



**Mapping Emotional Coping Interventions for Health Care Providers:
A Scoping Review**

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Declaration

I, Alison Teneal Andrew, do hereby certify that the work in the thesis titled, “**Mapping Emotional Coping Interventions for Health Care Providers: A Scoping Review**” has not been previously submitted for a degree nor has it been submitted as part of the requirements for a degree to any other university or institution other than the University of KwaZulu-Natal.

I hereby certify that this dissertation is my original research and thus, has been written by me, except where otherwise indicated. All segments of the paper that use quotations or describe an argument or concept developed by another author have been referenced, including all secondary literature used, to show that this material has been adopted to support my dissertation. I declare in this thesis all references and citations are formatted according to the guidelines set by the American Psychological Association (APA), 7th edition.

Signed

A solid black rectangular box used to redact the signature of the author.

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Abstract

Background: Primary Health Care (PHC) nurses in low and middle-income countries (LMICs) such as South Africa, are confronted by socio-economic inequalities that impact their health and well-being, and capacity to provide person-centred care (PCC). Concurrently, the organisational/system changes amplified pre-existing emotional strain (i.e., burnout, stress, and compassion fatigue). Through the driving of PCC, Human Resources for Health (HRH) strategies, the implementation of National Health Insurance (NHI) plan and re-engineering of PHC which aim to meet the global health care sector standards.

The delivery of emotional coping skill interventions capacitates PHC nurses to cope and provide optimum PCC in PHC. This scoping review focused on broadly reviewing emotional coping skill interventions for health care providers in LMICs. Subsequently, the findings were refined to infer knowledge on building emotional coping skills interventions, particularly for PHC nurses in the South African context.

Purpose: To map emotional coping skills interventions for health care providers within LMICs to improve the well-being of the PHC nurses to provide optimum care in PHC.

Methods and Analysis: The Arksey and O'Malley's framework scoping review was used to map evidence on emotional coping skills interventions for health care providers (i.e., nurses) within LMICs. Furthermore, the PRISMA-SCR flowchart and checklist were utilised to depict the search strategy. A narrative review approach was utilised to chart the data, and the database search was recorded as follows; author(s) & year of publication, study location (country), aims and objectives of the study, methodology, study population, intervention type, duration of the intervention, outcome measures, key findings, and limitations. Data were thematically analysed and guided by the Thomas and Harden (2008) thematic framework to identify trends and gaps.

Findings: The review distilled 5 eligible articles, published between the years 2015 to 2018. The findings revealed two major themes set by the study's research objectives. Theme 1 revealed a gap for context-specific interventions as there was a myriad of factors specific to the South African health care sector to be accounted for in the curation of interventions and a paucity of primary research on emotional coping skill interventions to cope with the adverse “people work” (i.e., burnout, stress, and compassion fatigue). Theme 2 revealed factors that contributed to improved well-being namely, education and training, communication, debriefing/venting, religion and spirituality, social support, humour, and duration of interventions and working hours.

Conclusion and Recommendations: The findings of the scoping review substantiate that emotional coping skill interventions exist in LMICs and are beneficial to the well-being of PHC nurses. From an organisational perspective, the findings demonstrate that the existing interventions propose a basis for future emotional coping skill interventions for PHC nurses to be capacitated with the necessary tools to cope. In addition, further primary research is required to propose a South African context of standard of best practice to shape subsequent interventions.

Keywords: *Emotional Coping Skill Interventions, Primary Health Care, Nurses, South Africa, Low and Middle-Income Countries, Burnout, Stress, Compassion Fatigue.*

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Chapter One: Introduction

1.1. Introduction

This chapter provides an overview of the background of the study, the problem statement, the purpose statement, and the significance of this study. In addition, this chapter will include a summary of the division of chapters to follow, as well as conclude with a summary of the chapter.

1.2. Background to the Study.

The nursing profession is embedded with high levels of social interaction, thus, to optimally navigate the social world, nurses must possess the capabilities to manage emotional dynamics and process emotional information (Lopes et al., 2011; Kinman & Leggetter, 2016). Lopes et al. (2011) advocate a positive relationship between the quality of social interactions and the ability to effectively manage emotions. The current organisational environment of South African health care providers is exposed to is socially, economically, and politically fast evolving. Consequently, this contributes to an effect on the emotional well-being and mental health of health care providers (Capone et al., 2022; Rusli et al., 2006; Petrus, 2017; Rispel & Barron, 2012).

There is an array of broad definitions of health and well-being. This review will view health and well-being from an emotional, health, mental, and psychological perspective (Danna & Griffin, 1999). In light of the global shift in the health care sector for better health care outcomes by global health care organisations such as the World Health Organisation (WHO), the South African health care system is undergoing multiple changes in the country's health care organization, resulting in a scale up in the volume and intensity of psychological, social, and physical work demands placed upon health care providers (Rispel & Barron, 2012; Truth, 2013; Van Ryneveld et al., 2020).

Notably, Primary Health Care (PHC) in South Africa face systemic changes from Human Resources for Health (HRH) reforms, the re-engineering of PHC, implementation of the National Health Insurance (NHI) plan, as well as the drive person-centred care, which infers the increased stress, burnout and compassion fatigue faced by health care providers (Almeida & Miclos, 2022; Bhayat et al., 2021; Naledi et al., 2011; Rispel & Barron, 2012; Van Ryneveld et al., 2020).

A backbone of the PHC system is nurses. Despite this, the country fails to dispense adequate PHC health care professionals to satisfy the needs of the country's population and is neither able to preserve the present health care workforce (Delobelle et al., 2011; Rispel & Barron, 2012; Van Ryneveld et al., 2020). PHC nurses are health care providers who are the first point of contact in PHC they are defined as essential, basic health care that is accessible to all members within communities (Ortega-Campos et al., 2019).

Studies have shown that the underlying reasons for South Africa's increasing levels of absenteeism, staff turnover, migration and low morale are due to the poor physical and emotional health of nurses (Asegid et al., 2015; Mudaly & Nkosi, 2015; Labonté et al., 2015; Rispel & Barron, 2012). Currently, the implementation of the NHI plan and PHC re-engineering strategies fail to address the deficiencies and unequal distribution within the current HRH reforms through the provincial, public, and private health care sectors (Heunis et al., 2019). However, the changes within the health care organisation call for PHC nurses to perform optimally. Notwithstanding the constant challenges within PHC and the South African health care sector (Almeida & Miclos, 2022; Rispel & Barron, 2012). Additionally, the role of the PHC nurse compromises of immense emotional labour due to the nursing profession possessing constant intensive contact with patients. Thus, a focus is placed on advocating for the health and well-being of PHC nurses (Almeida & Miclos, 2022; Kinman & Leggetter, 2016; Van der Colff & Rothmann, 2014;).

At a global level within health and social care, the term person-centred care has become progressively familiar in PHC. The humanistic care approach of to a level of care that involves care of the client or patient to be at the centre of care delivery to attain a life of meaning (Kim, 2022; McCance et al., 2011). For the driving of person-centred care to be a successful, PHC nurses are required to be well-trained on how to practice communicating in a person-centred manner and grasp genuine knowledge of the patient (Moore et al., 2017). However, global studies have found that when health care providers engage in holistic care namely person-centred care there is an extra demand placed upon the health care worker. Thus, impaired health status, is a result of the pre-existing high levels of stress, burnout, and compassion fatigue of the health profession.

In addition, health care providers in lower/middle-income countries (LMIC) and high-income countries (HIC) face different challenges within the implementation of this system change to person-centred care, due to the resource disparities that exist (Dewi et al., 2014; Docrat et al., 2019; Drach-Zahavy, 2009;).

Globally, the revitalisation of PHC is advocated specifically within countries that have constrained resource settings such as LMICs such as Brazil and South Africa (Munyewende et al., 2014). Considering the barriers that hinder PHC in LMIC settings from achieving better health care outcomes, specifically, difficulties in the implementation of mental health in primary health care, scarcity of financial and human resources (the scarce amount and types of health care providers who are supervised and trained in mental health care), complications of changing poorly organised services and the low priority that mental health is given (Eaton et al., 2013; Engelbrecht et al., 2021; Saraceno et al., 2007).

In addition, with the high number of PHC clinics and shortage of health care providers, particularly PHC nurses face an added workload burden (Kakuma et al., 2011; Mokoka et al.,

2010; Selohilwe et al., 2023). Consequently, a greater demand is placed upon PHC nurses, in that it calls for an increase of knowledge, passion, and working with large volumes of patients. More importantly, the capacity to be emotionally equipped to perform at their optimum capabilities and to provide compassionate care to connect with patients. In conjunction, with the responsibility to provide better health care outcomes (McCance et al., 2011; Ross et al., 2015; Temeng et al., 2023).

PHC is an environment that is extremely stressful and emotionally draining to work in and can lead to a person experiencing high levels of stress, burnout, and compassion fatigue (Almeida & Miclos, 2022; Mokoka et al., 2010; Temeng et al., 2023). According to Lazarus & Folkman (1984), stress is seen to be any circumstance where external and/or internal demands are evaluated as challenging or above the adaptive or managing resources of the group or the individual. According to Maslach et al., (1996), burnout is a syndrome consisting of depersonalisation, emotional exhaustion, and reduced personal achievement (as cited in Pinikahana & Happell, 2004). PHC nurses are prone to developing burnout and experiencing compassion fatigue as a result of the emotional labour and the nature of the job. When helpers are traumatized through assisting and helping others, is referred to as compassion fatigue (Almeida & Miclos, 2022; Potter et al., 2010; Wei, Ji, Li, & Zhang, 2017). Numerous studies conducted on stress, burnout and compassion fatigue have argued the need for emotional coping skills interventions, as they provide support mechanisms for stress, burnout, and compassion fatigue (Delgado et al., 2017; Lim et al., 2010a; Lim et al., 2010b; Maeda & Socha-Dietrich, 2018; Yeşil & Polat, 2023).

An investigation conducted by West et al., (2005), found that nurses are aware of barriers to overcome to meet the needs of their patients, and especially the barrier of offering patients emotional support. Considering the role which PHC nurses play in health care in terms of the emotional strain attached to their role. It is essential to equip PHC nurses with the necessary

tools to cope in the changing health care environment (Temeng et al., 2023). Hence, a greater need to advocate for the upskilling of health care providers with emotional coping skills to ensure good health and well-being for the health care workforce.

Concerning the organisational changes within the South African health care system towards PHC nurses and the need for organisational readiness in a system change, technical, and structural changes, 'workforce preparedness' is essential (Davy et al., 2015; Weiner, 2009). Kotter (1996) warned that half of the implementation failures for a change in the system have been estimated to be due to a lack of organisational readiness. Thus, when implementing a large-scale integration into the PHC sector, the workforce must be in readiness to ensure that the change is undertaken (Sharma et al., 2018). Workforce preparedness in the health care system provides the essential clinical technical skills and non-technical skills to cope (Maeda & Socha, 2018). Social skills (which are teamwork, leadership, and communication), and cognitive skills (which are situation awareness, planning, and decision-making), are effective in the execution of a series of tasks or a specific task and are often referred to as non-technical skills (NTS).

The link between medical errors and the NTS of health care providers has been a growing interest over the past two decades. High levels of non-technical skills, medical knowledge and technical knowledge are required to be conducted by health care providers such as nurses, to provide person-centred care that is effective and safe (Maeda & Socha, 2018; Scott et al., 2016). However, for the limits of this study, there will be a focus on the non-technical skills aspects of workforce preparedness, specifically delving into emotional coping skills. A study conducted by Petrus (2017), advocates for incorporating learning sessions designed towards the development of emotional coping skills for health care providers to enable health care providers to combat the negative effects of “people work” and change, as well as to be capacitated to deal with stress, compassion fatigue and burnout.

For ensuring consistency and clarity to the scope of this study “people work” is described as occupations that involve constant social interaction with others, as viewed in the nursing profession (Gray, 2009, as cited in Petrus, 2017).

