QUALITATIVE RESEARCH

Mental Health Experiences of Healthcare Workers During the COVID-19 Pandemic in High-Burden HIV and TB Provinces in South Africa and Recommendations for Support

August 25, 2021
This publication was produced at the request of the United States Agency for International Development. It was prepared independently by the Technical Support Services (TSS) Activity, implemented by Panagora Group, for USAID/South Africa.

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), through the United States Agency for International Development (USAID), produced this document for review. It was prepared by Panagora Group for the USAID/Southern Africa Bilateral Health Office and the Regional Health Office (RHO) Technical Support Services (TSS) Activity, Contract Number: 72067419C00001. The contents of this document are the sole responsibility of Panagora Group and do not necessarily reflect the views of USAID or the United States Government.

Recommended citation: USAID/Southern Africa Bilateral Health Office and the Regional Health Office Technical Support Services Activity. 2021. Mental Health Experiences of Healthcare Workers During COVID-19 in High-Burden HIV and TB Provinces in South Africa and Recommendations for Support. Silver Spring, MD: Panagora Group.

Panagora Group Contact:

Jasmine Buttolph
Global Health Director
Panagora Group
8601 Georgia Avenue, 8th Floor
Silver Spring, MD 20910 USA
jasminebuttolph@panagoragroup.net

Katie Reichert
Panagora South Africa Country Director
Chief of Party
USAID/South Africa Contractor
Technical Support Services (TSS) Activity
kreichert@panagorasouthafrica.net
Mobile: +27 (0) 64 074 8712

TABLE OF CONTENTS

ACRONYMS

APACE	Accelerating Program Achievements to Control the Epidemic
CCI	Centre for Communication Impact
CLWH	children living with HIV
COVID-19	coronavirus disease of 2019
EAP	employee assistance program
EC	Eastern Cape
EDC	Education Development Center
EHW	employee health and wellness
EWP	employee wellness program
FAQ	frequently asked questions
FS	Free State
GBV	gender-based violence
GP	Gauteng
HCW	healthcare worker
HIV	human immunodeficiency virus
HR	human resources
HREC	Human Research Ethics Committee
HRH	human resources for health
IEC	information, education, and communication
IP	implementing partner
IST	in-service training
IT	information technology
KZN	KwaZulu-Natal
LMIC	low- and middle-income country
LOE	level of effort
LP	Limpopo
MP	Mpumalanga

N/D	numerator/denominator
NDoH	National Department of Health
OVC	orphans and vulnerable children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
POC	point of contact
PPE	personal protective equipment
PSYSSA	Psychological Society of South Africa
R	South African Rand
RHO	Regional Health Office
RTC	Right to Care
TB	tuberculosis
TSS	Technical Support Services
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WC	Western Cape
WHO	World Health Organization

INSTRUCTIONS ON HOW TO READ THIS REPORT AND FREQUENTLY ASKED QUESTIONS

1. How should I read the report?

The report is divided into two parts to make the findings and recommendations as accessible and practically useful to the United States Agency for International Development (USAID), implementing partners, and other stakeholders as possible:

- Part A. Program Enhancement for Mental Health Support
- Part B. Research Report

Part A focuses on program implementation of the 11 practical recommendations that can be adapted and included in IPs' work plans and integrated into their existing mental health support structures and systems. The recommendations are not intended to be prescriptive and have been formulated from the research findings for IPs in the South African context. Part A also includes tools to support and facilitate application.

Part B is comprised of the research report, including background, methods, and findings sections. The findings are supported by direct quotes from the healthcare workers as they shared their experiences during the COVID-19 pandemic.

2. Who is the audience for this report?

- USAID and its implementing partners
- National Department of Health (NDoH) in South Africa
- Academic institutions
- Civil society organizations
- Healthcare workers (HCWs)

3. How have the recommendations been categorized?

The recommendations have been categorized to facilitate adaptation and implementation through the human resources for health (HRH) section of a USAID IP work plan. The recommendations are not exhaustive and can easily be adapted for each IP's unique context and needs. The recommendations are categorized as: 1) In-service training; 2) Routine staff meetings; 3) Staff recognition and awards; 4) Supportive supervision; and 5) Healthy workplace. For more information, refer to the following section in the report: How can the recommendations be integrated into work plans?

4. What is an EAP?

An employee assistance program (EAP) is a work-based intervention or initiative.[1] It is sometimes also known as an employee wellness program (EWP) or employee health and wellness (EHW) program. Not all employers have an established EAP in place; it depends entirely on the organization and the funds available. EAPs typically detail the services available to employees who are experiencing challenging times which may affect their productivity and psychosocial functioning.[2] Employers may refer employees to their medical scheme or refer to free services available in the public sector. EAPs can be outsourced to a third-party service

[1] "What is an Employee Assistance Programme?", Employee Assistance Professionals Association of South Africa, accessed August 20, 2021. https://www.eapasa.co.za/about-eapa-sa/what-is-an-employee-assistance-programme/
[2] Ibid

provider, or they can be in-house.[3] When EAPs are outsourced to a third-party, this usually indicates a paid contract is in place for service provision. EAPs provide a wide array of services, ranging from financial management to psycho-social support.

5. Can the recommendations be integrated into the existing EAP framework offered by IPs?

The findings from this research indicate that mental health support should not be seen as a stand-alone program; rather, it cuts across an organization's program activities. The recommendations were developed to fit within existing programming (for example, integrating debriefing into routine staff meetings, conducting site visits to provide support to community and health facility-based HCWs, and integrating in-service training on mental health into existing in-service training structures). These activities can play a critical role in normalizing mental health in the workplace, which is important for every team member, every day.

The recommendations can be integrated into existing EAP frameworks for HCWs. The IPs involved in the study provided information on the mental health support services they currently offer to HCWs: see Annex X. Mental Health Support offered by USAID Implementing Partners. These services are wide-ranging, from psychosocial support and financial management to HIV services. If not already in place, HIV services and referral can be integrated into mental health services support. IPs are encouraged to integrate the recommendations into existing activities to supplement the mental health support already provided to HCWs. The emphasis is supporting mental health as a cross-cutting priority at work, and not as a remedial action plan for HCWs who are "not coping."

6. How can IPs follow up with referrals for mental health support?

Beyond making information and services available to HCWs, IPs may want to assess uptake of mental health support, particularly during stressor events and/or when HCWs report a significant degree of psychological distress. If mental health support service uptake is low, then IPs will have information to take action and utilize the recommendations in the report to help strengthen uptake.

Under the recommendation E.2. Quarterly mental health check-ins, IPs can keep track of HCWs who choose to disclose that they have accessed mental health support. IPs can adapt the associated tool (E.2. Tool XI), which is a series of questions that can be used in a Google Form and sent to HCWs to check on their mental health and what type of services they have accessed. IPs are also encouraged to check with their EAP service provider to share anonymous information on mental health service uptake.

7. What are the roles and responsibilities of facilitators identified in the toolkit section of the report?

Each IP has a range of staff members that can be drawn on to facilitate the implementation of specific recommendations. We recommend the use of a cascade model to tap into existing competencies within the organization. For more information on the cascade approach, refer to: How can a cascade model be used to implement the practical recommendations?

Each recommendation includes the proposed facilitator, an estimate of the level of effort required, and other resources needed for implementation (refer to Format for the practical recommendations). This is accompanied by a narrative for the work plan.

[3] Ibid

8. How can management support the rollout of the recommendations?

The management of any organization plays a critical leadership role in creating a healthy workplace and normalizing mental health. They set the tone for team morale within the organization by showing affirmation and appreciation for HCWs' efforts. Management can encourage HCWs to access mental health support and share experiences of how they have accessed support to help destigmatize the topic of mental health. As much as managers need to support the HCWs that they supervise, they also need to be supported, and can also make use of the mental health support available.

Management can support structures that promote debriefing, as mentioned in the *Recommendations* section (refer to B.1. Routine debriefing sessions and B.2. Integrate debriefings about work-related challenges into routine meetings), as an integral part of providing mental health support to HCWs. They can also support and/or facilitate in-service training sessions detailed in the *Recommendations* section (refer to A.1. In-service training on mental health and the support available, A.2. In-service training on the different types of mental health support needs, A.3. In-service training on the intersection of culture, gender, and mental health, and A.4. In-service training on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events.

Refer to the *Findings* section for more information on what managers shared as their perspectives of how they can further support HCWs: What additional support do supervisors/managers recommend?

9. What are the budget costs for implementing the recommendations?

The recommendations are formulated to enable IPs to tap into existing resources and use a cascade model to implement the recommendations. Each recommendation includes estimated facilitator LOE and resources for implementation to incorporate into IPs' work plans. Due to the COVID-19 pandemic, we have encouraged most activities (e.g., in-service trainings, debriefing sessions, and surveys) to be conducted virtually, which will also reduce implementation costs.

To promote mental health information and the services available within an organization, refer to the recommendation E.1. Widely circulate mental health support information for virtual communication channels. These include: 1) An organization's intranet site; 2) Monthly emails and WhatsApp messages; and 3) Electronic IEC materials to share information on mental health and the services available. Refer to the associated tool (E.1. Tool X) for an example of a template for an organization's intranet, providing information on mental health and how HCWs can access mental health support.

PART A. PROGRAM ENHANCEMENT FOR MENTAL HEALTH SUPPORT

EXECUTIVE SUMMARY

Background

South Africa has the highest burden of HIV in the world, with 7.8 million people living with HIV (PLHIV) as of 2020.[4] It is a high-burden country for tuberculosis (TB), TB/HIV coinfection, and multidrug-resistant TB.[5] As of August 2021, South Africa had the highest burden of COVID-19 cases on the African continent[6] and just over 18 percent of the adult population had been vaccinated.[7] The COVID-19 pandemic has had a significant impact on the economy, with unemployment increasing from 23.3 percent at the end of June 2020 to 34.4 percent at the end of June 2021.[8] In June 2020, during the health facility or Siyenza[9] support calls, USAID-supported IPs shared that healthcare workers (HCWs) were experiencing immense distress working in the HIV and TB epidemic, which was compounded by the COVID-19 pandemic.

Purpose of the research

The aim of this qualitative research was to explore and assess the mental health experiences of HCWs during the COVID-19 pandemic in seven high-burden HIV and TB provinces in South Africa. The secondary objective was to determine what support is needed by HCWs to better cope with the COVID-19 pandemic.

Methods

This was a qualitative research study implemented in seven high-burden HIV and TB provinces in South Africa. The sampling was purposive by district and HCW cadre, and was balanced by gender, reflecting the South African healthcare workforce, which has a larger percentage of female workers. Participants were HCWs from nine USAID implementing partners (IPs) across 10 districts in seven provinces. Data were collected from March 31,2021, through June 4, 2021. Data collection was done through semi-structured in-depth interviews, with discussion topic areas focusing on the individual risks, psychological needs, and perceived effectiveness of coping mechanisms of HCWs. In total, 92 HCWs participated in the interviews when data saturation was reached. Data were organized thematically using NVivo qualitative data analysis software. Data analysis was iterative within and across the case descriptive analysis.

Findings and conclusions

HCWs experienced a wide range of emotions during the different periods of the pandemic and during the different levels of lockdown. The COVID-19 pandemic put a strain on the delivery of HIV and TB services to clients in South Africa. There were direct and indirect consequences on the mental health of

[4] "Country Fact Sheets, South Africa, 2020, HIV and AIDS Estimates," UNAIDS, accessed August 13, 2021, https://www.unaids.org/en/regionscountries/countries/southafrica.
[5] World Health Organization. *Global Tuberculosis Report 2019*. (Geneva, Switzerland: WHO; 2019). http://www.who.int/tb/publications/global_report/en/.
[6] World Health Organization. "WHO Coronavirus Disease (COVID-19) Dashboard, " WHO, accessed Aug 13, 2021. https://covid19.who.int/region/afro/country/za.
[7]COVID-19 South African online portal. "Latest Vaccine Statistics," Department of Health, Republic of South Africa, accessed Aug 13, 2021. https://sacoronavirus.co.za/latest-vaccine-statistics/.
[8]Department: Statistics South Africa, Republic of South Africa. *Quarterly Labour Force Survey Quarter 2: 2021*. (Pretoria, South Africa: STATS SA; 2021). http://www.statssa.gov.za/publications/P0211/P02112ndQuarter2021.pdf.
[9] USAID's Siyenza campaign is aligned with Operation Phuthuma, which supports South Africa's National Department of Health to provide antiretroviral therapy to an additional two million people living with HIV and retaining all those on treatment in care toward the achievement of epidemic control. During routine in-person site visits or virtual calls, Siyenza advisors identify challenges and limitations to service delivery, help generate measures to address them, and document and follow-up on specific actions.

HCWs due to the risk of COVID-19 infection, losses due to COVID-19, and the economic consequences of increased job losses and the loss of livelihoods for many South Africans. Mental health support is available for HCWs from their organizations; however, there is a need to create an environment that enables the uptake of support. Knowledge about the available mental health support varied depending on whether HCWs were office-based or health facility- or community-based, with health facility- and community-based HCWs in our study reporting lack of knowledge about the mental health support available. Moreover, there was an intersection between culture and gender that may be inhibiting HCWs from accessing mental health support. Many HCWs also reported vicarious experiences of trauma through the experiences of their clients or being exposed to contextual stressors (e.g., being the first responder to a child survivor of gender-based violence [GBV]).

A significant number of HCWs in the study reported the perception that mental health support available through their work was primarily for HCWs who had a mental health disorder. HCWs expressed the need for recognition of and affirmation for their efforts working in such trying times. Some HCWs expressed reluctance to get vaccinated for COVID-19. The need for support varied from rural to urban areas, with HCWs in rural areas expressing the need for resources, such as personal protective equipment (PPE) and transport to visit their clients for home visits. Rural-based HCWs reported that they often ran out of PPE and had to purchase their own supplies. Supervisors reported that they needed more information on mental health so that they could better identify HCWs that needed referral for mental health support.

Recommendations for USAID implementing partners

The recommendations are not prescriptive or exhaustive. They can be adapted to the needs of the IPs and their staff and integrated in existing program activities. It is recommended that IPs enable the uptake of mental health support for HCWs to perform optimally, which can be achieved by implementing activities such as raising awareness about mental health and the support available through an induction during orientation sessions.

It is also recommended that there be dialogues on: 1) the different types of mental health support needs; 2) the intersection of culture, gender, and mental health; and 3) COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events. These topics can be integrated in in-service training sessions that allow a safe space and an opportunity for an open dialogue where HCWs feel comfortable addressing concerns and questions that they may have about these sensitive topics. It is recommended that HCWs who report vicarious experiences of trauma from their interactions with clients or being exposed to contextual stressors have a space for a debriefing session, which can be integrated in routine team meetings. More serious cases of vicarious experiences of trauma can be referred for professional support for trauma management.

It is recommended that team supervisors integrate supportive supervision through site visits to create a supportive work environment and opportunities to actively affirm their HCWs' efforts. Supportive supervision site visits are also recommended to ensure that PPE is reaching rural-based HCWs. It is also recommended that there be a wider circulation of mental health support information in the work environment, such as through the IPs' intranets or WhatsApp messages. The topic of mental health should be an ongoing discussion, and it is recommended that HCWs are regularly engaged and that mental health check-ins are done on a routine basis (for example, quarterly), through wellness days or through virtual quarterly check-ins (see the Implementing Practical Recommendations section).

Recommendations for the Department of Health

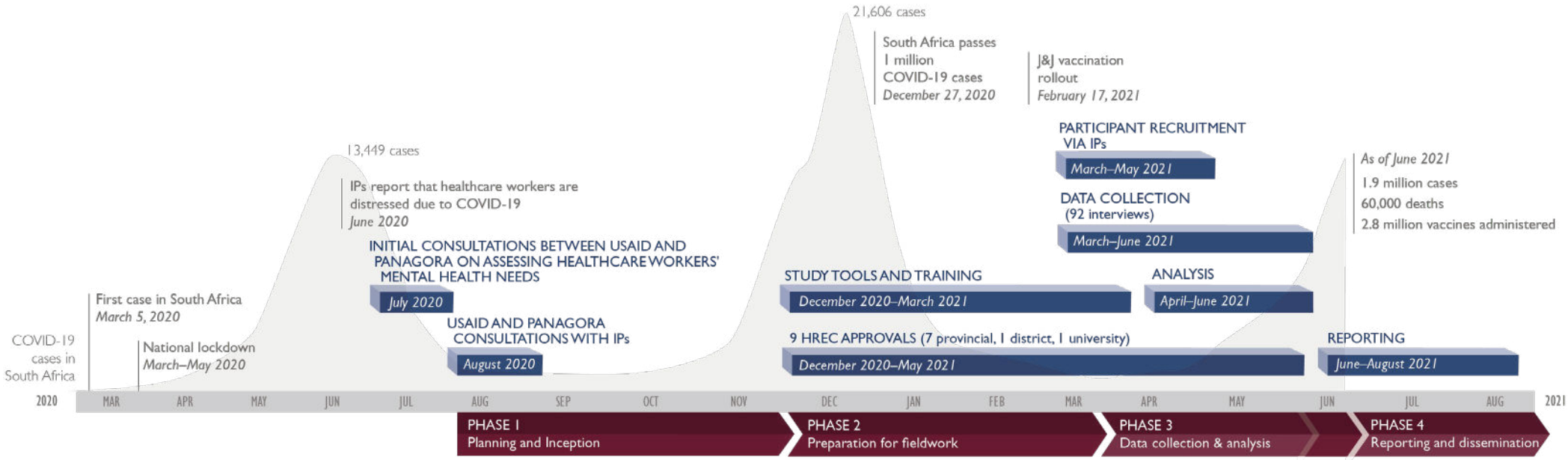
Depending on the context and resources, the recommendations can be adapted and integrated in the Department of Health's Employee Health and Wellness (EHW) program to provide mental health support for HCWs. It is also recommended that IPs share any lessons learned from their implementation of the recommendations or other initiatives through existing platforms with the provincial and district departments of health for mutual learning.

Recommendations for USAID

USAID can support the dissemination of the research findings and recommendations to key stakeholders, including IPs and the NDoH, and encourage IPs to incorporate relevant recommendations in their project implementation activities and work plans. In terms of accountability, it is suggested that Agreement Officer Representatives and IPs discuss how to monitor progress and provide feedback on their efforts to strengthen support to HCWs. An example is to include the recommendations in an IP's work plan and provide feedback through routine USAID-IP meetings. This can be done through the inclusion of a few slides on strategies adopted, progress to date, and outstanding action items.

IPs would benefit from technical support to strengthen their mental health programs for HCWs in terms of increasing mental health awareness, access, and uptake, so that HCWs can perform optimally and provide quality care to their clients. This could include further technical support to develop a comprehensive mental health support toolkit for HCWs.

Timeline of the COVID-19 Pandemic in South Africa and Mental Health Qualitative Research Activities | March 2020 to August 2021



INTRODUCTION AND KEY QUESTIONS

Key facts about the COVID-19 pandemic and the ongoing HIV and TB epidemics in South Africa

- South Africa has the highest burden of HIV in the world, with 7.8 million people living with HIV (PLHIV) as of 2020.[10]
- The country has one of the world's highest incidence rates of tuberculosis (TB), at 615 per 100,000 population as of 2019.[11]
- As of August 13, 2021, South Africa had the highest number of confirmed COVID-19 cases on the African continent, at 2,555,240 cases and 75,774 deaths.[12]
- As of August 13, 2021, 18.21 percent (7,249,021/39,798,201) of the adult population had been vaccinated.[13]
- The COVID-19 pandemic has had a significant impact on the economy, with unemployment increasing from 23.3 percent at the end of June 2020 to 34.4 percent at the end of June 2021.[14]

How did the South African government and USAID respond to the COVID-19 pandemic?

With the outbreak of the COVID-19 pandemic, it was expected that the virus would strain an already overburdened healthcare system in South Africa.[15] The South African government declared a national state of disaster under the Disaster Management Act, and the country went into full lockdown at regulation level 5 from March 2020 through May 2020. Level 5 indicates a high COVID-19 spread with a low health system readiness. Thereafter, the country imposed additional lockdowns at different levels to respond to the surge in COVID-19 cases. By July 25, 2021, South Africa moved to an adjusted level 3 lockdown to continue to halt the spread of COVID-19 cases. The United States Agency for International Development (USAID) implemented a phased response to the COVID-19 pandemic. Through USAID-supported implementing partners (IPs) in South Africa, the Agency responded rapidly to support the National Department of Health (NDoH) with activities ranging from providing support for community screening to surveillance and rapid response. (Annex I provides details on USAID's contribution to South Africa's COVID-19 response.)

How did the mental health of healthcare workers become a top priority for USAID and IPs?

During the health facility or Siyenza[16] support calls in June 2020, USAID IPs reported that HCWs were experiencing immense distress, working in the HIV and TB epidemics, and now compounded by the COVID-19 pandemic. HCWs are expected to be more affected by psychological distress because they experience multiple stressors, such as fear of infection; illness due to COVID-19 infection; the

[10] "Country Fact Sheets, South Africa, 2020, HIV and AIDS Estimates," UNAIDS, accessed August 13, 2021, https://www.unaids.org/en/regionscountries/countries/southafrica.
[11] World Health Organization. *Global Tuberculosis Report 2019*. (Geneva, Switzerland: WHO; 2019). http://www.who.int/tb/publications/global_report/en/.
[12] World Health Organization. "WHO Coronavirus Disease (COVID-19) Dashboard, " WHO, accessed Aug 13, 2021. https://covid19.who.int/region/afro/country/za.
[13] COVID-19 South African online portal. "Latest Vaccine Statistics," Department of Health, Republic of South Africa, accessed Aug 13, 2021. https://sacoronavirus.co.za/latest-vaccine-statistics/.
[14] Department: Statistics South Africa, Republic of South Africa. *Quarterly Labour Force Survey Quarter 2: 2021*. (Pretoria, South Africa: STATS SA; 2021).
[15] Salim S. Abdool Karim, "The South African Response to the Pandemic," *New England Journal of Medicine,* (June 11, 2020): 382:e95. https://www.nejm.org/doi/full/10.1056/NEJMc2014960.
[16] USAID's Siyenza campaign is aligned with Operation Phuthuma, which supports South Africa's National Department of Health to provide antiretroviral therapy to an additional two million people living with HIV and retaining all those on treatment in care toward the achievement of epidemic control. During routine in-person site visits or virtual calls, Siyenza advisors identify challenges and limitations to service delivery, help generate measures to address them, and document and follow up on specific actions.

experience of stigmatization; loss of a colleague, family member, and members of the community; extended work hours to cover for colleagues on leave due to COVID-19 exposure or illness; and facing difficult moral decisions ("moral injury") regarding the allocation of scarce supplies that impact in life-and-death situations for clients and peers.[17] The indirect impact of COVID-19 included the loss of jobs and livelihoods of many South Africans and the resultant burden expressed by many HCWs who became the sole breadwinners of their extended families. HCWs had to deal with the rapid service delivery changes and adjustments to mitigate COVID-19 exposure, and their own health risk concerns and personal losses. USAID, IPs, and Panagora Group recognized that this was a pivotal moment to understand and collectively respond to the needs of HCWs and, more specifically, the impact of the COVID-19 pandemic on mental health outcomes.

What was the aim of this qualitative research?

The aim of this qualitative research was to explore and assess the mental health experiences of HCWs[18] during the COVID-19 pandemic in seven high-burden HIV and TB provinces in South Africa. The secondary objective was to determine what support was needed by HCWs to better cope with the COVID-19 pandemic, and to assess what resources were available to support HCWs during COVID-19 pandemic.

Which Human Research Ethics Committee approved the research?

The research protocol was reviewed and approved by the Stellenbosch University's Human Research Ethics Committee (HREC) in December 2020 (see Annex II). The research protocol was also submitted and approved by the HRECs under the provincial departments of health in the following provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, and the Western Cape, in addition to district approval from the City of Cape Town. The details of the research phases are illustrated in at the end of the Executive Summary; participant recruitment and data collection began in March 2021.

