care service rendered by the participants to the community was an indication that commitment from both sides was needed to ensure that holistic palliative care and psycho-social support could be provided to everyone affiliated to St Joseph's. The findings were clear that St Joseph's needs a stronger commitment to providing knowledge, skills and career pathing to its core workers.

The findings showed that community development was encouraged, with emphasis placed on community education that could alleviate poverty and train and educate community members to acquire the necessary skills to sustain themselves and their families. This finding was confirmed in the AONTAS Community Education Network, which refers to adult education and learning, and aims to enhance learning, empower people and contribute to society (AONTAS, 2015). The findings were clear that LCHWs played a significant role in helping people in the communities where they worked with psycho-social services on a daily basis, which many regarded as their passion, calling and love for the job. This positive attitude can be associated with the conceptualisation made by researchers that a calling is

socially valuable work (Wrzesniewski *et al.*, 1997); and historically, Bellah *et al.*, (1985) who see conceptualised callings as a commitment to "a profession in which a person is linked to the large community and contributes to the common good" (p.66), which description fits the community work the participants in this study perform. I support the views formulated by Walters (2008) that there is an urgent need for something concrete to be done to give individuals and communities across the country, in both rural and urban areas, the help they require to fulfil their aspirations, and to join in building the social and economic fabric of society.

Traditionally, very few community projects had a learning infrastructure for their own particular reasons, and according to Yin (2005), it was the unique attributes of adult learners that enabled them to incorporate the principles of adult learning in the design of their instructions. The African theorist, Nsamenang (2011), expressed a different opinion which impacted on the learning processes of the LCHWs in this study. He reasons that developmental education hinges on the principles of the knowledge, skills and competencies a person requires for effective functioning, which cannot be massed together and learned at once. In reaction to the above statement, St Joseph's did not have an automatic learning infrastructure, so they endeavoured to develop one with the help of the findings obtained in this study. I found that the lack of organisational commitment played an important role in the training and development of the participants with skill resourcing needs. The findings of this study suggest that the commitment from the organisation appears to be minimal, and according to Bakker and Demerouti (2007), can be linked to the general understanding that the JD-R model and can be used to predict both employee burnout and engagement, and consequently organisation performance.

Social support, based on the management literature has primarily been addressed in terms of mentoring. According to Kram (1985), mentoring relationships provide social support in the form of both career development and psycho-social assistance. In this study, the participants followed an informal and unstructured mentoring practice. Although unstructured, this informal mentoring process made it possible for them to learn new skills and tasks. Darwin (2000) indicates that mentoring is presently at the forefront of strategies

to improve workplace learning. According to the results obtained, mentoring was used by the participants as a method to learn new tasks, and not as suggested by Darwin (2000) where the organisation initiated mentoring to support the participants. This finding was supported in the work of Baugh and Fagenson (2007) who described formal relationships as those which are formally initiated by the organisation and assign the mentor-trainee that facilitate and support developmental relationships.

LCHWs in this study came from different backgrounds. It was evident that they were people with skill-resourcing needs and that these differences affected their ability to perform well in their community projects as well as affecting their self-esteem. According to the results, they felt it was important to have someone to lead and guide them as adults to do certain tasks. It was immaterial to them whether the person who mentored them was a senior, junior, highly-skilled or low-skilled worker; the important aspect for them was to gain knowledge and understanding about how to work harder and better. Mentoring, in the context of this study, was an informal way of work and life for the participants. The above interpretations are in line with the work of Darwin (2000, p.203), in that "mentoring becomes a collaborative, dynamic, and creative partnership of co-equals, founded on openness, and vulnerability of both parties to take risks with one another beyond their professional roles". A difference between the results of this study and the report from Darwin (2000) lies in the reality that the participants operated on a very low level and mostly in an unprofessional academic role.

According to Jarvis (2004), coaching, in comparison with traditional forms of training, has the potential to provide a flexible, responsive development approach that can be used to support an increasing number of individuals within the organisation. It was evident from the results that in addition to mentoring practices at St Joseph's, the LCHWs used coaching as a training and learning method and as a form of transferring knowledge and skills about their tasks to each other, informally. This is not an unusual practice, according to Woodruff (2006), who views coaching as a powerful catalyst for transforming performance, because it is not just a remedial intervention for poor performance. The LCHWs in this study used coaching as an immediate measure to teach each other ideas in their work on a daily basis.

The findings also revealed that they used coaching as a method to complete their tasks more quickly, and not to measure their performance. In line with this finding, a study conducted by Xanthopoulou (2009) showed that the day-level coaching has a direct positive effect on day-level work engagement, which in turn, predicts daily financial return. Parsloe and Rolph (2004) and Whitmore (2000) indicate that if individuals are to take responsibility for their own development they need support, advice and a coaching relationship that will provide them with the appropriate support required for them to achieve their developmental aims. The participants were characterised by their skill-resourcing needs levels and demonstrated that they did not have the ability or necessary knowledge to develop their own aims. The JD-R model, in particular, the job resources element, speaks to this finding in the sense that it includes autonomy, social support, supervisory coaching performance feedback and opportunities for professional development which are verified to relate to work engagement, reciprocally (Xanthopoulou *et el*., 2009). In the context of this study, we can include work meaning construction in this concept.

5.4 ORGANISATIONAL CHALLENGES

In this theme, the emphasis is on knowing what the organisational challenges are saying about the LCHWs' ideas of work. These organisational challenges consist of lack of career pathing processes, lack of career guidance, inadequate employment processes at St Joseph's: *retention, succession-planning and promotion,* and they are addressed as one unit.

5.4.1 Lack of career pathing processes

The findings revealed a lack of career a pathing process as described in Section 4.3.3.3.1. Considering the need for knowledge and skills by the LCHWs in palliative care, the findings clearly show that these needs are directly related to organisational management. Gould (1979) and Orpen (1994), state that individual career management and organisational career management are correlated with career success. Community and adult education and training needs were included in the findings as part of the lack of career

pathing processes. Brown (2002) is of the view that there are four reasons why training needs assessment should be done before training programmes are developed; these are: identifying specific problems, such as the lack of career pathing processes; assessing lack of knowledge and skills in palliative care; obtaining management's support by making sure that the training contributes directly to the bottom line, and most importantly, that the training improves employees' work performance. Recruitment, training and development practices contribute to an employee's capabilities development and ensure the functional excellence which means the right people in the right positions. However, the findings of this study showed that the participants at St Joseph's were placed in jobs which they could not execute efficiently because of their lack of knowledge and skills, and interest in specific areas of their jobs. In addition, participants reported that they were not well informed on how to go about choosing their own careers. According to the literature, this is not a new phenomenon, as indicated through the study of information, advice and guidance for adults in key target groups. Hawthorn and Watts (2002), report that the main and overriding reason for adults to access guidance provision is a belief that it may help them enhance their job prospects. According to Castellano (2001), an organisation's human resources system which includes rewards, benefits and performance management practices can motivate employees to work and contribute to achieving organisational goals. The LCHWs take ownership of their careers, as indicated by Derr and Briscoe (2007), and the focus on the subjective or inner career becomes more important than that of the more objective, organisationally defined career.

At St Joseph's, the LCHWs inadequate knowledge and skills about palliative care and knowledge about how to conduct their duties more effectively could be contributory factors in their lack of appropriate training, mismatching of jobs and organisational lack of involvement in career pathing processes. The lack of self-knowledge, low self-image, and lack of confidence was prevalent in the findings, which further indicated the direct impact on the career pathing challenges faced by the low levels of education, lack of skills and illiteracy. There is an understanding that individuals are in the habit of linking their purposes for work to preferred goals, from which they automatically generate commitment attitudes. Therefore, 'self-directed' individuals are perceived to have their primary focus

on serving their own ends while 'other-directed' individuals possess a commitment to efforts that serve others. Work orientation potentially shares this attention focusing, such that individuals with a high-career orientation focus on themselves while individuals possessing a high-calling orientation emphasise others (Meglino & Korsgaard, 2006). The findings confirmed that the participants were no different from those in other studies in facing training, learning and work-related challenges, as corroborated in the work of Lent, Steven, Brown and Hackett (1994), who wrote that and individual's career development will be impacted by perceived support, opportunities, and challenges. This finding is also supported by Fidishun (2000), who suggests that adult learners become ready to learn when they experience a need to learn, in order to cope more satisfyingly with real-life tasks or problems. Adult learning is relevant to the LCHWs in this study who maintain an awareness of how their work serves others, such as the patients and OVC, according to Weiss, Skelley, Hall and Haughey (2003). These findings focussed on the learning and training needed by the participants who could pave their career paths by receiving training, learning and education from St Joseph's, and the findings are in line with the work of Morgan (2003), who indicates that work-based learning that connects with learning and experiences in the workplace, in formal and informal programmes, enables the individual to develop an understanding of the changing nature of the workplace and the changing patterns of employment in order to acquire and demonstrate employability skills. However, according to Holton, Knowles and Swanson (2005), there are different interpretations of how people learn, in a variety of ways and at certain stages of their lives. The formation of adult leaning theory addresses these differences in opinion and assists educators to understand and serve adult learners better. Similar reasons were identified by the LCHWs in this study. I was keenly aware that the LCHWs based their commitment to their current career paths on a variety of factors, including exogenous circumstances, personality, loyalty, workplace features, perceived job stress, work-life balance issues, and demonstrated employer support (Botuck & Levy, 1998; Griffeth, Hom & Gaertner, 2000; Ellenbecker, 2004).

The findings showed consistent behaviour of low self-knowledge and awareness, low confidence and lack of motivation amongst the LCHWs with skill-resourcing needs who

also grappled with the same career pathing problems, and career-indecision, which could only be as a result of no career pathing guidance and information about careers. The indecision from the LCHWs stems from the lack of proper career pathing guidance at St Joseph's and thus prevents them from benefiting from the possibilities of job progression and job security. Job resources may play either an intrinsic motivational role because they foster the growth of LCHWs, learning, and development, or they may play an extrinsic motivational role because they are instrumental in achieving work goals (Bakker & Demerouti, 2007). In this study, the role of job resources was demonstrated and supported by the findings that some of the participants had the ability to learn how to perform a task on an informal basis, without attending any formal training, and were able to master the tasks without further supervision; however, mentoring and coaching was applied in some instances. The findings confirmed that adult education was relevant in addressing the knowledge and skills needs of the participants. Adult education can be connected to the principles of Knowles (1980), in accordance with the theoretical perspectives that adults are internally motivated and self-directed. Adults bring life experiences and knowledge to learning experiences, and they are goal-orientated, relevancy-oriented and practical. In the context of this study, these six adult learning principles which included: adults are internally motivated and self-directed, adults bring life experiences and knowledge to learning experiences, adult are goal orientated, adults are relevancy orientated, adults are practical and adult learners like to be respected (Fidishun, 2000), were appropriate and needed to be incorporated into a work resourcing needs framework developed according to the experiences and needs obtained in this study.

The results suggested that the LCHWs needed knowledge about career pathing, because many of them were unsure about their jobs and some had no idea what a career path was. The work of Collin (2006) supports this research, for example, that career theories are not constructed in a vacuum, but rather constitute social, cultural and economic conditions as well as ways of thinking of people in specific contexts. In addition, Daniels, *et al* (2004) confirmed that LCHWs serve a critical function in the communities where they are working, often providing a service to the most marginalised poor communities, where none may otherwise be available. It therefore makes sense for the participant LCHWs in this

study to have a proper career path. As a reflection of their need for knowledge about career pathing, the LCHWs related the lack of proper career pathing to their performance and service provision to the patients and OVC. In identifying the need, the LCHWs were in line with the first principle of Knowles's (1990) theory, in which he states that adults need to know why they should learn about something before they engage in the learning process. I viewed the participants' positions as advantageous, because they had identified a need to have knowledge about their jobs which could be fulfilled by means of training and education. At the same time, the participants opened themselves up for the beginning of possible training toward lifelong learning and paving a structured career path.

It was not clear from the findings what training and education methods were used in the existing training plans provided to the participants; reference was made only to training provided by external community members. The practice at St Joseph's is not in line with the findings of a community health programme conducted in Iran, which reported that trust-based relationships with rural communities, selfless motivation to serve rural people and sound health knowledge and skills, are the most important factors facilitating successful implementation of a community health programme (Javanparast *et al.* (2011). Based on the need for knowledge and skills identified by the participants, it is clear that St Joseph's does not acknowledge the importance and that a gap exists. Adult learning plans were not identified for the benefit of the participants in the training plans of St Joseph's. However, reference was made to community education as a fundraising method and not for internal staff development. The people with skill-resourcing needs, LCHWs, were committed and loyal employees of St Joseph's, despite most of them not having structured or appropriate career paths, and the lack of organisational support was clearly visible. The necessity to remain employable intrinsically motivated participants to remain in their career paths, even though they did not have the ability or competencies to master their tasks, which was evident in their continual requests for knowledge and skills in palliative care.

St Joseph's played an important role in the development of career paths for the participants; however, the emphasis in the finding was on developing LCHWs into lifelong learners and not aimed at retaining their services should they wish to leave after receiving any form of

training. The work of Nemcek and Sabattier (2003) highlighted the need to restore and resurrect socially and economically shattered community organisations so they can make better use of available community health workers. It can therefore be inferred from this study that St Joseph's requires 'resurrection' in terms of focusing on the training and development of its lay community health workers. This line of thinking links up with the statement made by Phillips (1996) who indicates that, by developing employees, the organisation makes them more attractive to other employers, potentially making increased staff turnover more likely. In addition, literature further indicates that for St Joseph's to effectively manage their training and career guidance processes, the cost and benefits of programmes have to be measured (Chmielewski & Philips, 2002). In the same vein, Phillips and Phillips (2006) indicate that benefits, in terms of a training programme can be valued against the return on the investment in terms of the actual training. In order to strengthen and boost the roles of LCHWs in this study and for them to be well-trained, Nemcek (2003) reiterated the goals of the community programmes to which the participants are affiliated, must be linked to St Joseph's as well. These goals are interrelated and include therapeutic alliances (stronger relations between health-care professionals and lay persons in the community); improved, appropriate health-care utilisation (which has the potential to cut costs with early access, prompt diagnoses and treatment, greater use of primary care providers and fewer urgent care units), and reduced health risks (by educating the community about prevention, early diagnoses and treatment).