Current studies recommended that using emotion-focused coping skills predicted better mental health outcomes for nurses (Engelbrecht et al., 2021; Lim et al., 2010a; Lim et al., 2010b). In terms of emotional-focused coping skills, in place of looking for a way to perfect its cause, this form of coping deals with the unpleasant emotional effects of stress. The types of strategies that are included in emotion-focused coping skills are avoiding stressful situations, debriefing, exercising self-control over behaviour and feelings, seeking social support, and distancing from the problem at hand (Devereux et al., 2009; Engelbrecht et al., 2021; Lim et al., 2010a; Lim et al., 2010b). Therefore, engaging in emotional coping skill interventions will be significant in addressing the need to safeguard the health and well-being of PHC nurses to be well-equipped for person-centred care. Given that emotional coping skill interventions will assist PHC nurses in acquiring the necessary skills to cope with the emotional labour of their job role. In addition, the shift to providing care that is required by the South African health care system, as well as the global health care needs.

Contrary to LMICs, systematic reviews in high-income countries (HIC) have been conducted on emotional coping skills interventions within a myriad of countries, such as Australia, the United Kingdom, and Singapore which focused on the nurses. Based on the systematic reviews that were conducted it was found that emotional coping interventions are effective in reducing the stress, burnout and compassion fatigue that is faced by these health care providers (Lim et al., 2010a; Lim et al., 2010b; Temeng et al., 2023). However, with regards to LMICs, there is a need for knowledge with regards to emotional coping skill interventions, as there is little known. Given that studies show that HIC and LMIC face different challenges within PHC, there is a need to investigate emotional coping skills

interventions to shed light upon the shortcomings and strengths of LMIC emotional coping skills interventions.

A current review of health research has been increasingly represented by scoping reviews, in that a scoping review effectively conveys the depth and breadth of a field by mapping a range of evidence (Davis et al., 2009; Levac et al., 2010). Hence, through conducting a scoping review broadly on emotional coping skill interventions for health care providers, in particular nurses, in LMICs, literature within this area can be refined to infer knowledge on building an emotional coping skills intervention for PHC nurses in South Africa. Subsequently, emotional coping skills interventions can be used for the capacitation of PHC nurses in LMIC to cope with the system changes that are faced as well as the pre-existing stress, burnout, compassion fatigue. This study seeks to contribute to the enhancement of healthcare providers' lives in South Africa.

1.3. Statement of the problem.

The emotional and physical strain which PHC nurses experience in rural PHC facilities creates obstacles to the provision of high-quality person-centred care to patients and further poses a detriment to the temperamental health care sector of South Africa which consists of a mechanical and human resource shortage (Mohale & Mulaudzi, 2008; Mudaly & Nkosi, 2015; Selohilwe et al., 2023). The initiatives that are driven both globally and within South Africa have placed an immense strain upon the currently stressed, burnout and compassion-fatigued nurses, such as the re-engineering of PHC, the NHI plan, other HRH policies, and the drive of person-centred care. Given that PHC nurses need to be at the frontline in the delivery of person-centred care there is a need to broadly investigate the literature on emotional coping skill interventions, and to understand how PHC nurses can effectively cope with the current health care environment. This scoping review focused on mapping emotional coping skills interventions for health care providers within LMICs. It is hoped that this study contributes to

the literature on emotional coping skill interventions to help inform future studies and interventions that aid in improving the emotional coping skills of PHC nurses in the LMIC context, specifically South Africa. Notably, it is hoped that this scoping review contributes to the building of context-specific emotional coping interventions that are aligned with the needs of PHC nurses within the LMIC context, specifically South Africa.

1.4. Purpose of the study.

The purpose of this scoping review is to map emotional coping skills interventions for health care providers within LMICs to improve the well-being of the PHC nurses to provide optimum care in PHC. This review incorporated various studies to provide information with regards to the existing evidence for the emotional coping skills interventions for health care providers within LMICs.

1.5. Objectives of the study.

The key aim of this study was to review an array of studies that explore emotional coping skills interventions within the LMIC health care sector, to improve the well-being of PHC nurses and their capacity to provide optimum care within PHC. The objective and research questions of this scoping review were achieved by the scoping literature on the following databases such as Cochrane, EBSCOhost, OpenGrey, ScienceDirect and PubMed.

The following are the objectives of the scoping review:

1. To explore existing evidence of emotional coping skills interventions in health care settings.
2. To explore factors of the intervention that contribute towards the experience of improved well-being.

Due to the objectives of this study, the following are research questions that were posed to obtain the objectives of this study:

1. What is the existing evidence of emotional coping skills interventions in health care settings?
2. What factors of the intervention that contribute towards improved well-being?

1.6. Significance of the Study.

The mapping of emotional coping skill interventions in LMICs allows the study to inform the standard of best practice. Furthermore, the strengths and development opportunities to improve emotional coping interventions existing. It is hoped that this review will contribute to the advancement of future emotional coping interventions within LMICs, enabling PHC nurses to work at their optimum level to provide person-centred care. The outcome of the review will inform relevant stakeholders on the best approaches to emotional coping skill interventions, to provide PHC nurses with the best quality of work-life, specifically South Africa. Lastly, to contribute to the larger overall aim of providing better health care outcomes to ensure that there is an alignment to the global need.

1.7.Overview of Chapters.

Chapter One.

This chapter lays the foundation of the study, by providing an introduction to the research study. Thus, this study included a background to the study, an overview of the research problem and the purpose of the study, and the significance of the study. The chapter entailed the objective and the research questions that will guide the study.

Chapter Two.

This chapter provides a review of literature that pertains to emotional coping skill interventions for health care providers within LMIC. The chapter reviews the literature that

depicts the South African health care context. This chapter discusses the literature on the health care sector in LMIC, the literature gap of the study, as well as current and past literature on emotional coping skill interventions.

Chapter Three

This chapter provides the method of research that the study will follow, such as a step-by-step procedure that the scoping review shall entail. Furthermore, this chapter will incorporate the ethical considerations that were taken in the study.

Chapter Four

This chapter provides the results and discussion of the study's findings. The chapter will provide a synthesis and descriptive analysis of the extracted data from the scoping review of eligible articles. The discussion will offer an in-depth analysis centred around the study's objectives in relation to the findings of the scoping review.

Chapter Five

This chapter will provide a conclusion, based on the findings of the scoping review. Furthermore, this study will include recommendations and limitations that can be drawn from this study for future research.

1.8. Summary

This chapter focused on providing a foundation of the study, to introduce the research topic of the scoping review and the research problem faced. Additionally, this chapter outlined the research objectives and questions of the study, and the significance of the study. This chapter entailed an outline of the division and structure of the study.

The chapter to follow reviews the literature related to emotional coping skill interventions for health care providers in LMICs.

Chapter Two: Literature Review

2.1. Introduction

This chapter aims to provide an overview of the literature pertaining to the need for emotional coping interventions for health care providers. This review opens by setting the context of health care systems within LMIC. The chapter then proceeds to shed light on the backdrop and the current health system in South Africa with a specific focus on the health care reforms that are currently guiding the system/organisational changes within the South African health care system, which pose to impact on nurses. The chapter then proceeds to discuss preparing the health care workforce for organisational/system changes that are underway in the South African health care system. Next, coping is defined, and more specifically the study delves into the use of emotional coping skill interventions for the adverse effects of people work, such as stress, burnout, and compassion fatigue. The review defines the constructs of stress, burnout, and compassion fatigue to provide an understanding of the value of emotional coping skill interventions. This is followed by a brief overview of the literature on emotional coping skill interventions in HIC and LMIC. The chapter then closes off with a summation of the literature review, which indicates the direction that this scoping review followed.

2.2. Health Care Systems with LMICs.

The history of LMIC countries has been permeated with discrimination that is built upon race, gender, and an array of other social inequalities, which has posed pressure upon the health and well-being of health care providers. LMICs such as Uganda and Brazil face inadequate organisational policy frameworks, and a critical lack of essential resources such as sterile equipment, medications, and gloves, which leave nurses struggling to provide care that is aligned with ethical and professional standards. Thus, nurses within similar health care systems experience emotional labour such as moral distress due to the lack of resources that they are required to perform their necessary duties to patients (Harrowing & Mill, 2010; Sale & Smith-

Morris, 2023). Similarly, LMICs such as Ethiopia, Nepal, South Africa, and an array of others encounter similar social, economic, and political climates (Kassa et al., 2014; Moore et al., 2017).

An LMIC such as South Africa, encompasses an infrastructure that is shaped by the suppression of its indigenous individuals, the appropriation of their land and resources, and the practice of unjust laws, that were aimed at forcing black South Africans to work for a low wage for the white minority having to generate greater wealth. According to Cooper and Cartwright, (1994), the historical context of South Africa laid the roots of its health care system to result in dysfunctionality. Equally important are the policies during the periods of the country's history, from colonial suppression, apartheid dispossession, and thereafter the post-apartheid period. These factors contributed to health care providers within South Africa facing emotional labour which continues to affect the health care providers within the current health care system.

The troubled past of South Africa is shaped by the destruction of family life, the extreme violence, and significant income inequalities, which have inevitably burdened health services (Petersen et al., 2016). Considering the divide between South Africa's public and private health care sectors, displays drastic inequalities in health care provisions. Additionally, there is extensive funding for private health care which is provided by pocket payments from private health insurance, approximately 16% of the population is within the private health care system, in comparison to the 84% served by the public health care sector. The divide between private and public health continues to challenge ever-shrinking resources (Coovadia et al., 2009; Kautzky & Tollman, 2008; Mchunu et al., 2022). Thus, leaving health care providers burdened to treat the higher patient volumes.

For the public health care system to be strengthened, it is integral for a renewed commitment to primary health care (PHC), as it is a flexible and innovative strategy to accomplish. The

South African health care system similar to other LMICs is due to face a shortage of skilled health care providers, which is detrimental due to maldistributions that are pre-existing between the private and public sector, and rural and urban areas. The historical background of South Africa creates the best understanding of the country's human resource for health (HRH) development, planning, and implementation (Bhayat et al., 2021; Pillay, 2009).

Due to maldistribution in HRH of South African health care, the migration of health care providers both within (i.e. public to the private sector) and outside (i.e. developing to developed) South Africa, has been identified as a key issue for the health care system that impacts the well-being of health care providers (Bhayat et al., 2021; Clemens, 2007; Labonté et al., 2015; van Rensburg, 2014). George, Atujuna, and Gow (2013), state that the decision to migrate is more often not related to the pay of their salaries. Conversely, it is largely related to the extent to which they are happy in their job, their age and the level of stress they experience at work. Hence, equipping nurses with the tools that reduce their experience of stress, aid the decrease of migration in South Africa and overall ensure better health care outcomes.

2.3. Current System/Organisational changes within the South African system that impact health care providers.

The legislation and policies within South Africa's post-apartheid era have aimed at increasing the quality and access to care within a human rights framework (National Department of Health [NDH], 1997; NDH, 2010; NDH, 2011a; NDH, 2011b; Heunis et al., 2019). Current health care reforms have brought about the need for health care system/organisational changes (Petersen et al., 2016; Van Ryneveld et al., 2020).

2.3.1. PHC and the re-engineering of PHC

In 1978, it was posed by the WHO in the Alma Ata Declaration, that PHC entailed vital health care that is grounded in scientific and practical sound methods, that are created to be universally suitable to families and individuals, and within a cost bracket that is considered to

be affordable. Additionally, according to Naledi et al., (2011), the PHC approach is a ‘philosophy governing principles and strategies for organising health systems, central to which is the notion of health as a human right, with health systems seen as the vehicle to deliver that right equitably’ (p.18). According to Mogawa (2012), PHC is the mechanism to achieve the goal of providing the health care system with the necessary tools to provide universal access to efficient, appropriate, quality, and effective healing services, intending to promote and improve the health of individuals.

According to the WHO, the following definition of PHC was provided, which is used for this scoping review:

Primary health care is essential care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country’s health system, of which it is the central function and main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service (World Health Organization [WHO], 1978).

The essence of PHC is to bridge the gap between the socioeconomic issues and to ensure that better health outcomes are achieved. Despite the notable progression of PHC within LMICs, there remains significant gaps in the effectiveness and quality of the care being delivered compared to what communities and individuals require. There is a range of factors that are the underlying causes of the gaps that permeate PHC within LMIC countries, which

are similar to challenges that are faced in the South African PHC, such as poor motivation, misaligned incentives, low effort, inadequate training and the unavailability of supplies. Thus, it is unfortunate that PHC in multiple LMICs encompass poor health outcomes and are deficient in capacity (Bitton et al., 2017; Selohilwe et al., 2023).