Who participated in the national qualitative research?

A total of 92 HCWs were interviewed from March through June 2021, when data saturation was reached. A pragmatic qualitative data collection methodology was used. HCWs participated from nine USAID-supported IPs across ten districts in seven provinces. Data collection was done through semi-structured in-depth interviews. The interview guide included domains focusing on the individual risks, psychological needs, and perceived effectiveness of the coping mechanisms of HCWs. Please see the Eligibility criteria for sampling in PART B. RESEARCH REPORT for more details.

Are the research findings transferable and can recommendations be adapted and used in other settings?

The NDoH in South Africa and similar high HIV burden, low- and middle-income country (LMIC) settings can transfer the findings of this qualitative research to strengthen mental health support for HCWs. The recommendations can also be adapted and applied in the context of other conflicts, natural disasters, or emergency situations. The recommendations are practical and can be easily adapted by a variety of stakeholders. They are not intended to be prescriptive and have been formulated from the findings particularly for the South African context.

[17] United Nations. 2020. "*COVID-19 and the Need for Action on Mental Health.*" https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf.
[18] This is a sample of HCWs from USAID-supported IPs.

What are the key messages shared by HCWs?

- The COVID-19 pandemic put a critical strain on the delivery of HIV and TB services to clients under the care of HCWs.
- Mental health support was available for HCWs; however, there was a need to create an environment that better enabled the uptake of that support.
- Knowledge about the available mental health support varied depending on whether HCWs were office-based or health facility- and community-based, with health facility- and community-based HCWs having very little knowledge about the mental health support available in their organization.
- There was an intersection with culture and gender that could inhibit HCWs from using mental health support, with some men expressing that in their upbringing, they were taught to hide pain and emotions, that they "should be man enough" to handle pain without seeking help.
- HCWs reported vicarious experiences of trauma through the experiences of their clients or being exposed to contextual stressors (e.g., being the first responder to a child survivor of gender-based violence [GBV]).
- HCWs perceived that the mental health support available through their work was primarily for HCWs who had a mental health disorder.
- HCWs expressed the need for recognition and affirmation for their efforts working under the challenging conditions of the COVID-19 pandemic and in the ongoing HIV and TB epidemic.
- Some HCWs expressed reluctance to get vaccinated for COVID-19 for a variety of reasons (e.g., fear of adverse effects, lack of trust in the efficacy in the COVID-19 vaccines, insufficient information about the vaccine, suspicion about the origins of the vaccine).
- Rural-based HCWs shared that they often ran out of personal protective equipment (PPE) and had to purchase their own PPE.
- Supervisors expressed the need to have more knowledge about mental health so that they could better identify HCWs' mental health support needs and refer them accordingly.

What can happen if we do not pay attention to these key messages?

Mental health support is an integral element for optimal performance of the healthcare workforce[19] and is essential for South Africa to achieve its goals of reaching HIV epidemic control. HCWs' ongoing psychological distress can severely undermine performance, decision making, and well-being. It can also lead to increased absenteeism, affect productivity, and have an impact on team morale.[20] Ongoing psychological distress can lead HCWs to be less engaged with their work and affect communication with coworkers. It can likewise impact future mental health conditions.

What support do IPs already have in place?

This research provided an opportunity to assess the current mechanisms of mental health support that were in place among the IPs. Some of the mental health support provided by the IPs included assistance that was available through medical insurance and external providers that the IPs had sourced. However, what needed to be strengthened was the more widespread uptake of mental health support by the HCWs. The study found that information on mental health services did not always filter from staff at the central and leadership levels to cadres of HCWs providing support in the field; they were generally unaware of what services existed. We also found that HCWs misperceived the available mental health

[19] "Mental Health in the Workplace," WHO, accessed August 13, 2021, https://www.who.int/mental_health/in_the_workplace/en/.
[20] Ibid.

support as only for mental health disorders, rather than as an everyday tool to mitigate the many stressors that they experienced as part of their work. Similarly, many of the day-to-day best management practices that support mental health, motivate staff to work hard, and make work more fulfilling for HCWs—such as staff recognition and regular site visits—may have received lower priority for IPs that were extremely busy with program implementation or whose activities had been suspended during national lockdown periods.

What can IPs do to strengthen the mental health support available in their organizations?

IPs can adapt existing work plan and routine program activities to strengthen mental health support, drawing on the recommendations from this research. The recommendations provided in this report are a direct result of 92 qualitative, in-depth interviews with HCWs.

How can the recommendations be integrated in IPs' work plans?

The recommendations are categorized so that they can be implemented through the human resources for health (HRH) section of a work plan:

- In-service training
- Routine staff meetings
- Staff recognition and awards
- Supportive supervision
- Healthy workplace

How can a cascade model be used to implement the practical recommendations?

IPs can use a cascade model, whereby a staff member in the Human Resources (HR) Department provides information about specific content to management, and then management provides the same information to the HCWs they supervise. This is similar to the training cascade model, which involves training the trainers who then train other trainers, with this process repeated until the target population is reached.[21] Most IPs have staff who are skilled in organizational development or psychosocial support and can facilitate these sessions. The most common cadres of staff who can facilitate the topics are:

- HR managers
- HR administrators
- Social workers
- Program managers
- Medical doctors (for clinical topics)
- Nurses (for clinical topics)

[21] Lucian Ngeze, Ulfa Khwaja, Sridhar Iyer, "Cascade Model of Teacher Professional Development: Qualitative Study of the Desirable Characteristics of Secondary Trainers and the Role of Primary Trainers," 26th International Conference on Computers in Education, Manila, Philippines, November 2018, https://www.researchgate.net/publication/329251705_Cascade_Model_of_Teacher_Professional_Development_-_Qualitative_Study_of_the_Desirable_Characteristics_of_Secondary_Trainers_and_the_Role_of_Primary_Trainers.

What are the roles and responsibilities in supporting HCWs?

Role	Responsibility
HCWs	Awareness of own mental health needs, self-care to mitigate stress and anxiety, access professional help when needed, management of chronic mental health disorders.
HCW supervisors	Incorporate mental health support into routine trainings and meetings, provide direct support to HCWs (e.g., recognition, mentoring, and linkage to services).
HR staff* and program managers	Integrate mental health awareness and resources into onboarding (e.g., orientation), performance management, workplace wellness programs, and daily operations. Promote mental health support through widely circulating mental health information and the available services offered within the organization on various communication channels (e.g., company intranet, WhatsApp platforms, emails).
Chief of Party and IP leadership	Ensure mental health information, resources, and services are disseminated throughout the organization.
USAID	Support IPs to embed and strengthen mental health resources and tools into programming.

*Staff cadres vary within organizations. Administrative assistants often support HR staff in being the point of contact for disseminating communications. IPs may also have a communications manager to disseminate information to staff.

How are the practical recommendations identified in this report?

The recommendations are aligned to the HRH subsections of a USAID IP work plan. They are identified with the following details:

- Alphabetical letter (e.g., A)
- Number (e.g., 1)
- The name of the recommendation (e.g., In-service training on mental health and the support available)

The full recommendation for the example given above would be identified as: "A.1. In-service training on mental health and the support available."

What are the practical recommendations?

The practical recommendations given below are not exhaustive and can be easily adapted for an IP's context and needs:

A. In-service training
A.1. In-service training on mental health and the support available
A.2. In-service training on the different types of mental health support needs
A.3. In-service training on the intersection of culture, gender, and mental health
A.4. In-service training on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events

B. Routine staff meetings
B.1. Routine debriefing sessions
B.2. Integrate debriefings about work-related challenges into routine meetings

C. Staff recognition and awards
C.1. Creating opportunities for motivation and recognition by showing appreciation for staff in a challenging environment

D. Supportive supervision
D.1. Supportive supervision site visits for mentoring
D.2. Supportive supervision for PPE stock control

E. Healthy workplace
E.1. Widely circulate mental health support information
E.2. Quarterly mental health check-ins

What information is provided under the "Implementing Practical Recommendations" section?

The section is divided into three parts for each practical recommendation. Each practical recommendation has the following:

1. A table with a description of each recommendation, as follows:
    - Problem statement
    - Context
    - Recommendation
    - Approach
    - Facilitator
    - Level of effort (LOE)
    - Resources
    - Tool(s) provided
2. A narrative section that can be included in a work plan. The narrative section is written in first-person plural so that IPs can easily copy and paste the narrative section into their work plan and adapt it according to their context and needs.

3. Tool(s) for each recommendation. The tools provided can be easily adapted and are appropriate for the South African context. The sample tools come in various formats, including:
    - PowerPoint presentation templates
    - Discussion questions
    - Guiding principles
    - Templates with a script
    - Site visit form template
    - Link to an Excel tool
    - Interactive survey

Format for the practical recommendations

Each area is presented in a table, as follows:

Problem Statement	Information about the problem that was identified.
Context	The context of the problem.
Recommendation	The title of the recommendation.
Approach	The approach to use when implementing the recommendation.
Facilitator	The suggested cadre of staff to facilitate the recommendation.
Level of Effort	The estimated LOE needed to implement the recommendation. LOE will differ depending on the number of HCWs, resources available, and the content of the activity.
Resources	The resources needed to implement the recommendation. In light of the ongoing COVID-19 pandemic in South Africa, and to reduce costs, all recommendations can be implemented virtually.
Tool(s) provided	A list of tools developed to assist in implementing the recommendation. The tools are presented below each table.

IMPLEMENTING PRACTICAL RECOMMENDATIONS

The following are recommendations resulting from this research. They are not intended to be an exhaustive list or prescriptive. They were formulated based on the research findings and should be adapted to the context and needs of each IP and their HCWs. They are based on a South African context; however, they can be applicable to similar high HIV and TB burden, LMIC settings. The narrative section below is written in first-person plural so that IPs can easily copy and paste the narrative section into their work plans and adapt it according to their needs.

A guiding principle that cuts across all recommendations is confidentiality. It is important that confidentiality is taken into consideration in each and every recommendation. Mental health is a sensitive topic that is often surrounded by shame and stigma. The more staff feel confident that all activities listed in the recommendation are to be conducted in a safe and trustworthy manner, the more likely they will utilize the support offered. IPs should carefully consider how they can ensure confidentiality when implementing these recommendations (e.g., confidentiality agreements).

A.1. In-service training on mental health and the support available

Problem Statement	Health facility- and community-based HCWs are not aware of the mental health support that is available to them.
Context	Mental health support is available in the majority of IPs. The majority of office-based HCWs were aware of the mental health support available; however, health facility- and community-based HCWs reported that they were not aware of this support.
Recommendation A.1	In-service training on mental health and the support available.
Approach	Orient HCWs to the mental health support that is available when they are first hired and integrate this topic in virtual in-service training sessions to encourage access and serve as a reminder.
Facilitator	A cascade approach can be used, whereby the HR staff provide information to management, then management provides information to the HCWs they directly supervise.
Level of Effort	Approximately 1 hour of preparation time and 30 minutes to 1 hour to facilitate the in-service training.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content on mental health and the support available.
Tool(s) provided	A sample PowerPoint presentation, with content on mental health and the support available is provided in Tool 1.

A.1. Narrative for the work plan

A.1. In-service training on mental health and the support available

Description
We plan to orient HCWs on mental health and the support available in our organization through an induction process. A cascade approach will be used for this, whereby the HR staff member provides information to management, then management provides information to the HCWs that they directly supervise. We will also integrate this topic in an in-service training session to reinforce and remind HCWs of the support available and how to access it.

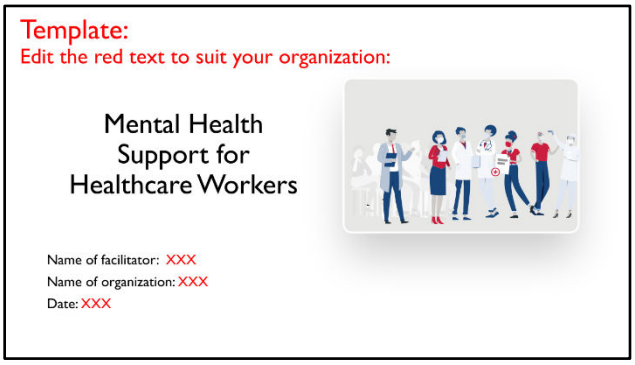
Purpose
The purpose of the orientation and in-service training is to ensure that office-based, health facility-based, and community-based HCWs are aware of the mental health support available in our organization and know how to access this support when needed.

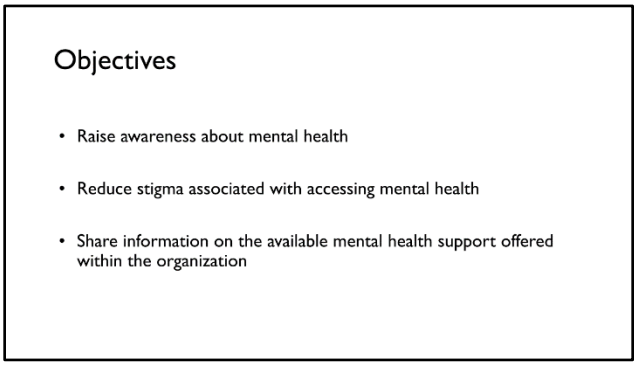
Level of Effort
Approximately 1 hour of preparation time and 30 minutes to 1 hour to facilitate the in-service training.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

A.1. Tool 1

Information about this tool: This tool can be adapted and used for ***Recommendation A.1. In-service training on mental health and the support available***. The content of the presentation is given below and is available in PowerPoint format.





Some ground rules

- Before we start our discussion, let's set some ground rules.
- We are going to discuss sensitive topics.
- There might be differences in our opinions.
- There is no right and wrong.
- So let's hear each other, without taking it personally.
- The point of this discussion is not to necessarily agree, but to reflect together.

Let's brainstorm together

What does mental health mean to you?

What is mental health?

Mental health is a dynamic concept, it is an integral and essential component of general health.

The World Health Organization (WHO) constitution states, "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[4]

- An important implication of this definition is that mental health is more than just the absence of mental disorders, or disabilities. Mental health is a state of well-being, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.
- Mental health is fundamental to our collective and individual ability to think, emote, interact with each other, earn a living, and enjoy life.

The promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities, and societies throughout the world.

(Source: World Health Organization. *Mental Health: strengthening our response.* March 30 2018. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthen-our-response)

Key facts about **mental health**

- Mental health should be a focus for everyone - even more so if you work in environments with high emotional stress
- Taking care of your mental health positively impacts your general health and well-being
- The way we consider mental health is determined by a range of socioeconomic (e.g., culture, gender), biological (e.g., genetics, substance abuse), and environmental factors (e.g., housing conditions, noise pollution)
- We can improve our mental health through cost-effective and easily accessible ways

Let's discuss

Has your view of mental health shifted after hearing these explanations?
If so, what has shifted for you?

In the context of the COVID-19 pandemic

COVID-19 has affected us all

- Developing resilience is crucial because it is the ability to adapt to this adverse event and develop new ways of coping.
- Resilience is the ability to adjust to the pandemic as an adverse event. It is about individuals having the capability to display behaviour that keeps themselves and others safe and healthy during the pandemic, and to perform key roles within families, communities and at work.
- Focusing on mental health increases our ability to cope with stressors, display healthy behavior, and perform our roles in our communities and families.

Stressors in the context of the COVID-19 pandemic

What are stressors?

- Stressor is a general term for any factor that increases a person's mental or physical stress. Stressors can be described as related to the environment (e.g., inadequate housing) or personal (e.g., health related, sexual, social or related to work)

(Source: Medical Dictionary. https://medical-dictionary.thefreedictionary.com/stressor)

Take a moment to consider this statement on the mental health of healthcare workers:

Statement 1 of 2

Healthcare workers have been experiencing **stressors**, such as increased workloads, higher exposure to the COVID-19 virus, witnessing deaths and extreme suffering, stigmatization, and difficult moral decisions ("moral injury"). Healthcare workers worldwide have been more affected by **mental health issues**, with the following irritation, anger, anxiety, helplessness, lack of motivation, tiredness, burnout, depression, trouble sleeping, and trouble concentrating.

(Source: United Nations. *Policy Brief COVID-19 and the Need for Action on Mental Health.* May 13, 2020. https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf)

Then discuss: How is this similar to your experience?

Take a moment to consider this statement on the mental health of healthcare workers:

Statement 2 of 2

Healthcare workers are also dealing with the impact of the pandemic on their own family members. Against this backdrop, they are expected to perform at work. Ongoing psychological distress can severely undermine healthcare workers' decision making and well-being, and may lead to severe conditions in the future. If not dealt with properly, it can leave psychological damage.

(Source: United Nations. *Policy Brief COVID-19 and the Need for Action on Mental Health.* May 13, 2020. https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf)

Then discuss: How does this affect work performance?

The support that is available to you

Mental health is important to us and it is a team priority.
It is our responsibility to care for ourselves, so that we can care for our clients.

We have the mental health support below in place:

(List the services your organization has in place. Below are examples.)

- Debriefing sessions occur monthly and are facilitated through your line manager.
- There is an Employee Assistance Program (EAP) through Discovery. For stressful events (such as the death of a family member or colleague), if you would like to talk to someone, we will refer you through the EAP program to talk to a counselor. The EAP program offers XXX.
- A quarterly well-being survey is conducted by the Human Resources Department to touch base with staff on their well-being.
- Annual team building to reflect on accomplishments and affirm the value of staff.

Let's discuss:

- Do these services address your needs as a healthcare worker?
- How can we make these services easier to access?
- What else can we do to support you to function at your best?

The contact for mental health support:

- Contact name: XXX
- Position of the point of contact: XXX
- Mobile number of the point of contact: XXX
- Office number of the point of contact: XXX
- Email address of the point of contact: XXX

Thank you

Your organization logo here

A.2. In-service training on the different types of mental health support needs

Problem Statement	There is insufficient mental health awareness and discussion about the different types of mental health support that HCWs need.
Context	HCWs have an understanding about the mental health support that is needed for their clients; however, there is little dialogue about the mental health support that HCWs themselves need.
Recommendation A.2	In-service training on the different types of mental health support that HCWs need. The in-service training could be in the form of a dialogue that addresses the different types of mental health support: (1) support for all individuals to function optimally; (2) support for a specific stressor event (e.g., death of a client); (3) support for chronic mental health disorders.
Approach	Virtual in-service training session.
Facilitator	A cascade approach could be used, whereby the HR staff member provides information to management, then management provides information to the HCWs that they directly supervise.
Level of Effort	Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content on the different types of mental health support needs.
Tool(s) provided	A sample PowerPoint presentation, with content on the different types of mental health support needs is provided in Tool II.

A.2. Narrative for the work plan

A.2. In-service training on the different types of mental health support needs

Description
Raising mental health awareness and increasing the dialogue about the different types of mental health support needs are important to ensure that HCWs are aware of their mental health and can access support. A cascade approach will be used for this activity, whereby the HR staff member provides information to management, and then management provides information to the HCWs that they directly supervise.

Purpose
The purpose of the in-service training is to create a space where dialogue can occur between the facilitator and HCWs to raise awareness about the three distinct mental health support needs: (1) support for all individuals to function optimally at work; (2) support for a specific stressor event (e.g., death of a family member); and (3) support for chronic mental health disorders.

Level of Effort
Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

A.2. Tool II

Information about this tool: This tool can be adapted and used for ***Recommendation A.2. In-service training on the different types of mental health support needs***. The content of the presentation is given below and is available in PowerPoint format.

Template:
Edit the red text to suit your organization:

The Different Types of Mental Health Support that Healthcare Workers need

Name of facilitator: XXX
Name of organization: XXX
Date: XXX

Objectives

- Discuss mental health in the context of the COVID-19 pandemic
- Discuss the different mental health support needs:
  1. Support for all healthcare workers to function optimally
  2. Support for a specific stressful event (e.g., death of a family member)
  3. Support for chronic mental health illnesses

Some ground gules

- Before we start our discussion, let's set some ground rules.
- We are going to discuss sensitive topics.
- There might be differences in our opinions.
- There is no right and wrong.
- So let's hear each other, without taking it personally.
- The point of this discussion is not to necessarily agree, but to reflect together.

Recapping: What is mental health?

Mental health is a dynamic concept, it is an integral and essential component of general health.

The World Health Organization (WHO) constitution states, "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

- An important implication of this definition is that mental health is more than just the absence of mental disorders, or disabilities. Mental health is a state of well-being, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.
- Mental health is fundamental to our collective and individual ability to think, emote, interact with each other, earn a living, and enjoy life.

The promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities, and societies throughout the world.

(Source: World Health Organization. *Mental Health: strengthening our response.* March, 30 2018. https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response)

Mental health in the context of the COVID-19 pandemic

The COVID-19 pandemic has had an impact on our lives personally and professionally. COVID-19 regulations such as avoiding social gatherings and ensuring social distancing are important public health interventions to mitigate the spread of COVID-19, but they can make us feel lonely and isolated from the ones we love.

As healthcare workers, we are expected to be more affected by mental health issues due to increased workloads, higher exposure to the virus, witness deaths and extreme suffering, experience stigmatization, and face difficult moral decisions ("moral injury") about scare supplies that can result in life-and-death situations for patients and peers.

(Sources: Centers for Disease Control and Prevention. *Coping with Stress.* Jan 22, 2021. https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html; UNAIDS Joint United Nations Programme on HIV/AIDS. 2020. "UNAIDS Data 2020." UNAIDS. https://www.unaids.org/en/resources/documents/2020/unaids-data.)

Discussion on mental health

- Why is it important for a healthcare worker to access mental health support?
- What different types of mental support needs may healthcare workers require?

Mental health support needs

There are three distinct mental health support needs.

1. Support to function optimally
2. Support for a specific stressful event (e.g., death of a family member)
3. Support for chronic mental health disorders

1. Support for all healthcare workers to function optimally

When we function at our very best in our work - we directly impact the care that our clients receive.

- What kind of support have you been provided with that has helped you to perform your work at your best?

2. Support for a specific stressful event

An example of a specific work-related stressful event is if a healthcare worker visited a home and sees that children do not have food.

- Do you think it is important to seek mental health support when you experience a specific stressful event? If you think it is important, why is it so? If you don't think it is necessary, please share your thoughts with us.

3. Support for chronic mental disorders

There are many different mental disorders, with different presentations. They are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others. Mental disorders include: depression, bipolar disorder, schizophrenia and other psychosis.

- How do you think that seeking mental health support for a chronic mental health disorder will help an individual function optimally and also provide quality of care to clients?

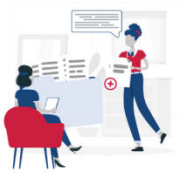
(Source: WHO webpage: https://www.who.int/news-room/fact-sheets/detail/mental-disorders)

Recapping the different types of mental health support needs

- There are different types of mental health support needs.
  1. Support for all healthcare workers to function optimally
  2. Support for a specific stressful event (e.g., death of a family member)
  3. Support for chronic mental health disorder
- Each of these mental health needs are distinct, however we need to respond to each of them effectively so that we can care for ourselves, and provide quality of care to our clients.

The contact for mental health support:

- Contact name: XXX
- Position of the point of contact: XXX
- Mobile number of the point of contact: XXX
- Office number of the point of contact: XXX
- Email address of the point of contact: XXX



Thank you

Your organization logo here

A.3. In-service training on the intersection of culture, gender, and mental health

Problem Statement	Lack of dialogue on the intersection of culture and gender that influences access to mental health support.
Context	HCWs shared that there were cultural and gender biases that may influence uptake of mental health support; however, there was little dialogue on this topic.
Recommendation A.3	In-service training on the intersection of culture, gender, and mental health.
Approach	Virtual in-service training session.
Facilitator	A cascade approach could be used, whereby the HR staff member provides information to management, then management provides information to the HCWs that they directly supervise.
Level of Effort	Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content on the intersection of culture, gender, and mental health.
Tool(s) provided	A sample PowerPoint presentation, with content on the intersection of culture, gender, and mental health is provided in Tool III.