In order to build human strengths at work rather than managing the weaknesses of employees, St Joseph's should initiate a positive approach in organisational behaviour, by applying corrective measures in terms of training, development and career pathing for the participants. This system-thinking process in terms of a learning environment was identified by Knowles (1973) decades ago, when he suggested that the facilitator should involve the LCHWs in preparing a set of procedures in advance that include: establishing a climate conducive to learning; creating a mechanism for mutual planning; diagnosing the needs for learning; formulating programme objectives that will satisfy the knowledge, skills and career pathing needs of the participants in the study; designing a pattern of learning experiences; conducting these learning experiences with suitable techniques and

materials; evaluating the learning outcomes and diagnosing their learning needs. I am of the view, as stated by Cameron *et al.* (2003), that positive organisational commitment calls for further study of what goes right in organisations, including the emphasis on identifying human strengths, producing resilience and restoration, fostering vitality, and cultivating extraordinary individuals.

5.4.2 Lack of career guidance

Based on the findings presented in Section 4.3.3.2, there are no formal career guidance strategies for LCHWs at St Joseph's. This perceived absence of a career guidance strategy at St Joseph's was a contributory factor to the lack of knowledge and skills in palliative care, incompatible career paths and poor work performance of the participants. According to the literature (Sergay, 2008), a career guidance and training strategy should be a mechanism that establishes what competencies an organisation requires now and in the future, as a means of achieving them. For St Joseph's to achieve and successfully implement an appropriate training strategy for the participants with skill resourcing needs, requires vision, focus, direction and an action plan, none of which feature in the findings. According to the JD-R model, job resources fulfil basic human needs, such as the needs for autonomy, competence, and relatedness (Bakker & Demerouti, 2007), for example, LCHWs require proper feedback to foster learning, thereby increasing job competence; whereas decision latitude and social support satisfy the need for their autonomy and the need for them to identify themselves with their job to construct meaning (Bakker & Demerouti, 2007). I subscribes to the encouraging statement by Orpen (1994) that career and training plans with specific goals and timetables are more likely to be successful. Illeris (2003) also confirms that a more all-encompassing definition of learning is based on a structure of learning involving two integrated processes: firstly, interaction processes between the learner and their surroundings (both social and cultural) which are dependent on time and locality factors. Secondly, inner mental acquisition and elaboration processes which are mostly genetic in nature and include the cognitive (knowledge and skills) aspects and emotional aspects (motivation and attitude).

The findings also pointed out that career guidance has not reached every LCHW at St Joseph's, in accordance with the policies formulated by government to redress the inequalities of the past, and of integrating the South African economy into the global economy (Oosthuizen & Bhorat, 2005). This finding is in line with Billett's (20001a) view about the reality that some limits to learning in the workplace exist, limits which include learning (either knowledge or practices) that is inappropriate but reinforced by the workplace; barriers to access and guidance for developing workplace practice; having to learn knowledge that is not accessible in the workplace; the lack of expertise or experience required to develop this knowledge, such as ideas that employer-sponsored training builds on already assumed developed fundamental skills; the reluctance of workers to participate in learning in the workplace. Because career guidance has not yet been applied at St Joseph's, I believe that it could be a reason for the participants' ignorance about the difference between having a career path and having a job. Their ignorance could also be ascribed to past research on career guidance having focused on a higher cognitive level than that of the LCHWs in this study. This finding is corroborated in the work of Watts and Sultana (2004), who report that career guidance services have traditionally been provided predominantly to school leavers and unemployed people, and such limited service provision is no longer adequate. The career field has been challenged to expand access and services for people across their different lifespans, and to transform provision to include more diverse methods and sources of delivery. In further correlation with the results obtained in this study, the OECD (2004b) and Watts (2000) report that the value of career guidance and development for individuals is unquestioned, and that it has been increasingly recognised and accepted for its social and economic importance to the nation generally, and particularly, to the participants in this study. Schaufeli and Bakker (2004) found evidence for a positive relationship between the job resources of performance feedback, social support and supervisory coaching, and work engagement in studies conducted by Hakanen *et al.* (2006) on a sample of Finnish teachers, with results showing that job control, information, supervisory support, an innovative climate, and social climate were all related positively to work engagement of LCHWs.

LCHWs were unaware of the contributions they made to the informal economy through the health-care services they rendered to St Joseph's, or directly to the communities in Bronkhorstspruit on a continual basis. The interpretation I made regarding this unawareness on the part of the LCHWs, as reflected in the findings, was not exactly in line with the assertion made by Watts and Fretwell (2004) that career guidance needs to be extended to include attention to the informal economy in the form of enterprise education and community capacity-building, linking career to the concept of achievement and sustainable livelihood. My findings correlates with the fact that skills and abilities make up attributes embodied in individuals that facilitate the creation of personal, social and economic well-being (OECD, 2001). Gorard (2003) cautions that it is not constructive to define the worker merely as an individual and the workplace as providing the structure or context, as both individual and workplace construct, and are constructed by, each other.

The results obtained in this study also correlate with the findings in a study conducted by Herr, Cramer and Niles (2004), who report that organisations and practitioners need to realise that adults across all life or career stages must continue to cope with trying to implement an evolving self-concept in their lifestyles, in their work, in their choices and in their career development planning. Consideration must also be given to most people's struggle throughout life to find a satisfactory match between their career needs and preferences and those associated with their work life. According to Dweck (2000), the timeless message of research on self-efficacy is the simple, powerful truth that confidence, effort, and persistence are more potent than innate ability. However, the difference in the context of the LCHWs in this study lay more in an innate ability to persevere in the continual execution of their various duties, despite lack of confidence, and having to work without the required knowledge and skills. As indicated by Hughes, Hutchinson and Neary-Booth (2007), in earlier research undertaken by the International Centre for Guidance Studies (iCeGS) on lifelong learning, there are three strands of employer activity in the adult career guidance field: those employers for whom adult career guidance is the primary factor; those employers which offer adult career guidance as an important part of their service offer, and those employers who have no interest in adult career guidance. On the other hand, Gorard (2003) makes a statement that while employers are aware that the skills

of their employees are very important to their businesses, those employees who were part-time, of lower-status, and less qualified than others, received very little training that was generalised or non-task specific.

Based on the document analysis and personal observations made during the site visits, I identified with the statement made by Walters (2008) and confirmed that there was definitely a need for specialised career guidance to be part of every community's organisational structure in order to provide extensive and continuous career guidance to community health workers, in particular, the people with skill-resourcing needs. This finding is supported in the work of du Toit (2005), who points out that NGOs and NPOs have played a significant role in the development of career guidance and placement services for unemployed work seekers in South Africa. Contrary to the above, the findings reveal that career guidance is a definite need by all participants and it is clear that St Joseph's, as a community organisation, did not actively participate in the career guidance processes for the employees in this study. Furthermore, the findings show that there was no joint venture with regard to career guidance between St Joseph's and the LCHWs, which is clearly not a standard career relationship practice, because it disempowers the participants in making their own career decisions. This finding connects to a view from Walters (2008) on the urgent need for something concrete to be done to give individuals and communities across the country, in both rural and urban areas, the career guidance help they need to join in building the social and economic fabric of society in South Africa. This view is supported in the following statement of Bloomer and Hodkinson (2000) who posit the idea of a learning career as a response to life-long learning policies, and these authors further argue that if life-long learning is a central concern for policy makers, then understanding how learning changes throughout the lifespan is important. In a South African context, Montgomery, Mostert, and Jackson (2005) conducted a study on a sample of primary school educators in the North West Province, and found that if high job demands are experienced without sufficient job resources to cope with these demands, burnout will develop, which in turn, could result in physical and or psychological ill-health. However, in this study, the LCHWs experienced high job demands and high job resources

simultaneously, without any evidence, however of physical or psychological ill health; instead, these group of employees remain engaged with their jobs.

5.4.3 Inadequate employment processes at St Joseph's: retention, succession planning and promotion

Section 4.3.3.3 reported on the inadequate employment processes of St Joseph's, as they relate to this study and are identified in the detailed descriptions of Bakker and Demerouti (2007), Lu *et al.* (2009), as follows: job resources may be located at the level of the organisation at large, and may include, among others, pay, career opportunities, job security, interpersonal and social relations (such as team climate, supervisor and co-worker support), role clarity (organisation of work), and the level of task (skills variety, task significance, autonomy, performance feedback. The findings of this research established that there was no synergy in the employment processes of St Joseph's, with specific regard to the retention, succession planning, and promotion of LCHWs, which can be regarded as a major contributory factor of their career pathing development in relation to the organisation's development and sustainability. The results indicated that St Joseph's was driven by the participants (human assets) who are directly responsible for the success or failure of St Joseph's and its related community projects. Therefore, training and career development play a critical role in attracting and retaining good workers and maintaining low levels of staff turnover. The importance of human resources and their management are vital in any organisation, according to the World Health report (2006) which has given another important boost to the global agenda of human resources for health (HRH). The report further added that there were three levers that influence workforce performance: job-related interventions that focus on individual occupations, support-system-related interventions and interventions that create an enabling environment, and focus on managerial culture and organisational arrangements. The LCHWs are St Joseph's greatest asset and it makes sense to invest time and money in continuing to develop them as members of the organisational workforce. According to Akindele (2007), organisations that recruit workers should become more selective in their choices, since poor recruiting and selection decisions can have long-term negative effects on the organisation's image. It

was evident that many of the participants were recruited without a proper employment process, which resulted in them being mismatched in their existing positions. This finding correlates with the work of Babaru (2003), who reports that many people in organisations today are in the wrong jobs, and as a result, are not using their full potential. Grant (2003) had a different view on this finding, which is that, when individuals perceive the task they are given is appropriate to their skill level, interests and knowledge, and believe that their work is recognised, they tend to value the organisation's contributions to these factors and strengthen linkages with it, such as commitment and entrenchment. The LCHWs however, worked for an indefinite period without the proper knowledge, skills, and under inadequate organisational employment processes, yet they were still dedicated, committed and entrenched in the work of St Joseph's. The findings of this study correlate with a statement by Salafsky *et al.* (2005) about retention of health workers, and particularly the fact that there are fewer health workers in rural areas; loss of health workers in these areas will severely contribute to accessibility problems.

Retention: It was clear from the findings that St Joseph's had no retention plan or process in place to drive and support their training and career guidance effectively, with specific reference to the retention of professional nurses and social workers who frequently leave the employment of St Joseph's for better prospects elsewhere. This supports the finding in research conducted by Irving, Coleman and Cooper (1997) that organisational commitment is an affective psychological attachment to the organisation. For example, LCHWs stayed with the organisation because they wanted to. However, the findings did not correlate with those of Greenhaus, Parasuraman, and Wormely (1990) that career plateauing can also have an impact on career satisfaction and turnover intentions, and may be more common for minority employees. I am of the view that improved planning, deployment and use of health workers can contribute to the reduction of stress among LCHWs, and at the same time contribute to improved retention. The people with skill resourcing needs (participants) demonstrated a long-standing work commitment to St Joseph's, and there was no history of these employees having left their jobs voluntarily or involuntarily. This was an indication that they were loyal to St Joseph's and committed to their jobs. Contrary to the results obtained in this study, the employees with skill-resourcing needs (minority)

remained in their jobs for longer periods. Morrow's (2011) view is that, although an organisation's practices are positioned to achieve high levels of talent retention and employee performance, little attention has been given to the role of affective commitment when establishing their human resources practices. St Joseph's, however, paid increasing attention to attracting, engaging and retaining key employees, such as fundraisers, financial managers, training facilitators, and professional counsellors and teachers, a line of thinking shared by Arthur, Khapova and Wilderom (2005) on the importance of retaining key employees and potential organisational leaders. In my view, LCHWs must form an integral part of the aforementioned key employee structure.

Mobility of employees is an inevitable process in organisations, and studies have shown a clear relationship between job satisfaction and retention (Lu *et al.*, (2005). According to the findings, there was no formal plan or criterion used by St Joseph's in the respective community projects or as part of their organisational capacity-building processes as a retention mechanism for the participants. This finding was different from that of Plowman, (2000), who reports that international donors and NGOs had taken organisational development to be a more appropriate approach to building organisational capacity. This is relevant to the above findings, in that organisations that endeavour to retain valuable employees are motivated to provide incentives and career paths that are consistent with the career values, expectations and aspirations that underlie the career orientation of these employees (Coetzee & Schreuder, 2009a). Tonelli *et al.* (2002) support the findings on retention, stating that the environment of change is demanding new policies and management practices that are specifically aimed at retaining people, because they become increasingly trained to work in an environment of uncertainty and technological sophistication. Unstable environments thus demand more action and cooperation from the workforce, which calls into question the relative values of work, remuneration, leisure, personal life and organisational citizenship.

It is evident in the results obtained, that St Joseph's focus was to improve the knowledge and skills of the participants through training and development, in order for them to retain their services, in particular, the LCHWs. Britton (1998) states that a healthy organisation

is characterised by being honest, concerned with people, and financially sustainable, as well as participatory in its approach to culture as a good employer.. An additional view from Smith (2005), which explains that significant retention factors positively associated with job retention include the perceptions that an employer promoted life-work balance, that a supervisor is supportive and competent, and that few job alternatives are available, particularly to the LCHWs at St Joseph's. In order for St Joseph's to cope with the dynamics of today's world and to enhance the knowledge and skills in palliative care from the participants, the NGO should look at its internal setting and ways of conducting the work through initiatives like position enrichment, encouragement of semi-autonomous or self-managed groups, minimisation of centralised authority and control.