Within the South African context, PHC has been a fundamental characteristic of the post-apartheid area. Granted that the implementation of PHC in South Africa demonstrated a positive impact on the health care system as compared to the precedence set by apartheid health care delivery, numerous factors continue to limit the success of PHC (Dookie & Singh, 2012; Druetz, 2018; Selohilwe et al., 2023). Naledi, Schneider, and Barron (2011) agree that a considerable body of evidence suggests that other LMICs such as Asia and Latin America experienced a positive impact of the classic PHC approach in light of the major health gains, sustainability, and feasibility offered by the classic PHC. Thus, the outcome of reviews done of PHC by the Pan American Health Organization and the WHO suggested that, despite the reported failures of the classic PHC approach on the other side of the coin, the successful experiences motivate a reformation of PHC. The South African health care system then began the journey of the re-engineering of PHC, to achieve a stronger health care system and thus, inferred an increased workload burden upon health care providers (Bhayat et al., 2021; Capone et al., 2022; Naledi et al., 2011; Petrus, 2017).

The PHC system during the apartheid period was characterized by centralized institutional care (acute care). The aim of the health care system within this period was to provide care that was aimed at providing a curative service, that responded to acute care needs (Petersen et al., 2016). According to Phillips (1993), in which the basis of the health care that was provided was a curative and preventative approach rather than concentrating on the preservation of health and health promotion (as cited in Petrus, 2017). Additionally, health care provided within the health care systems was task-orientated and organized vertically, as it stemmed from scarce

resources that existed in LMICs similar to South Africa such as Ethiopia, Sierra Leone, Uganda, and Nepal. Given that health care systems at the time did not offer the means to assist in conducting interventions and providing patients with health education to treat patients holistically (Harrowing & Mill, 2010; Moore et al., 2017; Vesel et al., 2015). Furthermore, the history of LMIC's health care systems lacks essential resources to enable health care providers to perform their basic functions. Consequently, provide health care providers with a pre-existing burden of stress, burnout and compassion fatigue that is constantly experienced.

The health care system that exists within South Africa, similar to other LMICs, has undergone dynamic changes and continues to evolve to meet WHO goals for better health outcomes (Dookie & Singh, 2012; Druetz, 2018; WHO, 2009). According to Naledi, Schneider, and Barron (2011), as an alternative to a curative, individual, vertical, and passive-oriented system commonly known as acute care to PHC, the re-engineering of PHC pursues to shift the current PHC system to an approach that is population-based, proactive and integrated which is referred to as person-centred care. Petersen et al. (2016), state that the required shift in the health care system, from acute care to person-centred (care that is integrated, decentralized, and community-based services) is delivered in the ambit of a human rights framework.

The drive of person-centred care allowed for the use of non-specialist health care providers who are trained to offer holistic care, such as the inclusion of mental health care, which was recommended as an approach to increase access in the context of a scarcity of mental health specialists (Petersen et al., 2016). Subsequently, the re-engineering of PHC places immense pressure upon the existing workload burdened health care providers, which is demonstrated by the immense role that health care providers play within the three streams envisaged for PHC. National Nursing Summit (2011), notes that the three streams envisaged for PHC are, first, for nurses and doctors to play a vital role in multi-disciplinary teams of clinically competent professionals and play. Secondly, nurses once more play a vital role in municipal, community

ward-based multidisciplinary health teams. Thirdly, it requires nurses again to lead the effective implementation of a national school-based PHC system. Consequently, Petrus (2017), suggests that the nursing profession in South Africa is plagued with nurses who are stressed-out and thus, exposed to high levels of strain as a result of the demands that are presently placed on professional nurses who experience the re-engineering of PHC.

PHC nurses frequently experience the impact of frustrated patients, as the first point of contact that patients experience in the PHC system is that of the PHC nurse (Ackerman, 2016; McInnes et al., 2020). Therefore, the negative impact of the nurse-patient relationship and demoralisation of nurses occurs due to patients holding nurses culpable for the shortages of staff and medical resources. Bakker et al. (2000) agree, granted it is personally rewarding to health care providers to assist individuals who experience major health care issues, however, the other side of the coin entails a stressful experience for health care providers when patients are not aware of the efforts made by health care providers to help them (as cited in Capone, Borrelli, Marino, & Schettino, 2022).

Moreover, Bakker et al. (2000) claim, that as time progresses, the stressful experience as an outcome of an imbalance may increase a health care provider's risk of mental and physical health. Additionally, an array of studies agrees, by postulating that a key aspect of providing excellent care to better patient outcomes involve the responsiveness to the patient's emotions (as cited in Capone et al., 2022). Conversely, the responsiveness to the patient's emotions in turn can be a significant predictor of nursing burnout and stress (Omdahl & O'Donnell, 1999; Stordeur et al., 2001). Therefore, due to the increased exposure to patients that health care providers experience and the added demands of driving person-centred care create a need to implement coping mechanisms to safeguard the health and well-being of providers.

According to Van der Colff and Rothmann (2009), a study which investigated occupational stress, work engagement, burnout, and sense of coherence of registered nurses in South Africa found that the most severe stressors that are experienced by nurses are staff shortages. Furthermore, Van der Colff and Rothmann (2009) infer that occupational stress as a result of job demands and lack of organisational support contributes significantly to depersonalisation and emotional exhaustion. In light of the shortage of health care providers, a lack of organisational support (lack of resources) is experienced, and thus, results in withdrawn employees who develop nonchalant attitudes towards their occupations and grow a depersonalised state of mind towards patients.

Thus, for PHC to be a success in South Africa, the health care organisation needs to avoid detrimental outcomes that negatively impact health care providers. Given that when health care providers are not capacitated with skills to cope with depersonalised emotions, that health care provider's experience shall tremendously hinder the delivery of person-centred care in PHC, which results in affecting the success of achieving better patient outcomes.

2.3.2. Human Resources for Health (HRH)

South Africa's HRH health care reforms result in changes in the health care organisation. HRH is essential to improving the health care system function and achieving good health care outcomes. However, the South African health care system is experiencing crises in management, production, retention, and recruitment (Bhayat et al., 2021; Mchunu et al., 2022; Rispel & Barron, 2012; Rispel & Blaauw, 2015). Workforce shortages, lack of management support, and access constraints are serious HRH challenges that exist in the South African health care system. The result causes nurses to experience stress and burnout, even though South Africa consists of well-developed health professionals and well-established training institutions (van Rensburg, 2014). Moreover, according to Mchunu et al., (2022), the well-known HRH crisis in management, production, retention, and recruitment is inadequately dealt

with by the revised HRH strategy, as well as by other reforms in the health care sector such as the National Health Insurance (NHI) Green Paper.

However, the impact of the HRH shortage results in health care centres having limited capacity to cope with patient demands due to the shortage of PHC nurses. Due to the shortage of nurses creates an overburdening of the existing PHC nurses, and thus, time spent with patients is reduced, the response to patients is delayed, and therefore a delay in treatment and discharge of patients. PHC nurses experience an increased workload which affects their effectiveness and efficacy in providing quality patient care and maintaining patient safety. Furthermore, PHC nurses incur an increase in mental exhaustion and high levels of stress, thus allowing for medical errors, which eventually increase unethical practices (Saikia, 2017; Naledi et al., 2011; Rispel & Barron, 2012). Thus, it is pertinent that PHC nurses are equipped with tools that are essential for coping with the mental exhaustion and stresses that occur on the job, especially due to the current HRH in the South African health care system.

2.3.3. National Health Insurance (NHI) Plan

An additional health care system reform that exposes organisational change in South African health care providers will be the NHI Plan, which aims at the renovation of the complete health financing system. The NHI aims to be equitable, inclusive, and comprehensive to cover all South Africans with no fee charged at the point of care. However, this aim entails an extensive reorganisation of training and HRH that staff the NHI plan involves (van Rensburg, 2014). Moreover, if implemented as planned, and if the HRH and necessary material can be mobilised, this plan shall promise equitable access and universal coverage to care for the South African population (Bhayat et al., 2021; Rispel & Barron, 2012). According to van Rensburg, (2014), the NHI plan, in theory, has the potential to create a new dynamic that strengthens the current workforce by retaining health care workers effectively, expanding access to health care

services, and prompting more effective public health services, especially South African PHC nurses.

Despite this, the lack of facilities and staffing of underserved regions within PHC pose the most significant challenge for the NHI plan. The NHI continues to evolve which implies that unforeseen consequences can weaken and cripple the current South African health care workforce and set in motion undesirable outcomes. Particularly if the current HRH shortcomings within public health care remain unamended (Dhai, 2023). Therefore, health care reforms have a major impact on the health and well-being of PHC nurses, in that there is an added burden of higher exposure to interactions with larger volumes of patients. Considering the added workload placed upon PHC nurses, there is a need to capacitate PHC nurses with the tools to cope.

The improvement of the health care system working environment, to achieve a context that is aligned with the value system and aspirations of nurses, and is reliant upon an increase in nurses' satisfaction. Subsequently, the individual, organisation, and health outcomes are then positively affected (Almeida & Miclos, 2022; Pillay, 2009). It is imperative to understand the South African health care system that health care providers are exposed to, in that it sheds light upon the pre-existing stressors that are faced, and thus, sets a basis for the need for this study.

Due to this change in the system within the health care system, there is a need to equip the health care workforce with the necessary tools to cope with the system change, to ensure that the PHC nurse's health and well-being needs are taken care of. Therefore, given the context of the South African health care system, there is a need to assist health care providers, particularly PHC nurses to be capacitated with the necessary tools to cope with the changes that are occurring within their organisation. Moreover, assisting in contributing to the success of the

HRH strategy, NHI plan and the re-engineering of PHC, given that health care workers such as nurses are the pillar of the success of the South African health care system.

This study follows that of a scoping review, to understand best practices for health care emotional coping skill interventions in South Africa, and it is required to broaden the parameters. Therefore, to capacitate health care providers within South Africa with the necessary emotional coping skills, there is a need to infer knowledge on interventions suited to an LMIC context, given that South Africa encompasses similar attributes to other LMICs.

2.4. Organisational Readiness of the health care system.

Organisations constantly experience change, thus, the health care sector is not excused from change, especially due to the dynamic occurrence of health care reforms that aim for the achievement of better health care outcomes (Almeida & Miclos, 2022; Petrus, 2017). Aforementioned, South Africa is undergoing various health care reforms, such as the implementation of the NHI plan and the re-engineering of PHC that has resulted in a domino effect of change, such effects in the HRH strategy. LMIC health care systems similar to South Africa face barriers to implementing change that are not faced by HIC countries (Scott et al., 2016). Petrus (2017), infers that when change and the resistance to change are effectively managed by employees, it is fundamental for the change to become a norm and for the change to be sustained. For health care organisation leaders to improve organisational change within the health care system, a change in perspective is required.

Leaders within the South African health care system require a change to enhancing health care providers in a living system, rather than enhancing health care delivery in a mechanistic model (Mash et al., 2008). Furthermore, Mash et al. (2008), infers that the faults of the mechanistic model of an organization are shown through the organisation change. Given that

the mechanistic model limits the room for flexibility and places importance upon control, using a correct number and mix of health care providers, efficiency, and lastly policy.

Thus, when health care organisation leaders use the mechanistic model, the response by health care providers will not be as transformative as expected. The simple reason is that the 'machine' consists of inanimate parts, whereas the health care system consists of people (Mash et al., 2008). Edmonds (2011) agrees, that the key to change within an organisation consists of the type of individuals within the organisation. Thus, it becomes imperative for LMIC health care providers to be equipped for the change, in light of the pre-existing burden of stress, burnout, and compassion fatigue that is experienced.

Health care reforms within South Africa bring about change in the health care system. Naledi et al., (2011) stipulated that to achieve better health outcomes, the re-engineering of PHC should be accompanied by a change of culture that encourages the implementation and planning to be system-wide. Furthermore, it is stated that people such as health care providers are required strategic partners for the mobilization of the change. According to Edmonds (2011), when organisations are unsuccessful at implementing change a high price is paid, which can result in outcomes of employees feeling demotivated and more especially losing key employees. Therefore, it becomes integral for leaders in the health care sector to ensure that health care providers are equipped for organisational change.