A.3. Narrative for the work plan

A.3. In-service training on the intersection of culture, gender, and mental health

Description
Creating safe spaces for dialogue on how culture and gender impact access to mental health support will help us reduce these barriers, open up access, respond to the needs of our HCWs, and ultimately increase the quality of care to our clients. A cascade approach will be used for this, whereby the HR staff member provides information to management, and then management provides information to the HCWs that they directly supervise.

Purpose
The purpose of the in-service training is to foster dialogue on this topic so that HCWs can reflect on their own preconceived ideas, and the extent to which these preconceived ideas may influence access to mental health support.

Level of Effort
Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

A.3. Tool III

Information about this tool: This tool can be adapted and used for ***Recommendation A.3. In-service training on the intersection of culture, gender, and mental health***. The content of the presentation is given below and is available in PowerPoint format.

Template:
Edit the red text to suit your organization:

How Culture and Gender Impacts Access to Mental Health Support

Name of facilitator: XXX
Name of organization: XXX
Date: XXX

This session should only be conducted after the session titled: Mental Health Support for Healthcare Workers

Objectives

- Discuss beliefs, norms and values that may have an impact on access and uptake of mental health support
- Discuss how culture may play a role
- Discuss how gender may play a role

Some ground rules

- Before we start our discussion, let's set some ground rules.
- We are going to discuss sensitive topics.
- There might be differences in our opinions.
- There is no right and wrong.
- So let's hear each other, without taking it personally.
- The point of this discussion is not to necessarily agree, but to reflect together.

Recapping: What is mental health?

Mental health is a dynamic concept, it is an integral and essential component of general health.

The World Health Organization (WHO) constitution states, "Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

- An important implication of this definition is that mental health is more than just the absence of mental disorders, or disabilities. Mental health is a state of well-being, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.
- Mental health is fundamental to our collective and individual ability to think, emote, interact with each other, earn a living, and enjoy life.

The promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities, and societies throughout the world.

(Source: World Health Organization. *Mental Health: strengthening our response.* March, 30 2018. https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response)

Let's discuss:
Culture and mental health

1. How is "mental health" perceived in different cultures?
2. Are these perceptions all the same or are they different?

To what extent could these perceptions prevent people from accessing mental health support or taking care of their own mental health?

Let's discuss:
Gender and mental health

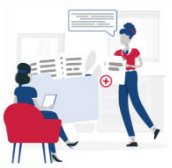
What are some of the stereotypes about the way men and women should behave, that might prevent people from taking care of their mental health by accessing support?

Imagine...

- What stereotypes about men and women would you like to change that would make it easier for them to access mental health support?
- What perceptions would you like to change in your culture that might make it easier for people of that culture to access mental health support?

The contact for mental health support:

- Contact name: XXX
- Position of the point of contact: XXX
- Mobile number of the point of contact: XXX
- Office number of the point of contact: XXX
- Email address of the point of contact: XXX



Thank you

Your organization logo here

A.4. In-service training on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events

Problem Statement	Reluctance to get the COVID-19 vaccine.
Context	HCWs stated that they did not have enough information about the COVID-19 vaccines. They also expressed that they did not have a space to ask questions and share their concerns about the different vaccines available for COVID-19.
Recommendation A.4	In-service training on COVID-19 misinformation; provide accurate information about the different COVID-19 vaccines and adverse effects.
Approach	Virtual in-service training session.
Facilitator	A cascade approach could be used, whereby a medical doctor provides the information to professional nurses, and the professional nurses provide this in-service training to HCWs.
Level of Effort	Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content for facilitating a session on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events.
Tool(s) provided	Sample discussion questions that could be used to facilitate this session are provided in Tool IV.

A.4. Narrative for the work plan

A.4. In-service training on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events

Description
It is important that our HCWs have accurate information about the COVID-19 vaccines. We want to create a space where HCWs feel comfortable asking questions about COVID-19 that they are unsure about, and which may be potentially sensitive.

Purpose
The purpose of the in-service training is to open a dialogue on the origins of COVID-19; community understanding of COVID-19; conspiracy theories; the development of the vaccines; and the risks, benefits, and clinical recommendations for the vaccine. A cascade approach will be used to facilitate this in-service training. We will have a medical doctor provide this in-service training to professional nurses. We will then assign our professional nurses to facilitate the in-service training sessions for HCWs.

Level of Effort
Approximately 1 hour of preparation time and 1 hour to facilitate the in-service training.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

A.4. Tool IV

Information about this tool: This tool can be adapted and used for ***Recommendation A.4. In-service training on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events.*** The tool is a set of discussion questions that can help the facilitator lead a dialogue on this topic, including a post-survey questionnaire.

DISCUSSION QUESTIONS FOR A DIALOGUE ON COVID-19 MISINFORMATION, ACCURATE INFORMATION ON COVID-19 VACCINES, AND ADVERSE EVENTS; AND A POST-SURVEY QUESTIONNAIRE

Part A. Discussion questions for a dialogue on COVID-19 misinformation, accurate information on COVID-19 vaccines, and adverse events
[Note for the facilitator: Share your personal experience on how you were vaccinated against COVID-19. Include any fears or concerns you may have had and how you overcame them. This helps break the ice and creates an environment that is more personal and relatable.]

Discussion questions for a dialogue:

- I have shared my experience getting vaccinated against COVID-19. Do you have any questions for me?
- Would anyone else like to share their experience of getting vaccinated against COVID-19?
- Can you share the information that you were provided on the origins of COVID-19?
- What are some of the perceptions about COVID-19 and the vaccine that you've heard in the community?
- What are some things that you've heard about the COVID-19 vaccine that you know are not true?
- How have you addressed this misinformation about COVID-19 with your clients?
- What are some of the fears that might be holding people back from getting vaccinated?
- Can you describe the stages of the COVID-19 vaccine development and how the clinical trials work?
- What are some risks and benefits of the COVID-19 vaccine?
- Can you describe the clinical recommendations for getting the COVID-19 vaccine?
- After this discussion, do you feel more comfortable getting the vaccine?

Let's make an action plan together:

- If someone has not gotten vaccinated, can I help you register online for the COVID-19 vaccine?
- Can I follow up with you in a week to see if you have received information about your appointment?

DISCUSSION QUESTIONS FOR A DIALOGUE ON COVID-19 MISINFORMATION, ACCURATE INFORMATION ON COVID-19 VACCINES, AND ADVERSE EVENTS; AND A POST-SURVEY QUESTIONNAIRE

[Note for the facilitator: After a week, follow up with the HCW and ask her/him what date s/he will be getting vaccinated. Provide support to the HCW, assure her/him that if s/he has any questions or concerns about the vaccine that s/he can contact you.]

Part B. Post-survey questionnaire

1. Full Name (optional)
2. Position (optional)
3. Date
4. Was this session helpful for you to understand COVID-19 and the vaccines that are available?
    a. Yes
    b. No
5. If you have not yet been vaccinated, do you feel more comfortable to get vaccinated now?
    a. Already vaccinated
    b. Yes
    c. No
6. Did this session help you address any fears you may have had about COVID-19?
    a. Had no fears
    b. Yes
    c. No
7. Do you feel confident enough to address community concerns after this session?
    a. Yes
    b. No
    c. Need more information
8. Is there any other topic that needs to be discussed regarding COVID-19 to help you perform better?
    a. Yes, please write down the topic here: _____
    b. No

[Note for the facilitator: This post-survey questionnaire can be sent out on a Google Form, which will allow for easier analysis of the results.]

B.1. Routine debriefing sessions

Problem Statement	Frustration among HCWs because of the lack of debriefing opportunities.
Context	HCWs expressed the need for debriefing sessions about their experience of traumatic events. HCWs are exposed to clients who are victims of GBV, children living with HIV (CLWH), and clients who have passed away from COVID-19. They need a safe space to debrief about this trauma and leverage collective support from the team.
Recommendation B.1	Routine debriefing sessions that allow HCWs to share their experiences of traumatic events and get collective support.
Approach	Virtual debriefing sessions.
Facilitator	Staff member who is experienced in facilitating psychosocial support discussions. (Most commonly, the cadres are nurses, social workers, and program managers.)
Level of Effort	Approximately 30 minutes of preparation time and 1 hour for the facilitation.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content for facilitating a debriefing session.
Tool(s) provided	Sample discussion questions that could be used to facilitate this session are given in Tool V.

B.1. Narrative for the work plan

B.1. Routine debriefing sessions

Description
Our HCWs are exposed to traumatic events when they provide services to clients who are survivors of GBV and who are CLHIV, and who may have had clients who passed away due to COVID-19. They need a space to debrief about this trauma with their colleagues to build collective and mutual support. Our nurses, social workers, and program managers will facilitate the debriefing sessions.

Purpose
The purpose of the virtual routine debriefing sessions is to create a space for HCWs to share the trauma that they have experienced in the field and access support from the team.

Level of Effort
Approximately 30 minutes of preparation time and 1 hour for the facilitation.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

B.1. Tool V

Information about this tool: This tool can be adapted and used for ***Recommendation B.1. Routine debriefing sessions***. Debriefing sessions can be heavy and emotional. Ensure that you are in the right state of mind to facilitate the session. Staff members who have experience in facilitating psychosocial support discussions are best suited to facilitate these sessions. Examples of these cadres are nurses, social workers, and program managers.

DISCUSSION QUESTIONS FOR FACILITATING A DEBRIEFING SESSION

[Note for the facilitator: Please emphasize with the group that these discussions are confidential. It is important that the team respects everyone's confidentiality because we want to create a safe space for sharing.]

Objective of the debriefing session
The objective of the session is to "hold the space" for HCWs who have experienced a traumatic event. Simply put, it is about sitting with someone in their experience of pain in a loving and caring environment.

Discussion questions for facilitating the debriefing session:

- Would someone like to share a difficult event he/she experienced when working that is still imprinted in his/her mind?
- What was the impact of this experience on you? Can you tell us some of the feelings and thoughts you experienced?
- Let's reflect together about what we have heard. Does anyone else identify with this experience? How?

[Note to facilitator: Take notes on the common feelings that emerge and are expressed. Contain overwhelming feelings with compassion and empathy, allow pauses.]

- Reflect back to the group. You can use sentences such as:
    - "It seems that this experience causes a lot of sadness in us."
    - "It seems that we struggle because we feel we're not doing enough."
- What can help us cope with these feelings?
- After we have discussed this, how are you feeling right now?

[Note to the facilitator: Check the emotional temperature of the room; end the session when you feel that the HCWs are calmer. It is important to use this session as an opportunity to share information on the mental health support services that are available to the HCWs.]

B.2. Integrate debriefings about work-related challenges into routine meetings

Problem Statement	Health facility- and community-based HCWs feel alienated. They requested positive affirmation and feedback from their direct line managers.
Context	Health facility- and community-based HCWs expressed the need for affirmation and support for the work that they are doing on the ground. There is often a disconnect between management and health facility- and community-based HCWs. Discussion of the challenges experienced by health facility- and community-based HCWs needs to be integrated in routine meetings for the team, to touch base with one another and with their direct line managers, to debrief with one another, and to set weekly team goals.
Recommendation B.2	Integrate debriefing about work-related challenges in routine meetings. This would provide opportunities for debriefing and recognizing the emotional component of work (focusing on the everyday activities of working to achieve team targets).
Approach	Virtual routine meetings.
Facilitator	Team supervisor (direct line manager)
Level of Effort	Approximately 30 minutes to prepare and 30 minutes to facilitate the meeting.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content for facilitating a teamwork debriefing meeting.
Tool(s) provided	Guiding principles to debrief about work-related challenges are provided in Tool VI.

B.2. Narrative for the work plan

B.2. Integrated debriefing about work-related challenges into routine meetings

Description

Team supervisors will integrate debriefings into routine meetings. Health facility- and community-based HCWs are often located in the field and may not have regular in-person contact with their supervisor/s.

Purpose
The purpose is to integrate debriefing about work-related challenges in routine meetings to discuss the team's progress, receive affirmation, and receive feedback from the supervisor. These meetings are important for ensuring that teams are on track to reach targets, and that supervisors are aware of site-level challenges. The meetings also create a space for teams to co-develop solutions to challenges that they are experiencing.

Level of Effort
Approximately 30 minutes to prepare and 30 minutes to facilitate the meeting.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

B.2. Tool VI

Information about this tool: This tool can be adapted and used for ***Recommendation B.2. Integrate debriefing about work-related challenges into routine meetings***. These are guiding principles that can help you prepare for your team debriefing meetings. These principles are not exhaustive. They are examples to help you structure your teamwork meetings to be more supportive of the HCWs you supervise.

GUIDING PRINCIPLES FOR INTEGRATING DEBRIEFINGS ABOUT WORK-RELATED CHALLENGES INTO ROUTINE MEETINGS

[Note for the facilitator: Please emphasize to the group that HCWs should not be afraid to disclose any work-related challenges. Challenges are a part of work. We want to normalize that everyone experiences challenges and that it is important to work together as a team to co-develop solutions to address them.]

Objectives of integrating debriefing about work-related challenges into routine meetings:

- Create a space for HCWs to discuss their team's progress.
- Set weekly team goals.
- Reflect on weekly team goals achieved in the previous week.
- Provide each other with affirmation on the hard work done.
- Ensure that the team is on track to reach targets.
- Ensure that supervisors are aware of site-level challenges.
- For HCWs to be given an opportunity to:
    - Discuss challenges that they may have experienced.
    - Develop solutions with their colleagues.
    - Provide feedback on their weekly progress.
    - Discuss where they need more support.
    - For team members to acknowledge other team members for exceptional work.
- For supervisors to:
    - Ask the team what they have experienced in the past week.
    - Provide affirmation to the team.
    - Ask the team about where they need more support.
    - Develop solutions with the team.
    - Provide feedback to HCWs on their progress.
    - Thank the team for its efforts. You can use sentences such as:
        - "[Insert HCW's name], thank you for your contribution last week; I commend you for [insert the activity]."
        - "[Insert HCWs name], that is a great suggestion [insert the solution] to overcome this work-related challenge."

GUIDING PRINCIPLES FOR INTEGRATING DEBRIEFINGS ABOUT WORK-RELATED CHALLENGES INTO ROUTINE MEETINGS

Tips for leading effective team meetings:

- Meet routinely and consistently.
- Limit the team meeting to 8-10 people (the ratio of a supervisor to team members may differ). Smaller groups create an opportunity for everyone to engage in the meeting.
- Prepare an agenda.
- Ask for input on the agenda from the team.
- Make the meeting exciting (e.g., celebrate a special moment).
- Use team meetings to collaborate.
- Keep track of action items and follow up items.
- Provide affirmation to the team.

C.1. Creating opportunities for motivation and recognition by showing appreciation for staff in a challenging environment

Problem Statement	HCWs reported that they felt a lack of affirmation and recognition.
Context	HCWs were already working in the extreme circumstances of the HIV and TB epidemic, which was compounded by the COVID-19 pandemic. In these circumstances, they were under pressure to achieve high targets and expressed a lack of recognition for their hard work, exhaustion from working long hours, and an immense fear of job loss.
Recommendation C.1	Show appreciation for staff in a challenging environment.
Approach	Examples are holding a virtual team building session to strengthen morale or circulating weekly highlight emails that showcase special efforts by a staff member every week.
Facilitator	A staff member skilled in organizational development could facilitate the virtual team building. An administrative staff member could compile the highlight emails that showcase a staff member weekly.
Level of Effort	Approximately 2 hours to prepare and 2 hours to facilitate team building. Approximately 30 minutes to compile a weekly highlights email.
Resources	Virtual meeting (e.g., Zoom or Google Meet), internet connection, and content for facilitating a debriefing session.
Tool(s) provided	A template to use for a weekly highlights email is provided in Tool VII.

C.1. Narrative for the work plan

C.1. Creating opportunities for motivation and recognition by showing appreciation for staff in a challenging environment

Description
HCWs are working under trying times right now with the COVID-19 pandemic, while striving to reach their targets for HIV and TB programs. We will hold a virtual team building to strengthen morale and support mental health in our team. A secondary purpose of this team building session is to integrate the different cadres of staff who do not necessarily work with one another in their day-to-day activities to increase awareness of everyone's role on the team. A staff member skilled in organizational development will facilitate this virtual team building session. We will also send out an email every week that recognizes team achievements and to highlight an individual HCW by sharing information about some of his/her personal attributes and professional achievements.

Purpose
Team building sessions and weekly emails provide an opportunity to recognize performance and highlight best practices. We will maintain a list of which HCWs have been profiled in the weekly email to ensure equitable recognition.

Level of Effort
Approximately 2 hours to prepare and 2 hours to facilitate the team building. Approximately 30 minutes to 1 hour to compile a weekly highlights email.

Resources
This will be conducted in a virtual meeting (e.g., Zoom or Google Meet), where an internet connection will be needed for the virtual session.

C.1. Tool VII

Information about this tool: This tool can be adapted and used for ***Recommendation C.1. Showing appreciation for staff in a challenging environment***. This is an example of a weekly highlights email that can be sent out by your organization. Each week a new staff member can be showcased.

WEEKLY HIGHLIGHT EMAIL TO RECOGNIZE TEAM ACHIEVEMENTS AND PROFILE AN INDIVIDUAL HEALTHCARE WORKER

Good morning [Organization name] team members! I hope you are all doing well. Here are the highlights for this past week.

[Organization name] updates

- Well done to our facilitators who have trained 15 counselors on motivational interviewing!
- Congratulations to the community-based HIV testing team that provided HIV testing services for 125 people at the Cheetah's soccer tournament in East London!

Happy birthday this week to our [Organization name] team members!

- June 1: Maria Nkambule, Nothando Makeba
- June 2: Carlitos Dlamini, Sihle Mbeki
- June 3: Fikile Hlope, Jerry Ndlovu

We are profiling a team member each week. Say hello to [Name of team member].

- [Name of team member] is from East London, Eastern Cape.
- She has been working as a nurse for 15 years in South Africa, and 5 years in eSwatini.
- She has completed 5 marathons and 2 ultra-marathons, loves to bake cakes on the weekend for her family, and enjoys reading murder mysteries.
- When asked why she enjoys working for [Organization name] she said, "I love working in this fast-paced environment. One of the pleasures of this work is seeing clients adhering to treatment and living a fulfilling life. These clients are an inspiration to me."

WEEKLY HIGHLIGHT EMAIL TO RECOGNIZE TEAM ACHIEVEMENTS AND PROFILE AN INDIVIDUAL HEALTHCARE WORKER

[Photo of team member]

Quote of the week
"Mistakes are a fact of life. It is the response to the errors that counts." -Nikki Giovanni

Thank you for reading the highlights for this week! If you have any questions, please do not hesitate to contact me.

Kindest regards,
[Name of team member sending out the weekly highlight]

D.1. Supportive supervision site visits for mentoring

Problem Statement	Disconnect between management and health facility- and community-based HCWs in terms of pressures to reach targets.
Context	Health facility- and community-based HCWs stated that their organization and their supervisors did not have sufficient sensitivity to the site-level challenges, or awareness of the site context when determining targets, or provide the support needed to achieve the targets.
Recommendation D.1	Supportive supervision site visits for mentoring.
Approach	Supervisors to conduct a standardized number of site visits or client home visits with HCWs.
Facilitator	Team supervisor (line manager).
Level of Effort	Approximately 2 hours to prepare and 2 hours to conduct a site visit.
Resources	Reimbursement for travel to and from the site visited.
Tool(s) provided	A template to use for the supportive supervision site visit is provided in Tool VIII.

D.1. Narrative for the work plan

D.1. Supportive supervision site visits for mentoring

Description
Supervisors who manage health facility- and community-based HCWs will conduct a standardized number of site or home visits with their staff.

Purpose
The purpose is for supervisors and health facility- and community-based HCWs to develop a closer working relationship so that staff feel that their supervisors understand the challenges that they face on the ground and are better positioned to support them to deal with the challenges. The team supervisor (line manager) will conduct the site or home visits.

Level of Effort
Approximately 2 hours to prepare and 2 hours to conduct a site visit.

Resources
Transportation costs to and from the site. This will be standardized with the local transportation reimbursement costs approved under the company and within USAID, with a range of South African Rand (R) 3.50 to R 5.00 per kilometer for reimbursement.

D.1. Tool VIII

Information about this tool: This tool can be adapted and used for ***Recommendation D.1. Supportive supervision site visits for mentoring***. This is an example of a supportive supervision site visit form that the supervisor and the healthcare worker fill out together.

SUPPORTIVE SUPERVISION SITE VISIT FORM

Objective of the supportive supervision site visit
Supportive supervision is a facilitative approach to supervision that promotes joint problem-solving, mentorship, and communication between supervisors and HCWs, which can improve performance and positively impact HIV and TB service delivery.

Instructions on how to fill out the form
The supervisor and the HCW fill out the form together. The supervisor should conduct regular site visits to the clinics or clients' homes with the HCW to get a better understanding of the challenges that the HCWs experience in the field and help the HCW deal with the challenges. [Note to the supervisor: Ensure that the HCW obtains consent from the client before the home visit. The HCW can explain to the client that this is part of a routine, standard practice of supervision to ensure that quality services are being provided to clients.]

Date of supportive supervision site visit:

Healthcare worker name:

Supervisor name:

Name of site:

Notes:

1. Areas where the healthcare worker is performing well:
2. Opportunities for the healthcare worker to improve:
3. Challenges that the healthcare worker is dealing with (include suggestions to deal with these challenges):
4. Additional support that needs to be provided:
5. The plan of action: (e.g., documents to access, people to speak to, training to attend):

Action	Person responsible	Timeline

Signature of the healthcare worker:

Signature of the supervisor:

D.2. Supportive supervision site visits for PPE stock control

Problem Statement	Shortages of PPE at the site level in rural areas.
Context	Rural-based HCWs reported that there was a shortage of PPE and that they often had to purchase their own hand sanitizers and masks.
Recommendation D.2	Supportive supervision site visits for PPE stock control.
Approach	Supervisors to conduct routine site visits to ensure that sufficient PPE resources are available.
Facilitator	Team supervisor (line manager).
Level of Effort	Approximately 2 hours to prepare and 2 hours to conduct a site visit.
Resources	Reimbursement for travel to and from the site visited.
Tool(s) provided	A PPE burn rate calculator tool is provided in Tool IX.

D.2. Narrative for the work plan

D.2. Supportive supervision site visits for PPE stock control

Description
Line managers are often based at the head office and rural-based HCWs are working remotely in rural areas. The COVID-19 pandemic is ongoing and ensuring that PPE is sufficient for HCWs is an important element for COVID-19 risk mitigation. Team supervisors need to ensure that the delivery of PPE is reaching site offices and that they are regularly checking the PPE burn rate. Team supervisors (line managers) will conduct routine site visits to check PPE stock levels and make sure that PPE stock level controls are in place.

Purpose
The purpose of the routine site visits is to ensure that PPE is reaching rural-based HCWs so that they are protected against COVID-19.

Level of Effort
Approximately 2 hours to prepare and 2 hours to conduct a site visit.

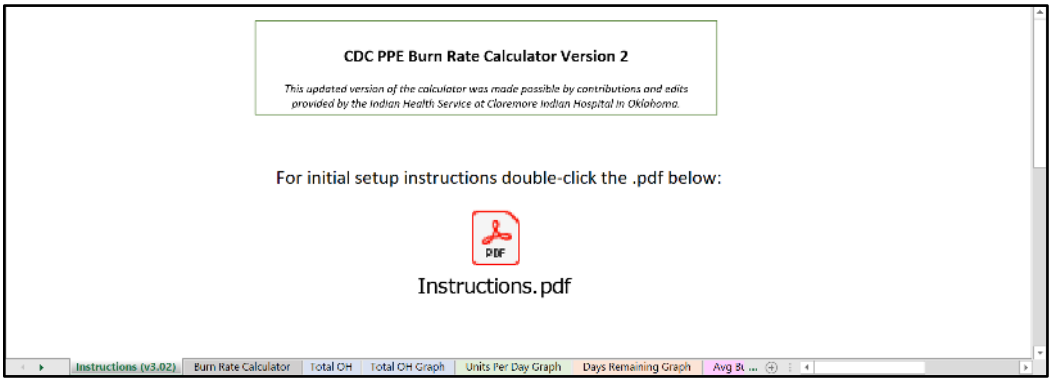
Resources
Transportation costs to and from the site. This will be standardized with the local transportation reimbursement costs approved by the IP and USAID, with a range of R 3.50 to R 5.00 per kilometer for reimbursement.