Succession planning: It was also evident from the findings that succession planning was needed at St Joseph's to identify positions that were critical to the success of the organisation and related community projects. This planning is connected with the abovementioned retention need. The absence of a succession plan contributes to sudden changes in the jobs of existing participants, and adds to their work pressures, particularly the people with skill-resourcing needs (LCHW). Personal resources are regarded as important in the working life of each participant in this study, and these resources are usually evidenced as self-esteem, self-efficacy, and optimism, according to Bakker, Albrecht and Leiter (2011). Lehmann *et al.*, (2005) and Dussault and Franceschini (2006) concluded that health workers leave their organisations for many reasons, not necessarily for financial reasons. These authors confirm this study's findings: that participants left because of working conditions with limited resources. According to the findings, these employees were expected to fill the roles of the employees who had left the employ of St Joseph's without prior notice, training or guidance. In association with the findings of this study, Luna (2012) describes succession planning as a systematic, long-term process of determining goals, needs and roles within an organisation and preparing individuals or employee groups for responsibilities relative to work needed within an organisation. I believes that the incorrect application of employment processes at St Joseph's to the absence of a formal retention and succession plan, directly affects the self-efficacy of the participants because it creates job insecurity that results in stress in relation to their work.

Pajares (2002) states that individuals have self-regulatory mechanisms that provide the potential for self-directed changes in behaviour, such as the evaluation of one's own self (self-concept, self-esteem, and values), and tangible self-motivators that act as personal incentives to behave in self-directed ways. This line of thinking relates to the work of Aamodt (2010) who indicates that the level of pay, lack of career guidance opportunities, unmet needs due to a lack of person-organisation fit, lack of support a from line manager, and working conditions or job stress are some of the major push factors that lead to unwanted staff turnover. These job demands and resources referred to by the previous author are in line with the interpretation of the JD-R model, and are relevant to the participants in this study, according to their roles. Demerouti et al (2001) and Bakker and Demerouti (2007) explain that poorly-designed jobs or chronic job demands, such as work overload, and emotional demands exhaust employees' mental and physical resources and may therefore lead to the depletion of their energy. The latter relates directly to the participants who are forced to work in positions where more qualified, knowledgeable, skilled and experienced staff are not available for various reasons.

As indicated by Luthans (2002), positive work and organisational psychology focuses on positively orientated human resources, strengths and psychological capacities that can be measured, developed and effectively managed for performance improvement in today's workplace. Similarly, Harter, *et al.* (2002) state work-related states and experiences are deemed valuable not only in their own right, but also as drivers for organisational performance. During the study, St Joseph's was in the process of developing a succession plan for the director who was about to retire in a few years' time. However, this idea was not formally reported on in the data collection process. As indicated by Rothwell (2010), succession planning was initially conceived of as a risk management strategy designed to mitigate the loss of key leaders in large organisations. Over time, however, succession planning has evolved and today it serves as a tool to manage knowledge and change, develop leadership capacity, build smart teams, and retain and deploy talent in a manner that helps an organisation operate at its greatest potential (Groves, 2003).

The work of authors like Fink and Brayman, (2006), and Zepeda, Bengtson and Parylo (2012) supports this study's findings, encouraging organisations such as St Joseph's to follow suit and to develop strategies to ensure that they are able to attract and retain talent. The complex nature of work and business in both the private and public sectors means that organisations cannot rely on the serendipitous replacements of talent, nor can they expect to have a pool of willing and qualified candidates ready and waiting, even during a recession. The work of Orpen (1994) also relates to these findings, describing a career sequence of related work experiences and activities that are aimed at personal and organisation goals, partly under the control of the individual and partly of others, and which happens through processes which a person goes through during his or her lifetime.

Promotion: The findings did not come up with any promotion processes for the participants who had been working at St Joseph's for many years in the same positions. As indicated by Hall and Mirvis (1995), careers focus outward on an ideal generalised career path of vertical progression which entails positions of responsibility, status and rewards as well as an offer of security for the employees. However, the participants did not have the privilege of experiencing the progression as suggested by these authors, because of the absence of formal promotion policies at St Joseph's. It was generally understood in the past that employee performance was often perceived as a function of skills and knowledge. However, according to WHO (2006), recently it has been recognised that performance is influenced by additional factors, and Zurn *et al.* (2005) characterise these factors as follows: if employees are to perform to their full capacity, it is not only employment issues that must be addressed, but also system and facility issues. Therefore, the performance of health workers depends not only on their competence, such as knowledge and skills, but also on their availability, which is their retention and their presence, their motivation and job satisfaction, as well as the availability of infrastructure, equipment and support systems, such as the management, information systems, resources and accountability systems that are in place. Further, the literature reveals that subjective career success is defined as an individual's feelings of accomplishment and satisfaction with his or her career, which is partially based on objective indicators (Wayne, Liden, Kraimer, & Graft, 1999). A further indication of the findings is that the participants viewed promotion as a measure of their

success and progress at work, which affected their jobs in many different ways, both negatively and positively, based on personal perceptions and experiences in their respective roles as carers. It can be inferred from the findings that good performance by the participants can be enabled through a supportive working environment, which correlates with Potter and Brought's (2004) explanation that a supportive working environment encompasses more than just having sufficient equipment and supplies; it includes systems such as decision-making, information-exchange processes, and capacity issues which include workload, support services and as infrastructure. Related experiences and behaviours from the findings are found in the work of Seibert, Kraimer, and Crant (2001), who explain that intrinsic or subjective variables that influence career progression include satisfaction with the rate of progress. Based on the findings, the participants' individual self-efficacy and belief in their abilities was shown to have a great impact on success or failure in their existing career paths at St Joseph's. Contrary to this finding, Bellah *et al.* (1985) Parry (2006) and Wrzesniewski *et al.* (1997) state that individuals who view their work as a career are concerned with the progress of continuous advancement within the organisation. However, Llorens *et al.* (2007) dispute the above statement in their finding that, as a result of lack of clear working protocols, the feeling of autonomy and self-efficacy decreases. The above findings are comparable to the research conducted by Madaus, Ruben, Foley, and McGuire (2003) who suggest that those with higher self-efficacy show higher levels of job satisfaction. Ellenbecker (2004) states that promotion could include exogenous circumstances (availability of other career paths), personality factors, loyalty, place-of-work characteristics, perceived job stress, work-life balance issues and demonstrable employer support, all to be considered as part of the promotion of people. Participants in this study were moved between jobs to fill in for a fellow worker who either resigned or who was not at work on a particular day, and not for promotional purposes. And from a job-demand perspective, this practice of filling in for co-workers could contribute to poorly designed jobs or chronic job demands, such as role stress should a participant not know how to perform the tasks in those roles in which they are placed. It may also lead to the exhaustion of the participants' mental and physical resources (Bakker & Demerouti, 2007). The results of a study by Rothmann and Jordaan (2006) on a sample of academic staff from South African higher education institutions, showed that job

resources such as growth opportunities, organisational support, and advancement predicted the vigour and dedication dimension of work engagement. Similarly, a study conducted by Mostert, Cronje and Pienaar (2006) on a sample of police officers in the North West Province found that job resources had a strong and positive relationship with work engagement. These authors argue that the availability of job resources, such as support from the organisation, advancement possibilities, growth opportunities, and socialising with colleagues at work may help police officers to cope with the demanding aspects of their work and simultaneously stimulate them to learn from, and grow in their jobs (Mostert *et al.,* 2006). However, in this study, LCHWs experienced high job demands with limited job resources, and persevered and intrinsically coped, despite the lack of support from St Joseph's, absence of growth and advancement opportunities, and if not addressed, could lead to serious burnout.

5.5 SUMMARY OF CHAPTER

The discussion of the findings was arranged according to the format used in the results chapter. These findings were linked to the related literature, the JD-R model from a community and adult education perspective which is the theoretical framework of this study, as discussed in Chapter Three, including my interpretations. In Chapter Six, the work resourcing needs framework is discussed.

CHAPTER SIX: WORK RESOURCING NEEDS FRAMEWORK

6.1 INTRODUCTION

In this chapter, based on the findings, I propose a work resourcing needs framework for St Joseph's to consider in terms of how the LCHWs could be supported in their work. Grounded in the three main themes, and the related sub-themes, specific focus is placed on the critical issues obtained from the presentation of findings in Chapter Four, and the discussion in Chapter Five.

There are specific concrete strategies that St Josephs could adopt to support the knowledge and skills needs of the LCHWs in relation to work meaning constructions that will enhance their efficiency in the palliative environment where they work. Some of these strategies relate specifically to St Joseph's and its commitment to the LCHWs to support their identified work meaning needs, and could contribute to the sustainability of the organisation.

6.2 KNOWLEDGE NEEDED BY LCHWS

Below are specific guidelines about palliative care that St Joseph's could use as a refresher course or for new training initiatives to enhance the knowledge needed by LCHWs. These guidelines can be integrated into St Joseph's existing training activities.

A lay-carer booklet could be compiled with the following basic requirements with regard to knowledge about **palliative care:**

- Participants must constantly be reminded that palliative care for pain and other symptoms is only a part of the complete home-care for patients and OVC, and it should include physical, psychological and spiritual activities.

- Basic physical care may include positioning, hygiene, skin care, and nutritional support for the patients and OVC, as well a spiritual and emotional support through which they can promote death with dignity for those affected and infected.
- It is important the LCHWs remained informed about counselling on interpersonal communication and bereavement, which can be as significant as the medical intervention in the course of chronic illness such as that experienced by the patients and OVC.
- Continuous assessment of community resources for support, and integration of home-care with other available forms of community care provided via St Joseph's, should remain a crucial point in the lay-carer booklet.
- Another important factor for participants to be constantly reminded of, is that providing palliative care at home to patients and OVC provides them with an opportunity for community education on, for example, voluntary counselling and testing (WHO, 2004).

It is clear that adult and community educators across the sector of education, health and agriculture have railed against the narrow focus on community and adult education, which sees its roles as meeting the needs of the economy and employers, or in the service of the government in providing skills training (Crowther, 2013). LCHWs need on-going training in palliative care, because it is such a complex phenomenon, therefore:

- LCHWs need to know how to manage uncertainty about how disease will progress and how fast.
- They must be trained to identify sudden and dramatic changes in the patient's and OVC's conditions, and need certain types of knowledge that can make the identification process easily recognisable.
- St Joseph's needs to develop a simple check-list for LCHWs to manage symptom and pain control, so helping them to acquire knowledge on how to identity new infections and other medical problems from patients and OVC who need specific treatment.

- LCHWs must be equipped with palliative care knowledge, and the ability to make appropriate decisions, for example, about the care of patients and OVCs which may be weakened by their illnesses.
- Based on the intensity and complexity of palliative care, St Joseph's must protect LCHWs from burnout, particularly during the end of life when a patient, orphan or vulnerable child is bedridden and needs continuous care. Regular staff relief or replacement processes must be put in place to spread the burden of care equally among all the LCHWs. In addition, professional counselling sessions can be arranged for LCHWs on a fortnightly or monthly basis, depending on the nature and number of high-care palliative patients and OVC (WHO, 2004).

As indicated by Merriman (2010), collaboration and networking between the community and St Joseph's palliative care services can be taken closer to the community. This could happen if St Joseph's applies its community education and mobilisation processes to create an environment where St Joseph's can work with community leaders, faith-based organisations and other NGOs and NPOs in Bronkhorstspruit to provide extended palliative care to patients and OVC. To encourage community involvement in palliative care, St Joseph's should aim to educate and mobilise adult community members continuously to attend health talks, specifically about palliative care outside the hospice. Effective collaboration between the community of Bronkhorstspruit and St Joseph's, will minimise the suffering of patients and OVC, and will improve palliative care. Encouraging collaboration, using the community and adult education processes as a motivating factor, will enhance palliative care in Bronkhorstspruit. While lack of participation in community and adult education for health initiatives could be due to circumstantial, institutional, or dispositional barriers in the community at large, in some cases, Crowther (2000) states that non-participation could perhaps be best understood as an active choice that is informed by prior experiences in the community.

Psycho-social support: St Joseph's could use a workshop to introduce psycho-social support to LCHWs by helping them to identify the major social reactions that HIV/AIDS patients and OVC experience. At this workshop, training facilitators can help the LCHWs

to understand how they can deal with the various reactions in the counselling process relating to psycho-social support. These workshops could include brainstorming sessions where LCHWs are divided into groups and the groups are tasked to brainstorm feelings and reactions that a person may experience on being diagnosed HIV-positive. Plenary discussion sessions can follow the brainstorming process when the groups have an opportunity to demonstrate and/or discuss their interpretation of their reactions and feelings. In this workshop, LCHWs must be made aware of the various psychological reactions in people who are affected and infected with HIV/AIDS. These psychological reactions include, though are not limited to: shock, anxiety, behavioural symptoms, denial, anger, guilt, depression, hypochondria, bargaining and acceptance (WHO, 1993).

Symptom and pain control, and adherence to antiretroviral (ARVs): LCHWs must constantly be reminded through on-the-job training or workshops of the importance of managing symptom and pain control, because they can affect the patient's and OVC's nutritional status and adherence to ARVs. The training process must highlight the importance for LCHWs to be aware that ARV can affect the way food works, how food can affect the way ARVs work, and that certain effects of the ARVs can prevent patients and OVC from eating well, which could lead to malnutrition. The training sessions must point out to participants that they should always refer patients and OVC to the health workers at St Joseph's when the symptoms and pain are severe, and also when they learn that those affected are not adhering to their ARV treatment. It is important that St Joseph's train LCHWs to help patients and OVC on how to manage common symptoms and pain related to HIV/AIDS by using basic communication skills (Ministry of Health, Uganda, 2008).