When an organisation undergoes extensive system change, the organisation must be prepared and equipped with the necessary tools for such change, for that organisation to perform at its optimum. Weiner (2009), states that a multi-faceted, multi-level construct is what organisational readiness for change is referred to. Organisational readiness for change is an organisational-level construct, thus readiness for change is referred to as change commitment and change efficacy. With regard to change commitment, the readiness for change can refer to

the individuals within the organisation having a shared determination to implement the change. It has been estimated that a lack of organisational readiness and preparation has the potential to contribute to half of the implementation failures that occur in systems change (Kotter, 2007; Gudergan et al., 2015).

Weiner (2009) claims that the benefits of organisational readiness allow for assisting members in the organization to evaluate available resources, task demands, and situational factors realistically. Therefore, in the health care sector, organisational readiness is necessary for health care providers that face pre-existing workload burdens and that now require to deliver person-centred care.

For the workforce to possess organisational readiness, there must become a need for structural and technical changes, as well as 'workforce preparedness'. For instance, when individuals are subjected to change there is heightened anxiety among individuals. Furthermore, from the extensive literature on health care workers being susceptible to high amounts of stress, burnout, and compassion fatigue. Thus, due to the further effects the system changes entail, these issues of stress, burnout and compassion fatigue are compounded. For that reason, when health care workers are subjected to such strain, they become unable to perform at their optimum level and provide holistic, integrated care that is person-centred.

Aforementioned in chapter one, workforce preparedness is an essential component of preparing employees for a change in the organization. Given that it is productive in times of a insecure and uncertain environments which causes employees to feel overwhelmed. Workforce preparedness requires employees to be capacitated with the necessary skills that foster greater mobility and encourage employees to accept change without a loss to the economy (Doeringer et al., 1991). Furthermore, a large focus of workforce preparedness rests upon the provision of

generic skills, such as non-technical skills (NTS), which is vital for system changes within the health care sector (Doeringer et al., 1991; Scott et al., 2016).

For this scoping review, this literature review focuses on non-technical skills, and more specifically under its ambit, emotional coping skills. NTS is imperative for the delivery of person-centred care, therefore, a necessary skill for health care providers that are impacted by the health care reforms in South Africa. Especially due to the shift for the re-engineering of PHC that calls for person-centred care.

In the review conducted by Scott et al. (2016), it was discovered that there was a need for comprehensive task analysis that examines non-technical skills that apply to LMICs and across settings, as well as to develop evaluation and training tools. Thus, due to the need for PHC nurses in South Africa to be capacitated with emotional coping skills to equip the health care workforce for the system change and assist with the management of the added stress, burnout and compassion fatigue of delivering person-centred care due to South Africa's health care reforms (Yeşil & Polat, 2023). Therefore, there is a need to establish what emotional coping skills can assist in achieving this objective.

2.5. The importance of health and well-being for health care providers.

Health and well-being are of utmost importance, in that one-third of a worker's daily life are used up at their workplace. Extensive research illustrates that one of the most stressful professions of health care providers, more specifically the nursing profession (Almeida & Miclos, 2022; Danna & Griffin, 1999; Engelbrecht et al., 2021; Lim et al., 2010a; Lim et al., 2010b). The stressful nature of the nursing profession is due to extensive working hours, the emotional nature of patient demands and interpersonal conflicts, as well as inter-professional demands.

The issues faced have further evolved due to the changing health care environments, budget cuts and new technologies. The work and personal stress that these health professionals face increases due to all these factors combined. Considering the experiences the nurses have within their workplace, regarding the emotional, physical, social or mental nature of the work, can affect how they will perform in the workplace (Almeida & Miclos, 2022; Khamisa et al., 2017). Due to the nature of these experiences, these affect the overflow into the non-work domains of the nurse's life, it is imperative to ensure that the health and well-being of PHC nurses are well managed.

Cooper and Cartwright (1994), agree that there is an acknowledgement that an individual's personal and work life are not to be regarded as detached entities, as they are entangled and interrelated spheres. Thus, these spheres, the individual's personal and work-life have reciprocal effects on each other. In light of the stress that the individual experiences due to everyday life coupled with work-related stress can initiate emotional and physical outcomes that are considered to be detrimental.

A study conducted by Winwood and Lushington (2006), found that the psychological strains that are experienced by health care providers at work spill over during the non-work time, resulting in lowered recovery from antecedent stress/fatigue experienced at the end of a shift and affecting sleep. This is due to the excess mental and physical demands that are placed upon the individual's mind and body. Furthermore, according to Boyd (1997), when employees face poor health and well-being, there is potential that both the organisation and the employee are affected in negative ways, in that there will be lower quality decisions, productivity, and high absenteeism within the workplace. Therefore, equipping PHC nurses with emotional coping skills, allows PHC nurses to use their skills in both their personal and work life.

The driving of person-centred care in the South African health care system introduced measures to lower patient suffering and neglect, by providing patients with care that entails a subsequent requirement for the nurse to cultivate a highly compassionate role. In the health care sector, it is apparent that when a patient's trust is gained through the means of PHC nurses being compassionate and empathic, and the outcome is that patients have a more favourable prognosis, experience less pain, and tend to be compliant. When nursing practitioners cultivate compassionate and caring relationships with their patients, the practitioners, in turn, are capable to improve their well-being. There is an array of literature that provides evidence of the positive role that compassion towards the nursing practitioner, in that it guards them against burnout and work-related stress (Donoso et al., 2015; Munyewende & Nunu, 2017; Yeşil & Polat, 2023). Thus, to reduce patient waiting times, which increases patient satisfaction, nurses must continue to respect, listen, and treat their patients politely.

In order for PHC nurses to be able to perform holistic care, they must be at their optimum level of health and well-being. The literature suggests that there is a need to protect the nurse from the repercussions of the compassionate nature that this role entails, which is commonly referred to as emotional labour (Kinman & Leggetter, 2016).

2.5.1. Emotional Labour

Studies show that a major contributor to the high levels of stress, compassion fatigue and burnout observed in health care providers is due to the emotional demands of the health care sector (Kinman & Leggetter, 2016). The effort involved in managing feelings when the job role specifies that certain emotions should be displayed and other emotions should be concealed is referred to as emotional labour, which is found in a PHC nurse job role. There are three elements that exist in a job that contributes to emotional labour, (1) intensive interaction with the public; (2) the necessity to produce an emotional state in other people; (3) a set of explicit

or implicit rules pertaining to the type of emotional display that is appropriate and inappropriate (Kinman & Leggetter, 2016).

According to Delgado et al., (2017), within all aspects of the health care provider's daily work a major factor is emotional labour. Moreover, the experience of emotional labour concerning interpersonal interactions is apparent across genders, health contexts, and clinical fields. However, there can be a detrimental effect on the health care providers to their work, well-being and relationships with colleagues, families, and patients when they experience high levels of emotional labour. Additionally, within the health care sector workplace adversity arises due to emotional labour experienced by health care providers.

Delgado et al., (2017), contends that the emotional demands at work do not have to be perceived to hinder rather they can be used to promote health and well-being in the health care sector among health care providers and motivation experiences. This is supported by a study conducted by Donoso et al. (2015), in that the positive benefits of caring on nurse's well-being and motivation found that if the internal emotional resources are accessible to nurse's, emotional demands that the nursing profession face can encourage well-being and motivation.

It is further stipulated that the burnout syndrome regarding the diminution of nurse's emotional resources, is related to low extrinsic rewards attained (i.e., poor promotion prospects) and an imbalance of high extrinsic efforts spent (i.e., job demands). Thus, a need arises to safeguard the emotional state of health care providers such as nurses, to gain the positive connotations related to burnout. Multiple studies show that emotional coping skill strategies such as mindfulness training, stress management training, and cognitive behavioural training aim to reduce the stress and burnout that health care providers face (Lim et al., 2010a; Lim et al., 2010b; Tetrick & Winslow, 2015). Hence, this notion motivates for this scoping

review to delve within emotional coping skill interventions ensure that PHC nurses are capacitated with the correct skills to safeguard their well-being.

2.6. Defining Coping.

A study conducted by Koh et al. (2015), found a reduction in psychological morbidity and burnout when health care practitioners use coping mechanisms. Furthermore, the study on health care practitioners found coping mechanisms assist in coping better against burnout and the prevention of burnout. Lazarus (1966), interpretation of coping is the process of the transaction between the stressor that an individual experiences and the individual. According to Lazarus & Folkman (1984), the method by which a person manages the demands of the environment/person relationship that are evaluated to be stressful is referred to as coping. Blount et al. (2007), adds that historically coping is a construct that has been subcategorized in an array of ways. Moreover, views coping as a dynamic process, which changes in the responses to the constant demands of the stressor.

Pearlin & Schooler (1978) stipulates that coping behaviours can pose a protective function, which can be exercised in three manners: the emotional consequences of issues experienced are kept within manageable bounds; neutralization of an experience problematic character by perceptually controlling the meaning of the experience; and lastly, by modifying/ eliminating conditions that cause a growth in issues that are experienced. Kleinke (1991), view coping as the behavioural and cognitive efforts that a person makes to manage a situation or circumstance that is assessed as possibly stressful or harmful (as cited in Van der Colff & Rothmann, 2009).

Furthermore, according to Fleishman (1984), results and strategies are what coping can be referred to as coping, as a result, can be viewed as the subsequent outcomes of the selected strategy for the person (as cited in Van der Colff & Rothmann, 2009). Coping as a strategy, can be viewed as the various methods that a person can use to manage their exact circumstance.

Coping strategies can be split into avoidance or approach-oriented process, thus, either passive or active coping. Active coping is when the strategy moves towards the stressor, whereas passive coping is when the strategy moves away from the stressor which is the type of coping that is explored in this review (Van der Colff & Rothmann, 2009; Yeşil & Polat, 2023).

According to Pearlin & Schooler (1978), coping modes that are seen to be effective are unevenly distributed within our societies, with regards to those that are educated, males and those that are wealthy that make more use of the effective mechanisms that exist (Pearlin & Schooler, 1978). Blount et al. (2007), states stress and coping occur within a complex framework, with the effectiveness of the specific coping strategies that work to influence emotional, quality of life, physical health, and psychological and behavioural functioning. Thus, it is essential to be understood for the development of successful interventions.

According to Lazarus & Folkman (1985), individuals either make use of emotional or problem-focused coping mechanisms when they are required to deal with a specific issue. With regards to emotional-focused coping, instead of looking for a way to perfect its cause, emotional-focused coping deals with the unpleasant emotional effects of stress. The types of strategies that are included in emotion-focused coping are avoiding stressful situations, exercising self-control over behaviour and feelings, and distancing from the problem at hand (Lim et al., 2010a; Lim et al., 2010b; Yeşil & Polat, 2023). According to Lazarus & Folkman (1985), problem-focused coping interventions deal with strategies that aim to weigh and generate different solutions, define the issue, and guide a plan of action. According to Lim et al., (2010a), the types of problem-focused strategies are planful problem-solving and confrontive coping.

According to Bennett et al. (2001), problem-focused coping is seen as the most effective coping mechanism to deal with stress, however, with regards to emotional-focused coping

mechanisms studies have shown to improve mental health of nurses, through self-control and distancing is seen to be significantly effective (as cited in Lim et al., 2010a). In the same way, a study which viewed the coping capabilities and stress experienced by nurses in Ireland found that emotional coping skill strategies were effective when used to deal with stress (Evans & Kelly, 2004). Thus, due to the emotional labour that nurses experience that causes stress, burnout and compassion fatigue, emotional coping strategies are found to be an effective tool that PHC nurses use to cope.

Literature on emotional labour mainly zoned in on untangling the consequence of emotional regulation experienced at work. Thus, many researchers have constantly expressed the need for additional research to be conducted on how to encourage healthier coping strategies to cope with emotional demands experienced at work and diminish the use of surface acting by individuals at work to gain an understanding of emotional coping strategies that exist in HIC. (Hülshager et al., 2013; Judge et al., 2009).