D.2. Tool IX

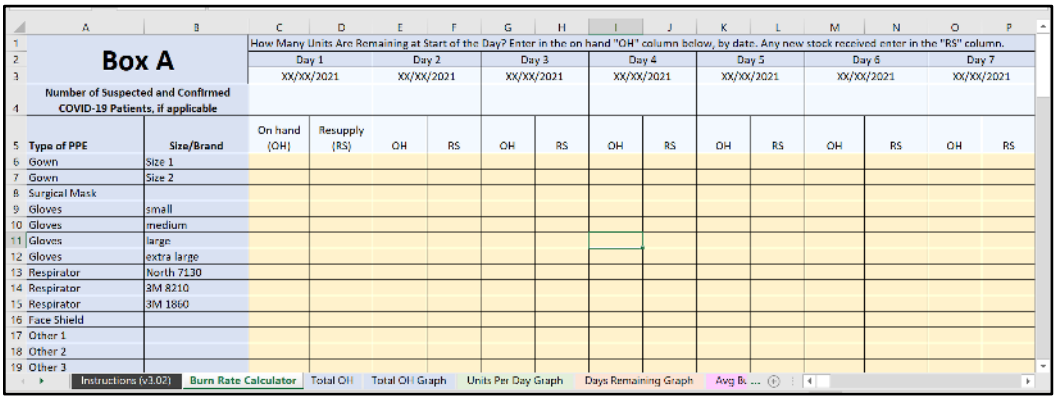
Information about this tool: This tool can be adapted and used for ***Recommendation D.2. Supportive supervision site visits for PPE stock control***. This tool is a Microsoft Excel spreadsheet. We have included the link below for you to download the tool. Screenshots of the first two tabs of the tool are shown below. Team supervisors should ensure that the logistics officer (or the staff member responsible for site supplies) has a similar tool that keeps track of the PPE burn rate. The supervisor should be able to call the logistics officer to get the PPE burn rate. Supportive supervision through a site visit is recommended to also ensure that the logistics officer is using the tool correctly.

Source for the tool: Centers for Disease Control and Prevention. "Personal Protective Equipment (PPE) Burn Rate Calculator." Updated March 24, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

The first tab in the PPE burn rate calculator tool is shown below. It also has an instructions manual in a PDF format.



The second tab of the burn rate calculator is shown below.



E.1. Widely circulate mental health support information

Problem Statement	HCWs shared that they did not have information, education, communication (IEC) materials about how to access mental health support.
Context	A repeated theme from the interviews was HCWs' lack of information and communication around mental health support. Supporting mental wellness must be recognized as a cross-cutting priority at work, not a remedial action item for HCWs who are "not coping."
Recommendation E.1	Widely circulate mental health support information.
Approach	Circulate mental health support information through the following communication channels: (1) organization's intranet site; (2) monthly emails and WhatsApp messages; and (3) electronic IEC posters.
Facilitator	A staff member from the Human Resources Department and administrative staff.
Level of Effort	1) Approximately 1 hour to update the intranet; 2) 30 minutes to create the monthly emails and WhatsApp messages; and 3) Approximately 2 hours to compile the content in a template and distribute the electronic poster to staff through email.
Resources	The electronic IEC materials will be distributed through virtual platforms, such as the intranet, emails, and WhatsApp messages.
Tool(s) provided	A sample template that can be used for the organization's intranet is given in Tool X providing information on mental health and how HCWs can access mental health support.

E.1. Narrative for the work plan

E.1. Widely circulate mental health support information

Description
1) We will add the information we provide for mental health support to our intranet site so that everyone has access to this information. 2) We will send out monthly emails and WhatsApp messages with information on mental health support through the Human Resources Department. 3) We will distribute electronic IEC posters where we emphasize mental health as a team and individual priority so that HCWs can provide quality care to their clients. A staff member from the Human Resources Department and administrative staff can prepare and share this information.

Purpose
The purpose is to create awareness about mental health and the support provided by the organization.

Level of Effort
1) Approximately 1 hour to update the intranet; 2) 30 minutes to create the monthly emails and WhatsApp messages; and 3) Approximately 2 hours to compile the content in a template and distribute the electronic poster to staff through email.

Resources
The electronic IEC materials will be distributed through virtual platforms, such as the intranet, emails, and WhatsApp messages.

E.1. Tool X

Information about this tool: This tool can be adapted and used for ***Recommendation E.1. Widely circulate mental health support information***. This is a sample template that provides information on mental health and how HCWs can access mental health support.

MENTAL HEALTH INFORMATION FOR THE ORGANIZATION'S INTRANET

Mental health and the workplace
Our organization operates in South Africa, which has the highest global burden of HIV in the world and one of the highest for TB. This brings complexities and stressors related to our work, which are further compounded by the COVID-19 pandemic. As we navigate the circumstances of the COVID-19 pandemic, we recognize the emotional stress our staff experience. We also recognize that their mental health is critical to their general well-being and to ensuring that we function optimally—both personally and professionally—to provide excellent quality care to our clients.

Mental health support is available
If you would like more information on the available mental health support that we offer, please contact the team member below for more information:

- Contact name: XXX
- Position of the point of contact: XXX
- Mobile number of the point of contact: XXX
- Office number of the point of contact: XXX
- Email address of the point of contact: XXX

E.2. Quarterly mental health check-ins

Problem Statement	A significant number of HCWs reported feeling burnout.
Context	HCWs reported being exposed to traumatic events in the field (e.g., being the first responder to a child who has just lost her/his mother due to COVID-19). They said that there were few follow-ups to check-in on their mental health.
Recommendation E.2	Quarterly mental health check-ins (or more regularly, if needed).
Approach	Conduct a quarterly mental health check-in virtually with HCWs through an interactive survey on a Google Form. The survey will give the option for HCWs to remain anonymous if they so choose.
Facilitator	Human Resources Department
Level of Effort	Approximately 4 hours of preparation to develop and administer the survey, and 6 hours to analyze the data and follow up with staff who need mental health support. This LOE depends on the size of the organization.
Resources	Internet connection to develop the Google Form and circulate the electronic survey.
Tool(s) provided	A sample interactive survey that asks a series of questions to check-in on the mental health of HCWs is provided in Tool XI.

E.2. Narrative for the work plan

E.2. Quarterly mental health check-ins

Description
Our staff are exposed to traumatic events in the field due to the HIV and TB epidemic, which are further compounded by the COVID-19 pandemic. The mental health of our staff is very important. We will conduct a quarterly mental health check-in with our staff through a short survey on a Google Form. The survey will give the option for HCWs to remain anonymous if they so choose. The survey will be facilitated by the Human Resources Department.

Purpose
The purpose is to ensure that staff who have been exposed to traumatic events in the field receive the proper referral to mental health support that they may need.

Level of Effort
Approximately 4 hours of preparation to develop and administer the survey, and 6 hours to analyze the data and follow up with staff who need mental health support.

Resources
Internet connection to develop the Google Form and circulate the electronic survey. Learn how to create a survey in Google Forms by watching this video on YouTube.

E.2. Tool XI

Information about this tool: This is an example of a series of questions that can be used in a Google Form and sent to HCWs to check in on their mental health. This tool can be adapted and used for ***Recommendation E.2. Quarterly mental health check-ins***.

MENTAL HEALTH CHECK-IN SURVEY

Welcome: We recognize the considerable pressure and emotional stress brought on by the context in which you work. You and your mental health are important to us. We would therefore like to "check in" and assess the support that you are receiving. You can choose to remain anonymous or to share your name. Either option is fine.

Terms of reference for mental health:

1. World Health Organization definition of mental health: Mental health is a dynamic concept associated with the capability to cope with increasing stressors, to display healthy behavior, and to perform roles in communities and families.
2. Anyone can seek mental health support for any of the following reasons:
    - To perform optimally
    - For a stressor event (e.g., loss of a colleague/client/family member)
    - For a mental health disorder

I**nstructions on how to fill out the survey:** Please fill out the survey so that we can respond more effectively to your needs. It is a short survey that will take just a few minutes of your time.

1. Name (optional)
2. E-mail address (optional)
3. Mobile number (optional)
4. Date
5. Position at work
6. How would you describe your mental health over the past 2 weeks on a scale of 1 to 5 (1 is not coping well and 5 is coping very well).
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5
7. How many days in the past month have you woken up and not wanted to come to work?
8. Have you experienced any of the following in the past 2 weeks:
    a. Stress
    b. Exhaustion/fatigue
    c. Burn out
    d. Anxiety
    e. Insomnia/sleepless nights
    f. Other

MENTAL HEALTH CHECK-IN SURVEY

9. To what extent have any of these symptoms undermined your work performance? On a scale of 1 to 5 (1 means very little impact and 5 means that your work performance has been significantly negatively impacted).
    a. 1
    b. 2
    c. 3
    d. 4
    e. 5
10. Do you know who to contact in the organization if you need mental health support?
    a. Yes
    b. No
11. Have you accessed mental health support from the organization in the past 3 months?
    a. Yes (Please specify what kind of support you accessed: _____)
    b. No
12. Did you find the mental health support helpful?
    a. Yes
    b. No
    c. Please share the reasons why it was helpful or not helpful in the space below.
    _____
13. Would you like to receive further information about the mental health support that is available?
    a. Yes (Please share an e-mail address or mobile number where we can reach you.)
    _____
    b. No

PART B. RESEARCH REPORT

BACKGROUND

Mental health is a dynamic concept. In the context of the COVID-19 pandemic and in a healthcare setting, it is associated with a HCW's ability to cope with increasing stressors, to display healthy behavior, and to perform roles at work and in communities and families. HCWs may be increasingly affected by mental health issues because they experience higher workloads and exposure to COVID-19, witness deaths and extreme suffering, experience stigmatization, and face difficult moral decisions ("moral injury") about scarce supplies that can result in life-and-death situations for clients and colleagues.[22] HCWs' ongoing psychological distress can severely undermine decision-making and well-being and can impact mental health disorders in the future.[23]

An interdisciplinary group of people with lived experience of a mental health disorder and 24 global experts, convened by the United Kingdom Academy of Medical Sciences and the mental health research charity MQ: Transforming Mental Health, met at the start of the COVID-19 pandemic in March and April 2020 to explore the psychological, neuroscientific, and social effects of the COVID-19 pandemic and rapidly develop research priorities to inform immediate funding priorities.[24] After the consultations with the interdisciplinary group and public surveys, it was recommended that the international community, researchers, and funders prioritize research to address how to mitigate mental health consequences for vulnerable groups during the COVID-19 pandemic, with HCWs considered to be one of the vulnerable groups.[25]

The World Health Organization (WHO) and several other institutions have developed guidelines to provide psychological support for HCWs working in the context of the COVID-19 pandemic. The guidelines emphasize that there is an urgent need for research strategies to improve access to evidence-based psychological interventions for HCWs, especially in LMIC settings.[26]

Understanding the psychological distress of HCWs during the COVID-19 pandemic can help with understanding their needs. A qualitative study which enrolled 20 nurses who provided care for COVID-19 patients in the First Affiliated Hospital of Henan University of Science and Technology in China conducted interviews to explore the nurses' psychology.[27] There were four themes identified: 1) negative emotions (e.g., fatigue, discomfort, helplessness) were present in the early stage of the COVID-19 pandemic; 2) self-coping mechanisms included psychological and life adjustment, rational cognition, team support, and altruistic acts; 3) there was growth under pressure, including increased gratefulness and affection, self-reflection, and the development of professional responsibility; and 4) positive

[22] United Nations Executive Office of the Secretary-General. "Policy Brief: COVID-19 and the Need for Action on Mental Health." May 21, 2020. https://doi.org/10.18356/13fff923-en.
[23] "Mental Health in the Workplace," WHO, accessed August 13, 2021, https://www.who.int/mental_health/in_the_workplace/en/.
[24] Emily A. Holmes, Rory C. O'Connor, V. Hugh Perry, Irene Tracey, Simon Wessely, Louise Arseneault, Clive Ballard, Helen Christensen, Roxane Cohen Silver, Ian Everall, Tamsin Ford, Ann John, Thomas Kabir, Kate King, Ira Madan, Susan Michie, Andrew K Przybylski, Raz Shafran, Angela Sweeney, Carol M Worthman, Lucy Yardley, Katherine Cowan, Claire Cope, Matthew Hotopf, Ed Bullmore. "Multidisciplinary Research Priorities for the COVID-19 Pandemic: A Call for Action for Mental Health Science," *Lancet Psychiatry.* (June 2020): 7:547-60. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7159850/.
[25] Ibid
[26] Lei Yang, Juan Yin, Duolao Wang, Atif Rahman, and Xiaomei Li. "Urgent Need to Develop Evidence-Based Self-Help Interventions for Mental Health of Healthcare Workers in COVID-19 Pandemic," *Psychological Medicine*, (2020): 1-2.
[27] Niuniu Sun, Luoqun Wei, Suling Shi, Dandan Jiao, Runluo Song, Lili Ma, Hongwei Wang, et al. "A Qualitative Study on the Psychological Experience of Caregivers of COVID-19 Patients." *American Journal of Infection Control.* (2020): 48 (6): 592-98.

emotions occurred simultaneously with negative emotions.[28] The study concluded that psychological growth and self-coping were factors in maintaining the mental health of nurses.[29]

Understanding the experiences of HCWs would better formulate the support that they need. A qualitative study was conducted in Hubei, China, which aimed to describe the experiences of HCWs providing support to COVID-19 patients.[30] Semi-structured, in-depth interviews were conducted with nine nurses and four physicians, with three themes identified: 1) the feeling that this was their "duty" to be fully responsible for patients' well-being; 2) challenges including exhaustion due to a high workload, working under a new context, adjusting to new protective gear, and managing relationships under the high stress environment; and 3) there was resilience amid challenges, as HCWs utilized self-management strategies to cope and identified sources of social support, with HCWs feeling they achieved transcendence from working under the high-stress environment.[31] The findings concluded that comprehensive support should be provided to promote HCWs' well-being, and intensive training is needed to support preparedness under crisis.[32]

As the COVID-19 pandemic rapidly moved across the globe, national psychological boards developed support material and guidance to respond to HCWs' well-being. The British Psychological Society developed a guidance document that was adapted from the National Health Service briefing paper for the well-being of staff during the COVID-19 response, which provided guidance that HCWs should be provided with mental health support during the different phases of the pandemic.[33] Similarly, the Canadian Psychological Association addressed issues to consider in terms of the psychological care of HCWs and discussed the need for mental care support.[34] In South Africa, the Psychological Society of South Africa developed a resource packet providing guidance on mental care support to HCWs during the COVID-19 pandemic.[35]

To respond promptly to mental health support for medical staff, a psychological intervention plan was developed at the Second Xiangya Hospital in Hunan Province, which had a large number of suspected COVID-19 patients accessing care.[36] However, the implementation of the psychological intervention for staff faced challenges; even though nurses showed signs of psychological distress, they did not access psychological help.[37] A 30-minute interview survey with 13 medical staff at the hospital determined that the primary needs of staff included restructuring services to accommodate more breaks, better rest facilities, and training to deal with difficult patients, as opposed to psychological interventions for the medical staff.[38] This also highlights the need to better understand where HCWs need support, in terms of resources and logistical assistance.

---

[28] Ibid
[29] Ibid
[30] Qian Liu, Dan Luo, Joan E. Haase, Qiaohong Guo, Xiao Qin Wang, Shuo Liu, Lin Xia, Zhongchun Liu, Jiong Yang, and Bing Xiang Yang. "The Experiences of Health-Care Providers during the COVID-19 Crisis in China: A Qualitative Study." *The Lancet Global Health* (2020) 8(6) e790-98.
[31] Ibid
[32] Ibid
[33] Julie Highfield, Elaine Johnston, Gail Kinman, Robert Maunder, Lisa Monaghan, David Murphy, Amra Rao, Katie Scales, Noreen Tehrani, and Michael West. 2020. "The Psychological Needs of Healthcare Staff as a Result of the Coronavirus Pandemic." *British Psychological Society*. https://www.bps.org.uk/sites/www.bps.org.uk/files/News/News%20-%20Files/Psychological%20needs%20of%20healthcare%20staff.pdf.
[34] Anita Gupta. "Psychological Care of Frontline Health Care Providers During the COVID-19 Pandemic: Issues to Consider," *CPA Webinar*, April 8, 2020. https://cpa.ca/cpa-webinar-psychological-care-of-frontline-health-care-providers-during-the-covid-19-pandemic-issues-to-consider/.
[35] Psychological Society of South Africa. 2020. "COVID-19 Resource Pack for Psychology Practitioners." https://www.psyssa.com/covid-19-resource-pack-for-psychology-practitioners/.
[36] Qiongni Chen, Mining Liang, Yamin Li, Jincai Guo, Dongxue Fei, Ling Wang, Li He, et al. "Mental Health Care for Medical Staff in China during the COVID-19 Outbreak." *The Lancet Psychiatry* (2020) 7(4):e15-16.
[37] Ibid
[38] Ibid

A study conducted in Beijing on the psychological well-being and basic needs of medical workers in a 24-hour fever clinic in Peking Union Medical College Hospital applied qualitative and quantitative evaluations with 19 nurses, 16 doctors, and two clinical technicians, finding PPE shortages.[39] The study showed that 26.6 percent (8/37) of medical staff reported a low appetite and 29.7 percent (11/37) had sleeping problems, at times needing sleeping pills.[40] Technicians expressed that they felt emotionally unstable, doctors felt nervous after hearing other doctors were infected, and nurses expressed negative emotions (e.g., worrying about infection, missing their family members, and feeling stressed with the heavy workload).[41] Recommendations included monitoring the psychological and physical needs of the medical staff to help develop psychosocial interventions that would be beneficial and adjusting working schedules appropriately to their needs.[42]

A systematic review of the literature conducted on the mental health challenges faced by HCWs during the COVID-19 pandemic showed that sociodemographic variables (such as profession, age, gender, the location of work, and the department of work), psychological variables (e.g., self-efficacy), and poor social support were associated with an increase in stress, anxiety, depressive symptoms, and insomnia among HCWs.[43]

It is important to understand HCWs' specific needs before developing effective strategies to support them, and the most direct way to find out their concerns is to ask HCWs directly.[44] This is a key component of ensuring that effective strategies are in place for HCWs, rather than employing generic strategies to reduce stress.[45] A webinar on the burden of COVID-19 on HCWs in South Africa provided data that the level of concern for personal and family well-being and passing COVID-19 infection to family members was significantly high and that severe psychological distress was expressed by all cadres of HCWs who participated in the survey.[46] The findings from these studies highlight the need to develop targeted support interventions for HCWs based on their perceptions and on their contexts.

[39] Jinya Cao, Jing Wei, Huadong Zhu, Yanping Duan, Wenqi Geng, Xia Hong, Jing Jiang, Xiaohui Zhao, and Boheng Zhu. "A Study of Basic Needs and Psychological Wellbeing of Medical Workers in the Fever Clinic of a Tertiary General Hospital in Beijing during the COVID-19 Outbreak." *Psychotherapy and Psychosomatics* (2020): 89(4):252-54.
[40] Ibid
[41] Ibid
[42] Ibid
[43] Mamidipalli Sai Spoorthy, Sree Karthik Pratapa, and Supriya Mahant. "Mental Health Problems Faced by Healthcare Workers due to the COVID-19 pandemic–A Review." *Asian Journal of Psychiatry*, (2020): 51:102119.
[44] Tait Shanafelt, Jonathan Ripp, and Mickey Trockel. 2020. "Understanding and Addressing Sources of Anxiety Among Health Care Professionals During the COVID-19 Pandemic." *JAMA: The Journal of the American Medical Association*, (June 2, 2020): 323:(21)2133-34.
[45] Ibid
[46] Mosa Moshabela. "Webinar: Burden of COVID-19 among Healthcare Workers in South Africa," *Burden of COVID-19 among Healthcare Workers*, September 11, 2020.

METHODS

Data collection was conducted from March 31,2021, through June 4, 2021.

Research team

- The research team consisted of experienced researchers who had implemented qualitative studies from USAID/South Africa, Panagora Group, and Stellenbosch University. The team included a Doctor of Social Science (socio-behavioral science lead), psychologist, and public health specialists.
- The research team had support from a research staff trained in qualitative studies and on Good Clinical Practice.

Design

- Purposive sampling: Intentional selection of participants based on their ability to explain a particular phenomenon, theme, or concept. It involves an iterative process of selecting participants rather than starting with a predetermined sampling frame.[47]
- Qualitative method: Utilized to understand the meaning for participants in the study of the situations, events, and actions which they engage with; the context in which the participants act; the influence of the context on their actions; and the procedure in which the activities take place.[48]
- Deductive logic: Utilized to identify cross-cutting themes. Deductive logic is the procedure of reasoning from one or more statements (premises) to reach a logical conclusion.[49]
- The research design was exploratory, descriptive, and pragmatic to formulate practical guidance for USAID-supported IPs to strengthen mental health support for HCWs.
    - Exploratory: Exploratory research seeks to find out what is happening, in particular, for situations that are unknown or need more information for understanding, to generate new insights and ask questions, generate ideas and hypotheses for future research, and assess phenomena in new light.[50]
    - Descriptive: Descriptive research seeks to give an accurate profile of situations, people, and events.[51]
    - Pragmatic: Pragmatic research seeks to deconstruct a problem by investigating its complex interrelated components to better understand the entire situation. The objective is to present alternatives and to take appropriate action.[52]
- Data collection was through semi-structured in-depth interviews. In-depth interviews are a method of qualitative data collection that involves a trained researcher interviewing a participant on the pertinent topic. It is excellent approach for generating understanding and providing information on the identified topic(s).[53]

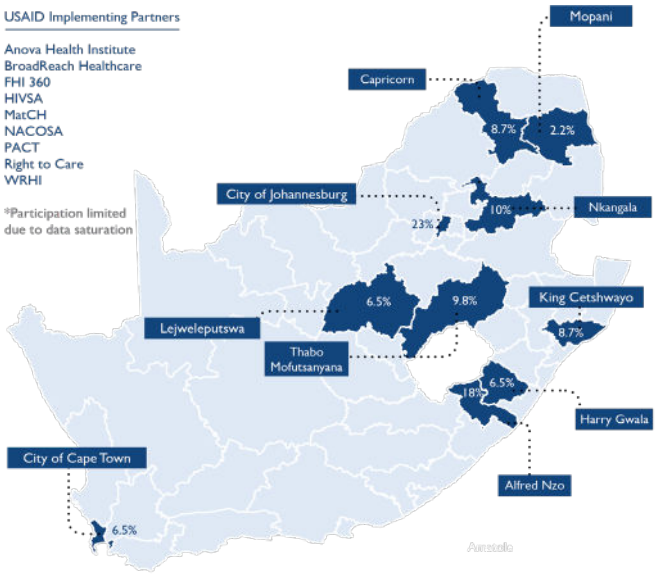
---

[47] R.S. Robinson, "Purposive Sampling," In: A.C. Michalos (eds) *Encyclopedia of Quality of Life and Well-Being Research* (Dordrecht, Netherlands: Springer, 2014), https://doi.org/10.1007/978-94-007-0753-5_2337.
[48] Graciela Tonon, "Qualitative Methods," In: A.C. Michalos *Encyclopedia of Quality of Life and Well-Being Research*. (Dordrecht, Netherlands: Springer, 2014), https://doi.org/10.1007/978-94-007-0753-5_2339.
[49] Markovits, Henry, "The Development of Deductive Reasoning," In: Jacqueline P. Leighton and Robert J. Sternberg, Eds., *The Nature of Reasoning* (pp. 313-338) (Cambridge: Cambridge University Press, 2003), doi:10.1017/CBO9780511818714.012
[50] Lucy Gilson, Ed., *Health Policy and Systems Research: A Methodology Reader* (Geneva, Switzerland: Word Health Organization, 2012), https://www.who.int/alliance-hpsr/alliancehpsr_reader.pdf.
[51] Ibid.
[52] N.J. Salkind, "Pragmatic Study," In: Neil Salkind, Ed., *Encyclopedia of Research Design* (Thousand Oaks, California: Sage, 2010), https://dx.doi.org/10.4135/9781412961288.n326.
[53] Greg Guest, Emily E. Namey, Marilyn L. Mitchelle, "In-Depth Interviews," In: *Collecting Qualitative Data: A Field Manual for Applied Research* (Thousand Oaks, California: Sage, 2013), https://dx.doi.org/10.4135/9781506374680.n4.