Ethnic differences, beliefs and values: St Joseph's needs to make LCHWs aware that as counsellors, like any other health professionals, they are expected to provide a service to all people, irrespective of their race, culture, religion, or any other grouping. As counsellors, LCHWs need to be sensitive to the world of each patient and OVC. LCHWs must receive training to understand that counselling is a process whereby patients and OVC are challenged to evaluate their own values honestly and then decide for themselves in what

ways they will modify these values and their behaviour. The training must highlight to LCHWs that effective counselling takes into account the impact of culture on patients' and OVC's perceptions of the world. In the context of St Joseph's, it is imperative that LCHWs engage in multi-racial discussions to get a deeper understanding that culture is about the values and behaviour shared by a group of individuals. It is important that LCHWs be aware that culture does not refer just to an ethnic or racial group, but can also be influenced by age, gender, life style or socio-economic status. LCHWs must be trained to refrain from being hooked in their own culture and clinging to their own beliefs, thus failing to recognise the world of the patients and OVC with whom they interact with on a daily basis.

6.3 SKILLS NEEDED BY LCHWS

With regard to the findings and the specific skills needs identified by the participants, the following recommendations are made to St Joseph's to consider:

Nutritional and cooking skills: For St Joseph's to integrate nutrition into its holistic palliative care and support to patients and OVC, a trainer manual for LCHWs should be part of their training programme to help people living with HIV/AIDS (PLHIV) and themselves as carers to improve nutritional practices within the organisation. LCHWs must be trained in basic nutritional care and support for PLHIV. This training programme for LCHWs could be scheduled for four days, and possibly conducted at one or two different periods, depending on the organisation's operations and the training resources available. Training should be prepared ahead of time, and it would be advisable to have a training kit that has the necessary training aids and demonstration materials organised by topic and training session. A more cost-effective way is for St Joseph's to print or photocopy training aids. Bearing in mind that the LCHWs are all adults, a competence-based participatory training approach can be used because it reflects the key principles of behaviour change communication with a focus on the promotion of small manageable actions, a recognition of the widely accepted theory that adults learn best by reflecting on their own personal experiences. In addition, the approach uses the experiential learning cycle method and prepares each LCHW for hands-on performance of their skills. During the training process,

LCHWs should act as resource persons for each other, and benefit from community practice. It is however very important for St Joseph's to ensure that LCHWs are trained beforehand in community mobilization, HIV infection and progress, HIV management with ARVs, support of PLHIV/OVC as well as monitoring palliative care activities. Pre- and post-assessments must be conducted to evaluate LCHWs' knowledge and skills in order to give training facilitators an idea of their training needs. LCHWs must learn the basics of nutrition needed by patients and OVC in order to make it easier for them to understand the relationship between nutrition and HIV (WHO/FAO, 2002).

LCHWs must be introduced to the food groups available in the community and their importance. These introductions can include food demonstrations and discussion. Activities about food can be organised during training sessions, and LHWs can bring different types of food from their own communities to compare and share. The sharing and comparing will enable them to identify different types of food. LCHWs need to be taught how to make balanced meals and introduced to the different food groups, such as staple foods, like cereals, roots and tubers that give energy; food groups that include plant and animal sources that provide protein, minerals and vitamins (beans, peas and nuts) which are also known as body-building foods; protective foods such as vegetables and fruits, (dark-green, leafy green orange-coloured vegetables, and oranges, guava, mangoes and watermelon, among many others). Other foods such as fats, oil and sugar must also be introduced to LCHWs, because these foods provides energy and taste, for example butter, oil, sugar and honey. Most importantly, LCHWs must know that water is important for life and is necessary every day. It must be emphasised that drinking artificial juices, sodas, alcoholic drinks, sweets and biscuits should be reduced or eliminated, as they interfere with the consumption of healthy foods and drinks. Teach LCHWs to identify and describe other ways of increasing the required food values, by asking questions and engaging in discussions. Introduce the six important ways of increasing food values to LCHWs, which includes frequency of meals, minimally three main meals and two small snack meals; point out to LCHWs that these frequency meals will increase for those who are sick or who are recovering from illness. Inform LCHWs about how much can be eaten at each meal. The thickness of food is important, because if food is too thick, it will be difficult for the patient

or OVC to chew and to swallow; and if the food is too watery, the energy level of the food is reduced. LCHWs need to know about the various food groups, because each food serves the body differently and that it is important to a variety of foods from each food group in order for the patients and OVC to eat well. Actively feeding and supporting are important actions, and to feed patients and OVC, having access to food, growing and preparing these foods is essential, which is where the gardening and farming projects play a role (WHO/ Food & Agriculture Organisation (FAO) 2002).

Academic and office management: LCHWs will only be able to meet their skill-resourcing needs for academic and office management skills if St Joseph's first focuses on their adult literacy levels which include, report writing, reading, writing, numeracy and literacy. To do this, St Joseph's needs to plan an adult literacy programme and to consider all the specified skill-resourcing needs in relation to the community needs and the resources the organisation has available, as well as considering the needs of LCHWs. Attention must be paid to the LCHWs motivation, based on what they see as necessary in their lives and understanding what their goals are. St Joseph's should bear in mind that the LCHWs' lives dictate the used of their newly acquired skills so it is important that St Joseph's recognises the LCHWs as adults, and this regard, the adult literacy programme must accept this group of LCHWs as adult learners with knowledge and not as empty vessels. St Joseph's can employ one-on-one tutoring, and interview potential volunteers to help the LCHWs not only to read and write, but also to understand the literacy needs in the community where they are working (Rabinowitz, 2014).

Auxiliary health care: The concept of social auxiliary work was defined by the United Nations Organisations as "a paid worker in a particular technical field with less than full qualifications in that specific fields who assists and is supervised by a professional worker" (Racionzer, 2010). In order for St Joseph's to assist LCHWs who wish to become fully qualified auxiliary workers, a formal workshop should be arranged to explain in detail what such training requires in order for them to make an informed decision about this choice of training. The following aspects are important to address at the formal workshop: LCHWs must be informed that only people who are registered as social auxiliary workers with the

South African Council for Social Service Professions (SACSSP) may practise (Act 110 of 1978). It is important to point out to the LCHWs that auxiliary workers do not practise independently of social workers, and that includes any work with individuals, families, routs and communities. They must also be informed that, as auxiliary workers, although they are allowed to work without the physical presence of a social worker, all guiding and supervisory functions will always remain with a social worker. Another important aspect for the LCHWs to know is that no experienced or senior social auxiliary workers can be placed in a supervisory position over other auxiliary workers. According to the rules of the SACSSP, St Joseph's must apply for approval from the Council if it wishes to appoint more than two auxiliary workers for each social worker. St Joseph's should be aware that, when identifying a social worker to guide and supervise LCHW auxiliary workers, the person does not have to be employed by the organisation. It is important that St Joseph's remind the identified social worker that he or she is not required to be physically at the organisation's premises to supervise, but that the supervising social worker must be available to the social auxiliary LCHWs at all hours and not only at certain fixed hours. Proof that social auxiliary LCHWs will be working under a designated social worker's supervision is required and it is imperative that St Joseph's inform the designated supervising social worker that he or she would be legally co-responsible for the acts of the social auxiliary LCHWs. LCHWs have to comply with the codes of ethics as social auxiliary workers and no unregistered LCHW is allowed to practise social auxiliary work or pretend to be a social auxiliary worker. During the time a LCHW is undergoing the training course, irrespective of whether it is a learnership or formal course, conditional registration with the SACSSP is compulsory. Once LCHWs successfully complete their social auxiliary work training course and the certificate in Social Auxiliary has been issued, full registration with the SACSSP becomes compulsory. The period of study for social auxiliary work extends over a period of twelve months. LCHWs who are interested in studying social auxiliary work must have personal attributes that include, but are not limited to, a sincere interest and faith in people; a belief in people's potential; an ability to communicate with people; a genuine interest and desire to contribute to the well-being of human beings; a strong sense of responsibility and an optimistic outlook.

Gardening and farming: It is necessary for St Joseph's to expand on their existing garden and vegetable projects by promoting home and school gardens to improve the nutrition security of households, in particular those affected by HIV/AIDS. St Joseph's can make home and school gardens part of a comprehensive community nutrition strategy, enhancing community education for all the people living with HIV/AIDS, because these gardens are a source of nutritional security and play an important role in supporting livelihoods of those affected and infected as well as of their households. In order for St Joseph's to boost the health and immune systems of the patients and OVC, they need to put mechanisms in place to monitor and maintain well-tended and structured home gardens, not only for the protein-energy requirements, but also to provide the necessary antioxidants needed. For optimal benefit, St Joseph's could establish an agriculture project that would also train and educate the community members of Bronkhorstspruit to use home and school gardening as a source of income, and not only to focus on health and nutrition. According to Crowther (2011, p. 15):

> What is needed is a vision of education which makes a vital contribution to a humane, democratic and socially just society, as well as a thriving and sustainable economic life.

Through this newly established agricultural project, St Joseph's can make use of proper referrals and marketing practices; surplus produce can be sold to provide additional and much needed income. To make these home and school gardens more effective, St Joseph's should host regular, free educational workshops in the community that highlight the fact that home and school gardens can help address the difficulties faced by those affected and infected with HIV/AIDS, and make it possible to have access to affordable, and locally available nutritional foods. St Joseph's could also assess the resources and capabilities of the households and school and make recommendations on the following different types of small gardens: kitchen, sack, tyre, pot or wall container, hanging, conventional double-dug organic and square-foot gardens, which are low-cost and locally available and can be viable for households that are struggling with resources and labour issues. In an addition, St Joseph's could use LCHWs as an example to inform community members of the additional

benefits of home and school gardens such as recycling household waste and turning it into organic mature. This can further serve as an income-generating activity for those affected and infected with HIV/AIDS in Bronkhorstspruit. A strong focus on income-generation is required from St Joseph's, because the gardening and farming project can help support households in their livelihood challenges, and by selling the surplus production for income, these households would be in a position to sustain their livelihoods (Food & Agriculture Organisation (FAO), 2007).

According to the Department of Education and Skills (DES), (2000), community education is seen in two ways: first, "as an extension of the service provided by second- and third-level educational institutions into the wider community" (p.110), and second, as "a process of communal education towards empowerment, both at an individual and collective level" (p.110). Community education is both in and of the community and has a "collective social purpose and an inherently political agenda to promote critical reflection, challenge existing structure, and promote empowerment" (p.113). Therefore, through this agricultural project, St Joseph's can seek to actively promote garden-based learning in schools as a response to the impact of HIV/AIDS on OVC. St Joseph's can use this gardening initiative to educate OVC about food production and natural resource management for good nutrition and improved life and livelihood prospects in the wider community of Bronkhorstspruit. St Joseph's can also use their own facilities to provide aftercare garden-based learning for OVC to increase the relevance and quality of their education by introducing them to food and nutrition-related knowledge and skills. During these contact sessions, agricultural training facilitators from St Joseph's could provide OVC with practical experience in food production and natural resource management. Agricultural training facilitators from St Joseph's could introduce innovations and simple techniques that OVC can take home to their families and apply in their own household gardens and farms. St Joseph's must make the agricultural main curriculum about improving OVC nutrition by supplementing school feeding programmes with fresh micronutrient and protein-rich products, and increasing OVC's nutritional knowledge and skills for the benefit of the entire family. This can also applied to St Joseph's feeding schemes (Junior Farmer Field (FAO), 2009).

Lay counselling: It is important that LCHWs understand that there are different types of counselling in HIV/AIDS. These include crisis, preventative, supportive and family counselling. The counselling process could also be discussed in a workshop and, to make it more effective, role play would be an ideal way for LCHWs to act out the different types of counselling. These groups could be split into two, with one sub-group acting out an HIV/AIDS-related case for crisis counselling and the other sub-group having a preventative counselling case. There should be flexibility in the role plays, with LCHWs taking turns to be observers or to be part of the role play in acting out a certain type of counselling session. The training facilitator could use role-play to identify whether the counselling situation is a crisis, preventative, supportive or family counselling situation, and ask LCHWs to apply it in their own context when they are out in the field. Basic guidelines that participants can apply during counselling sessions are:

Crisis counselling: LCHWs need to understand and adhere to the fact that crisis counselling focusses on the patients' and OVCs' feelings and accepts their personal definition. Regardless of the nature of the crisis, the LCHW, as the counsellor, must accept the situation, remain calm and maintain self-assurance. Basic guidelines for LCHWs to apply as interventions during crisis counselling sessions need to be drawn up. These basic guidelines must also include what the LCHWs are not allowed to do during a crisis counselling session.

Preventative counselling: It is important that the training facilitators explain to LCHWs that preventative counselling is strictly aimed preventing being infected with HIV and preventing its transmission to other people. LCHWs must know that preventative counselling is divided into primary prevention, which refers to patients and OVC who are at risk and not known to be infected, and secondary prevention for patients and OVC known to be HIV-infected or likely to be HIV-infected.

Supportive counselling: LCHWs should be trained to understand and accept that people with HIV face many problems. The focal point for St Joseph's is to ensure that LCHWs become knowledgeable in all the issues that supportive counselling focuses on. LCHWs

need to know that supportive counselling is an active process of empowering HIV-positive patients and OVC and those affected to live positively.

Family counselling: For LCHWs to succeed in their counselling endeavours with the patient and OVC, St Joseph's should consider the individual that is infected as part of a family system that can provide some of the solutions to the patient's and OVC's problem. To achieve active participation of family members in the counselling sessions, St Joseph's must focus on skills such as widening the system, circular linking questions, re-framing, use of the genogram, together with all the usual counselling skills which enable counsellors (LCHWs) to explore with the patients and OVC, sources of support within the family system (HIV/AIDS Counselling, 1997).

LCHWs must be trained to understand that the counselling process is divided into three stages, and that there is no fixed time or number of sessions required to complete any of the three counselling stages. LCHWs must be trained in how to effectively manage and steer the three counselling stages, which consist of the beginning state, (normally regarded as the relationship-building stage), middle or information gathering stage, and the end stage.

Beginning stage or relationship building stage: LCHWs need to be guided on how to prepare an action plan that addresses the needs of the patient or OVC who requires counselling. The patient or the OVC indicates how he or she would like his/her problem be addressed; the lay counsellor first determines what the patient or OVC thinks should be done about the problem then makes certain what the patient or OVC expects from the counselling session. The lay counsellor describes to the patient or OVC chances of realistic hope for change or assistance that may be provided, and at the same time explains the reasons where it is not possible to give the required support.