According to Beddoe and Murphy (2004), mindfulness-based interventions involve a process of learning by dealing with all experiences and simultaneously being less reactive and judgemental. Mindfulness practice includes elements such as acceptance, developing resources to care for others, self-reflection, opening to difficulties without avoidance and self-care. von Hammerstein et al. (2019), stipulates that mindfulness does aim to alter an individual's emotions or thought, and the aim is to alter the individual's relationship with them. Mindfulness-based interventions provide a manner for individuals to experience life directly, with the absence of being filters through pre-conceptions, expectations, and beliefs (Beddoe & Murphy, 2004). A study by Hülshager et al., (2013), found that emotional coping skills interventions such as mindfulness are found to be a productive manner for employees to cope with the emotional job demands.

An additional emotional coping intervention is stress management interventions, which comprises a range of interventions that fall under the umbrella of stress management intervention, and provides the potential for employee health and well-being, as well as individual development (Edwards & Burnard, 2003; Dewe & O’Driscoll, 2002; Tetrick & Winslow, 2015). The aim of stress management interventions endeavours to enable workers to cope with challenging situations by developing their coping abilities and skills (Tetrick & Winslow, 2015). An emotional coping skill intervention study conducted by Van der Klink et al., (2001), viewed four stress management interventions such as relaxation techniques, organization-focused interventions, cognitive-behavioural approaches and multi-modal techniques. The study found that overall stress management interventions were effective for stress that is experienced at work. More specifically, it was found that cognitive-behavioural approaches were the most effective. The various styles of emotional coping skill interventions are essential to be understood when viewing emotional coping skill interventions as a way to equip PHC nurses to be able to manage the organisation change, as well as the adverse effects of people working in the health sector.

Van der Klink et al., (2001), postulate that in order to determine the most effective manner to improve the development of intervention strategies that are more effective, there is a need to gain insight into the conditions under which an intervention is the most operative. Consequently, this review aims to add value by closing the gap in setting a foundation of what are the emotional coping skill interventions that already exist, through mapping context-specific emotional coping skill interventions that exist within the LMIC context.

2.7. Emotional coping skill interventions and the adverse effects of people work.

There is an array of literature on health care providers being susceptible to high amounts of stress, burnout, and compassion fatigue. The further effects of the system changes entail added pressure upon the PHC nurse, thus, these issues of stress, burnout and compassion fatigue are

compounded. Consequently, the issues of adverse effects of “people work” become barriers for health care providers in delivering person-centred care in the health care system and dealing with the organisational changes. Given that PHC nurses are not at their optimal level of health and well-being to effectively perform their duties. Hence, this review will provide an understanding of the adverse effects of “people work” and system changes such as stress, burnout and compassion fatigue, as well as provide an understanding of emotional coping skill interventions and the adverse effects of people work.

2.7.1. Stress

The South African health care system exposure to system changes, Patrick & Lavery (2007), postulate that those that are affected by system changes in the South African health care system contributes to stress-related outcomes for those affected by the changes. Thus, due to the complex relationship that exists between coping and stress, it is essential to understand how stress is defined. Regarding stress, it is well-known globally that one of the most stressful professions is nursing. There has been extensive research on the disastrous effects that nursing stress brings about (Lim et al., 2010a; Lim et al., 2010b; Yeşil & Polat, 2023). According to Lazarus and Folkman (1984), stress is seen to be any circumstance where external and/or internal demands are evaluated as challenging or above the adaptive or managing resources of the group or the individual.

Positive responses to stress are termed ‘eustress’, while the negative responses to stress are suitably termed to be ‘distress’. Thus, stress should be looked at as a continuum, in which the person can range from eustress to that mild/moderate distress, and lastly that of severe distress (McVicar, 2003). However, even though stress can have positive outcomes depending on the context, it is still essential to possess emotional coping skills, when dealing with stress.

McVicar (2003) postulates that to combat the occupational stress experienced to achieve a healthy workforce, it is essential for counselling and support to be offered. In the study conducted by Van der Colff & Rothmann (2009), a hypothesis stated that “Approach coping and seeking emotional/social support predict low burnout and high work engagement; whilst passive coping strategies (i.e., avoidance, turning to religion and focus on and ventilation of emotions) predict burnout and low work engagement.” (p.8), was confirmed. However, Delobelle et al. (2011), suggests that from a study that was conducted, health care providers such as nurses are seemingly gratified with the job itself remains to be a strong job satisfier even though nurses within the study were frustrated by certain issues. This finding agrees with an array of other studies that indicate that the majority of nurses within South Africa hold the nature of their job to a high value despite their working conditions which result in an experience of stress (Delobelle et al., 2011; Erasmus & Brevis, 2005). Thus, inferring that when nurses are equipped with the necessary coping mechanisms to cope with occupational stress, particularly that of emotional coping. It results in the outcomes of burnout that health care providers experienced are lowered and as well as, an increase in work engagement.

Boyle et al., (1991), state that due to the multiple stressors experienced by nurses, that are not amenable to change by an individual nurse, thus, the use of emotional coping interventions can contribute to an essential part of coping. Given that emotional coping interventions assist in changing one’s attitude in the direction of the stressor(s). In the literature that is an array of studies that encompass positive ways for health care providers to positively cope with the detrimental effects of stress that affect their physical and mental well-being, these are coping strategies such as using relaxation techniques and debriefing sessions (Lim et al., 2010a; Lim et al., 2010b; Van der Colff & Rothmann, 2009; Yeşil & Polat, 2023). In other studies, it suggests that emotional coping skills interventions such as social support are mainly required for the improvement of the workplace environment and dynamic change of social climate

uncertainty. Moreover, it is suggested that improvement can aid in the prevention of burnout (Chang et al., 2006; Devereux et al., 2009).

2.7.2. Burnout

Patrick & Lavery (2007), states that one of the stress-related outcomes that an individual who experiences change is burnout. Thus, essential to be understand this for nature of this scoping review. According to Maslach et al., (1986), burnout is a syndrome consisting of three different components depersonalisation (DP), emotional exhaustion (EE) and reduced personal achievement (PA), due to the extended exposure to situational and environmental stressors that infer an outcome of work-related stress. PHC nurses are prone to developing burnout and experiencing compassion fatigue as a result of the emotional labour and the nature of their job (Potter et al., 2010).

In the nursing profession, it is reported that burnout is at its highest, due to the environment that the nurses are exposed to for a prolonged measure of time. Furthermore, nurses have a scarce amount of resources within their working environment, with a growing number of responsibilities. However, nurses are required to deliver empathetic humane, proficient, culturally sensitive, and moral care to provide person-centred care. Thus, burnout is a likely outcome, due to the imbalance between dealing with their stressful working environment and delivering care which is of high quality (Khamisa et al., 2015).

Literature shows that there is an array of studies that encompass positive ways for health workers to positively cope with the detrimental effects of burnout (Khamisa et al., 2015; Laschinger & Fida, 2014; Payne, 2001; Yeşil & Polat, 2023). In a study, it was found that due to hospice nurses using effective coping strategies, showed low levels of burnout. Conversely, this does not imply to label some nurses as ‘bad’ or ‘good’ at coping with burnout, as the effectiveness often most interventions depend on the situation or circumstance that is present

(Payne, 2001). Additionally, a study conducted on nurses in acute mental health settings found that emotional coping strategies such as social support lowered burnout levels. Moreover, the study found that social support played an instrumental role in decreasing the emotional exhaustion experienced by nurses (Devereux et al., 2004).

2.7.3. Compassion Fatigue

A caregiver is what several nurses would define themselves to be, as from the onset they are primed to be nurturers (Joinson, 2000). According to Potter et al. (2010), when helpers are traumatized by assisting and helping others, is referred to as compassion fatigue. Compassion fatigue is considered to be a deeply emotional, spiritual and physical consumption that is supplemented by a considerable amount of emotional pain. Notably, compassion fatigue is a negative and caustically less term than that burnout, and thus, in the end, it leads the caregiver to suffer from emotional exhaustion (Aycock & Boyle, 2009).

From various studies, it can be further seen how detrimental compassion fatigue is to the nursing profession and there is a need for more effective interventions to assist in reducing compassion fatigue among nurses. In the literature that is an array of studies that encompass positive ways for nurses to positively cope with the detrimental effects of compassion fatigue. For instance, when developing and detecting information on what are effective emotional coping interventions, it is an essential issue to incorporate. These studies are similar in that they state how essential the social support of the worker is, in that it assists in reducing compassion fatigue (Aycock & Boyle, 2009; Jakel et al., 2016; MacRitchie & Leibowitz, 2010).

A study conducted in Jordan (LMIC), which investigated coping strategies for critical care nurses that experience compassion fatigue, found that the use of emotional coping interventions such as seeking social support resulted in lowered levels of compassion fatigue (Al Barmawi et al., 2019). Thus, indicates that in a nurse's working environment, a social support system is important, particularly due to the high amount of patient interaction that is experienced.

Hence, when viewing the stress-related outcomes of person-centred care, coping with the adverse effects of the nursing profession, and organization/system changes, it is revealed how stress, burnout and compassion fatigue can affect the health and well-being of health care providers. Nevertheless, from an array of studies, it is seen how the use of emotional coping skill interventions has a positive effect on the health and well-being of nurses. Thus, having effective emotional coping skill interventions is seen to be highly beneficial to PHC nurses, and will, therefore, assist them in coping with the system change that the South African context experiences.

2.8. Emotional Coping Interventions

2.8.1. High-income countries (HIC) research

From the various studies done on stress, burnout and compassion fatigue, various emotional coping skills interventions were used to improve nurses' health and well-being, provide person-centered care, cope with the adverse effects of the nursing profession, and organization/system changes. The emotional coping skills interventions health care providers most commonly used were self-control, seeking social support from peers and family, relaxation techniques and positive appraisal (Aycock & Boyle, 2009; Jakel et al., 2016; Joinson, 2000; Potter et al., 2010; Payne, 2001). In a systemic review done by Lim, Bogossian, & Ahern (2010a), on Australian nurses, it was found that an essential aspect of how nurses cope with stress is found within the social support of their family.

A quantitative study conducted by Aycock & Boyle (2009), examined interventions that are used to manage compassion fatigue that is faced by oncology nurses. It was found that peer support can be positive, in that peer support is a resource, as it is a therapeutic strategy, and reduces the isolation that the nurses feel when a patient passes on. Conversely, peer support has a negative connotation, in that it can turn out to be the opposite of therapeutic. As in the case of nurses attempting to provide emotional support to their colleagues, their colleagues

may not be able to reflect on their feelings and attitudes, thus creating a difficult dynamic to exist. Payne (2001) conducted a study on a group of nurses and was interested in their coping styles, stressors and demographics as predictors of burnout. The study found that positive reappraisal, where efforts are made to produce a positive meaning by concentrating on individual growth, is an emotion-focused intervention that was found to be used by hospice nurses, which was beneficial. Positive reappraisals at times would be more beneficial, as it would assist the nurses to use their experiences to be able to gain knowledge and prosper. However, there were instances in which problem-focused coping interventions, such as stress inoculation training are beneficial to the nurses, as it informs nurses on how to implement appropriate coping interventions.

In a quasi-experimental design study conducted by Jakel et al. (2016), on the effects of using a provider resilience mobile application (PRMA) to reduce compassion fatigue among oncology nurses. It was found that compassion fatigue is an issue with oncology nurses, and that there is a need for more effective interventions to address this issue. This study also suggests that multiple intervention styles should be considered to compensate for the many needs of nurses.

From these studies emotional coping skill interventions are essential for nurses, in that it has a positive effect on their health and well-being, thereby enabling them to provide optimal care. Furthermore, in a systemic review done by Lim et al., (2010b), it was found that there is a high turnover in the profession of nursing is experienced, with a number of these nurses voicing their intent to leave the nursing profession. The study shows that nurses who possess emotional coping skills have the ability to reduce the negative effects of detrimental issues in health care systems, and there can be lower turnover in the profession of nursing to be experienced. As a result, there will be a positive effect in the care provided, as there will be more nurses to attend

to patients. Thus, it can be seen that emotional coping skill interventions have a positive effect on the care that is provided.