- Discussion topics were on the individual risks, psychological needs, and perceived effectiveness of coping mechanisms.
- Data were organized thematically using NVivo qualitative data analysis software.
- Data analysis was iterative within and across the case descriptive analysis.

Setting

- High-burden HIV and TB provinces
- High-burden COVID-19 districts
- Seven provinces
- Nine USAID-supported IPs
- Ten districts
- Geographical locations: urban, peri-urban, rural
- Work locations: office, health facility-based (clinics and hospitals), community-based



Map of districts and distribution of the 92 research participants

Recruitment

- Sampling was done to ensure diversity in the HCW cadres and in the districts.
- The sampling was purposive by district and HCW cadre, and balanced by gender, reflecting the South African healthcare workforce, which has a larger percentage of female workers.
- USAID and Panagora Group briefed the IPs' Chiefs of Party in August 2020 about the research. A protocol was developed and submitted to Stellenbosch University's HREC in November 2020.
- The protocol was approved in December 2020 by the Stellenbosch University's HREC. In February 2021, Panagora Group began receiving the provincial departments of health HREC approvals.
- In March 2021, USAID and Panagora Group circulated a Frequently Asked Questions (FAQ) document about the research and a recruitment form to the IPs' Chiefs of Party. (Annex V provides the FAQ document and the recruitment form is in Annex VI.)
- The Chiefs of Party delegated a point of contact (POC) for each IP to be the liaison between the researchers and the potential participants.
- All USAID IP HCWs in the participating districts were informed about the research via email by the IP's POC. HCWs who were interested in the research filled out the recruitment form, which was a Google Form (a free online tool).
- These volunteers were then contacted by the Panagora Group researchers to arrange for a date and time for participation in the research.
- In some districts, we received more volunteers than were required for data saturation. In those instances, we prioritized data collection with participants from gender or health worker role groups that were less well represented in the sample at that point.

Eligibility criteria

- Any of the 10 cadres of HCWs: 1) linkage officers, 2) administrative clerks, 3) nurses, 4) doctors, 5) data capturers, 6) orphans and vulnerable children (OVC) officers, 7) group facilitators, 8) care workers for children/youth, 9) mentors, and 10) lay counselors.

- The titles of HCWs differed by IP. If the duties and responsibilities fell within any of the cadres listed above, they were included.
- HCWs met the eligibility criteria if they were 18 years or older and worked for any USAID-supported IP or sub-partner in the seven provinces listed in Table 1.
- There were 15 eligible districts; however, only 10 districts participated due to data saturation. The 15 eligible districts were: City of Cape Town, City of Johannesburg, Buffalo City, Alfred Nzo, Ugu, Harry Gwala, Thabo Mofutsanyane, King Cetshwayo, Lejweleputswa, Sedibeng, Gert Sibande, Nkangala, Capricorn, Mopani, and Ehlanzeni.

Tables 1 to 7 provide the sociodemographic data of the participants.

Table 1. Number of participants per province and district

Province	Number of participants per district	Numerator/denominator (N/D) (%)
Eastern Cape (EC)	Alfred Nzo (17)	17/92 (18%)
Free State (FS)	Thabo Mofutsanyane (9)	15/92 (16%)
	Lejweleputswa (6)	
Gauteng (GP)	City of Johannesburg (21)	21/92 (23%)
KwaZulu-Natal (KZN)	Harry Gwala (6)	14/92 (15%)
	King Cetshwayo (8)	
Limpopo (LP)	Capricorn (8)	10/92 (11%)
	Mopani (2)	
Mpumalanga (MP)	Nkangala (9)	9/92 (10%)
Western Cape (WC)	City of Cape Town (6)	6/92 (7%)

Table 2. Number of recruits who became participants and who agreed to share their data

Category	Number	N/D (%)
Recruited	188	188/188 (100%)
Scheduled for an interview	118	118/188 (63%)
Unable to make the interview	25	25/118 (21%)
Participated	93	93/118 (79%)
Participated and agreed to share their data	92	92/118 (78%)

Note: Not all HCWs recruited were called due to data saturation or because they did not meet the eligibility criteria (e.g., they did not work for a USAID-supported IP).

Table 3. Geographical areas of work

Geographical area	Provinces							N/D (%)
	EC	FS	GP	KZN	LP	MP	WC	
Urban	1	2	9	3	5	6	4	30/100 (30%)
Peri-urban	1	7	12	5	3	2	2	32/100 (32%)
Rural	16	7	3	6	3	3	0	38/100 (38%)

Note: Some participants worked in more than one geographical area.

Table 4. Primary place of work

Place of work	Provinces							N/D (%)
	EC	FS	GP	KZN	LP	MP	WC	
Health facility	1	7	1	10	3	9	2	33/92 (36%)
Community	0	0	5	1	0	0	1	7/92 (8%)
Health facility and community (Rotating)	16	6	10	3	1	0	0	36/92 (39%)
Office	0	2	5	0	6	0	3	16/92 (17%)

Table 5. Age distribution across provinces

Age group	Provinces							N/D (%)
	EC	FS	GP	KZN	LP	MP	WC	
18–25 years	1	1	2	1	4	2	0	11/92 (12%)
26–32 years	6	6	7	5	0	4	2	30/92 (33%)
33–40 years	6	5	7	3	5	1	3	30/92 (33%)
41–48 years	3	0	4	2	1	1	0	11/92 (12%)
49–56 years	1	3	1	2	0	1	0	8/92 (9%)
57–64 years	0	0	0	1	0	0	0	1/92 (1%)
+65 years	0	0	0	0	0	0	1	1/92 (1%)

Table 6. Gender distribution across provinces

Gender	Provinces							N/D (%)
	EC	FS	GP	KZN	LP	MP	WC	
Female	16	6	15	11	7	4	5	64/92 (70%)
Male	1	9	6	3	3	5	1	28/92 (30%)

Table 7. Cadre of staff

Cadre	N/D (%)
Linkage officer/case navigator	9/92 (10%)
Administrative clerk/secretary	1/92 (1%)
Nurse	7/92 (8%)
Doctor	2/92 (2%)
Data capturer/data support officer	13/92 (14%)
OVC officer	1/92 (1%)
Group facilitator/peer educator	11/92 (12%)
Care worker for children/youth	2/92 (2%)
Mentor	4/92 (4%)
Lay counselor/HIV counselor	8/92 (9%)
Technical advisor	1/92 (1%)
Monitoring and evaluation officer	2/92 (2%)
Senior administrator	8/92 (9%)
Pharmacy assistant	1/92 (1%)
Facility case manager	3/92 (3%)
Cluster team lead	3/92 (3%)
Gender-based violence case officer	4/92 (4%)
Social auxiliary worker/social worker	9/92 (10%)
Community healthcare worker	3/92 (3%)

Data collection process

- Due to the COVID-19 pandemic, the in-depth interviews with participants were conducted remotely by the researchers using a virtual platform (Zoom, Google Meet, Microsoft Teams). For more information on lessons learned from conducting a virtual research study, refer to the following section: Annex IV: Lessons Learned from Conducting Research During the COVID-19 Pandemic.
- In-depth interviews were done with one participant at a time, which allowed for privacy and gave each participant the opportunity to speak freely.
- The interviews were conducted by (1) a facilitator, whose primary task was to manage the flow of the discussion using a semi-structured interview guide (Annex VII); and (2) an observer, whose primary task was to take notes. For some interviews, one researcher took on both responsibilities, facilitating the interview and taking notes.
- The interviews lasted between 60 minutes to 1.5 hours, were audio and video recorded, and password protected.

Data analysis processes

- Data analysis was iterative within and across the case descriptive analysis.
- The researchers used the field notes and the audio recordings to populate a case description form within 48 hours of the interview. (The case description form is provided in Annex VIII.)
- The form included sections on each research objective: (1) health workers' mental health experiences under COVID-19; (2) how they managed psychological stress; (3) their recommendations for supporting health workers; and if relevant, (4) their thoughts as supervisors or managers.
- The case description form also included a section for the researchers to reflect on their interpretation of the interview with the participant.
- The team met approximately weekly to discuss the cases as the data were collected, including obtaining input on how to interpret the findings from the socio-behavioral science lead.
- Data were organized thematically using NVivo qualitative data analysis software.
- Comparisons were done across case descriptions to identify responses that were descriptively normative and those that were exceptional.
- A preliminary set of responses was drafted on the research's objectives, which the research analytic team (co-investigators from Panagora Group and the Stellenbosch University) discussed to finalize, by consensus, the language for each research objective response.
- We then returned to the case descriptions to extract quotes and narratives with which to illustrate the findings.

Limitations

The findings from this research are limited for three reasons.

- First, it was conducted only among HCWs who were employed by USAID-supported IPs. Their experiences may be somewhat different from HCWs employed by the NDoH, given the relative uncertainty about employment contract renewal by nongovernmental organizations and community-based organizations that are dependent on foreign aid.
- Second, the sample included only participants who volunteered to report on their mental health experiences, which may under-represent the experiences of people with the worst mental health issues, who may be inhibited from volunteering to talk about these experiences in a research context. Conversely, it may over-represent the experiences of people with work-related stress who may want to discuss their concerns about work-related issues more freely, and who used the research as a platform to do so, whereas other HCWs may not have had

similar issues and, therefore, did not volunteer to share them. We mitigated this potential limitation by: 1) clearly articulating during the recruitment process why we needed a variety of perspectives; 2) sampling for diversity in age, gender, district, and HCW role, representing the healthcare workforce in South Africa; 3) collecting in-depth data and contextualizing them relative to the participants' work and personal experiences; 4) including supervisor perspectives about staff needs; and 5) implementing a multi-layered analytic process to sense-check our interpretations.

- Third, in line with the research aim, the recommendations are based on the participants' perspectives and, using an analytical research lens, our interpretation of what gaps need to be addressed. The recommendations are not proof that specific interventions will be successful in addressing the gaps. Sequential research would be needed to measure the success of the interventions.

Ethics and informed consent

- The research protocol was reviewed and approved by the Stellenbosch University's HREC, with the HREC reference number of N20/11/073_COVID-19, on December 14, 2020.
- The research protocol was also submitted and approved by the HRECs under the provincial departments of health in the following provinces and with the HREC numbers shown: Eastern Cape (EC_202101_012), Free State (FS_202101_011), Gauteng (GP_202101_041), KwaZulu-Natal (KZ_202101_025), Limpopo (202104_009), Mpumalanga (MP_202101_008), and Western Cape (WC_202101_025), and district approval from the City of Cape Town (Ref: 28086), with the dates of approval spanning from February through to May 2021.
- The participant information leaflet and the informed consent form were translated and made available in the 11 official languages of South Africa: English, Afrikaans, Xhosa, Ndebele, Zulu, Tswana, Swati, Sotho, Southern Sotho, Venda, and Tsonga.
- The consent procedure was conducted in the participant's preferred language.
- Completed consent forms were emailed and/or sent to the physical address, as requested by the participant.
- During the consent process, participants were informed that participation was entirely voluntary, that their feedback was confidential and could not be linked back to them, and that they could withdraw from the research at any time.
- At the end of the interview, all participants were asked whether the interviewer could call them again in a few days to check on their well-being.
- All participants were provided with a Directory of Services prepared by Panagora Group (Annex IX) that lists external mental health support available for participants. The Directory also lists social support for GBV, substance abuse, and food shortage.
- In addition, Panagora Group collected information about any mental health support offered by IPs, so that participants could first be referred internally in their organization (Annex X). If their organization did not have an employee wellness program or internal referral support, the participant was referred to external providers given in the Directory of Services.
- Video and audio recordings, and the case description forms, were anonymized and stored on a password-protected Google Drive available only to the research team.
- The researchers conducting the in-depth interviews were not from the same communities as the HCWs to maintain privacy and confidentiality of the matters discussed.
- Video and audio recordings, and case descriptions were not shared with the participants' supervisors and managers.
- Participants were provided with logistical support in the form of airtime in the amount of R 150, which was standardized to the local airtime provided by other studies being conducted in the

area. The airtime was provided for participants to be able to reach out to seek mental health counseling or social services support because an interview about mental health experiences may spur the need for support.

- In terms of ethics and to safeguard the participants and researchers, for COVID-19 risk mitigation, the research involved no in-person interactions between the participants and the research team. All interviews were conducted virtually.
- Panagora Group provided a research packet for each participant that included the participant information leaflet, consent form, and PPE (i.e., hand sanitizer and a mask).
- Dissemination of the research findings is an ethical obligation. Dissemination of the findings and recommendations has been done virtually due to the ongoing COVID-19 pandemic in South Africa. The aim of the virtual dissemination is to reach a wide array of audiences, ranging from the funders, NDoH, USAID-supported IPs, HCWs, and civil society organizations.
  We intend to publish the results in an international peer-reviewed journal.

HEALTHCARE WORKERS SHARE THEIR STORIES

Findings

The overall goal of the research was to contribute to the knowledge on how to better provide mental health support to HCWs working during the COVID-19 pandemic. The subsections of the in-depth interview guide were used to structure the findings.

What is it like to be a HCW working during the COVID-19 pandemic?

HCWs experienced a range of extreme emotions

Participants (HCWs) experienced a wide range of emotions during the different phases of the pandemic and during the different levels of lockdown.

- During the first lockdown, which began in March 2020, HCWs expressed feelings of uncertainty in their personal and professional lives. Several HCWs shared their shock and disbelief when COVID-19 reached South Africa and as the number of COVID-19 cases started to increase dramatically. Some HCWs said that they experienced panic attacks, sleepless nights, and loss of appetite, which were exacerbated by the uncertainty that the COVID-19 pandemic brought to their personal and professional lives.
- HCWs who were single mothers or single fathers felt overwhelmed by the additional duties of taking care of children at home, helping children with schoolwork, and now working from home.
- Participants discussed the grief they experienced with the loss of family members, friends, or colleagues due to COVID-19. Many who lost loved ones were in shock because they felt that they had just been notified about a family member or colleague being sick, and then within a couple of days, the loved one had died.
- HCWs expressed concern about the economic impact that COVID-19 had on them or that it might have if they lost their job because there had been a big increase in retrenchment and job loss. They worried about having to provide financially for their families because many of their family members had lost their jobs, leaving them as the sole breadwinner. They expressed concern about losing their job if they did not reach HIV/TB performance targets; they said that it was more difficult to reach clients during the COVID-19 pandemic.
- Some participants reported that although this was a time of uncertainty, it had brought them closer to their immediate family, the ones living with them in their homes. Several HCWs said that they had gotten over the initial shock now that South Africa was a year into the COVID-19 pandemic; however, whenever a new wave (peak) was predicted to hit South Africa, they started to have anxiety.

"I was very scared to sleep alone, the anxiety of going to sleep and not waking up in the morning."
-Participant HCW who was previously infected with COVID-19 (female, 35 years, urban office-based)

"I got hopeless when I lost my family members, you don't know how to support and what to do. The pain doesn't go away, some days are worse than others."
-Participant HCW on the loss of family members due to COVID-19 (female, 39 years, urban office-based)

"It becomes a challenge when people are not coming into the hospital, it makes it difficult to reach the targets the funders want, if we don't reach the targets, obviously we won't get funding, then that means I'll lose my job."
-Participant HCW on the impact of COVID-19 (female, 24 years, peri-urban health facility-based)

"I experienced a lot of anxiety to the point I had panic attacks, not knowing what was going to happen, the pressure to get things right without the time to figure it out."
-Participant HCW on the personal and professional impact of COVID-19 (female, 47 years, urban office-based)

"I lost two of my grannies to COVID-19. One of my grannies was the breadwinner. For three days we did not have food. We were sitting together, we don't have food, we don't have a plan, we don't have anything. It was the time of avocados [season]. We ate the avocadoes for three days. We said, 'God thank you.' We managed to cope, although it was very hard."
-Participant HCW reflects on the personal family loss, and economic impact of COVID-19 (male, 34 years, rural health facility-based)

HCWs felt guilty for not being able to continue providing quality care to clients due to the COVID-19 pandemic

Across the board, HCWs expressed how the COVID-19 pandemic affected the services that they were providing to their HIV and TB clients, OVC, survivors of GBV, and clients affected by substance abuse under their care. They expressed concern that they had a duty to conduct home visits, according to their job, but were prohibited from doing so due to the COVID-19 lockdown.

- They communicated a sense of guilt. They described situations where PLHIV had interrupted treatment because the HCWs could not provide the kind of quality support that they had been providing pre-COVID, such as accompanying clients to the clinic or reminding clients to pick up their treatment. HCWs who traced clients who were HIV and/or TB positive to help them reinitiate treatment or begin treatment felt that it was very challenging during COVID-19 because the frequency of their home visits was reduced, and community members did not always welcome them in the home due to fear of getting infected with COVID-19.
- Personnel who worked more closely with TB clients felt that the TB clients were being overlooked due to COVID-19. Moreover, clinics were missing the opportunity to test clients for TB. Because the symptoms of TB and COVID-19 are so similar, clinics might be overlooking a client for TB testing, instead sending the client to get tested for COVID-19. HCWs who worked in clinics said that they saw an increase in the number of clients who interrupted treatment for HIV and TB; the number of clients they had to follow up increased.

- HCWs also shared that they felt that clients were afraid to come to the clinic because of fear of getting infected with COVID-19 at the clinic.
- HCWs who provided support to GBV survivors, OVC, and CLWH felt a deep sense of guilt for not being able to provide quality services to their clients during the initial lockdown and with the ongoing pandemic. The frequency of home visits declined and the communication method with clients changed to the telephone. They also shared that there was an increase in GBV, and an increase in food shortages among CLWH and OVC, which caused them to feel a tremendous amount of guilt.

"COVID has affected the program a lot. When COVID started, we were expecting to retain patients in care, but they don't come to the facility. We worry every day; you need to meet the targets."
-Participant HCW reflecting on the impact of COVID-19 on targets (female, 56 years, rural office-based)

"The perpetrator takes advantage of the pandemic because people are scared to come out. Most families are at home. Some men take [out their] frustration on women and children."
-Participant HCW reflecting on the rise in GBV cases due to COVID-19 (female, 26 years, urban health facility-based)

"Ooooohhh it makes us feel [starts crying]...it makes us feel like we are not doing enough...There was another case of a child who committed suicide, he didn't have enough to provide for the family. Because of the pandemic, we couldn't go check on this. It's hurting us. It's giving us a bad record to our community. We are failing them even though it is beyond our power."
-Participant HCW expresses guilt in not being able to provide quality care during the pandemic to her clients (female, 33 years, peri-urban community-based)

"Before, we used to help patients get their medication. It affected the relationship between me and my beneficiaries, my patients. My patients miss me. They say, 'Now you are abandoning us.' They say, 'Now it's the pandemic, you abandon us.' They don't trust us now."
-Participant HCW describes the frustration she has experienced by not being able to reach her clients during the pandemic (female, 43 years, rural health facility- and community-based)

HCWs felt a constant and pervasive fear of acquiring COVID-19

HCWs stated that they were in constant fear of contracting COVID-19, or getting reinfected with COVID-19, or infecting their family with COVID-19.

- HCWs who visited clients in their homes said that they were at an increased risk of acquiring COVID-19. They shared that most people in the communities were not wearing masks and were not following COVID-19 safety and prevention regulations.
- Participants expressed great concern about infecting their families with COVID-19, especially those living with elderly grandparents. They expressed how overwhelmed they felt when they thought about getting infected with COVID-19; some had sleepless nights.
- Some participants shared instances when they had a cough or started to feel flu-like symptoms, that they were very worried and got tested often to ensure that they did not have COVID-19. For those who had previously been infected with COVID-19, they worried that they would get reinfected. They talked about the physical pain they experienced, how their body felt when they had COVID-19, and how they never wanted to feel that pain again. Some shared experiences of their COVID-19 symptoms, including loss of smell, taste, or hearing, and shared the fear of

never regaining these senses.

- HCWs who were mothers or fathers really worried about getting infected with COVID-19 and leaving their children behind. They worried about how their children would be taken care of and the pain a child would have to endure without a mother or father.
- Participants also expressed concern about the community's conspiracy theories about COVID-19 and reluctance to get vaccinated. Similarly, the COVID-19 conspiracy theories were brought up by several HCWs and their own reluctance to get vaccinated. There were several HCWs who mentioned the withdrawal of the Johnson & Johnson COVID-19 vaccine. They stated their concern and skepticism about the efficacy of the vaccine because it had been temporarily withdrawn. They also mentioned the stories they had heard in the community from people who believed that the vaccine was designed to "wipe out" populations.

"Honestly speaking, when I think about COVID, I think I'm going to die, my heart beats faster. I also think about my family."
-Participant HCW talking about the fear of getting infected (female, 40 years, peri-urban health facility-based)

"I don't think I'll be vaccinated. I have this situation with iron, so I think I'll have side effects. I don't want to have it."
-Participant HCW hesitant about the vaccine (female, 26 years, urban health facility- and community-based)

"The fear is not only from the beneficiaries. I also have fear. I fear I'll infect my family. That fear sits on your unconscious."
-Participant HCW talking about the constant fear of getting infected with COVID-19 (female, 56 years, health facility- and community-based)

"We are going into the hospitals as frontline healthcare workers; we go into environments where we know there are COVID cases. Even though you know you are protected with the masks and such, you know fully that you are at risk. Then you go home, then you know you are also putting them [your family] at risk...I've also had relatives that have passed away. So, we are affected in every way. Some are very close workmates that I have worked with."
-Participant HCW shares his fears of infecting his family and the loss of family and colleagues from COVID-19 (male, 46 years, urban health facility-based)

How are HCWs coping under the COVID-19 pandemic?

Coping mechanisms among HCWs

HCWs reported a wide array of coping mechanisms that they have put in place to deal with stress.

- The majority of participants shared that they had a strong faith in God and prayed regularly, which they felt helped them deal with the daily pressures of life and the additional stress brought on by the COVID-19 pandemic.
- To destress, several HCWs described activities that they have put in place to help them, such as going to the gym, running, and playing soccer. It was common to hear HCWs say that they relieve stress by watching movies, the news, sitcoms, chatting on social media, going out to the movies with friends, going out to dinner with friends, and spending time with their family.
- Some HCWs said that they had accessed mental health support, such as seeing a psychologist who they had paid for themselves; accessing an employee wellness program offered by their

organization; accessing free mental health support available through a social services organization; and seeking prayer, guidance, and conversation with a pastor or elder in the church.

- In terms of mental health support, there was a difference between those who were office-based and those who were health facility- and community-based. Health facility- and community-based workers were not as aware of the mental health support available. Office-based HCWs were more aware of the support available and were able to share what assistance their organizations provided for mental health support.
- There were a few HCWs who shared that they had substance abuse challenges, which they said were exasperated when there was uncertainty in their life. Those who reported that they had a strong family support structure, trusted confiding their challenges to their family members for advice and support.

"I try to manage everything through prayer, that's what makes me stronger. If it wasn't for it, I think I'd have quit a long time ago."
-Participant highlighting the importance of faith as a coping mechanism (female, 29 years, rural health facility-based)

"I know talking is medicine."
-Participant HCW stresses the importance of sharing (female, 43 years, rural health facility- and community-based)

"When you combine family support with your internal resilience, it gives you that killer combination to approach difficult situations."
-Participant HCW on the importance of family support (male, 30 years, urban health facility-based)

Resilience and adaptability of HCWs

Despite challenging personal and professional hardships during COVID-19, HCWs expressed resilience and reported that the current COVID-19 life was now the "new normal." Even if they became the sole breadwinner for a family of ten, they were still going to work and were "grateful for a job." Having access to their HIV and TB clients changed during the COVID-19 pandemic.