Middle or information gathering stage: St Joseph's needs to build on the beginning stage and equip LCHWs with skills to gather the required information to support the continuing expressions and discussion of feelings, where reference is made to formal and informal

resources. LCHWs must be guided to monitor progress and modify counselling plans where necessary, and they must be trained to be meticulous in promoting the continuation of changes in patient or OVC behaviour during counselling sessions. LCHWs need to be coached on how to help patients or OVC to move towards acceptance and control of their conditions or situations.

End stage: St Joseph's needs to assist LCHWs by providing them with a professional counsellor during their initial lay counselling sessions, to help the patient or OVC to summarise the presenting problem or the day's session and provide them with some framework to work on before the next session. LCHWs will require extensive training in ending the relationships with patients and OVC; they need to know when it will be appropriate to ascertain that the patient or OVC can cope with and adequately plan for day-to-day functioning, and to make sure that support systems such as family, friends and support groups are available to help them carry through their plan of action (USAID, 2005).

Basic life skills, training and education: St Joseph's should take cognisance that there are particular skills that need to be learned by LCHWs, because they in turn, must train and educate patients, orphans and vulnerable children who need palliative care to learn self-management skills for treating their disease. They also require skills that will help them to live with the illness. To ensure that LCHWs have the necessary skills in palliative care, these skills must be taught, practised and reinforced on a monthly basis. Taking into consideration the educational background of the LCHWs in relation to their skills needs in palliative care, St Joseph's should focus on the following when planning any form of skills training to these workers (Hammerton, Toliman, Guatemala and Gottlieb (2000): establish the literacy levels of each participant; assess the levels of their reading and writing ability to determine where they would fit in better in the palliative care skills training plan.

Hahn *et al.*, (2011) suggest another practice which St Joseph's could consider: focusing on recovery training for the participants, which can include relaxation, or mindfulness. LCHWs can learn which activities best help them to recover from their work-related efforts through the application of recovery training. This recovery training could benefit the

LCHWs because, according to Bakker and Demerouti; Bakker, Nachreiner, and Schaufeli (2001); Schaufeli & Bakker (2005); Schaufeli and Salanova (2007), it is important to understand that job demands are strongly associated with burnout which can eventually lead to ill health outcomes, sometimes called the health impairments process.

There are basic educational principles that St Joseph's must take into consideration for all training programmes that involve the LCHWs. As adults, the process of teaching LCHWs is as important as the content of the training. The strategies and techniques that will be used in their work should be modelled and should include active, and multiple learning techniques, discussion, practical hands-on learning activities and should, as far possible, limit passive learning. The internet versions of the JD-R model questionnaires can be customised by St Joseph in such a way that tailored feedback informing participants about the most important job demands and resources, and pictures for those with literacy challenges can be used (Bakker & Demerouti 2007, Bakker *et al.*, 2013). Because LCHWs are adult workers, trainers at St Joseph's should be sensitive in their planning of training for them, specifically sensitive to low self-confidence, humiliation and fear, which at times, can be deeply ingrained in them individually. Encourage active participation, active listening to co-workers, freedom to ask questions, provide them with opportunities to make their own mistakes in terms of critical thinking (Helping Health Workers Learn, 2005, p. 538). Another skills training method that St Joseph's could use is role play and drama, which can be an effective method and a fun learning way to empower the LCHWs with the necessary skills as they identify them before any role play or drama activity. The after-effects of such learning activities last for life in many cases, and the approach is regarded as very effective for lay-adult learners. Trainers at St Joseph's can plan skills training for LCHWs that will provide them with opportunities to learn how to perform more complicated tasks, which can be broken down into simple, clear steps and demonstrated many times by an experienced health professional. Training topics can also be broken down into small definable skills and tasks, which an effective way to teach the knowledge and skills related to history and vital signs. Completing as many different types of such training, will enhance LCHWs' knowledge and skills in palliative care (Helping health workers learn, 2005, pp. 280–281).

A number of the skills needed in the context of this study share a common cause in that they are partnered with the well-being of community members as well as the overall sustainability of St Joseph's. The above can be achieved if St Joseph's assesses the most important job resources that need attention before starting the skills training mediation processes (Bakker & Demerouti, 2014; Bakker *et al.*, 2013). The necessary skills identified above were highlighted during the data collection process and confirmed by the research findings. However, to ensure a holistic approach to the skills training needs assessment, the steps outlined in the illustration below should be followed. These basic steps for a skills training needs assessment (STNA) start by identifying the requirement for each job, followed by a needs assessment per individual. Thereafter the identification of training needs should be conducted in order to develop an individual training plan for each staff and volunteer worker indicated in Figure 6.1.

Figure 6.1: Basic steps for a skills training needs assessment (STNA) for LCHWs

In addition to conducting the skills training needs assessment, St Joseph's could also conduct a job explication for each LCHW, illustrated in Figure 6.2. Doing the training needs assessment and job explication for all LCHWs, will ensure greater synergy and alignment of roles and responsibilities with the organisation's goals and objectives.

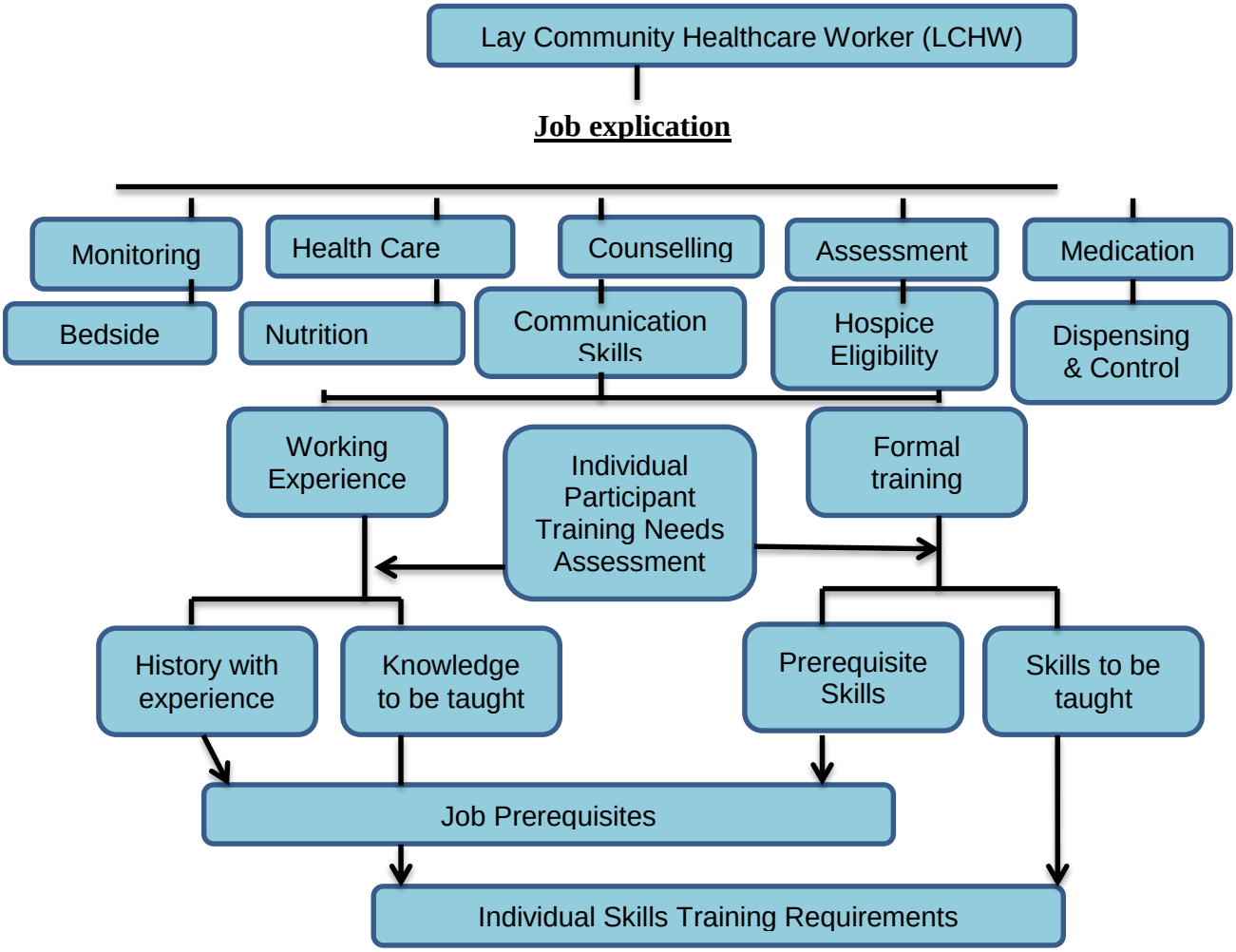

Figure 6.2: An illustration of a basic job or task analysis process for individual LCHWs

These jobs or task processes are likely to contribute to greater job satisfaction, increased productivity as well as heightened levels of self-efficacy, as indicated by the jobs demand resources model (Bakker & Demerouti, 2007). A job profile should be drawn up for each position at St Joseph's and the key performance indicators identified, as a guide to what is expected of all staff and volunteer workers. Minimum requirements must be identified for each job. However, this should be done in consultation with LCHWs. The process must make provision for and recognition of prior learning and affirmation of experience. These job profiles can be used at a later stage as a basis for establishing a performance management tool. A number of the skills needed in the context of this study share a common cause in that they are partnered with the well-being of community members, as well as their sustainability. It is therefore crucial for St Joseph's to ensure effective, affordable and sustainable delivery of training for LCHWs in order for them to gain the necessary skills for behavioural change which can be communicated to all the community members in and around Bronkhorstspruit. In order to accomplish the abovementioned goal, St Joseph's can plan around having on-the-job training to accommodate this process, where LCHWs can be trained in areas of nutrition, food and cooking sciences. However, if the training is conducted or outsourced, what is of cardinal importance is that the training is accredited by the relevant SETA as this will contribute to the long-term career pathing strategy of the organisation. As indicated by Luthans *et al*. (2006), St Joseph's can use on-the-job training as a platform whereby LCHWs can receive examples of how to develop their personal resources in their daily work routines, and through which they can acquire new competencies that will help them to execute their daily job tasks more efficiently.

Academic and office management skills must form a core part in the training and career guidance strategy for staff and volunteers. In the context of this study and based on the diverse background of the staff and volunteers, part of the curriculum should include cross-cultural communication, reading and listening skills, organising information and taking notes, critical thinking and problem-solving skills. These academic skills will add value to staff members' community projects work as well as to their personal growth. St Joseph's should provide a platform for LCHWs to practise reading and listening in order to master the skills over time. According to Demerouti *et al*, (2011); Luthans *et al.* (2006), personal

resources such as optimism, resilience and self-efficacy can be taught. Effective listening skills can be acquired if staff and volunteers monitor their progress and comprehension, ask questions during reading sessions, make predictions and are able to determine the importance of specific statements found while reading (Di Tommaso, 2005). According to Pauk (2001), a system of guided notes can be used to help LCHWs develop organising note-taking skills. Training does not always have to be formal; creative ways of learning should be explored as well, and when LCHWs are being trained, facilitators should be mindful that the learners can have fun and still learn.

Community education: In order to create community awareness with regard to adherence to all treatment in palliative care, it is advisable for St Joseph's to prepare a work plan to reach agreement on health education with the communities their serve. According to the Secretariat of the Taskforce on Active Citizenship (STAC) (2007), education for citizenship, which is not confined to schools and colleges, is crucial and the role of community and adult education is also important. Create visit checklists for LCHWs to use when they carry out their follow-up and support visits in the communities. Educate LCHWs about the importance and the frequency of follow-up home visits, and about educating the community that these home visits are focussed on the well-being of patients and OVC as well as their family and friends. LCHWs must also educate the community that all follow-up visits benefit community members affected and infected with HIV/AIDS if nutrition issues are integrated into other palliative care and support activities. St Joseph's should include monitoring of health, nutrition and assessment of dietary intake during follow-up visits in the work plan. This work plan needs to include reaching an agreement to address barriers to good nutrition, for example, the implementation of the important expected behaviours from patients and OVC receiving palliative care from the LCHWs. It is important that the work plan point out to the community how follow-up visits from the LCHWs help to increase adherence to treatment such as ARV's and prolong the lives of those affected and infected with the epidemic. St Joseph's must make certain that the work plan clearly defines the support and encouragement the community receives as a partner in serving those who are ill because of HIV/AIDS. During follow-up visits to the community, LCHWs must review, on a regular basis, the meal plans of patients and OVC, and their

exercise and physical activities (Ministry of Health, Uganda, 2008). In order for St Joseph's to ensure its success and future sustainability, the work plan must place community education and mobilisation at the centre of the organisation's approach. St Joseph's needs to enhance community capacity and mobilise local communities, faith-based organisations and other non-government organisations to identify their needs around palliative care and to develop and carry out prevention, care and support activities as a collective. The Report of the Taskforce on Active Citizenship (2007), called for "expansion of education for social responsibility in schools, youth, and community and adult education sectors". It specifically recommends:

> The inclusion of workshops on active citizens/voter education as a constituent element of adult/community education programmes (STAC, 2007, p.21).

St Joseph's must therefore customise the work plan to host community education workshops that will raise community leaders' knowledge, awareness, and empathy concerning HIV/AIDS, more specifically, of palliative care. In order to strengthen the relationship with the community, St Joseph's should educate and inspire the community by holding forums, engaging local media, designing public service announcements, drafting letters to the editor, launching social media campaigns or simply by holding home health parties, parent and family meetings, and public education campaigns to generate further awareness about palliative care with a particular emphasis on adherence to treatment for patients and OVC (Whitley, 2002). The goal of community education campaigns addressed through public campaigns for St Joseph's must be to generate awareness, motivate action, encourage funding and keep the community focused on the importance of palliative care to all affected and infected with HIV/AIDS (Fox, 2011).