2.8.2. Low/middle-income countries (LMIC) research

From the various studies done on stress, burnout and compassion fatigue, various emotional coping skills interventions were used to improve nurses' health and well-being, so that they can provide care to patients that are person-centred. In a quantitative study conducted by MacRitchie & Leibowitz (2010), which was based on a non-probability sample of sixty-four trauma workers, and examined their secondary traumatic stress, social support, empathy, and level of exposure. Like other studies done on compassion fatigue in the health science field, it was found that when there is a high degree of social support there is a reduction in secondary traumatic stress (STS) (Khamisa et al., 2015; MacRitchie & Leibowitz, 2010; Van der Colff & Rothmann, 2009). However, from the various literature, there is a need to delve deeper into emotional coping skill interventions in LMICs, to develop or apply other more effective emotional coping skills interventions, and that will decrease the stress, burnout and compassion fatigue that exists.

Moreover, to gain an understanding of emotional coping skill intervention that is specific to the LMIC context. Given that there is a need to further understand non-technical skills specifically, emotional coping skill interventions, within the LMICs. In that, these interventions can assist health care providers in dealing with the effects of the system/organisational change within the health care sector due to HRH reforms, such as the re-engineering of PHC, and the NHI plan, which place immense pressure on health care providers in South Africa. The literature supports that emotional coping interventions impact on the person-centred care that health care providers, and more specifically PHC nurses provide to their patients.

2.9. Summary

The presented literature motivates the overall importance of health and well-being for PHC and how the delivery of care is optimized when health care providers are at their optimum. Thereafter, the review sheds light on the context of this scoping review by viewing the state of the South African health care system, as well as indicating the need for emotional coping skill interventions for organisational readiness in the South African context. The review then indicates how essential emotional coping skill interventions are for the adverse effects of people work, especially for the health care profession. Thereafter, the review of literature views research that has been conducted within HIC and LMIC on emotional coping skill interventions.

From the review of emotional coping skill interventions, there have been reviews in HICs, such as in Singapore and Australia that have consolidated information on coping (Lim et al., 2010a; Lim et al., 2010b). However, such studies are needed within the LMIC context, to create and develop effective emotional coping skills interventions, which can capacitate PHC nurses with the correct tools to manage the stressors that they experience in the South African context. Given that such tools are expected to achieving better health care outcomes.

Due to the study being a scoping review, this study viewed emotional coping skill interventions within the LMIC context, given the similarities that South Africa holds with other LMICs. Hence, the primary aim of this study was to map emotional coping skill interventions for health care providers in LMIC and weigh the applicability to the South African context. Moreover, this study aims to infer knowledge for further studies to be conducted on emotional coping skill interventions for PHC nurses in bridging the gap between local implementation and global knowledge.

Chapter Three: Methodology

3.1. Introduction

This chapter describes the methodology used in this scoping review study. The purpose of this scoping review is to map evidence on emotional coping skill interventions for health care providers in LMICs within existing research and literature and identify factors of the interventions that contribute towards the experience of improved well-being. This chapter provides a discussion of the research approach and method used, rigour, and provides the ethical implications for the study.

3.2. Methodological Approach.

To achieve the aim of this study the methodological approach used a scoping review. According to Levac et al., (2010), scoping reviews are defined as the process of summarizing and mapping a variety of evidence in which to carry out the depth and breadth of a field. Scoping reviews disseminate and summarize findings in research and assist in confirming the need to embark upon conducting a full systematic review, by examining the range, nature and extent of research activity, and looking at the existing literature to identify gaps. Furthermore, a scoping review tends to encompass a wide-ranging question that investigates what has been done in a field (Arksey & O'Malley, 2005; Westphaln et al., 2021; Peters et al., 2022). According to Peterson et al., (2017), scoping reviews can be used in a variety of disciplines of research that a researcher investigates, however, they are especially popular within research pertaining to health care (Davis et al., 2009; Peterson et al., 2017; Peters et al., 2022). Given that a study conducted by Pham et al. (2014), found that the majority of scoping reviews addressed a health care topic, which was 255/344 (74.1%) reviews.

Arksey and O'Malley (2005) mentioned that a scoping review encompasses a rigorous process. It is imperative to understand that the purpose of a scoping review differs from that of a systematic review, in that a scoping review aims to address a broader range of topics, unlike

a systematic review that attempts to collect empirical evidence from a fairly small number of studies that addresses a narrowly-defined question (Pham et al., 2014). Additionally, a scoping review is beneficial due to the systematic manner in which published literature is mapped and the comprehensive examination of broad topics.

Scoping reviews have been considered to be unpopular as compared to systematic reviews, nevertheless, a scoping review requires an extreme amount of effort and number of hours. However, in recent years the uptake of scoping reviews has increased due to the methodical developments made to enhance the rigour of scoping reviews (Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022). According to Davis et al., (2009), it was found that a scoping review that is well done encompasses a reinterpretation of original evidence and depth of analysis, which gives a contribution to conceptual definitions and clarification. Munn et al. (2018), posit that a significant difference between the systematic review and the scoping review pertains to the review question, in that there is a broader 'scope' and more extensive inclusion criteria in the scoping review as compared to the traditional systematic review.

This study is designed to use the key strengths of the scoping review methodology. The research methodology of a scoping review involves the capability of extracting the essence of a range of literature and providing a significance and meaning that is intellectually creative, as well as, developmental (Davis et al., 2009; Peters et al., 2022). The summarised and accessible format in which the results of a scoping review are presented allows for an effective placement of the findings for users such as practitioners, policy makers, as well as consumers of the general public (Arksey & O'Malley, 2005; Peters et al., 2022).

This is relevant to the tenets of this study, given that this study aims to cast a wide net within LMICs to gain an understanding of best practices for emotional coping skill interventions for health care providers. Moreover, the study hopes that the evidence found will assist the development of context-specific emotional coping skill interventions for PHC nurses and

weigh the applicability to the South African context. This scoping review will follow the framework of Arksey & O'Malley (2005) in conjunction with the refined guidelines of Levac et al., (2010), as well as recommendations by Westphaln et al., (2021) & Peters et al., (2022). In addition, the scoping review adheres to the procedure laid out by the JBI approach given that it is the most defined, rigorous and updated approach (Peters et al., 2020).

3.3. Search Strategy

To achieve the aim of this research study, the search strategy of this scoping review was comprehensive and included reviews and empirical studies that are both unpublished (grey literature) and published. This search strategy involved searching various electronic databases, which were utilised to search for articles related to the aim of this scoping review.

The search strategy involved systematically searching various electronic databases from the EBSCOhost Database Platform, PubMed, and ScienceDirect. More specifically, Academic Search Complete, PsycARTICLES, PsycINFO, Cumulative Index to Nursing and Applied Literature (CINAHL), Web of Science, Cochrane Library and MEDLINE (Ovid) were utilised to search for articles related to the aim of this scoping review. The search included searching for grey literature using the OpenGrey database to identify any additional literature on the subject matter.

To achieve the aim of this research study, the search strategy of this scoping review encompassed a summation of the following three steps (Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022).

- An initial limited search of at least two online databases relevant to the topic.
 - Thereafter, there is an analysis of the text words that are within the title and abstract of the found papers, as well as of the index terms that are used to describe the articles.
- Using all the identified keywords and index terms that were found in Step 1, there was a search conducted through the included databases.

- The reference list of all the identified articles and reports was thereafter searched for additional studies.

In conjunction with the steps mentioned above, a flowchart was used to reach the aim of this scoping review, as it is critical to document the process of a scoping review study. An adapted version of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-ScR) extension for scoping reviews (PRISMA-ScR) layout was used for this study (Tricco et al., 2018). According to Tricco et al., (2018), PRISMA- ScR involves a 22-item checklist to assist researchers in improving the reporting of scoping reviews. Moreover, PRISMA-ScR is designed to assist users (i.e., policymakers, organisational leaders, and health care practitioners) in building a greater understanding of terminology, underlying concepts, and key items of scoping reviews (Tricco et al., 2018). Therefore, the rigour of the search strategy suits the methodology required for this scoping review.

3.4. Protocol Design

This scoping review was guided by Arskey and O'Malley's (2005) 5-step framework for undertaking a scoping review and the refined guidelines of Levac et al., (2010), as well as recommendations by Westphaln et al., (2021) & Peters et al., (2022).. The following steps were followed;

- (1) identifying the research question,
- (2) identifying relevant studies,
- (3) selecting studies,
- (4) charting the data,
- (5) collating, summarising and reporting the results.

3.4.1. Step 1: Identifying the research question.

Arksey and O'Malley (2005), posit a recommendation pertaining to the development of the research question of the scoping review, to generate a greater depth and breadth in the coverage

of studies to be included in the review, a wide approach should be maintained (Westphaln et al., 2021; Peters et al., 2022). According to Khalil et al. (2016), this step is critical to the methodology of a scoping review, in that it contributes by linking and clarifying the research question and the purpose of the scoping review. The overall aim of this study is to map emotional coping interventions within LMICs to create and develop emotional coping skills interventions, which can capacitate PHC nurses with the correct tools to manage the stressors that they experience in the South African context. Therefore, this study aimed to maintain a larger ambit of studies to be included in the scoping review by developing the research question below.

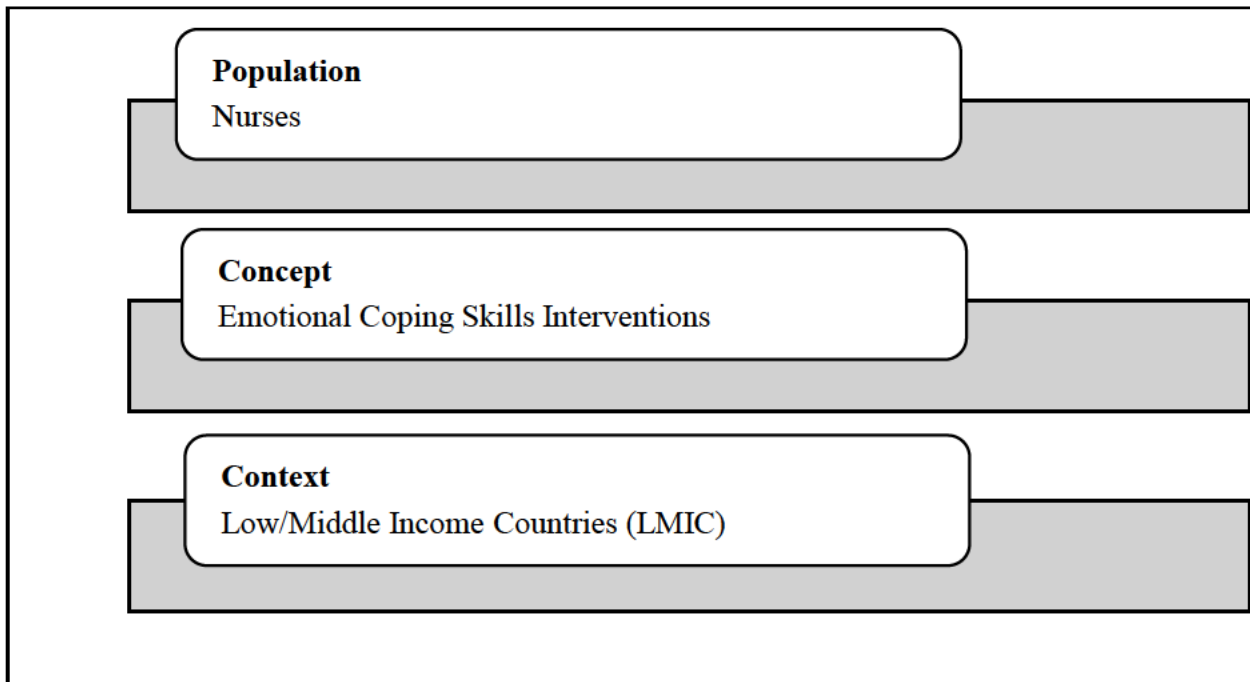
The central research question developed for this study is defined as:

- What are the existing emotional coping skill interventions for health care settings?

The sub-research question:

- What factors of the intervention contribute towards improved well-being?

Given that the scoping review is underpinned by the recommendations of the Joanna Briggs Institute for scoping reviews and therefore, used the population, concept, and context (PCC) framework (Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022). Therefore, the research question of this scoping review was guided by the PCC framework as in Figure 1, to guide the scope of this scoping review.