- HCWs mentioned innovative interventions that they implemented during the pandemic to reach their clients, such as quickly changing home visit schedule plans to obtaining client contact details, and telephoning clients on a regular basis to find out if they were on antiretroviral treatment or TB treatment. They shared their interventions with joy and pride.
- The normalization of adherence to COVID-19 regulations (wearing masks, hand sanitizing before entering stores/workplaces/banks, social distancing, refraining from group gatherings) was described as the "new normal."
- The office environment changed dramatically for HCWs. They described new clinic layouts that they had implemented to follow COVID-19 regulations and decrease the chances of high-risk clients from acquiring COVID-19.

"We just told ourselves our life is in our hands, how we react to COVID is our business. If you want to stay safe, you need to adhere to the regulations."
-Participant HCW expresses self-efficacy behavior (female, 29 years, rural health facility= and community-based)

"I was so scared, I'm still scared. I'd think I'm having a headache or fever. I'd think *is it just in my head?* But now I know it's just the fear. I feel like I'm adjusting now."
-Participant HCW shows resilience (female, 36 years, urban health facility-based)

The intersection of culture and gender as a barrier to uptake of mental health support

Several HCWs shared that the term "mental health" did not exist in the community in which they grew up. They said that if someone wanted to seek mental health support, some people might think that that person was "bewitched."

- Some HCWs described the perception that as a woman in their culture, seeking mental health support was unheard of, that they were taught to deal with challenges in a certain way, that seeking mental health support was not part of the conversation.
- Some men shared that as a man, you were taught not to seek mental health support, that they should be "man enough" to deal with it.
- Discussions also revealed that HCWs utilized African traditional health practices.

"It can be influenced by your upbringing. A man doesn't cry. It doesn't mean a man literally doesn't cry, it means a man doesn't rush out and cry for help. You try to help yourself first and then you look for help."
-Participant HCW reflects on how gender influences coping mechanisms (male, 28 years, rural health facility-based)

"What I'm worried about is the understanding of COVID. Because of our upbringing, they don't believe in COVID until you get infected. The same happened with HIV. We worry for them, but they don't worry for themselves."
-Participant HCW on COVID denialism (female, 51 years, peri-urban health facility-based)

"When it comes to mental health, there's still stigma. People are afraid to ask for assistance, they feel they might be categorized as weak. We need continued education; we normally don't talk about mental health."
-Participant HCW reflects on the stigma attached to mental health (male, 30 years, urban health facility-based)

"The presumption is that it's mostly white people dominating the access, rather than blacks...the older generation believes in traditional practices."
-Participant HCW shares thoughts on access to mental health support (male, 30 years, urban office-based)

"As Africans, we believe in traditional medicine. On my third month, I make sure I come back with herbs we use through washing. It helps me to feel I know I'm protected because I use this kind of medication."
-Participant HCW shares his beliefs in African health practices (male, 40 years, peri urban office-based)

What additional support do HCWs need?

Support to manage the everyday burden of work to function optimally

HCWs expressed the need for mental health support in the form of debriefing sessions with colleagues. They suggested that a platform was needed for them to share their professional and personal challenges.

- The majority of HCWs preferred to have an external facilitator assist with the debriefing sessions. They said that they would be able to "speak freely" and "not be judged" if the facilitator was an external person. (Note: For the practical recommendations given in Part A of this report, to adapt the findings into recommendations for limited resource settings, we have recommended that IPs use existing staff members who are skilled in psychosocial support to facilitate these sessions. We recognize that there may not be resources available to hire an external facilitator.)
- HCWs also suggested having training available on mental health and on the mental health support available so that they can take better care of themselves and their clients, and even identify clients who may need mental health support and appropriately refer them for services.
- Several HCWs said that they would like to be shown appreciation for their work, and that this would help them perform better. HCWs in rural areas mentioned the need for tangible resources, such as PPE, uniforms, and transport, to visit clients located far away from them. Several HCWs in the rural areas shared that they had a shortage of PPE and often had to purchase their own PPE for use at work.

Support and referral for specific stressor events (e.g., loss of a family member)

For specific stressor events, such as the death of a family member or someone close to the HCW, participants mentioned the need to have the option to share their grief through a one-on-one counseling session. In this case, they preferred to have an external counselor or psychologist provide the service rather than someone from their organization. HCWs mentioned that this service could be provided by social workers who are experienced in providing support for loss and grief. They said that this service would not have to be ongoing; rather, having the option of seeing a counselor once or twice would be beneficial in coping with their loss and grief.

Support and referral for HCWs experiencing a chronic mental health disorder

In these instances, where a HCW may need support beyond debriefing sessions and a once-off counseling session, participants expressed the need to know more about what support is available and how they can access it. The HCWs suggested having information about mental health support widely circulated in their organizations so that they would know who to contact.

"We would like to be debriefed about everything, as we know this pandemic has done a lot of damage. We need people to give us strength and motivation. We need someone to make us feel better."
-Participant HCW asks for debriefing sessions to support HCWs because of the pandemic (female, 25 years, rural health facility- and community-based)

"I think we need some kind of debriefing, focusing on the whole team. We're working with COVID people. People pass away, you get angry, afraid, you have mixed feelings, and you still have to work."
-Participant HCW asks for debriefing sessions to support HCWs because of the pandemic (female, 40 years, peri-urban health facility-based)

"We could die in the line of duty. The employers should recognize the work we do on the ground in terms of remuneration, because we're going the extra mile. But even an email to thank us would do, a personal email."
-Participant HCW expresses the need for recognition (male, 40 years, rural office-based)

"A nurse tested COVID-19 positive, and she died at work in the clinic. She suddenly couldn't breathe; she was put on oxygen. By the time the ambulance got there, she was not breathing anymore. No one even stopped us to talk about this, it was business as usual."
-Participant HCW reflects on the death of a colleague at work due to COVID-19 (male, 30 years, health facility- and community-based)

"In [organization name], we have lost quite a number of colleagues. Because of this COVID restriction, the only thing you get is a message…it's not the same as someone who says, "Sorry, sorry" and pats your back. There is a human element missing. I feel one-on-one sessions, they are the best. When someone is next to you, you can debrief."
-Participant HCW reflects on the death of colleagues due to COVID-19 and the need for mental health support (male, 46 years, urban health facility-based)

What additional support do supervisors/managers recommend?

Appreciation for staff
Several supervisors were unaware of the mental well-being of the staff they supervise. They recommended that they should show more appreciation for their staff. They recognize that this can be improved because almost everyone was overburdened with trying to reach targets, that most supervisors did not take the time to appreciate their staff for their work performance.

Support for professional experiences to be shared
There were some who recognized that their staff needed mental health support. They knew that their staff were dealing with challenging cases in the community (clients affected by GBV, CLWH, clients with substance abuse problems), and needed a space to debrief and reflect on their work. They also suggested having debriefing sessions available for their staff so that they could share professional experiences about what has worked to help them in dealing with challenging cases in the community.

"Me being the type of manager I am, I'm the one who picks them up. I appreciate the effort they put in. I acknowledge when we face difficulties, when we're not feeling okay. It opens our minds to look for assistance. It's not rocket science."
-Participant supervisor reflects on the support managers can provide to staff (male, 30 years, urban health facility-based)

"I feel I'm not supporting them enough, because I also have my targets to reach. The staff who are working in the community would benefit from a psychologist, to see them once a month. It would take a load off my shoulders. I provide them with supervision support and the therapist would provide them with emotional support, that will help."
-Participant supervisor reflects on the type of support that could be offered to staff (female, 24 years, peri-urban health facility-based)

"They need mental health support…when I go to different hospitals, there will be news that three members got infected, they are all up in arms…there is this fear that they are going to get infected. You find there are so many hospitals and clinics that are closed, because they need to fumigate. Our staff need that psychological support, the fear is just too much. It's overwhelming."
-Participant supervisor shares his experience of what staff are going through and where he thinks they need support (male, 46 years, urban health facility-based)

"They need support in terms of counselling. Since they're working with the clients. I usually do one-on-one supervisions to check them, but it's not enough. They're feeling very stressed, although we are trying all means to assist them. Working with the community, checking beneficiaries [clients] is stressful."
-Participant supervisor reflects on what her staff have experienced and where she thinks they need support (female, 34 years, urban community and health facility-based)

CONCLUSION

The research revealed that HCWs had to deal with a wide range of emotions during the COVID-19 pandemic, including fear of getting infected with COVID-19 and guilt for not being able to provide clients with quality care. Coping strategies included prayer, exercising, social support, and entertainment. The study findings indicate that mental health support is available for HCWs, but there are barriers that undermine access. These barriers include inadequate knowledge about support services available (especially among health-facility and community-based HCWs) and about mental health as a whole. Culture and gender biases also undermine access to services. There is a need to foster an enabling environment for service uptake, with targeted interventions integrated into current programming. This includes incorporating discussions on topics such as mental health, types of mental health support, services available, culture and gender biases, and information about COVID-19 into staff orientation activities, training sessions, and meetings. Management and leadership have an important role to play: they can champion the cause of mental health and motivate their staff to access services available to them. Debriefing sessions where HCWs can share their experiences in dealing with clients under significant psychological distress is also recommended. HCWs in South Africa are dealing with the COVID-19 pandemic on top of the HIV/TB epidemics in the country. Therefore, it is of utmost importance that they are provided with the support they need to perform optimally under these circumstances.

ANNEXES

Annex I

USAID'S CONTRIBUTION TO SOUTH AFRICA'S COVID-19 RESPONSE

MARCH 2020 - MARCH 2021

STORY

HEALTH WORKER JOURNEY: LERATO

Lerato is a community health worker at Anova in Khayelitsha, Western Cape province.

CLIENT JOURNEY: PATRICK

Patrick is a 52-year-old taxi driver living with HIV in the City of Johannesburg.

*Lerato and Patrick's stories are illustrative

Anova provides Lerato with personal protective equipment (PPE) and training while she participates in the nationwide door-to-door COVID-19 screening campaign.	Lerato is featured in a community radio program telling the public how they can access HIV treatment while staying safe.	Lerato's health facility receives national guidelines to adjust client flow and seating to reduce possible COVID-19 transmission. Lerato screens clients for COVID-19 and HIV at the facility.	Lerato delivers HIV treatment to clients at home so they wouldn't have to come to the health facility.	Anova trains Lerato and her teammates in their home language so she can educate clients on hygiene to prevent COVID-19 transmission.	Lerato uses the eLabs app to access client COVID-19 results and phones those who test positive to tell them to quarantine and get medical help if needed.	Lerato's health facility receives help to ensure adequate stock of HIV medications, PPE, and other commodities.	Lerato submits her name to the Department of Health as part of the first phase of vaccine rollout. She is looking forward to getting it.
Patrick receives a visit from a community health worker in April, who told him how to prevent COVID-19 transmission and where to get help if he had any symptoms.	Patrick's taxi was branded with COVID-19 messaging encouraging mask-wearing and hand-washing. He follows guidelines on how many passengers he can safely transport.	Patrick is contacted by a local contact tracing call center telling him that his neighbor tested positive for COVID-19. He is encouraged to quarantine for two weeks and receives food assistance.	Patrick's uncle contracts COVID-19 and is admitted to a field hospital established by Right to Care. He becomes very ill and has to go on a ventilator donated by the U.S. Government.	Patrick's two children come home excited because their school has a new hand-washing station and they learned a fun song to sing when they wash their hands.	Patrick starts coughing and decides to go to his local health facility for a COVID-19 test. He tests negative, and receives his latest viral load result because the facility is using eLabs.	Patrick is eligible for multi-month dispensing because of his low viral load, and his facility has enough stock to give him three months of his HIV treatment.	Patrick receives educational materials informing him that he will be part of phase 2 vaccine rollout for people living with HIV.

KEY ACHIEVEMENTS

COMMUNITY SCREENING:
Support for the national screening campaign

- 5,000 CHWs trained and mobilized
- 14 districts across 7 provinces
- 14,000 mobile phones loaded with screening app

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT:
Communication on COVID-19 prevention, transmission, symptoms, and myths

- 19 million reached via radio, print, and social media
- 150,000 vulnerable children and families reached
- 8 million reached with messaging on staying safe in school

SURVEILLANCE AND RAPID RESPONSE:
Secondment of technical experts, preparedness planning, and case finding/contact tracing

- 16 COVID-19 readiness action plans developed for 104 hospitals
- Established a Gert Sibande district COVID-19 contact tracing call center

CASE MANAGEMENT:
Training health workers and provision of equipment and commodities

- 1,000 ventilators donated to 170 hospitals
- 24 tons of medical equipment and supplies
- Oxygen readiness assessments at 150 facilities
- Established 3,300-bed field hospital in East London

INFECTION PREVENTION AND CONTROL (IPC):
Facility readiness support and WASH in communities

- 15,000 medical staff trained in IPC
- More than 2,500 facilities supported with IPC
- 169 handwashing stations installed in communities, 121 schools, and 18 facilities
- 227,000 masks produced by a local cooperative

LABORATORY SYSTEMS:
Support for specimen transport and timely diagnostics

- Supported eLabs rollout at 579 health facilities

COORDINATION AND OPERATIONS:
National-level guidelines, supply chain support, and strategy planning

- 13 strategy documents on disaster medicine developed for NDoH
- Supported forecasting of national HIV, TB, and COVID-19 supply chain needs
- Developed a COVID-19 PPE availability dashboard, used by 2,400 facilities

GOING FORWARD:
Support for vaccine rollout

- Health financing and governance
- Service delivery
- Supply chain strengthening

USAID
FROM THE AMERICAN PEOPLE

Annex II. Human Research Ethics Approval from Stellenbosch University

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Notice

New Application

14/12/2020

Project ID :19296

HREC Reference No: N20/11/073_COVID-19

Project Title: Mental health of health workers in COVID

Dear Dr. Graeme Hoddinott

The **New Application** received on 25/11/2020 was reviewed and **approved** by members of **Health Research Ethics Committee** via **expedited** review procedures on 14/12/2020.

Please note the following information about your approved research protocol:

Protocol Approval Date: 14 December 2020

Protocol Expiry Date: 13 December 2021

Please remember to use your Project ID 19296 and Ethics Reference Number N20/11/073_COVID-19 on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Please note that for studies involving the use of questionnaires, the final copy should be uploaded on Infonetica.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/ProjectView/Index/19296

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Mrs. Melody Shana

Coordinator

HREC1

National Health Research Ethics Council (NHREC) Registration Number:

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1)•IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects;the South African Department of Health (2006). Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes andStructures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.

Annex III. Timeline of Research Activities

Activity	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021
Two consultation meetings with implementing partners (IPs) about the research protocol: 14 IPs (August 28, 2020) and 2 IPs (Anova and RTC) February 9, 2021												
HREC scoping review and report submitted (October 7, 2020)												
Research protocol draft finalized (Panagora and USAID review October 28, 2020)												
Academic institution partnership scoping review												
Request for proposal sent out to academic institutions (October 27, 2020), Technical Evaluation Committee grading (November 3, 2020), Selection memo reviewed by Head Office												
Supplies procured (laptops, signature pads, sanitizers, steel cabinets, audio recorder, NVivo license, stationary)												
Good Clinical Practice Level 2 course attended by six co-investigators (November 9–10, 2020)												
Contract with the Stellenbosch University signed (April 14, 2021)												
Submit research protocol to the Stellenbosch University HREC & obtain approval (submitted: November 25, 2020, approved: December 14, 2020)												
USAID sent out the formal communication to IPs to begin the research												
13 briefing sessions with IPs to explain the recruitment process (RTC, FHI 360, NACOSA GBV, HIVSA, Wits RHI, BR, Anova, Pact, and MatCH)												
Research protocol submitted & approved by City of Cape Town HREC (submitted: December 23, 2020, approved: February 17, 2021)												
Research protocol submitted to NHRD (January 29, 2021), approved: Eastern Cape (February 1), Free State & KZN (February 11), Western Cape (March 9), Gauteng (March 19), Mpumalanga (May 7), Limpopo (May 18)												
Researchers trained (8 sessions, 20 hours) (dates of training: December 14, 2020; January 29, 2021; February 12, 19 & 26, 2021; March 5, 12 & 19, 2021)												
Interview guide refined through mock interviews with Panagora Group team												
Data collection												
Data analysis												
Writing of findings												
Writing of Human Research Ethics Committee Reports												
Disseminate to stakeholders												
Writing of journal article												
Plan for next steps after the research, development of training & interventions												

Annex IV. Lessons Learned from Conducting Research During the COVID-19 Pandemic

This qualitative research was implemented virtually due to the COVID-19 pandemic. For this reason, standard procedures, such as the informed consent form and the in-depth interview, had to be adapted to a virtual environment. Despite the challenges brought by the virtual platform, the research was successful, the interviews took place online, during which participants shared openly about their mental health experiences, expressing a wide range of emotions during the interviews, as they would have done in a face-to-face setting. Some participants got quite emotional when they shared their mental health experiences during the COVID-19 pandemic. The lessons learned during the process of conducting a virtual research during the COVID-19 pandemic are presented here.

Researchers should be flexible about working under challenging conditions and be savvy about information technology to navigate the research's virtual interviews

Pre-COVID, participants would normally be interviewed face-to-face, especially for a qualitative research, where discussions are longer, and the researcher and participant engage in an open-ended conversation. Due to the COVID-19 pandemic, the process was adapted, whereby participants came to the IP's office to have the virtual interview with the researcher. The equipment was provided by Panagora Group had the software needed for the online interview and for the participant to complete the consent form. However, it was often the case that some participants were located too far away from the IP's office. They either used a work device at their site office or at their home, if they were working from home that day. In many situations, there were electricity outages and unstable internet connectivity. Rescheduling was not uncommon for these reasons. Sometimes only one part of the interview could be completed, and the second part had to be completed over the following days.

The online consent form itself presented challenges. It entailed the use of the Adobe Reader software; the researchers and participants needed to be comfortable with this software. We found that most health facility and community-based participants found it very challenging to navigate signing an online consent form. We encountered participants who did not know how to log onto a virtual meeting or did not know how to increase the volume on a laptop. Researchers had to be savvy about information technology (IT) to help troubleshoot IT challenges remotely with the participant, on the participant's work laptop, or on Panagora's research laptop that was sent to the IP's office.

Researchers needed to be well trained as interviewers and in first-line support for interviews that were emotional

A face-to-face setting makes it easier for the researcher to develop a rapport with a participant. It also facilitates the provision of first-line support. The virtual interviews required more attention from the researcher to fill the gap of the physical presence. As the researchers developed a bond with the participants, participants shared with a significant degree of honesty and vulnerability. Some participants were emotional during the interview and were provided with first-line support and referral to mental health support or social services support, as needed. During the follow-up calls, participants shared with researchers that the interview itself was a positive experience and gave them the chance to speak openly and freely about what they were experiencing.

Stakeholder engagement with the implementing partners is paramount

Exploring the mental health experiences of HCWs during a pandemic is a sensitive subject. It raises concerns about the impact of the interviews on the well-being of participants, that is, the HCWs employed by the IPs. It is advisable to have an open dialogue and engagement with IPs to explain the research protocol, and to listen to and address any concerns. This process may take some time; however, it is a critical part of the stakeholder engagement process during research. IPs need to support

the research for their HCWs to participate. IPs were concerned that the mental health of their staff would be affected during the conversations and about who would provide mental health support to their staff. We mitigated this by developing a Directory of Services (Annex IX) before that start of data collection. It lists existing mental health, GBV, substance abuse, and food shortage support for participants to access if they needed support after the call.

A local point of contact should be delegated as a liaison

The virtual interviews entailed comprehensive logistical support, that is, the shipment of equipment to the IPs' site offices and ensuring that the laptop was set up for every interviewee who came to the site office. A local POC from the IP was identified to help ensure that the laptop was turned on, the signature pad and the Wi-Fi dongle were connected, and to ensure the safe storage of the equipment and supplies. Having a local POC from the site office was critical for the interviews to take place in this virtual context. For the purpose of the research, the research team conducted briefing sessions with the local POCs, which proved to be a good strategy for them to fully engage with the logistics of the research and to support the implementation of the research on the ground because we could not be there in-person to conduct interviews. The briefing sessions allowed the local POC to ask questions about the research protocol and their role in the research implementation. The research team developed a close and collaborative working relationship with the local IPs' POCs. The day-to-day routine of virtual interviews can be unpredictable, including the frequent need to reschedule interviews due to challenges with electricity outages, internet connections, and equipment problems, which required a prompt response by the POC, in coordination with the research team. The added logistics due to the COVID-19 pandemic demanded time and attention from the IPs' POCs on the ground, bearing in mind that some of them were quite stretched due to regular work in the context of the pandemic.

Coordination efforts with different actors for a virtual research takes a considerable amount of time

Because the interviews could not happen in-person, the coordination of interviews led to the research team engaging with many different stakeholders to ensure that an interview could actually take place. The research team liaised with the IP's POC for the logistics of the interview and with the IP's IT staff member to ensure that the laptop was set up for the interview. The procurement team at Panagora was also involved in the logistics process. The research team coordinated with the procurement team for the delivery and collection of equipment and supplies that rotated among the IPs. Attention was required to ensure that procedures were appropriately followed to procure equipment and supplies; ship and collect equipment; and provide airtime to participants through a virtual platform. The research team was also responsible for ensuring that participants were followed up after the interview to check on their well-being. Table A1 describes the procedures put in place by Panagora Group to ensure that a virtual nationwide research could take place.

Table A1. Strategies put in place by Panagora Group to conduct virtual research during the COVID-19 pandemic

Standard research procedure pre-COVID-19	Adaptation of research procedures due to COVID-19
Consent forms would be done in person, with the researcher going through an informed consent procedure with the participant. After the participant agrees, the participant signs and the researcher signs.	The consent form had to be adapted to an online version. Panagora Group purchased signature pads (similar to signature pads at the bank), which allowed participants to sign electronically.
If a participant could not read or write, the researcher carried ink pads for participants to sign consent forms with their thumb print.	The signature pads that were purchased had the capability for a fingerprint scanner that would be used by participants who could not read or write.
A copy of the completed consent form was given in person to the participant.	We arranged for the consent forms to be emailed and/or sent to the participant's physical address.
In-person interviews	Virtual interviews occurred through virtual platforms, such as Zoom, Google Meet, and Microsoft Teams. Panagora Group shipped laptops to the participating IPs to be available for participants to use. A remote help desk application called AnyDesk was added to the laptops so that researchers could help participants navigate logging onto the virtual interview and to sign the consent form. Panagora Group also purchased a Wi-Fi dongle and had to ensure that data were available for internet access for the virtual interviews. The equipment was also insured by Panagora Group and the insurance company had to be updated every time the equipment moved from one location to the next.
Audio recording of interviews	Virtual video and audio recordings were done.
For this research, we provided participants with R 150 of airtime. If this were an in-person interview, R 150 airtime cards would have been provided to participants in person.	In the virtual setting, we collected the participants' mobile numbers and names of their mobile providers. The Panagora Group procurement team purchased individual airtime for each participant.
Research packet given to participants in person.	The research packets, which consisted of the participant information leaflet, consent form, a notepad, pen, and PPE (mask and hand sanitizer), were shipped ahead of time to each of the IP site offices to which participants came for the interview.

A qualitative research study exploring the mental health experiences and the support services needed of frontline healthcare workers during the COVID-19 pandemic in seven high-burden HIV and TB provinces in South Africa

FAQs

1. What is the objective of the study?

The aim of the qualitative study is to explore and assess the mental health experiences of frontline healthcare workers employed by participating USAID-funded implementing partners serving in the COVID-19 pandemic in seven high HIV and TB burden provinces in South Africa. The secondary objective is to explore what support services are needed by frontline healthcare workers to cope with the COVID-19 pandemic. To this end, in depth-interviews will be conducted.