Establishing a mentoring programme:

Mentoring is an effective way for St Joseph's to facilitate communication and mutual support among LCHWs. It serves as an entry point for new LCHWs with more supportive orientation and initial training, and at the same time, mentoring will offer seasoned LCHWs

career development and promotion opportunities. Establishing a mentorship programme at St Joseph's will develop a culture of continuous learning and problem-solving within the organisation. St Joseph's can task senior managers to review background information about effective mentoring programmes, and make resources available before making a decision to implement such a programme. The identified candidate for the mentoring coordinator's position must demonstrate the formal and informal influence that will ensure success in the design, implementation, and growth of the mentorship programme.

A clear and inspiring job description for mentors must be drawn up, and the responsibilities outlined; they may consist of:

- Interviewing applications to fill positions of LCHWs;
- Playing a role in assessing mentees' competencies, whereby experienced professional permanent employees can assist trainers;
- Providing opportunities to coach and support LCHWs;
- Being active in LCHWs' classroom training, workshops and briefing sessions;
- Providing regular feedback and information to managers and supervisors based on the experiences with mentees;
- Participating actively in St Joseph's operation and management team meetings (Peer Mentoring, 2003, p.7).

Regular reviews of St Joseph's organisational practices should be conducted to determine if they support, align, or conflict with the mentoring programme. More specifically, human resource and disciplinary policies must be revised periodically and in line with the statutory employment requirements. St Joseph's must design the necessary reporting and policy expectations, tools, and processes to support the mentors in following best practice and tracking their activities. It is very important that St Joseph's implement a communication system with supervisors, schedulers, and other affected LCHWs to ensure widespread understanding of the mentors role and responsibilities, including the mentoring programme goals, and the organisation's expectations of all LCHWs in their respective and related roles.

Designing a coaching initiative:

In order for St Joseph's to carry out its responsibilities effectively in a manner that builds LCHW commitment, enhances retention, and draws out the best possible performance from them, the following coaching initiatives should be considered and cognisance taken that coaching is a skill that supervisors and managers can learn through initial training and other employee support services.

St Joseph's should identify a suitable manager to review background information about coaching and relevant resources before implementation. A decision must be made by St Joseph's about which employees will form part of the team that will design the coaching initiative and provide the programme oversight and support to LCHWs who are being coached. The organisation must ensure that the coach coordinator's goals and objectives are identified, and the organisational culture of retention plan, goals, and criteria for evaluation must be reviewed on a continuous basis. The coach coordinator should ensure that available curricula and instructional options are reviewed, and decide what initial training and ongoing skill enhancement sessions to provide, including all policy, procedure and practice changes. St Joseph's must develop a plan for the delivery of initial training for all managers and supervisors to attend such training over a period of time. Similarly, a system of support to assist managers and supervisors in using the skills post-training needs to be developed. LCHWs must receive ongoing feedback and input from managers and supervisors regarding expectations in order to improve St Joseph's practices all the time. St Joseph's needs to ensure that all LCHWs are orientated to the coaching approach initiatives. Most importantly, managers and supervisors require continuous support through counselling and peer support opportunities in using coaching supervision skills. Ensure that changes are being made in training, support, and other aspects of the coaching initiative based on the feedback and shortfalls in goals. Provide opportunities to employees who express interest and who demonstrate skills to play support roles such as trainers, coaches to other supervisors, managers and communicators. St Joseph's must make sure that supervisors and managers who are implementing the coaching initiative receive ongoing support and skill building, which can be one-on-one coaching, and coaching discussion groups (Coaching Supervision, 2005).

6.4 ORGANISATIONAL CHALLENGES

Lack of career pathing processes: According to the JD-R model, the impact of job demands, job and personal resources on work engagement, job satisfaction, burnout, well-being and performance requires investigation. These aspects were prevalent in the findings, and general practices at St Joseph's can be introduced that will enhance the personal and job resources of the LCHWs. Developing proper training plans that incorporate communication, skill-resourcing needs, changes in tasks, emotional demands, work overload and role conflict, need to be developed in order to minimise job demands at St Joseph's.

Practical suggestions for LCHWs to develop career paths further through learning at St Joseph's:

St Joseph's needs to select and orientate individual trainers, and select and contract external training programmes for LCHWs to attend. LCHWs must be informed of any new learning opportunity in the organisation and they need to be given options to enrol in learning activities of their choice. It is important that training programmes are scheduled in consultation with LCHWs. St Joseph's must ensure that LCHWs are actively engaged in learning programmes to explore and pursue available career ladders. LCHWs must be encouraged to be involved in professional development activities, and St Joseph's must assess how well they are learning and addressing issues as they become known. St Joseph's should encourage LCHWs to engage actively in on-the-job-learning, too; this type of learning should be captured and documented in order to be used by everyone in the organisation.

Training evaluation needs to be conducted regularly and St Joseph's must ensure that its trainers are assessed for their performance in their roles. LCHWs (the trainees) must report on their learning experiences in the organisation. St Joseph's should create a platform for LCHWs to provide their input and also be part of the success of learning processes within the organisation. It is important that St Joseph's implement learning opportunity

enhancements to address identified learning gaps during the evaluation process. The team must meet regularly to discuss and evaluate learning, based on the criteria established during the personal development career preparation process. The human resources at St Joseph's can enhance career pathing development by establishing an infrastructure that fosters employee (LCHWs) participation. It is important that St Joseph's understands and accepts that employee participation in decision-making is fundamental to creating a supportive workplace environment, to improving continuous holistic care, as well as maximising the potential of employees to contribute their best knowledge, skills and talents to the success of the organisation, and more specifically, to construct meaning to their work in their palliative care setting. It is recommended that St Joseph's design the infrastructure for employee participation as indicated below:

In the first place, the management of St Joseph's needs to make a commitment to support employee participation in their day-to-day decisions about palliative care and related work operations in the organisation. Management at St Joseph's must identify initial areas of concern or those that they want the LCHWs participation efforts to focus upon, such as workload balancing and time management. The goals to be achieved through LCHW participation, for example, improving work-balancing issues between the LCHWs and the patients and OVC will reduce time spent on simple tasks. St Joseph's must elect a team that will design and drive the LCHWs' participation activities and also be responsible for the programme oversight and support. It is further necessary for St Joseph's to ascertain what current pathways exist for LCHWS at all levels and at the various departments and walk-in-centres and to be engaged in problem-solving around issues that directly affect the palliative care process of patients, OVC, as well as the working environment. Through continuous organisational assessment, management must identify whether or not LCHWs feel that their input is valued and used by St Joseph's. The best practice approach recognises that LCHWs have the most personal contact with patients, OVC and therefore are in the best position to understand how policies and practices affect their ability to establish palliative caring relationships. Best practices that effectively engage LCHWs should include flexible job tasks, according to their competencies; work load balancing, and time management. Best practice should also ensure improvement processes about

quality of palliative care for patient and OVC, including care planning. It is important for St Joseph's to constantly evaluate current practices and develop alternatives, such as the re-designing of jobs, recruitment and selection processes, and community and adult education.

To support LCHW participation and to foster adult education in the workplace, St Joseph's needs to provide reasonable accommodation for LCHWs to access quiet places and the necessary resources, for example a table, pencils, writing paper and other relevant resources. The organisation must also ensure that LCHWs have free access to information needed that will inform discussions and efforts that will bring about positive change in the workplace. A defined process must be developed by which LCHWs can make suggestions and provide their input. Importantly, training for mangers, supervisors and participatory LCHWs in decision-making processes must happen regularly.

As indicated by McElroy (2001b), training can enhance affective and normative commitments in St Joseph's because it can improve the individual participant's perception of self-importance. However, with regard to continued commitment, the author believes that this will happen only if a connection with new skills acquisition is clearly established. The underlying factor to secure conducive employment processes for St Joseph's requires commitment to organisational goals and project objectives and that its human resource management practices contribute to their success (Scheible & Bastos, 2006). Therefore, for St Joseph's to implement the LCHWs participation process, its commitment must provide the following:

The LCHW participation initiative must be communicated effectively for all employees to understand and support. Ensure that employees who are involved to drive this initiative, such as LCHWs, managers and supervisors are thoroughly informed about the process. It is imperative that LCHWs, managers and supervisors receive training in participative processes and decision-making to ensure that they participate fully in this process. In support of training, St Joseph's must ensure that regular meetings are conducted according to the initial planning in order for participating LCHWs to feel that their input is valued

and that there is consistency in the participation process. It is further important that this process consist of equity and parity and that the suggestions made during the participatory meetings for improvements and changes are supported by LCHWs and management. Open communication about activities and outcomes of participation must happen to keep LCHWS and management informed of the developments, encourage their feedback, and build their ongoing support. Management must address all resource issues, and provide information and coach LCHWs as and when needed as a way of showing that their efforts are supported by management. In order to sustain this initiative, St Joseph's must make sure that LCHWs who are engaged in decision-making receive ongoing support and skill building opportunities, which may include on-the-job training, workshops or one-on-one coaching.

Lack of career guidance: From the research findings, it emerged that the lack of a clear policy on career guidance severely limits the career pathing processes of St. Joseph's. Participants can learn through job crafting training to pro-actively change their own work environment as suggested by Tims *et al.* (2012), Wrzesniewski and Dutton (2001). The organisation must therefore develop a clear policy on career guidance, giving all staff and volunteers the opportunity to contribute to this policy. St Joseph's should take note of the following comment by Schaufeli and Bakker (2004, p. 296), which states that job resources that have an influence on career pathing, are strongly associated with engagement and are defined as "those physical, psychological, social, or organisational aspects of the work context [that] can reduce the health-impairment effect of job demands, are functional in achieving work goals, and stimulate personal growth, development and learning". Although job crafting can lead to increased levels of the participants' engagement and lower levels of burnout according to Bakker *et al.* (2012b), Petrou *et al.* (2012), and Tims *et al.* (2013), based on the JD-R model, engagement and burnout can also predict job crafting. St Joseph's should therefore ensure that the policy is a living document and is evaluated periodically to ensure its ongoing relevance. The policy must be clear on the objective of career guidance of the organisation, ensure that sufficient and necessary resources are allocated for career guidance, encourage a culture of lifelong learning and contribute to addressing the skills shortages the organisation faces. Therefore, in the

context of this study, work engagement should be regarded as a positive, fulfilling, work-related state of mind of each participant that is characterised by their vigour, dedication, and absorption (Schaufeli *et al.*, 2002).

In order for St Joseph's to facilitate the gaps in their career guidance policies and practices, it is recommended that they implement a career development programme that will address the career guidance needs of the LCHWs in a holistic manner. This career development programme will teach LCHWs how to work towards their own goals while continuing to render an effective palliative care service to the community on behalf of St Joseph's. As indicated by Merchant (2008), career development is not about getting ahead, but about getting to be the best the individual LCHW can be, and in finding a place in St Joseph's where they can express excellence and contribute to the goals of the organisation. The organisation must therefore ensure that its career development includes vertical issues such as promotion and upward mobility, as well as horizontal movement which is about lateral job transfers within the organisation. In order for St Joseph's to fit into the current competitive community work environment, it will be imperative to create a work environment which fosters growth and development. St Joseph's needs clearly defined career development plans of action that to prepare LCHWs for the future and sustain the organisation's ability to meet needs. LCHWs will only be able to make practical career decisions based on St Joseph's current and future needs, and the organisation will benefit more if it uses existing LCHWs to fill new positions. St Joseph's must take cognisance that the desired outcome of a career development programme for LCHWs has to match their needs as well as the needs of the organisation itself. LCHWs must have the opportunity to identify career needs and St Joseph's must support them in achieving these needs within organisational realities (Merchant, 2008). St Joseph's should concentrate on the two main components of its career development programme: career counselling and career training.

Career counselling: Through the career counselling process, St Joseph's will be in a position to provide a path for the LCHWs to assess their career needs. St Joseph's should ensure that the main objective of career counselling is to support LCHWs in exploiting their strengths and potential in order to avoid mismatches between the individual LCHW's

aspirations, capabilities and organisational opportunities. The organisation can also make career counselling an appropriate part of the LCHWs performance, because it will involve issues related to their work performance. It is advisable for St Joseph's to identify a trained professional career counsellor to evaluate the LCHWs strengths and weaknesses instead of the immediate managers or supervisors. St Joseph's human resources department must support the career counselling process, and must take responsibility for maintaining personnel files as well as having a basic understanding of the human resource initiative within the organisation. In order for the career counselling to be effective, St Joseph's should ensure that the people involved in the career counselling process possess good counselling skills such as sensitivity, flexibility and the ability to communicate at all levels and in the relevant languages. St Joseph's must capture information about each LCHW counselled, for example, their aptitudes, motives, experience, work characteristics and capabilities, which can be obtained from their self-assessment of individual needs, values and personal goals. St Joseph's must, at all times, take responsibility for improving the resources and structures to support the career counselling process. In order to reduce or eliminate false hopes and expectations from the LCHWs, the following four basic steps which are, self-assessment, action plan, evaluation and monitoring, in the career counselling process must be applied:

Firstly, St Joseph's must start with each LCHW's self-assessment. This assessment must cover their work environment and determine whether a match exists between the individual LCHW's preference and that of the organisation. Secondly this process should then conclude with an action plan that will outline specific tasks for each LCHW to follow in order to accomplish the established goals. Thirdly, these action plans must be in writing and outline the actual steps necessary to prepare each LCHW for further career growth. Action plans need to be realistic and measurable to allow St Joseph's and the LCHWs to evaluate the individual LCHW's progress. Furthermore, the plans must be specific and must contain achievable developmental objectives, and the required resources to achieve these goals. Lastly these plans need to be flexible enough to enable the LCHWs to re-assess their needs and desires throughout their careers.

The training component will contribute to LCHWs' growth and development by enhancing their knowledge, skills and abilities in their current job categories and will also prepare them for promotional and future opportunities. St Joseph's can accomplish the latter by providing effective proficiency, on-the-job, and career speciality training for LCHWs. The organisation must ensure that proficiency on-the-job training is closely coordinated with its overall training efforts. It is important that proficiency training subjects consist of those elements of the training programme that are unique to St Joseph's and its operations.