Figure 1*PCC Framework***3.4.2. Step 2: Identifying relevant studies.**

In this step of the search strategy, the relevant studies were identified. In light of the above-mentioned, the search of the following databases was conducted to identify relevant resources for this study; Ebscohost Database Platform, and Pubmed. More specifically, Academic Search Complete, PsycARTICLES, PsycINFO, Cumulative Index to Nursing and Applied Literature (CINAHL), Web of Science, Cochrane Library and MEDLINE (Ovid) were utilised to search for articles related to the aim of this scoping review. To search for grey literature, the OpenGrey database was used to identify any additional literature on the subject matter. The selected databases were chosen for their relevance and applicability in the field of healthcare research. Furthermore, a hand search was conducted for all reference lists of included studies to identify additional studies of relevance. In this search strategy, both breadth and depth are integral to the search. The following guidelines were followed, due to the personnel resources, budget,

and time (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022):

- (1) The decision-making around the scoping review was guided by the study's research question.
- (2) During the search process, there was a collaborative effort and a suitable team that consisted of relevant expertise. The team consisted of the supervisor, the co-supervisor and the primary researcher of this scoping review.
- (3) There was an acknowledgement of the limitations and the decisions taken within this search strategy.

3.4.2.1. Search Term Strategy

The research team developed an extensive list of primary and secondary search terms as well as filtering methods. The primary search terms as in Table 1, were focused on the key emotional coping skills-related terms while the secondary search terms as in Table.2, including a broader set of keywords. The search strategy for the scoping review was piloted to examine the suitability of the elected keywords and electronic databases, as in Table 3.

Table 1

Primary Key Words

Population	Concept	Context
• Professional Nurses.	• Emotional Coping Skill Interventions	• Low/Middle Income Countries.
• Nurse Practitioner	• Psychological Well-being.	
• Registered Nurses.	• Stress.	
	• Anxiety	
	• Burnout.	
	• Emotional Labour.	

	<ul style="list-style-type: none"> • Compassion Fatigue. 	
	<ul style="list-style-type: none"> • Depression. 	

Table 2

Secondary Key Words.

Population	Concept	Context
<ul style="list-style-type: none"> • Care Giver. 	<ul style="list-style-type: none"> • Happiness. 	<ul style="list-style-type: none"> • Clinics.
<ul style="list-style-type: none"> • Medic. 	<ul style="list-style-type: none"> • Emotional Exhaustion. 	<ul style="list-style-type: none"> • Community Health Centre.
	<ul style="list-style-type: none"> • Fatigue. 	<ul style="list-style-type: none"> • Community Care.
	<ul style="list-style-type: none"> • Run Down. 	<ul style="list-style-type: none"> • Mobile Clinics.

Table 3

Pilot Search of Scoping Review

Date of Search	Keyword Search	No. of Publications Retrieved	Search Engine Utilised
2 February 2019	“emotional coping skill interventions for nurses”	8,458	ScienceDirect

3.4.2.2. Search Term:

To acquire the literature that is relevant to this research study, the following search term was decided through trial and error and using Boolean search terms:

- ‘emotional coping skill interventions for nurses’

3.4.3. Step 3: Study selection.

The scoping review process of literature within this study consisted of screening titles, abstracts, and full-text articles, of which an iterative team method was used to study and extract data. Therefore, there was an elimination of studies in the study selection process that did not address the central research question of the scoping review. This process was conducted by two investigators with the third one being the final check. In the case that there are any articles that the two reviewers do not agree on, the third reviewer assisted in the selection. The title and abstract were screened for inclusion guided by the inclusion and exclusion criteria (Eligibility Criteria), as in Table 4. Given that the exclusion and inclusion within the eligibility criteria as in Table 4. which is grounded on the main research question of the study ensured that from the outset of the scoping review, consistency of the decision-making between all reviewers (Arksey & O'Malley, 2005; Westphaln et al., 2021; Peters et al., 2022). All relevant and appropriate articles were included in the full-text review. In terms of software tools used to select eligible articles, Endnote was used to screen titles and thereafter, Rayyan was utilised to screen abstracts. Therefore, all reviewers were capacitated to systematically tracked and selected eligible articles. Furthermore, the full-text articles were assessed to determine whether they met the set inclusion criteria (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022).

Table 4

Eligibility Criteria

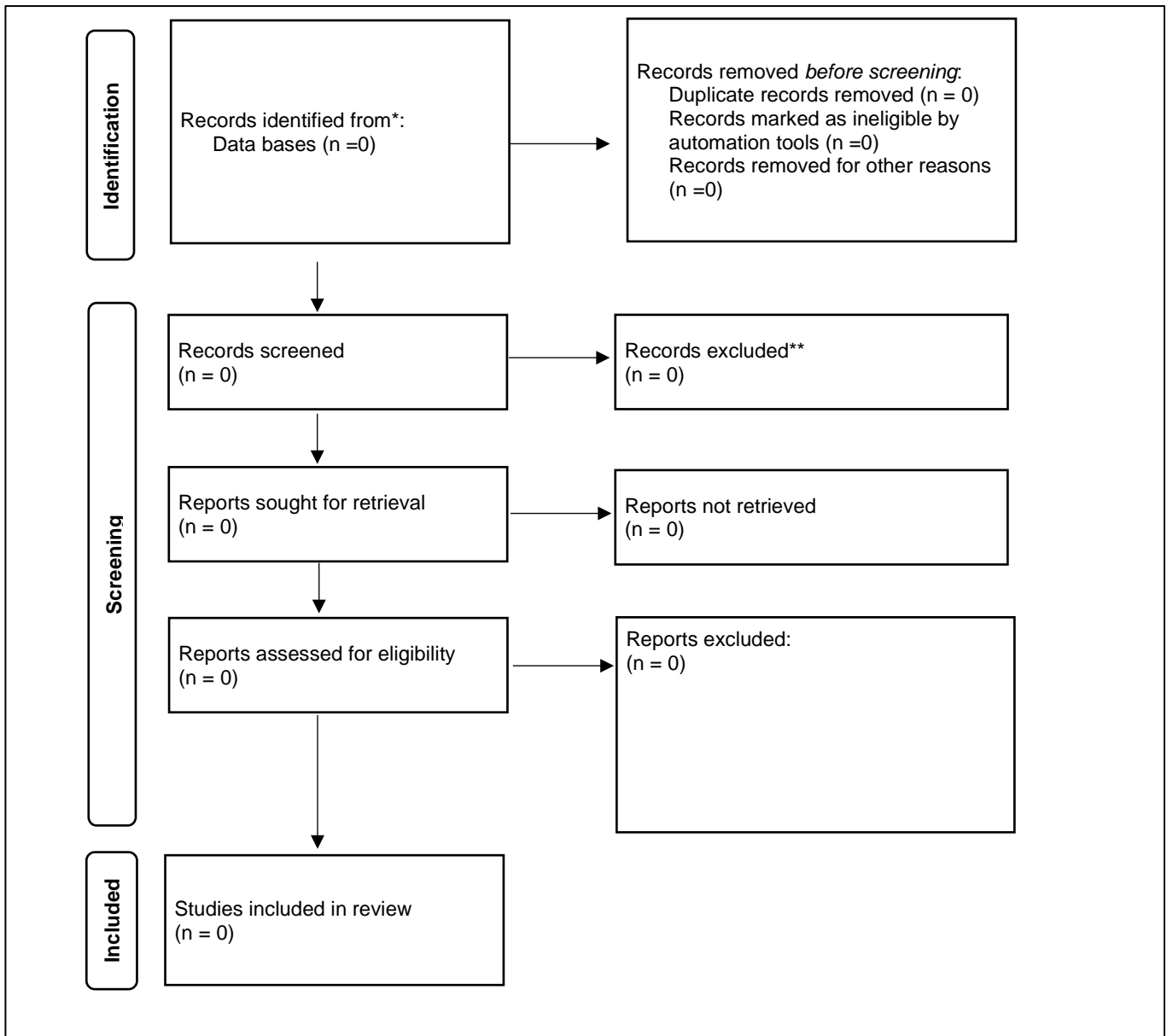
Inclusion	Exclusion
<ul style="list-style-type: none"> All study designs. 	<ul style="list-style-type: none"> Any other health care professional and no nursing students.
<ul style="list-style-type: none"> studies that focus on Registered Nurses. 	

<ul style="list-style-type: none"> • studies that focus on Mental and Emotional Health. 	<ul style="list-style-type: none"> • Physical Health unless a link between mental health is established.
<ul style="list-style-type: none"> • studies based in Low and Middle-Income Countries (LMICs). 	<ul style="list-style-type: none"> • High-Income Countries (HIC).
<ul style="list-style-type: none"> • English Articles. 	<ul style="list-style-type: none"> • All articles that are not translated into English.
<ul style="list-style-type: none"> • Studies that include evidence on interventions. 	<ul style="list-style-type: none"> • Situational Analysis or similar or epidemiological.

To critically document the screening results a flowchart was used to critically document, in order to achieve the aim of this scoping review. The flow diagram used within the screening of the results for this scoping review was the adapted version of the PRISMA-ScR, in Figure 2 (Tricco et al., 2018). According to Moher et al., (2010), PRISMA-ScR involves a four-phase flow diagram, as well as a (PRISMA-ScR) checklist in Appendix 1. To assist researchers in improving the reporting of meta-analyses and systematic reviews is the aim of PRISMA-ScR. Moreover, PRISMA-ScR is especially used for the evaluation of interventions and is thus suited to the aim of this scoping review. Due to the purpose of this study, this flowchart was used to assist in reporting with regard to this scoping review.

Figure 2

Example of the PRISMA-ScR flow diagram for the scoping review process (Tricco et al., 2018).



3.4.4. Step 4: Charting the data.

To chart the data, the study was guided by a narrative review approach. According to Mays et al., (2005), a narrative review of literature entails interpreting, explaining and summarising evidence of a particular question or topic. A narrative review of literature allows for a variety

of types of evidence to be reviewed such as quantitative or qualitative, this is flexible. Due to the purpose of this study, this approach is suitable since a scoping review was conducted.

Furthermore, from each study, the process-oriented information and the contextual information were extracted. Information retrieved from the database searches was recorded as follows; author(s) & year of publication, study location (country), aims and objectives of the study, methodology, study population, intervention type, duration of the intervention, outcome measures, key findings, and limitations. In this step of the search strategy, the following was taken into consideration (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022):

- (1) The data-charting form. (This form was comprised of the variables that were extracted, that answered the research questions of the scoping review.)
- (2) In an iterative manner, the data charting was conducted. The extracting data, comparing progress and updating the data-charting form were independently conducted by two researchers.
- (3) In analysing process-related data, qualitative content analysis and extra planning were applied.

The charting of the results was aligned with the research objective and questions of this scoping review. Furthermore, the charting of the results of this scoping review was done in an Excel table format as in Table 5.

Table 5*Data Charting Form*

Author(s) & Year of Publication
Study Title
Study Location (Country)
Methodology
Aims and Objectives of the Study
Study Population
Intervention Type
Duration of the Intervention
Outcome Measures
Key Findings
Limitations

3.4.5. Step 5: Data summary and synthesis of the results.

The aggregated findings of the information provided an overview of the individual research studies. In this stage of the scoping review, to provide an overview of the literature in this study, the nature and the extent of the articles that were reviewed were represented in qualitative and quantitative data. Thus, tables and graphics charts were used, thereafter it was followed by a presentation of qualitative synthesis (thematic analysis). Moreover, the thematic synthesis was guided by three stages, first, to the code text 'line-by-line', second, developing descriptive themes and third, creating analytical themes (Thomas & Harden, 2008). In this scoping review, descriptive themes were developed to categorise and summarise the included studies. Furthermore, analytical themes were formulated by interpreting the significance and implications of the descriptive theme findings in relation to the research questions or objectives of the review.

The data summary and synthesis of the results stage, this stage was divided into three different steps that shall be distinct (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022).

- (1) Analysis (qualitative and numerical analysis).
- (2) Reporting on the findings of the scoping review, and the reporting on the outcomes of the review that are related to the research outcomes.
- (3) A reflection of the meaning and the implications and the meaning of the findings that are in relation to the objectives of the research study.

3.5. Rigor

Peters et al. (2020), recommend that an ideal scoping review shows methodological and procedural rigour. In light of the raised questions on the rigour of scoping reviews. Levac et al., (2010), suggested recommendations which aim to improve the rigour of scoping reviews, such as:

- (1) filtering the search strategy built upon screening titles, and then abstract taken from the search,
- (2) decisions about the selected study are based on the inclusion and exclusion that is held during the onset of the scoping process,
- (3) during the beginning, midpoint, and final stages of the abstract review process, a minimum of two researchers review full articles for the scoping review's inclusion.