2. What is mental health?

Mental health is a dynamic concept. The World Health Organization defines it as a state of physical, mental, and social well-being and not merely the absence of disease or infirmity, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.

3. Why conduct a study if frontline healthcare workers' psychological distress and the need for mental health care support have already been established?

Understanding the psychological distress of frontline healthcare workers during the COVID-19 pandemic can help with understanding their needs. A number of studies conducted during the COVID-19 pandemic have highlighted the importance of consulting them to inform the development of an appropriate and relevant set of interventions. In cases where this consultation and engagement did not take place, some frontline healthcare workers have demonstrated low adherence to psychological interventions put in place in health facilities.

4. Who is going to be interviewed?

In order to minimize service disruptions, only frontline healthcare workers employed through non-governmental organizations that have a cooperative agreement with USAID/PEPFAR to provide direct service delivery within healthcare facilities and communities will be interviewed. The findings of the study will be generalizable to other frontline healthcare workers, including those from the National Department of Health.

Participants will include frontline healthcare workers from the 15 USAID-supported districts: City of Cape Town, City of Johannesburg, Buffalo City, Alfred Nzo, Ugu, Harry Gwala, Thabo Mofutsanyana, King Cetshwayo, Lejweleputswa, Sedibeng, Gert Sibande, Nkangala, Capricorn, Mopani and Ehlanzeni. These districts are in the following provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, and the Western Cape.

Participants will include individuals from the following cadres: 1) linkage officers, 2) administration clerks, 3) nurses, 4) doctors, 5) data capturers, 6) orphans and vulnerable children officers, 7) group

facilitators, 8) care workers for children/youth, 9) mentors, and 10) lay counsellors.

5. Some frontline workers might be hesitant to share such intimate experiences. How will researchers deal with this issue?

The interview process will ensure confidentiality and privacy throughout. Interviews should take place in a space without interruptions, where participants can speak freely. To this end, interview times and locations will be arranged with participants, provided managers are informed. Individual data will not be shared with managers, colleagues, or other parties. Only aggregate data will be shared for the purpose of the study.

6. Who will conduct the study?

The study will be conducted by Panagora Group and the University of Stellenbosch. The study received Human Research Ethics Committee (HREC) approval on December 14, 2020. HREC approvals are being obtained from provincial departments on a rolling basis. As HRECs are obtained, participant recruitment will commence in that province. As of March 1, 2021 approvals are available for Eastern Cape, Free State, KwaZulu Natal and City of Cape Town.

7. How will participants be recruited?

First and foremost, participation from your frontline healthcare worker staff is voluntary. If they accept to be interviewed, we would ask them to come to your offices for a virtual call with the research team. The recruitment will entail the following steps:

1. Your organization chooses a Point of Contact (POC) and shares this **Frequently Asked Questions (FAQs) document** about the study.
2. Panagora's POC will engage with your POC to:
    a. coordinate with your POC to use a safe and private space in your offices for the virtual interviews to take place.
    b. understand which wellness services your organization offers and that you would like the study team to reinforce after the interviews.
    c. coordinate voluntary recruitment of study participants from your frontline healthcare worker staff pool.
3. Panagora's POC will ship to your organization's POC a loan laptop for participants to use during the virtual interview, as well as a small steel cabinet for storing the laptop when not in use.
4. The POC shares the communication about the study with target participants, along with a Recruitment Form (in Google Form) for potential participants to fill out their contact details if they are interested in participating in the study.
5. Once the google form is completed by a participant, a member of the research team will follow-up via phone or email with the potential participant to explain the study.
6. If the potential participant is interested in the study, then a day and time for the interview will be scheduled.
7. The research team will inform the POC on a weekly basis on the number of participants who expressed interest and to coordinate the day and time that the participant will come to the offices to be interviewed.
8. Two trained researchers will conduct the interviews via Zoom (one who will be conducting the interview and one who will be observing and writing the case description).
9. Recruitment of participants will stop when data saturation has occurred and no new content emerges.

10. Panagora's POC will coordinate collection of the laptop and steel cabinet when saturation has been reached.

8. Why will in-depth interviews be employed?

In-depth interviews provide a participatory and flexible approach that contextualize a participant's experiences and perceptions. Participants are more likely to share sensitive information once they have formed a rapport with the researcher and a space of trust has been established.

9. How will the interview be conducted?

If a participant requires a translator for the interview, this will be arranged (this information is acquired through the Recruitment Form). Before beginning the interview, the participant will go through an informed consent procedure on the virtual call and sign an electronic consent form online. The researcher will ask if the participant would like his/her consent form sent electronically via email or if a copy should be sent to his/her physical address. Participants will receive a study packet with the Participant Information Leaflet and Consent Form, a directory of mental health and social services, and a notepad and pen to write down notes.

10. Can the interview be self-administered?

No. The qualitative study involves an in-depth interview process guided by trained researchers to get a deeper understanding of the experiences of healthcare workers. In addition, it is crucial to have a controlled environment to ensure that the consent procedure can take place with the participant's signature and researcher's signature and a safe space is available for the interview to be conducted.

11. What topics will be included in the interview?

General demographics: personal data and job details.
Personal experience during the COVID-19 pandemic: the impact of the pandemic on the work, family, and personal life of the participants.
Managing psychological distress: what coping mechanisms frontline workers use and how effective they are considered to be, as well as to what extent they are making use of existing support services provided by implementing partners.
Recommendations for services: given their experience, what recommendations they have for support services and how information on services should be disseminated.

12. How will researchers deal with the potential for the interviews to trigger difficult feelings among participants, such as anxiety?

Researchers are trained on first line support: they will be able to hold participants' space and contain negative feelings. Participants can stop the interview at any time and withdraw from the study with no consequences, which will be explained as part of the informed consent process.

13. What happens after the interview?

Once the interview is finished, the researcher will refer the participant to employee wellness services available to your staff by your organization. Additionally he/she will be provided with a list of available services for mental health support outside their organization (free of charge), which will also include social services support is needed for social challenges, for example, such as Gender-Based Violence,

alcohol abuse and drug abuse. This list of mental health and social services, with contact details, will be part of a participant research pack which will be provided to each individual via email. Participants will be provided R150 in airtime to be able to reach out to seek support as needed, but will not be provided with money for counselling sessions (this amount is standardized with other studies taking place in the area).

Participant interviews will take place from March through to May 2021, with concurrent data analysis as interviews are completed. Study data will be used to identify findings and recommendations for implementing partners and USAID, which will likely be available in July 2021 and shared with implementing partners and participants virtually.

14. How much time will the interview take as IPs have programmatic targets to meet and we need our staff to reach them?

Interviews will take between 1 to 1.5 hours. The research team will coordinate with the participant for interview times that have the least impact on their work and managers will be informed by the research team.

15. Is it possible to maintain mental health in the context of the COVID-19 pandemic?

In the context of the COVID-19 pandemic, mental health is associated with a person's capability to cope with increasing stressors, to display healthy behavior, and to perform roles in communities and families. It does not mean the absence of psychological distress. Developing resilience is crucial, as is the ability to adapt to an adverse event and develop new ways of coping.

16. Frontline healthcare workers already have built-in resilience to perform their job. Why are they more affected by the COVID-19 pandemic?

Frontline healthcare workers worldwide have been more affected by mental health issues, as they have increased workloads, higher exposure to the COVID-19 virus, witness deaths and extreme suffering, experience stigmatization, and face difficult moral decisions ("moral injury"). In addition, frontline healthcare workers are dealing with the impact of the pandemic on their own family members. Against this backdrop, they are expected to perform at work with limited support.

17. Why is it important to tackle the issue of mental health among frontline healthcare workers?

Frontline healthcare workers ongoing psychological distress can severely undermine decision-making and well-being, and may lead to severe conditions in the future. If not dealt with properly, it can leave psychological damage.

The Technical Support Services (TSS) Activity assists USAID/South Africa's Health Office to problem-solve technical priorities and develop creative, innovative solutions to strategically allocate resources, strengthen connections with partners, and replicate best practices and efficient models.	**Panagora Group Contact:**	
	United States Jasmine Buttolph | Global Health Director Panagora Group 8601 Georgia Avenue, Suite 905 Silver Spring, MD 20910 United States E: jasminebuttolph@panagoragroup.net	**South Africa** Katie Reichert | Chief of Party USAID/South Africa Contractor Technical Support Services Activity Walker Creek Office Building, 90 Florence Ribeiro Ave, Pretoria, 0181 South Africa E: kreichert@panagorasouthafrica.net M: +27 (0) 64 074 8712

This document was produced for review by the United States Agency for International Development. It was prepared by Panagora Group for the USAID/South Africa Technical Support Services (TSS) Activity, Contract No. 72067419C00001, and therefore uses USAID branding as outlined in the TSS Branding and Marking Plan.

Annex VI. Recruitment Form for the Mental Health Research

Information about this annex: The content below was captured on a Google Form and used as the recruitment form for the research.

Recruitment Intake Form

Please provide us with your details so we can contact you to set up the interview. Thank you.

* Required

1. What is your name and surname? *

2. What is your email address? *

3. What is your phone number? (please list all of them if more than one) *

4. Which organization do you work for? *

4a. ANOVA
4b. BroadReach
4c. Centre for Communication Impact (CCI)
4d. Education Development Center (EDC)
4e. FHI 360
4f. HIVSA
4g. MatCH
4h. Mothers2mothers
4i. NACOSA
4j. PACT
4k. Right to Care
4l. WRHI
Other:

5. Which district do you work in? *

5a. City of Cape Town
5b. City of Johannesburg
5c. Buffalo City
5d. Alfred Nzo
5e. Ugu
5f. Harry Gwala
5g. Thabo Mofutsanyane
5h. King Cetshwayo
5i. Lejweleputswa
5j. Sedibeng
5k. Gert Sibande
5l. Nkangala
5m. Capricorn
5n. Ehlanzeni
Other:

6. What is your job title? *

6a. Linkage officer
6b. Administration clerk
6c. Nurse
6d. Doctor
6e. Data capturer
6f. Orphans and vulnerable children officer
6h. Group facilitator
6i. Care worker for children/youth
6j. Mentor
6k. Lay counselor
Other:

7. Would you be comfortable having the conversation conducted in English?

Yes
No

8. Please specify the language if you are not comfortable with English

Your answer

9. The interview will probably take up to 2 hours. It will be done via Zoom. How comfortable are you with this platform? (Wi-Fi connectivity will be arranged by Panagora Group).

I know how to use it.
I am not comfortable with it; I would need help for the interview.

10. What are the best days and times to contact you? *

Annex VII. Interview Guide for the Mental Health Research

Semi-structured, in-depth interview guide to be used by researchers with HCWs in the Mental Health Research

After introducing yourself and Panagora Group, explain the interview guide's content and purpose:

We know that being a HCW is not easy right now. We want to find out more about what you are experiencing, what resources you are currently using and finding useful, and what gaps in support exist from your perspective. We expect that the interviews with participants will take place from February through June 2021. Simultaneously, we will be conducting data analysis on the data that come in. The data from the interviews will be analyzed for findings and recommendations to be shared with implementing partners and USAID. We expect that we will have the findings and recommendations available in August 2021. We will disseminate them to IPs, USAID, and HCWs. This process will most likely take place through a virtual platform, such as Zoom. We want you to know that your participation is voluntary and that you can stop the interview at any point. First, we want to know a bit of basic background information about you.

1. District where you work?
2. Is the area where you work considered urban, peri-urban, or rural?
3. Is your primary place of work:
   a. Health facility
   b. Community
   c. Above site (i.e., roving around health facilities and/or community settings)
4. What is your date of birth?
5. Please tell us a bit about yourself. How did you begin this line of work?
6. What is your current job title and your role in this position?
7. How many years have you been at this position?
8. Are you employed with [IP] as a part-time or full-time employee?

Thank you. We are now going to start the main discussion. We would like to stop being the one talking and give you space to share your experiences. We are not here to judge, and we are happy to hear the "bad" and the "good." To remind you, we will keep your story confidential by reporting it anonymously. Do you have any questions before we begin?

Section A: Personal Experience During COVID-19 Pandemic

9. How has the COVID-19 pandemic affected the work you are doing on the HIV/TB epidemic in South Africa? *[Note to interviewer: HCWs are already under-resourced in the context of the HIV/TB epidemic. Probe to see how this has affected the quality of care they provide to their clients.]*
10. When the HIV/TB epidemic initially began and was at its peak, what experiences did you feel and how does that compare with the COVID-19 pandemic? How do you think South Africa has learned from the HIV/TB epidemic in responding to the COVID-19 pandemic?
11. What are the services that your health facility is providing for COVID-19 clients in the facility and in the community?
12. Tell me about the changes COVID-19 has caused to your workload and routines. Has there been any task shifting or any shift in your relationships with clients?
13. How were you informed about COVID-19 by your employer?
14. Can you describe the PPE you are using?
    a. How do you feel about the PPE you are using?

b. Can you please tell us about the training you were given with regard to PPE? What are your thoughts about the PPE training that was provided to you?

15. Tell us about the changes that COVID-19 has caused to your daily routines, your family, social relationships, etc.
16. Have you or anyone you know been infected with COVID-19? What can you tell us about the experience? [*Prompt for: what was the interviewee's reaction?*]
17. Can you tell us about how you feel when you think about getting infected (or reinfected) with COVID-19?
18. Do you worry about infecting your family with COVID-19? Can you tell us more about how you feel?
19. When you think about COVID-19, what makes you more anxious? (*Prompt: understand factors that prompt psychological distress.*)
20. Can you please share with us how you have been feeling over the past 2 weeks? [*Do not prompt. Let them talk first, unpack feelings*.]
21. How did your feelings change over the phases of the pandemic?

[Note to the interviewer: At this point, pause and ask the interviewee how he/she is doing, remind the interviewee that he/she can stop the interview at any point.]

Section B: Managing psychological distress

22. What are some ways you have been coping with the feelings brought on by the pandemic? [*Prompt: explore coping mechanisms, such as self-care, friends, church, family, without suggesting any.*]
23. In a given week, how much time (if any) do you devote to self-care? By self-care, we mean time to take care of your well-being. Tell me more about it.
24. Are you aware of any support in your organization or outside your organization with medical schemes or programs that are a part of the Department of Health? Who provides the support? [*Prompt for peer support at work, wellness programs, hotlines, group therapy, etc.*]
25. Have you accessed any of the support? If so, how did you initiate accessing the support?
26. If you are already using support, have it been helpful?
27. If you did not access support provided by your employer, can you please explain the reasons why you did not access the support?
28. What are your personal views about mental health and "seeking help" to support you? Do you only see "seeking help" when there are moments of crisis, or do you see seeking help as a continuous method of care and support to function?
29. What have you been taught about the topic of "mental health?" As a professional, what have you been taught about the topic of "mental health?"

Section C: Recommendations

30. Do you feel you need additional support to deal with your daily life now? [*If s/he does not, explore the reasons why.*]
31. If yes, what kind of additional support do you need? [*Do not prompt. Let her/him talk first, s/he may mention training, debriefing sessions, restructuring of services, peer support, psychological support (hotline, online psychologist, online group therapy, onsite counseling), shelter, food, childcare support, caregiving support.]*
32. If information about the availability of support were to be made available to you through a directory of services, what would be your preference in terms of channels of communicating it to you and your peers where you work? [*Prompt: IP intranet, posters in staff areas, SMS, WhatsApp, radio, not interested.*]

33. What barriers could prevent HCWs from accessing support? [*Prompt for: distance; cost of services; schedule conflict with work; not available in local language; not properly explained/not perceived as effective; bad reputation; cultural stigma; stigma associated with mental health.*]
34. Once the pandemic is over, what permanent changes would you like to see in place with regard to support to HCWs?

Thank the participant for the work that they have been doing, express appreciation for their contributions, and explain the support available and how they can access it. Ask if it would be okay for the interviewer to contact him/her again in a few days to see how they are doing and to offer help with accessing support if s/he has not yet done so. [*Interviewer to be aware that in this section, the participant may share that s/he has not been able to talk to anyone about this and may thank you for your time. Please take note of this as well.*]

Section H: Additional questions for supervisors of HCWs

1. How many people and what cadres do you supervise?
2. How do you perceive the well-being of the staff you supervise to be now? Has it changed over the phases of the pandemic?
3. In your opinion, what are the main challenges staff are facing and the kind of support that staff need?
4. How would you like to support your staff?
5. What are the challenges you face in supporting your staff?
6. What would you need to support your staff?
7. Once the pandemic is over, what permanent changes would you like to see in place with regard to support to HCWs?

Thank the participant for the work that they have been doing, express appreciation for their contributions, and explain the support available and how they can access it. Ask if it would be okay for the interviewer to contact him/her again in a few days to see how s/he is doing and to offer help with accessing the support if s/he has not yet done so.

Annex VIII. Case Description Form for the Mental Health Research

Information about this annex: The content below was used as the case description form. For the purposes of this report, we have made the boxes smaller; however, in the actual case description form, the boxes are larger, and researchers can use as many pages as needed.

Participant Research Code: _____

Research Assistant Full Name: _____

Date of Interview: _____

[For the interviewer: write down what the participant says in the box and/or additional boxes provided after the questions]

Background

1. District where you work?
2. Is the area where you work considered urban, peri-urban, or rural?
3. Is your primary place of work: a. Health facility b. Community c. Above site (i.e., roving around health facilities and/or community settings)
4. A standard question: is your sex at birth female or male?
5. What is your date of birth?
6. Please tell us a bit about yourself. How did you begin this line of work?
7. What is your current job title and your role in this position?
8. For how many years have you been at this position?
9. Are you employed with [IP] as a part time or full-time employee?

Section A: Personal Experience During COVID-19 Pandemic

Section B: Managing Psychological Distress

Section C: Recommendations

Section D: Additional Questions for Supervisors of HCWs

Interpretation and Thoughts of the Researcher

MENTAL HEALTH STUDY PROTOCOL

DIRECTORY OF SERVICES

What is MENTAL HEALTH and How Can I Get Help?

Mental health is a dynamic concept. Mental health is an integral and essential component of health. The World Health Organization (WHO) constitution states, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living, and enjoy life. On this basis, the promotion, protection, and restoration of mental health can be regarded as a vital concern of individuals, communities, and societies throughout the world.

Key Facts about Mental Health

- Mental health is more than the absence of mental disorders.
- Mental health is an integral part of health; indeed, there is no health without mental health.
- Mental health is determined by a range of socioeconomic, biological, and environmental factors.
- Cost-effective public health and intersectoral strategies and interventions exist to promote, protect, and restore mental health[1]

In the context of the COVID-19 pandemic, mental health is associated with a person's capability to cope with increasing stressors, to display healthy behavior, and to perform roles in communities and families. It does not mean the absence of psychological distress. Developing resilience is crucial, as is the ability to adapt to an adverse event and develop new ways of coping.

Frontline healthcare workers worldwide have been more affected by mental health issues such as irritation, anger, anxiety, helplessness, lack of motivation, tiredness, burnout, depression, trouble sleeping, and trouble concentrating. They have been experiencing increased workloads, higher exposure to the COVID-19 virus, witnessing deaths and extreme suffering, stigmatization, and difficult moral decisions ("moral injury"). In addition, frontline healthcare workers are dealing with the impact of the pandemic on their own family members. Against this backdrop, they are expected to perform at work with limited support.

Ongoing psychological distress can severely undermine frontline healthcare workers' decision-making and well-being, and may lead to severe conditions in the future. If not dealt with properly, it can leave psychological damage.[2]

[1] Source: WHO: World Health Organization. 2018. Mental Health: Strengthening Our Response. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

[2] Source: United Nations. (May 13, 2020). *Policy Brief COVID-19 and the Need for Action on Mental Health.* https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf

Against this backdrop, a number of organizations in South Africa are offering support services that can benefit frontline healthcare workers.[3] The services vary in content and format, as well as the type of professional who provides the service. Some services are geared towards healthcare workers, such as the Healthcare Workers Care Network, Pedriatric Adolescent Treatment Africa (PATA), and EMGuidance. Others are directed to the general public, such as the South African Depression and Anxiety Group (SADAG) and Lifeline Johannesburg.

EMGuidance (EMG)

A mobile and web-based medicines and treatment platform for medical professionals.

Available Services:	Knowledge basis and referral to the Healthcare Workers Care Network. The healthcare provider creates an account over the website. After EMGuidance checks his/her credentials, the person is granted access to the platform. EMG provides services for healthcare professionals registered with the Health Professions Council of South Africa (HPCSA), the South African Nursing Council (SANC), or SAPA.
Delivery Method:	EMG provides information with regards to medicine for healthcare workers. It has opened a channel dedicated to COVID related to personal protective equipment (PPE), vaccines, pharmacology updates, articles on mental health. It has developed two surveys on mental health.
Beneficiaries:	Doctors, nurses, pharmacists, and allied workers.
Languages:	English
Cost:	Free
Contact: https://emguidance.com/	

Healthcare Workers Care Network

A multidisciplinary team offering mental health support to healthcare workers in South Africa. The Network is supported by the South African Medical Association (SAMA), the South African Depression and Anxiety Group (SADAG), the South African Society of Psychiatrists (SASOP), the South African Society of Anaesthetists (SASA), and the Psychological Society of South Africa (PsySSA).

[3] Panagora contacted the services listed under mental health between January 11 and February 15, 2021, to verify the status of resources available. Please note that resources should be checked on a regular basis to ensure accessibility.

Available Services:	General mental health. The HWCN provides healthcare workers with four counseling sessions and crisis intervention due to the COVID-19 pandemic.
Service Providers:	Psychologists, psychiatrists, and counselors.
Delivery Method:	Helpline and individual sessions.
Beneficiaries:	Any health facility staff, including porters and cleaning staff.
Languages:	English, isiZulu, Sesotho.
Cost:	Free

Contact: https://www.healthcareworkerscarenetwork.org.za/
Individual sessions: https://www.healthcareworkerscarenetwork.org.za/online-form
Helpline: 0800 21 21 21 / SMS: 43001

LifeLine Johannesburg

Part of a family of 17 centers countrywide, all operating autonomously in response to local need. LifeLine provides counseling and connects people with the tools they need to better handle stress and improve their emotional health.

Available Services:	General mental health counseling and crisis intervention.
Service Providers:	Lay counselors.
Delivery Method:	Helpline, WhatsApp, and individual sessions (services all currently virtual).
Beneficiaries:	LifeLife serves the general population, but healthcare workers also benefit.
Languages:	All official languages.
Schedule:	Crisis line: 24/7. Counseling sessions are booked during working hours.
Cost:	Free

Contact: www.lifelinejhb.org.za
Social media: Facebook and Twitter[4]
24/7 telephone counseling: 011 728 1347 / 0861 322 322
WhatsApp (virtual booking): 065 989 9238
Tel (Office): 011 728 1331; (Soweto): 067 091 0845 / 074 129 6960; (Alexandra): 011 443 355

[4] LifeLine Johannesburg Facebook: https://www.facebook.com/LifeLine.Johannesburg/ and Twitter: https://twitter.com/lifelinejhb

Pedriatic Adolescent Treatment Africa (PATA)

An action network of health providers and facilities in sub-Saharan Africa, PATA offers a collaboration, capacity building, and peer-to-peer exchange platform to close gaps and build bridges of linking, learning, and partnership in the pediatric-adolescent HIV response.

Available Services:	PATA provides capacity building, linking and learning, and resource development. PATA has an action plan to support healthcare workers during the COVID-19 pandemic, providing COVID-19 resources, surveys, a platform for messages of support, and debriefing sessions. The debriefing platform is temporarily unavailable (pending funding). Healthcare workers can also access existing training toolkits (not COVID-19 specific). An emergency response fund is available for health facilities and community-based organizations to ensure uninterrupted HIV and SRHR service provision. Online training can only be accessed by being engaged in a specific PATA program. Toolkits are available for anyone to use.
Languages:	English
Cost:	Free
Contact:	http://teampata.org/

The South African Anxiety and Depression Group (SADAG)

A national NGO that provides a support mental network to the general population.