Career speciality training: St Joseph's can use career speciality training as a tool to provide LCHWs with opportunities to improve the knowledge, skills, and abilities which they require to perform their daily duties beyond the minimum levels. Furthermore, the organisation should incorporate speciality training courses of instruction offered by external institutions and other organisations, into its training policy (Merchant, 2008).

These components are essential to the success of the career development process for St Joseph's to benefit the LCHWs, as illustrated in Figure 6.3.

Figure 6.3: Career development programme components

Employment processes at St Joseph's: As mentioned above, an aspect contributing to poor career pathing at St. Joseph's is the lack of adequate employment processes. In practicing good human resource management in terms of St Joseph's recruitment, selection, induction, training, and career pathing processes, this process can enable engaged and efficient participants to practice job crafting by adjusting the task-related aspects of their jobs in order to achieve their personal and work-related goals (Tim *et al.*, 2012). Burnout was hypothesised in a study conducted by Maslach, Jackson and Leiter (1996), in that burnout is a direct result of the presence of various demands and absence of resources that has the potential to lead to undesirable outcomes such as physical illness, health impairment, staff turnover and absenteeism.

Strategic approaches for St Joseph's to provide career pathing and guidance support to LCHWs to address life challenges:

St Joseph's must design its approach to provide support to LCHWs for life challenges that disrupt the success of their employment; such challenges may consist of transportation, housing, child care, financial management and family and work relationships. Ideally, this support should be assigned to a counsellor, who would be involved with pre-employment readiness sessions with new LCHWs, as well as continuous support. This role may also rely on community support where LCHWs can be referred for further assistance. The organisation must orientate managers, supervisors, and mentors to its support services programme in order to be prepared to refer LCHWs to services as their needs arise.

St Joseph's needs to introduce the identified support service counsellor to the LCHWs before the programme starts. The organisation must make sure the LCHWs understand the role of the identified support service counsellor and that they receive the assurance that they have access to the counsellor at any time they need it. LCHWs should be comfortable with access to the support service counsellor. St Joseph's must plan for regular check-ins with LCHWs, during occasions such as orientations, on-the-job-training sessions, workshops, support group sessions, planning committees, as a foundation to build trust and to provide early intervention. St Joseph's should also plan a schedule of workshops and

sessions that will cover topics that support LCHWs in addressing work and life issues, such as time management, communication, budgeting and financial management, success with challenging patients, OVC, and their own children.

In order to ensure that outreach materials reach all LCHWs and help them to access all support services with regard to career pathing and guidance, the organisation must collect feedback from LCHWs on the quality of support services, outreach, and workshops being offered at St Joseph's. Most importantly, St Joseph's must draw up a set schedule for reviewing outcomes and conduct improvement activities. Should the targets not be met as planned, the support service programme and any other organisational programmes that involve the LCHWs should be reassessed. In order to sustain the support service programme, St Joseph's must assign mentors to individual LCHWs to fill a supportive role that will contribute their access to the support services (Opportunity Partnership and Empowerment, 2007).

Retention: Based on the findings, low job satisfaction was found to be a significant predictor of St Joseph's turnover, and in this study, organisational commitment played an important role in the turnover process (Baroudi, 1985; Blau & Boal, 1987; Sjoberg & Sverke, 2000). For St Joseph's to retain good staff and volunteers, allowances should be made in the training and career guidance strategy for continuous identification of possible risks of losing knowledge and skills through resignations, ill-health, death or retirement. In order to retain staff, cognisance must be taken that hiring employees is only the first step, and building awareness of the importance of employee retention is an important part of St Joseph's. The costs associated with employee turnover can include donor funding, clients and business, and mostly, damaged morale. In addition, there are costs incurred in screening, verifying credentials and references, interviewing, hiring and training new LCHWs (Alberta Government, Human Resources and Employment, 2010). The organisation must develop a formal, structured retention plan that will enable it to manage the talent of their staff and volunteers, and the purpose of the retention policy at St Joseph's should provide suitable incentives and recognition of staff in order to provide a working environment conducive to meeting the needs of staff and ensuring that required talent is

sourced, maintained, acknowledged and retained. According to the Sloan Work and Family Research Network, Boston College (2005), employee retention is defined as a systematic effort by employers to create and foster an environment that encourages current employees to remain with the organisation. St Joseph's must recognise the social support need, because, even though the participants are present at work, they are not productive, which is an indication that they are investing the minimum effort and at the same time avoiding the daily job demands and other demands by applying a preservation of resources strategy to adapt to their working environment and protect themselves (Hobfoll, 2011).

A retention plan would mitigate the current skills shortages by providing staff attraction and retention strategies. However, St Joseph's must take note in the work of Igbaria and Greenhaus (1992), who indicate that job satisfaction has a stronger direct effect on turnover intention than organisational commitment. These strategies should be designed to attract, develop and retain staff with critical and necessary skills, for example, the nurses and social workers who leave the employment of St Joseph's for other organisations that offer improved benefits and conditions of service. Therefore, St Joseph's should focus on attracting knowledgeable and skilled employees in palliative care, retaining them, and preserving their active engagement, which requires a detailed understanding of what aspects of their work environment foster work-related well-being. Participants indicated that they received meaningless or unreasonable tasks, including activities that should be assigned to someone else, which were mainly aimed at the participants with skill-resourcing needs. Bjork, Bejerot, Jacobshagen, and Harenstam (2013) show that such illegitimate tasks are associated with negative consequences and are regarded as job demands. The secret to St Joseph's retaining its key LCHWs lies in its commitment to their training and development. An important reason for St Joseph's to spend money on the training of the participants is that they will acquire new knowledge, skills and abilities. These participants will become highly valuable; consequently, if these participants do not receive commitment from the organisation to continue their employment with St Joseph's, the organisation will not only to lose the ability to compete with other NGOs conducting similar work, but will also lose its investment in employee training. It is important for St Joseph's and the human resources management to understand that commitment develops

naturally and cannot be taught. Part of the retention plan should include exit interviews with LCHW workers who are leaving St Joseph's. The outcome of the exit interviews may provide management with an understanding why LCHW workers leave the organisation.

A strategic approach to employee retention at St Joseph's may include:

- Adopting effective methods of engagement, safe and healthy workplaces and creating flexible work arrangements.
- Addressing and reducing barriers that prevent LCHWs from performing their daily duties, in order for them to participate eagerly to the operations of the organisation.
- Putting in place effective policies, procedures and practices that reflect effective retention practices will benefit the organisation, because such policies demonstrate the value of the LCHWs. At the same time, this approach will enhance the LCHWs' commitment and service delivery levels.
- Giving LCHWs recognition, flexible work arrangements, work-life balance, employee engagement, health and safety, communication, workplace diversity, formal wellness programmes, inclusion and employee development in developing retention strategies (Yukon Government, Economics Development, 2006).

Succession planning: It is necessary for St Joseph's to develop a succession plan that contributes to and supports the transitions and challenges faced by staff and volunteers. Having a clear and well-communicated succession plan in place will assist in retaining all talented staff and volunteers at all levels of the organisation. Hindrance demands are stressful and considered by the participants as unnecessarily preventing their personal growth, development and growth accomplishment (Cavanaugh *et al.,* 2000). The implementation of a well-planned succession plan in the framework of the training and career guidance strategy could enable St Joseph's to serve staff and volunteers better by investing the necessary time and effort in identifying and developing multiple high potential leaders.

The succession planning processes must identify the long-term goals and objectives of St Joseph's, and analyse future requirements for health-care services provided to the

communities. Ensuring that there is synergy between the succession planning and the values of the organisation, as well the needs and interests of all staff and volunteers, is another important factor in the succession planning process. In this this study, the participants perceived their challenging job demands as obstacles that they needed to overcome; job demands that include work pressure and complex tasks. Therefore, St Joseph's should take note that the latter are positively related to work engagement of the participants (Crawford, *et al.*, 2010) when they are working on their succession-planning. St Joseph's should ensure that succession planning is closely intertwined with its workforce planning process. Workforce planning allows the importance of job roles to be reviewed and critical training needs to be identified and prioritised (Kiyonaga, 2004). As a start to developing a succession plan, St Joseph's needs the commitment from the board members, management, staff and volunteers to establish a strategic alignment. The participants could learn to set their own personal goals and use their strengths at work more innovatively (Lindley & Harrington, 2006). St Joseph's needs clear programme goals in place (identifying succession targets and analysing talent pools) to guide the succession planning of all positions in the organisation. Succession strategies could be linked to the workforce planning of St Joseph's to develop a succession management plan. Once the succession planning process is implemented, continual monitoring and evaluation are needed to retain the succession planning process. Figure 6.4 shows a succession planning process.

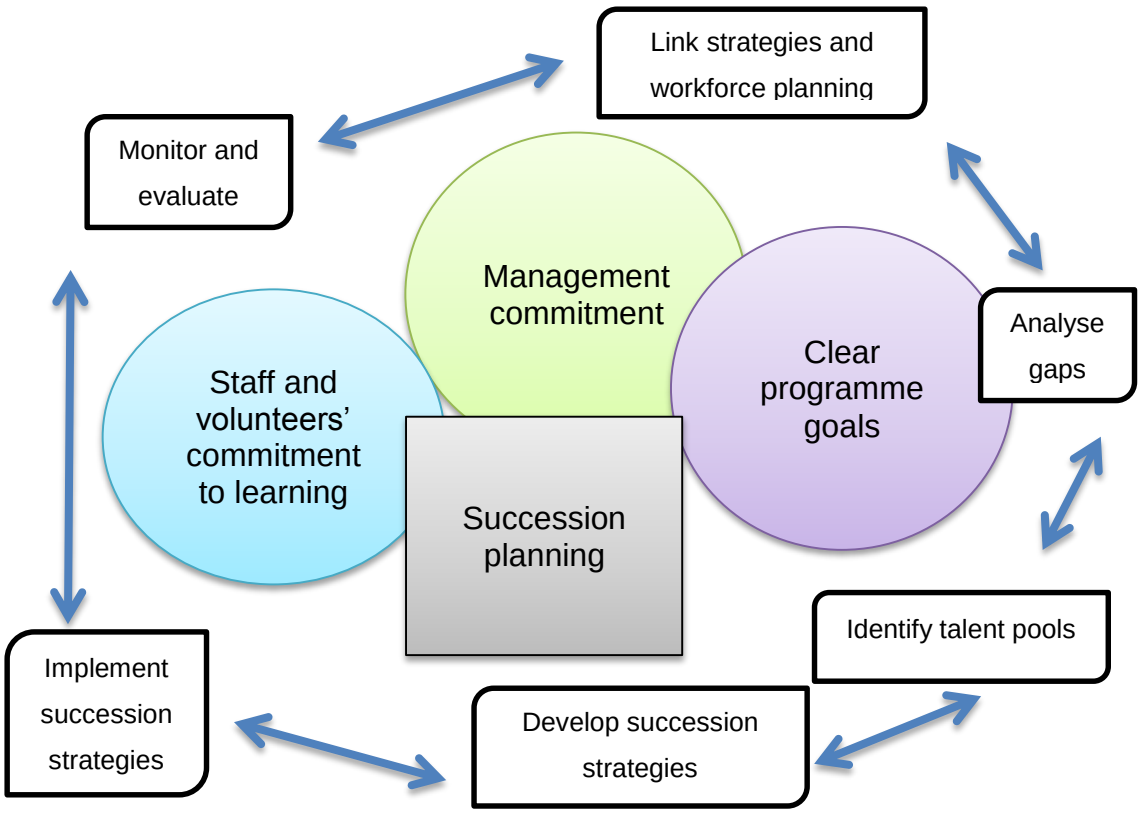

Figure 6.4: A presentation of a succession planning process for St Joseph's

Promotion: It is not feasible to have a retention and succession plan without having a promotion plan. High involvement work practices such as job design, incentive practices, flexibility, training opportunities promotion criterion, information sharing and direction setting, and high involvement work processes which include power, information, rewards and knowledge are all related to St Joseph's turnover (Huselid, 1995, Vanderberg, Richardson & Eastman, 1999), which must be taken into consideration when drafting employment policies.

It is imperative to create an enabling environment at St Joseph's that will ensure opportunities for promotion for all LCHWs. A clear and comprehensive promotion policy will contribute to the career pathing strategy of the organisation and enhance the organisation's recruitment and retention strategy. This type of engagement can only be effective if St Joseph's is committed, because engagement is connected to positive

organisational outcomes such reduced turnover intentions and increased commitment (Bakker & Demerouti, 2007). Allowing staff to contribute to the overall policy on promotions will also ensure that promotions in St. Joseph's are accepted as fair, equitable and above board. Based on the presentation of the findings (Chapter Four), the discussion thereof (Chapter Five) and the joint recommendation of a work-resourcing needs framework, the JD-R model has the potential to satisfy "the need for specificity by integrating various types of job demands and job resources, depending on the context under study" (Bakker & Demerouti, 2007, p. 320).

As the theoretical framework of this study, the JD-R model and its two elements provided a structured foundation to analyse the work meaning that the participants make of their different roles as lay community health workers in an extensive palliative care environment. There are various work-related, personal resources, and organisational-commitment components in this chapter which could only be addressed through the JD-R model to be able to come up with a suitable, sound work meaning resourcing needs framework for the participants as illustrated in Figures 6.5 and 6.6, based on the discussion in the previous sections of this chapter. Figure 6.5 outlines the job-demands in relation to the role of the organisation and the LCHWs in this study. Figure 6.6 outlines the job-resources regarding the organisation's commitment, role of the human resources management in terms of the LCHWs engagement and well-being. If St Joseph's takes all these needs into consideration and attends to them by using the recommendations made in the framework, and if these knowledge, skills and organisational processes are met by St Joseph's, the participants will receive much-needed support and commitment from the organisation, and through that, will find themselves in a favourable position to meet the demands of their respective jobs, thus enabling them to be more efficient employees.

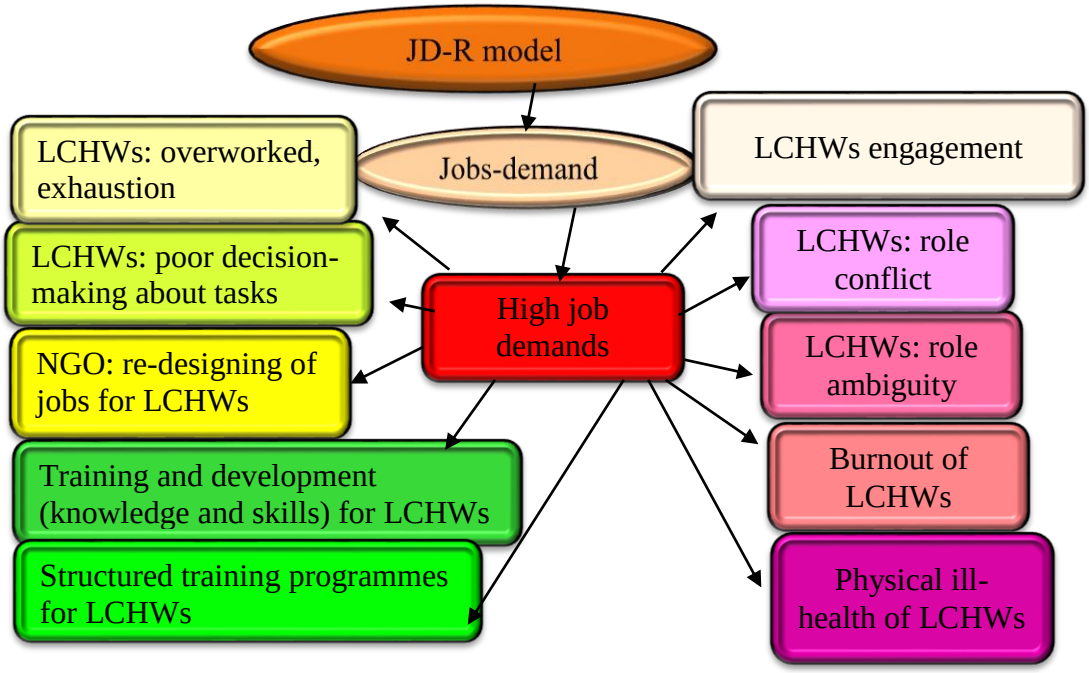

Figure 6.5: Illustration of the JD-R model's element of job-demands in relation to the responsibility of the organisation in terms of the role LCHWs in this study.

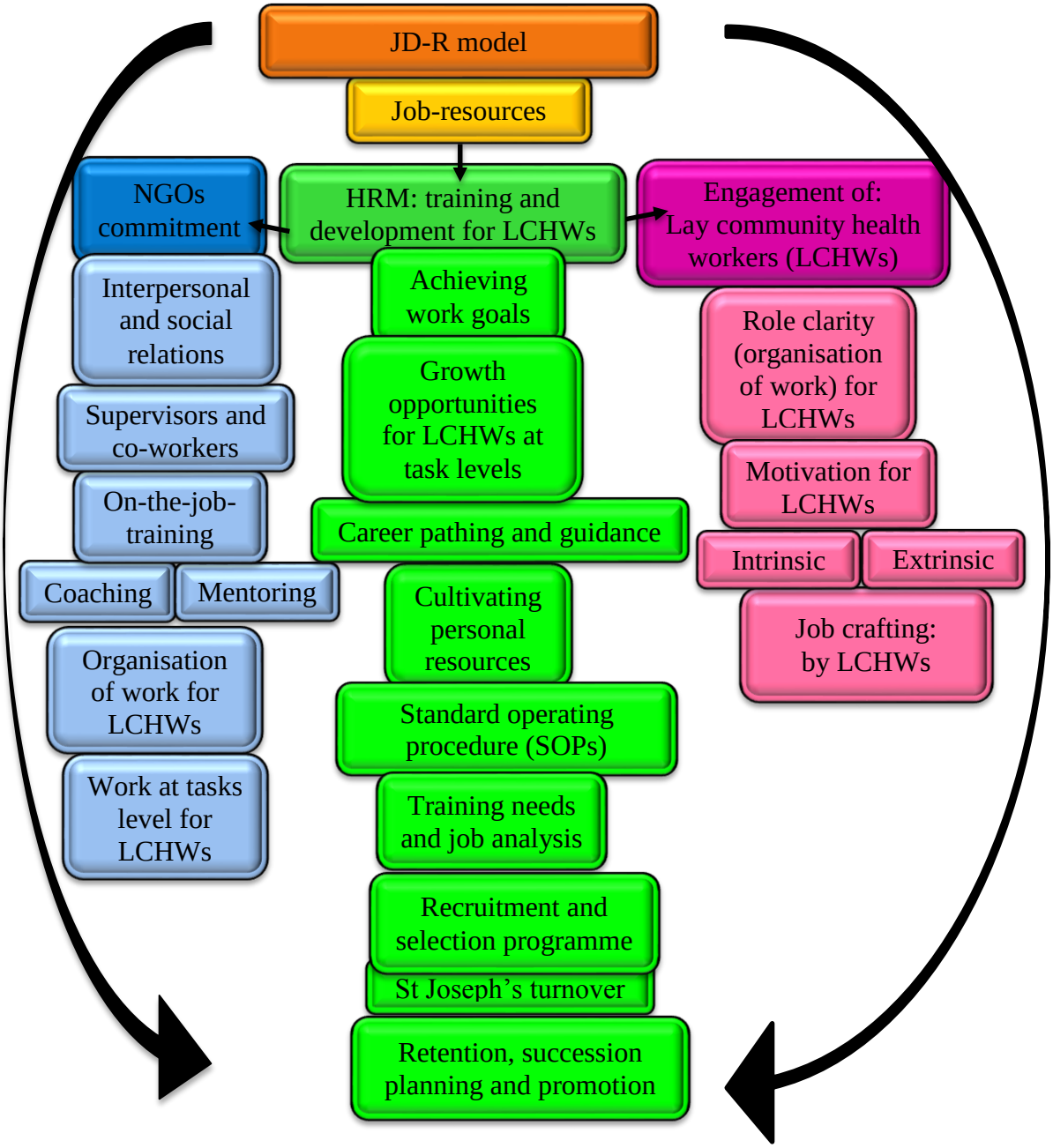

Figure 6.6: Illustration of the JD-R model's element of job-resources regarding St Joseph's commitment; role of the human resources management in terms of the LCHWs engagement and well-being.

6.5 SUMMARY OF CHAPTER

The focus of this chapter was aimed at presenting a suitable work meaning resourcing framework, co-constructed by the participants in this study. This framework was initiated by the participants in this study who voluntarily participated, identified and shared their work resourcing needs from their personal lived experiences and understanding in their unique palliative care environment. All the themes that emerged from this study could be incorporated into the JD-R model with its two elements, job demands and job resources, which served as the main pillars from the work meaning resourcing needs framework. The uniqueness of this framework is that the focus was on improving the work lives of the lay community health workers, who have serious skill-resourcing needs in a rural area of Bronkhorstspruit, at an organisation that provides extensive palliative care to patients, orphans and vulnerable children and to their surroundings, marginalised communities. Because South Africa is plagued by the HIV/AIDS epidemic, this framework can be used in similar organisations who are working with lay community health workers with skill-resourcing needs, not only in the health sector, but also in the agriculture sector. The LCHWs in this study were seemingly engaged employees, and they demonstrated energetic and effective connections with their work activities as they see themselves in their roles as carers, capable of dealing with the demands of their respective jobs (Schaufeli, Bakker & Salanova, 2006).

CHAPTER SEVEN: CONTRIBUTIONS, LIMITATIONS AND SUGGESTIONS

7.1 INTRODUCTION

In this chapter, contributions are discussed in relation to theory, policy and practice. I also discuss the limitations of this study, and provide suggestions for future research.

7.2 THEORETICAL CONTRIBUTION

According to the JD-R model, job demands are initiators of a health impairment process and job resources are initiators of a motivational process. The model specifies how demands and resources interact, and predicts important organisational outcomes. Studies on work engagement using the JD-R model as a framework have confirmed that work engagement is mainly predicted by job resources, particularly when job demands are high (Bakker, Hakanen, Demerouti, & Xanthopoulou, 2007). Moreover, Demerouti *et al.* (2001) suggest that demands and resources lead to different component outcomes of burnout. Specifically, they predict that demands are associated with exhaustion, while resources are inversely associated with depersonalisation (disengagement). As Schaufeli and Bakker (2004) noted, demands and resources are unlikely to be independent. This study however, shed light on how this model can be applied in the educational sector for LCHWs within particular organisations, such as St Joseph's. Using the JD-R model as the theoretical framework in this research shows how community and adult education can be linked and applied in the JD-R model and resources theory. This study is a first attempt to explore work meaning constructions by LCHW in an HIV/AIDS palliative care setting from a community and adult education perspective, using the JD-R model.

7.3 POLICY CONTRIBUTION

Firstly, because this study identified the need for more organisations such as St. Joseph's, it addresses issues in terms of what government needs to do to support and facilitate such organisations. Community-based organisations need to look at human resources policies and how to put policies in place in terms of how they function.

7.4 PRACTICE CONTRIBUTION

The original contribution to the study: Since there are so many community organisations in South Africa such as St Joseph's, it is expected that more such organisations will emerge as a result of the continuous spread of HIV/AIDS. The experiences shared by St Joseph's and its LCHWs can be a good learning experience for other organisations involved in similar community work because they, too, should have good retention, succession, promotion, training and development policies, practices and procedures in place. Community organisations need to assist LCHWs to acquire specific knowledge and skills with regard to their job tasks and job roles. It is important that community organisations expose their LCHWs to knowledge productions as seminars, workshops and one-day-courses. These are core intervention activities and processes that community organisations like St Joseph's need to carry out for their LCHWs to remain sustainable.

7.5 SUGGESTIONS FOR FUTURE RESEARCH

Further research could contribute to the enhancement of knowledge, skills, understanding and practices of LCHWs, in particular those with skill-resourcing needs in terms of managing their training, career pathing and personal development in their roles as palliative carers to the patients and OVC. This study lays the foundation for future research that focuses primarily on structured recruitment and training processes that will incorporate the findings from this study to address the plight of LCHWs who need an identity in the workplace that will enable them to construct meaning of their work. The Department of Health should conduct a general needs analysis enquiry on the roles of LCHWs with skill-resourcing needs, on recruitment, career pathing, training and development and the status of community health organisations, in terms of their commitment to this initiative in Gauteng and make it a compliance factor. Consideration should be given to a large-scale cross-provincial study whereby comparisons can be made of other community organisations which employ and practice effective recruitment, career pathing, training and development programmes to continually enhance the competencies and abilities of LCHWs. More qualitative longitudinal study on work meaning construction for LCHWs

in the education sector should be considered, using the JD-R model, and a customised, formal programme developed that encompasses all the skill-resourcing needs identified in this study. It should be tested in terms of how it could add value to the work meaning of LCHWs. This qualitative study employed a phenomenological approach. It is therefore recommended that other designs be explored and should include larger groups, where such designs could be ethnographical and related to job demands.

7.6 LIMITATIONS OF THE STUDY

A possible limitation with regard to the study was during the interview process when the participants could have changed behaviours and answers due to the Hawthorne effect, as outlined by Leedy and Ormrod (2005). The phenomenological approach used in this study relied only on the participants' perspectives regarding their experiences about work meaning constructions. Therefore, the validity of the findings would be compromised if the answers and behaviours of the participants were altered in any way. I assumed that the participants in this study would be objective and truthful in their answers to the research questions during the interviews. A possible influence could have been that they knew that they were under study, and that the responses regarding their experiences could have been purely polite and not really what they felt. Thus, it is possible that the participants gave answers that they thought I wanted to hear for the purpose of the study as linked to the concept of socially desirable responding, which is a type of response bias. According to Paulhus (2002), a response bias is any systematic tendency to respond to a questionnaire on some basis that interferes with truthful self-reports.

The study was not balanced in terms of gender. The majority of participants were female. I only interviewed black and white participants and was unable to report on experiences shared from persons of mixed or Asian descent. It is not uncommon to find missing race groups because the racial mix depends on the location and the context of the study, and will vary between the provinces and the regions. Under certain circumstances, all race groups may be present, in others it could be one, two or three. At times, I experienced difficulties in remaining neutral and professional; the difficulties described by the

participants created feelings sadness in both my and the interpreter at certain points of the interviews. In order to address some of the limitations mentioned above, I would do some things differently if the study was to be undertaken again. Instead of just a qualitative study using focus groups, perhaps a combined qualitative and quantitative study could have been conducted. In attempting to address the language and comprehension abilities of focus group participants, I would make use of an ABET facilitator to assist. I interviewed only the Director of St Joseph's, as a representative of the Board, and thus limited the organisation's perspectives in the study. Therefore, to ensure successful implementation of the recommendations, the Board members of St Joseph's should be invited as participants, as they are the key stakeholders in the organisation.

7.7 CONCLUSION

I can look back with much relief, because I was afforded an opportunity a few years back to make a difference in the lives of LCHWs, through this study. I feel I have used the opportunity optimally, co-constructed by the participants, and revealed significant results and unique contributions that brought out the value of work meaning construction based on their lived experiences. This research study reaffirmed that the work of LCHWs is unique and meaningful to them, to the people they care for, to the health sector in South Africa, and nationwide. Their dedication, intrinsic motivation perseverance as engaged employees stood out in the results, which allowed their voices to be heard (as a group of people with skill-resourcing needs) from a different, but solid approach; all these factors play a prominent role in the sustainability of St Joseph' Care and Support Trust which is doing such a fine job in the palliative care field. I sincerely pray that the findings transcend the boundaries of St Joseph's and provide guidance for the many others that exist and continue to work with palliative care patients and OVC.

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