Available Services:	SADAG's main service is the call center/helpline, where counselors are trained to provide first line of support, develop an action plan, and refer to service providers, including psychologists, psychiatrists, and substance abuse. SADAG relies on a comprehensive referral system, both private and public. It also has nearly 200 support groups, led by patients for patients.
Service Providers:	Lay counselors.
Delivery Method:	Helpline and support groups (currently online due to the pandemic).
Beneficiaries:	SADAG serves the general population, but healthcare workers also benefit. SADAG has support groups for people with depression and anxiety.
Languages:	All official languages.
Schedule:	Helpline: 24/7

Cost:	Free

Contact:
Dr Reddy's Help Line: 0800 212 223
Cipla 24hr Mental Health Helpline: 0800 456 789
Cipla WhatsApp Chat Line: 076 882 2775
Pharmadynamics Police & Trauma Line: 0800 205 026
Adcock Ingram Depression & Anxiety Helpline: 0800 708 090
ADHD Helpline: 0800 554 433
DSD Substance Abuse 24hr Helpline: 0800 121 314 / (SMS): 32312
Suicide Crisis Line: 0800 567 567
SADAG Mental Health Line: 011 234 48 7
Akeso 24hr Psychiatric Response Unit: 086 143 5787

What is GENDER-BASED VIOLENCE and How Can I Get Help?

The United Nations defines violence against women as "any act of gender-based violence (GBV) that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Intimate partner violence refers to behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors.

Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object."[5]

Organizations that Offer Assistance to Victims of Violence[6]

South African Police Service

In a case of domestic violence or sexual assault, the South African Police Service will help the victim to find medical attention, shelter, and victim counseling.

SAPS Emergency Number: 10111

[5] Source: https://www.who.int/health-topics/violence-against-women#tab=tab_1
[6] Source: Services listed under the GBV section were found in the website below. Panagora populated their respective information as it is reflected on each organisation's website. https://www.gov.za/faq/justice-and-crime-prevention/where-can-i-find-organisation-offers-assistance-victims-violence?gclid=Cj0KCQjwrsGCBhD1ARIsALILBYqfC0ABa7J-MlXyrVuZXvIF6f8EOvdvGbEONKjhMywznn4dOyombPoaAvUsEALw_wcB#

People Opposed to Woman Abuse (POWA)

A feminist, women's rights organization that provides both services, and engages in advocacy in order to ensure the realization of women's rights and thereby improve women's quality of life.

Available Services:	Shelter services for clients (and their children where relevant) who have been the victims of GBV. These services are located in the East and West Rand, and a "second stage" house is located in Berea. POWA also provides several forms of counseling to clients (including shelter clients), such as face-to-face counseling, support groups (facilitated by a social worker), and telephone counseling and referrals. The Legal and Advocacy Department at POWA also assists women (approximately 50 per month) with telephonic and face-to-face-legal advice to women, court preparation and support, and referral to other professionals and practitioners (pro bono).
Service Providers:	Lay counselors
Delivery Method:	Women can access our counselling through our branch offices. We currently have six satellite offices and two confidential shelters. Our offices are strategically located in areas for women from economically disadvantaged communities and women from the Johannesburg inner city for easy-to-access services.
Beneficiaries:	Women who have experienced violence.
Schedule:	Counselor is available Monday to Sunday, 8:30 am to 16:30 pm

Contact: http://www.powa.co.za
Tel: 011 642 4345/6 / (Lockdown counseling number): 076 694 5911
Email: itumeleng@powa.co.za
Social media: Facebook and Twitter[7]

Tears Foundation

A women-led organization that provides support, regardless of ethnicity, religion, culture, or socioeconomic background or location. TEARS Foundation provides assistance nationwide with a 24-hour free SMS service to anyone who has access to a cellphone.

Available Services:	The service identifies the closest center to the victim and links or connects victims to facilities that offer the following services: • Individual/group/couples counseling

[7] POWA Facebook: https://www.facebook.com/powa.berea/ and Twitter: https://twitter.com/POWA_SA

	• Support groups • Volunteer opportunities • Link victims to emergency shelters • Refer rape victims to medical facilities for medical attention • Follow up with police on behalf of victims with case numbers • Provide victims with advice on how to apply for a protection order • Refer child victims to child-friendly facilities • Guide women and men on how to leave abusive relationships The Foundation refers male victims to the Moshate Men's Rights Organization (Mashilo, tel: 082 397 7873, email: mashilo@moshomong.co.za)
Service Providers:	Lay counselors
Delivery Method:	Referrals
Beneficiaries:	Men and women who have experienced violence.
Contact: http://www.tears.co.za/ Tel: 010 590 5920 / Free SMS helpline: *134*7355# Email: info@tears.co.za Social media: Facebook and Twitter[8]	

Thuthuzela Care Centers

One-stop facilities that serve as a critical part of South Africa's anti-rape strategy, TCCs reduce secondary victimization and build a case ready for successful prosecution.

Available Services:	TCCs are designated emergency forensic and medical service centers available to survivors in the 72 hours immediately after a rape occurs. They are based at 54 hospitals across South Africa.
Beneficiaries:	Survivors of rape
Contact: https://rapecrisis.org.za/what-is-a-thuthuzela-care-centre/	

[8] Tears Foundation Facebook: https://www.facebook.com/TearsFoundationSA and Twitter: https://twitter.com/Tears_SA

What is SUBSTANCE ABUSE and How Can I Get Help?

Substance abuse means someone who uses drugs or alcohol to excess. Substance abuse causes great emotional stress and suffering. It can lead to unemployment, family alienation, and criminalization. Drug users are at risk of developing depression or becoming suicidal. Drug users spend a lot of time, money, or energy on drugs. This cycle can be changed at any time. There is help available:

Alcoholics Anonymous

Alcoholics Anonymous (AA) is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, multiracial, apolitical, and available almost everywhere. There are no age or education requirements.

Available Services:	AA meetings consist of nonprofessional men and women, not professionals such as counselors or psychologists. The meetings are not religiously based; they welcome members of all religions, agnostics and atheists alike. There are no restrictions, people can come and go as they please and there are no sign-up or subscription fees.
Beneficiaries:	Anyone with a drinking problem.

Contact: https://aasouthafrica.org.za/
Helpline: 0861 43 57 22

Al-Anon GSO South Africa

Al-Anon is a mutual support group to help families and friends of alcoholics.

Available Services:	Al-Anon Family Groups is a spiritual fellowship, not a religious one, where members share their own experience. Meetings are conducted on a walk-in basis.
Beneficiaries:	Adults, teens, and children who have been affected by someone else's alcoholism.

Contact: https://www.alanon.org.za/
Helpline: 0861 25 26 66

Narcotics Anonymous South Africa

Narcotics Anonymous (NA) is a free, non-profit fellowship of people for whom drugs have become a major problem. NA's program is open to addicts of all ages, nationalities, cultures, creed, gender identity, and religions. Services available in Johannesburg, Pretoria, Eastern Cape, and KwaZulu-Natal.

Available Services:	Most members are recovering addicts who meet on a regular basis throughout South Africa to prevent each other from relapse. They focus on the disease of addiction rather than drugs themselves. Meetings are open to all genders, races, creeds, or religions.
Beneficiaries:	Drug addicts who have a desire to stop using.

Contact: https://na.org.za/
Tel: 011 509 0031 / 083 900 6962

The South African Anxiety and Depression Group (SADAG)

SADAG is a well-established national NGO whose aim is to provide the population with a support mental network.

Available Services:	SADAG offers support with regards to substance abuse in the form of a helpline or counselling.
Beneficiaries:	Drug users and friends/family
Schedule:	Counselor available Monday to Sunday, 8:00-20:00; helpline open 24/7.

Contact: https://www.sadag.org/
Helpline: 0800 12 13 14 / (SMS): 32312
Email (counseling): zane@sadag.org

SANCA

SANCA is a nongovernmental organization that seeks to prevent and treat alcohol and drug dependence.

Available Services:	Highly effective primary and secondary prevention services, as well as comprehensive treatment programs, including Ukwelasha (isiZulu for "treatment"): a comprehensive SANCA treatment model; and the "Change or Be Changed" and "Key to Life" comprehensive group work programs.

	Aftercare is the most important part of treatment.
Delivery Method:	Community development programs are implemented in urban, semi-urban and rural areas using the Community Anti-Drug Coalitions of America (CADCA) strategy. SANCA regularly engages with different universities forming part of the research being conducted at these institutions throughout the country.
Beneficiaries:	Chemically dependent people and their families.
Contact: https://www.sancanational.info/ Contacts: https://www.sancanational.info/contact SANCA centers: https://www.saferspaces.org.za/uploads/files/SANCA_Contact_List.pdf	

What is FOOD SHORTAGE and How Can I Get Help?

South Africa's deteriorating food security is mainly driven by the COVID-19 pandemic and mitigation measures, as well as high food prices, drought, and economic decline.[9] The South African Social Security Agency (SASSA) and Siyabonga Africa provide benefits for those in dire need[10].

Social Relief of Distress Food Parcels

The South African Social Security Agency (SASSA) has been providing special COVID-19 Social Relief of Distress (SRD) grants.

Republic of South Africa

Available Services:	SASSA will issue SRD in the form of food parcels as temporary assistance for persons who are unable to meet their or their families' most basic needs. Beneficiaries may electronically submit an application for social relief of distress or a social grant over and above any other available means of lodging such applications.
Beneficiaries:	SRD is paid to South African citizens, permanent residents or refugees who have insufficient means, including people: ● Receiving temporary disability grants that lapsed in March 2020 ● Experienced disasters in their communities, such as floods and fires, as defined in the Disaster Management Act of 1978 ● If a family breadwinner died within the last 12 months

[9] Source: https://reliefweb.int/report/south-africa/south-africa-ipc-acute-food-insecurity-analysis-september-2020-march-2021-issued#:~:text=South%20Africa's%20deteriorating%20food%20security,IPC%20Phase%203%20or%20above

[10] Source: Services listed under the food shortage section were found as a result of internet research. Panagora populated their respective information as it is reflected on each organization's website.

	• If everyone in a household is unemployed and needs government assistance in the form of food parcels • Child-headed household • Cannot work for medical reasons for a period of six months
Schedule:	Call center available during working hours.
Contact: https://www.gov.za/covid-19/individuals-and-households/social-grants-coronavirus-covid-19 Tel: 0800 60 10 11 WhatsApp: 0600 12 34 56, select SASSA.	

Siyabonga Africa

Siyabonga Africa is committed to eradicating poverty and bringing about positive change for the people of our country. Although we provide food, blankets, clothing and basic necessities to those who are destitute, our ultimate aim is to create environments and opportunities that enable people to find their way out of poverty.

Available Services:	Food vouchers to help vulnerable families affected by job losses and lockdown regulations during the Covid-19 pandemic.
Beneficiaries:	Focus on women in distress, the elderly, child-headed families, zero income households and people with disabilities.
Contact: https://www.siyabongaafrica.org.za/ Online application: https://applications.siyabongaafrica.org.za/ WhatsApp: 072 8488 315.	

Annex X. Mental Health Support Offered by USAID Implementing Partners

Information about this annex: The information below was provided by a delegated staff member from each IP, who was the point of contact during the Mental Health Research.

IP name: Anova Health Institute
District(s): Cape Town
Service(s) available: Workplace Via Discovery (Employee Assistance Program) EAP services
Beneficiaries: Linkage officer, administration clerks, nurses, doctors, data capturers, mentors, lay counselors, additional staff
How are staff referred: Employee Wellness Program
Mental health services contact details: Shariefa Patel - Abrahams, 083 783 1601
GBV services contact details: NACOSA, Western Cape, Cape Town
Substance abuse services contact details: City of Cape Town's Matrix-certified clinics, 080 043 5748, NACOSA, 021 552 0804; in addition to various organizations

IP name: Anova Health Institute
District(s): City of Johannesburg
Service(s) available: Workplace Via Discovery (Employee Assistance Program) EAP services
Beneficiaries: Linkage officer, administration clerks, nurses, doctors, data capturers, mentors, lay counselors, additional staff
How are staff referred: Human Resources Department, Employee Wellness Programme, External Independent Counselor
Mental health services contact details: Nthabiseng Magagula, 083 965 7269; Ncumisa Zitho, Wellness Coordinator, 011 581 5000, zitho@anovahealth.co.za
GBV services contact details: Stevensons Building, 3rd floor, 62 Juta Street, Cnr De Beer Street, Braamfontein, 2017, Johannesburg, South Africa, Tel: +27 (0) 11 339 3589, Fax: +27 (0) 11 339 6503
Substance abuse services contact details: 24 hours: 0800 320 420 or through the Discovery website or app; PATA counselling for HCWs line 076 763 9991
Cross roads Johannesburg: missions: +27 74 895 1043
Emergency: +27 84 840 0079
Emergency: +27 64 386 5831
Office: +27 10 597 7784
Fax: 086 672 4585

IP name: Anova Health Institute
District(s): Mopani
Service(s) available: Workplace Via Discovery (Employee Assistance Program) EAP services
Beneficiaries: Linkage officer, administration clerks, nurses, doctors, data capturers, mentors, lay counselors, additional staff
How are staff referred: Human Resources Department, Employee Wellness Programme. We refer the staff member to their medical aid scheme.
Mental health services contact details: Mr. Nkuna Tiyisekani, HR Manager, 076 281 5215
GBV services contact details: Department of Social Development
Substance abuse services contact details: Discovery Healthy Company

IP name: Anova Health Institute
District(s): Sedibeng
Service(s) available: Workplace Via Discovery (Employee Assistance Program) EAP services

Beneficiaries: Linkage officer, administration clerks, nurses, data capturers, mentors, lay counselors, additional staff
How are staff referred: Employee Wellness Program
Mental health services contact details: Khanyisile Mthembu, Covid coordinator, 063 939 3395
GBV services contact details: POWA Gauteng
Substance abuse services contact details: SANCA Gauteng

IP name: BroadReach (APACE)
District(s): Ugu, Gert Sibande, King Cetshwayo, Nkangala, City of Johannesburg, and Cape Town
Service(s) available: Employee Wellness Programme: includes telephone counseling, face-to-face counseling (where possible), life management, and invaluable services (e.g., financial information/debt, medical advisory services for health-related queries, e/Care-health and wellness information useful articles, legal support, and managerial services).
Beneficiaries: Linkage officer, administration clerks, nurses, doctors, data capturers, lay counselors, additional staff
How are staff referred: Human Resources Department, Employee Wellness Programme
Additional information: Employee Assistance Programme is available for all BroadReach APACE staff. The information is provided on our platforms with monthly information and discussions relevant to our employees.
Mental health services contact details: Tshepo Ayah, Senior HR Business Partner, 066 232 4451

IP name: Centre for Communication Impact South Africa (CCI SA)
District(s): Alfred Nzo, Buffalo City, Lejweleputswa, Thabo Mofutsanyane, City of Johannesburg, Sedibeng, Ugu, King Cetshwayo, Capricorn, Mopani, Ehlanzeni, Nkangala, Gert Sibande, City of Cape Town
Service(s) available: Psychosocial support through the service provider Careways
How are staff referred: Human Resources Department, Employee Wellness Programme, External Independent Counselor
Beneficiaries: Staff
Mental health services contact details: Suraya Maharaj, Human Resources Manager, 079 299 8956 and Tebogo Makgoka, Human Resources Operation Officer, 066 299 9140
GBV services contact details: Careways, 011 847 4000
Substance abuse services contact details: Careways, 011 847 4000

IP name: FHI 360 (Family Health International 360)
District(s): Ehlanzeni, Gert Sibande, Nkangala, Capricorn, Giyani, King Cetshwayo, Ugu, Lejweleputswa, Thabo Mofutsanyane, Sedibeng (Gauteng Regions A, B, C, D, E, F & G)
Service(s) available: FHI 360 funded Discovery Medical Aid for psychosocial support options, Kon Terra for psychosocial support options, Thuthuzela Sites for psychosocial support, and Lifeline for psychosocial support. This is offered for free to all employees.
Beneficiaries: Linkage officers, administration clerks, nurses, doctors, data capturers, orphans and vulnerable children officers, group facilitators, additional staff
How are staff referred: Human Resources Department, Employee Wellness Programme, External Independent Counselor. We refer the staff member to their medical aid scheme.
Mental health services contact details: Bonginkosi, Human Resources Department, 073 707 3981
GBV services contact details: https://www.npa.gov.za/sites/default/files/
Substance abuse services contact details: Tranquility Clinic, 011 782 5093, 011 782 3418, 079 341 1139, enquiry@tranquilityclinic.co.za

IP name: Future Families
District(s): Capricorn and Mopani
Service(s) available: (1) Provision of PPE to all staff as well as ensuring that we screen and record temperature; (2) Provide remote services to beneficiaries through calls and bulk SMS; (3) Allow staff to work from home and attend meetings virtually; (4) Provide COVID-19 training through FPD sponsored by USAID; (5) Appoint COVID-19 Coordinators for smooth identification of COVID and support to staff, support for survivors of gender-based violence, and AGYW & AGYB.
Beneficiaries: Nurses, doctors, group facilitators, care workers for children/youth, lay counselors, additional staff
How are staff referred: Human Resources Department
Mental health services contact details: Vivian Machokonye, Senior Social Work Manager, 071 471 1192
GBV services contact details: Future Families
Substance abuse services contact details: NICRO (Capricorn)

IP name: HIVSA
District(s): Sub-districts D, E, G, and Sedibeng
Service(s) available: We do not have in-house capacity to handle such issues. Affected team members contact HR either directly or through their respective managers and get referred to an external service provider.
Beneficiaries: Administration clerks, nurses, data capturers, orphans and vulnerable children officers, group facilitators, care workers for children/youth, additional staff
How are staff referred: External independent counselor
Mental health services contact details: Lifeline offices, now at Funda Centre in Soweto, 067 019 0845 / 074 129 6960
GBV services contact details: Thuthuzela Care Centre, 011 933 1140 / 011 211 0632
Substance abuse services contact details: National Institute for Crime Prevention and the Reintegration of Offenders (NICRO), 011 492 2905

IP name: Kheth'Impilo
District(s): Alfred Nzo
Service(s) available: Trauma debriefing, psychosocial support for infected and affected personnel, referrals to vaccination, PPE, resources to work from home
Beneficiaries: Linkage officer, administration clerk, data capturer, orphans and vulnerable children, group facilitators, care workers for children and youth, lay counselors, additional staff
How are staff referred: Human Resources Department, Employee Wellness Programme
Mental health services contact details: Mcebisi Hlope, District Coordinator, 078 496 0000 and Yanga Nqenqa, Human Resources Officer, 072 333 2738
GBV services contact details: Child Line, 067 815 2526
Substance abuse services contact details: Child Line, 067 815 2526

IP name: MatCH
District(s): Harry Gwala District, Alfred Nzo District, Buffalo City Metro District, Nelson Mandela Bay District, O.R. Tambo District, and Sarah Baartman District
Service(s) available: Employee Assistance Programme - Kaelo Lifestyle. Services offered: counseling, legal advice, financial advice, children and teenager support, road accident coverage, managerial support, and trauma intervention.
Beneficiaries: Linkage officer, administration clerks, nurses, doctors, data capturers, group facilitators, care workers for children/youth, mentors, lay counselors

How are staff referred: Human Resources Department, Employee Wellness Programme. We refer the staff member to their medical aid scheme.
Mental health services contact details: Sifiso Myeni, HR Manager, 066 499 1920; Mavis Chingono, HR Manager, 066 510 4157
GBV services contact details: Kaelo Company, 086 163 5766, e-mail: asknelson@kaelo.co.za, website: www.kaelo.co.za
Substance abuse services contact details: Kaelo Company; 086 163 5766; e-mail: asknelson@kaelo.co.za; website: www.kaelo.co.za

IP name: mothers2mothers (m2m)
District(s): Gert Sibande, Ehlanzeni, Nkangala
Service(s) available: ICAS is m2m's wellness provider (https://www.icas.co.za). In March 2020 and March 2021, our project arranged for an ICAS psychologist to conduct a round of small debriefings (on Zoom) with all staff; small group composition was determined by roles/district locations and were 60-90 minutes in length and aimed at reducing grief and increasing psychosocial coping during the pandemic. Options for a discussion with a telephone-based counselor is always available. Employees can choose their preferred language and convenient times and locations for their counseling sessions. Calling ICAS is free from both landlines and cellphones.
Beneficiaries: Linkage officer, administration clerks, nurses, data capturers, group facilitators, mentors, lay counselors, additional staff
How are staff referred: Human Resources Department
Additional information: All staff affiliated with the USAID-funded/m2m-led Children and Adolescents Are My Priority (CHAMP) project in three districts of Mpumalanga Province (Nkangala, Ehlanzeni, Gert Sibande)
Mental health services contact details: Lindiwe Mphahlele, HR Officer, 079 184 7316, Lindiwe.Mphahlele@m2m.org, or employees ask through their line supervisor and then requests are channeled to HR
GBV services contact details: ICAS, 011 380 6800, https://www.icas.co.za/
Substance abuse services contact details: ICAS, 011 380 6800, https://www.icas.co.za/

IP name: PACT SA
District(s): Thabo Mofutsanyane, Capricorn and City of Johannesburg
Service(s) available: ICAS and Reality EAP Service Providers
Beneficiaries: Administration clerks, data capturers, group facilitators, care workers for children/youth
How are staff referred: Employee Wellness Programme
Mental health services contact details: ICAS or Reality EAP, 080 021 4773, support@healthinsite.net
GBV services contact details: Health Insight, 0800 214 773, support@healthinsite.net
Substance abuse services contact details: Health Insight, 0800 214 773, support@healthinsite.net

IP name: Right to Care
District(s): Thabo Mofutsanyane and Ehlanzeni
Service(s) available: Genesis Service, which is based in Johannesburg; no support services specifically for COVID-19
Beneficiaries: Linkage officers, administration clerks, nurses, data capturers, mentors, lay counselors
How are staff referred: Human Resources Department
Mental health services contact details: Program coordinators and Lucy Mofokeng (HR), 082 781 6275

GBV services contact details: PACT - Thabo Mofutsanyane and Ehlanzeni, https://www.pactworld.org/country/south-africa
Substance abuse services contact details: Ministry of Social Development, 012 312 7479, 021 465 4011

IP name: Wits Reproductive Health and HIV Institute (WRHI)
District(s): City of Johannesburg, Sedibeng, Buffalo City, Alfred Nzo, Ugu, King Cetshwayo District, City of Cape Town, Mopani, Capricorn, Lejweleputswa, Thabo Mofutsanyane, Nkangala, Gert Sibande, Ehlanzeni
Service(s) available: SADAG, HCWs Care Network, PATA, CSVR, Grace Counselling, The National Medical Frontliners counseling line, ER24 services, staff debriefing through external providers
Beneficiaries: Linkage officers, nurses, data capturers, group facilitators, mentors, lay counselors, additional staff
How are staff referred: Human Resources Department, External Independent Counselor. We refer the staff member to their medical aid scheme, Demand Creation Officers
Mental health services contact details: Technical Advisor and Counselling Psychologist, Kerry Gordon, 011 358 5376
GBV services contact details: DSD GBV Helpline: 080 042 8428. This is supported by a USSD, "please call me" facility: *120*7867#. Nationally available.
POWA lockdown counseling number: 076 694 5911 - covering Gauteng
Other national helplines:
Crime Stop (all cases of rape, sexual assault, or any form of violence): 086 001 0111
Childline (report child abuse, toll-free line): 080 005 5555
Domestic Violence Helpline (Stop Women Abuse): 080 015 0150
NACOSA is an IP for GBV services: 021 552 0804 (Cape Town), 043 726 2146 (Eastern Cape)
Thuthuzela Care Centres all over the country - see list: THUTHUZELA CARE CENTRES (justice.gov.za)
Contact and number for substance abuse services: SANCA, Phone: 011 892 3829. WhatsApp 076 535 1701, https://www.sancanational.info/

IP name: EDC - has not provided information

IP name: NACOSA - has not provided information