The methodological approach that was used in this scoping review was transparent and rigorous during the overall research process to increase procedural consistency, objectivity and transparency (Tricco et al., 2018; Westphaln et al., 2021; Peters et al., 2022). This scoping review was guided by the supervisors of this master's thesis, hence, there were regular meetings with the supervisors throughout the review process.

During the abstract review process of the scoping review, supervisors accessed and were consulted with, for discussions about uncertainties and challenges on the selection. Peer

checking was constant throughout the study for feedback, in terms of the search terms and as well as, inclusion and exclusion of documents.

Furthermore, to ensure the literature reviewed in the study was a broad search various databases and search engines were used, moreover, the search term was created to show rigour in including a high amount of literature. This study included grey literature to limit the risk of publication bias. For the purpose of including various types of literature by including literature with non-significant, negative, contentious findings rather than limiting to published literature with hypothesis-affirming, positive, and significant findings (Haddaway et al., 2015).

3.6. Ethical Considerations.

There are two dimensions of research ethics which are procedural ethics and ethics in practice, which is also known as micro-ethics. Procedural ethics is when research is done on humans, approval is required from the research ethics committee to commence before the commencement of the research process. Ethics in practice is the ethics that are faced by the researcher on an everyday basis in the research process (Blanche et al., 2006). This study made sure that these dimensions were maintained:

Risk to participants

- This scoping review does not include participants, thus there was no direct or indirect (i.e., emotional, biological, and physical harm or wrongfulness) risk caused to any participants.

Benefits

- To improve the emotional health and well-being of PHC nurses in South Africa, to capacitate PHC nurses with emotional coping skills interventions for the system changes in the health care sector. To infer future research for emotional coping skills intervention, by identifying research gaps. To provide an understanding of best

practices for emotional coping skills intervention, to assist in the development of emotional skill coping interventions in South Africa.

Consent

- Due to this study not including participants, no informed consent was required.

Permissions

- Given that the study is a scoping review, ethical issues were limited, as no human participants were required for the enquiry this study. The collection of data was conducted using literature extracted from academic databases. Therefore, this study is exempted from ethics conducted in traditional research. This study was given full approval – no risk/exemption ethical clearance by the Humanities & Social Sciences Research and Ethics Committee as available in Appendix 2.

The research data was securely stored for five years in the offices of the School of Applied Sciences at the University of Kwa-Zulu Natal. After five years, the research data will be shredded and disposed of adequately. This research will be made publicly disseminated through the University of Kwa-Zulu Natal resources and databases. Throughout this research process, these ethical considerations were upheld.

3.7. Chapter Summary

This chapter aimed to provide an outline of the methodology for this scoping review. Therefore, this chapter discussed the research methodological procedure that this study used, the rigour and lastly the ethical considerations in this study.

Chapter Four: Results & Discussion

4.1. Introduction.

This chapter presents two sections, namely the results and discussion. The objectives were to map and synthesize the data on emotional coping skills interventions within the LMIC health care sectors and the factors of the interventions that contribute towards the experience of improved well-being for PHC nurses. Thus, the results section provides a descriptive analysis by providing a narrative account of the nature, extent, and distribution of the eligible articles in the review (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022). The discussion section intends to provide an in-depth analysis that explores the objectives of this study and is presented through themes that emanate from the data.

4.2. Results

This section describes the analysed articles within this study, such as setting, geographical location, temporal distributions, databases, study design, gender, age of participants, outcome measure, and intervention delivery. To provide a mapping of the findings and numerical analysis, the study includes tables, charts, and graphs. Thereafter, the evidence extracted from the selected articles of the scoping review is presented within the data extraction table.

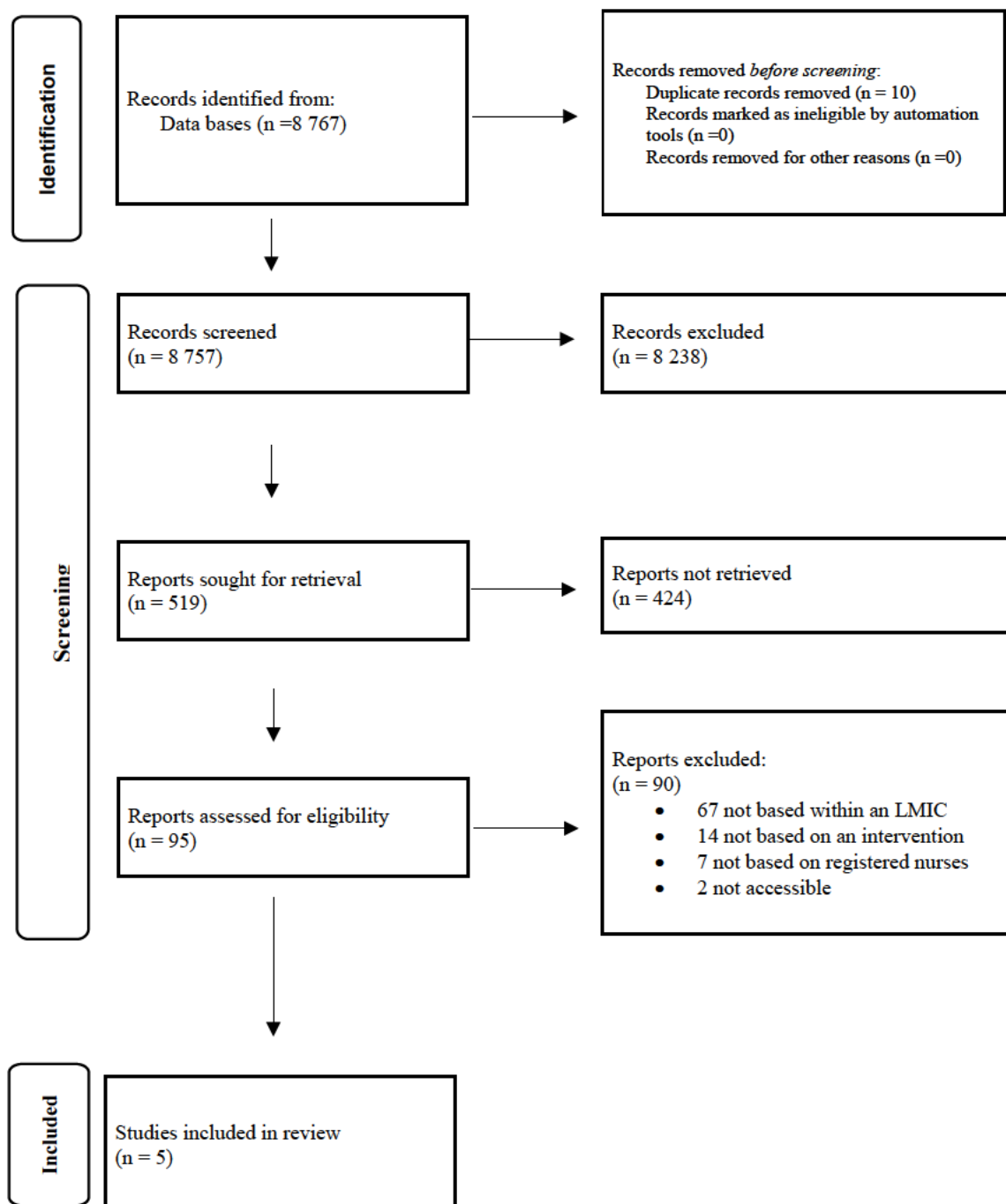
4.2.1. Search Strategy Utilised.

The data collection for the scoping review was conducted on the 28th of February 2018. The extensive search yielded 8 767 records through nine electronic databases. Subsequently, the search yielded 8 757 unique records after the removal of duplicated records from the initial search. The title screening step excluded 8 238 records that did not meet the eligibility criteria. The abstract screening step 424 reports were not retrieved as reports were inaccessible due to subscriptions barriers required for access as well as reports were missing

on the online databases. Therefore, following the title and abstract screening, resulted in 8662 studies being excluded and 95 studies retained for screening in full text. In total, this study included 5 studies that met the requirements of the study's inclusion criteria. This search illustration is in Figure 3.

Figure 3

PRISMA-ScR flow diagram of the depicting selection process of the screening result



4.2.2. Characteristics of included studies.

Table 6

Summary of characteristics in the included studies

Variables	Number of studies	%
Regions		
• Asia	4	80.00%
• Africa	1	20.00%
Study Design		
• Quantitative	3	60.00%
• Mixed Methods	1	20.00%
• Quasi-experimental pre-post-test	1	20.00%
Publications per year		
• 2015	2	40.00%
• 2017	1	20.00%
• 2018	2	40.00%
Databases		
• ScienceDirect	4	80.00%
• PubMed	1	20.00%
• Ebscohost Database Platform <i>(Academic Search Complete, PsycARTICLES, PsycINFO, Cumulative Index to Nursing and Applied Literature (CINAHL), Web of Science, and MEDLINE (Ovid))</i>	0	0.00%
• Pubmed	0	0.00%
• OpenGrey	0	0.00%

• Cochrane Library	0	0.00%
Setting		
• Hospital Setting	2	40.00%
• Mental Health Service	1	20.00%
• Other	2	40.00%
Outcome Measures		
• Stress	4	80.00%
• Burnout	1	20.00%
Intervention Delivery		
• Group-Based Delivery	3	60.00%
• Mixed Delivery (Individual & Group-Based)	1	20.00%
• Unspecified	1	20.00%

4.2.3. Study Characteristics.

4.2.3.1. Settings and Geographical Locations.

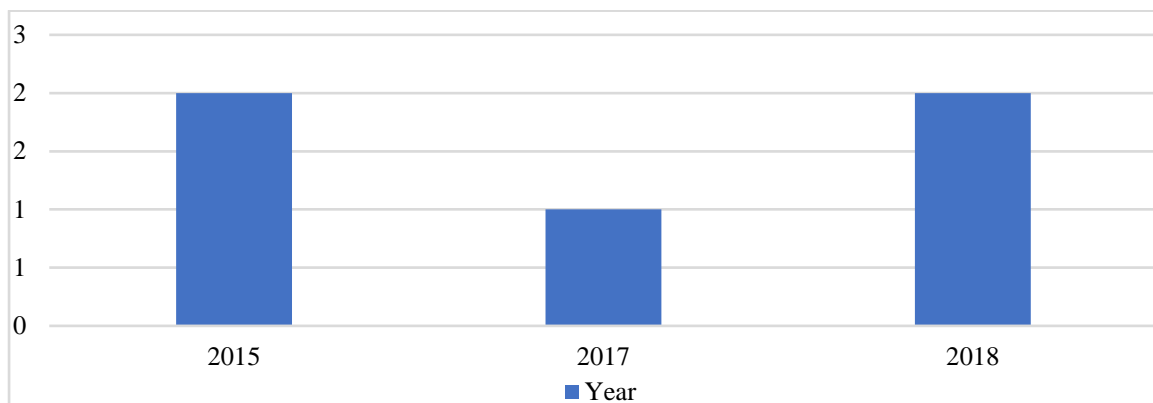
The articles included within the current study incorporated participants within a hospital setting (n=2, 40%), and a mental health service (n=1, 20%), whilst other included studies (n=2, 40%) did not specify the health care setting of the included participants. The inclusion criteria aimed to include articles in countries that are classified as LMICs. The search revealed the majority of the articles from the Asian region (n=3, 80%) (i.e., Indonesia, China, Tawiah, and India). There was only one article that was conducted in an African region (n=1, 20%) which was in the country of Rwanda (Iyamuremye & Brysiewicz, 2015) as presented in Table 6.

4.2.3.2. Temporal Distribution and Databases.

Articles included within the review were published between the period of 2015 to 2018 in Figure 4. In that (n=2, 40%) were published in 2015, (n=2, 40%) in 2017 and (n=1, 20%) in 2018. The research utilised 9 databases that were scoped to discover eligible articles related to the objectives of the study. The majority of the articles (n=4) were found using ScienceDirect, and only one article was eligible from PubMed.

Figure 4

Number of publications per year.

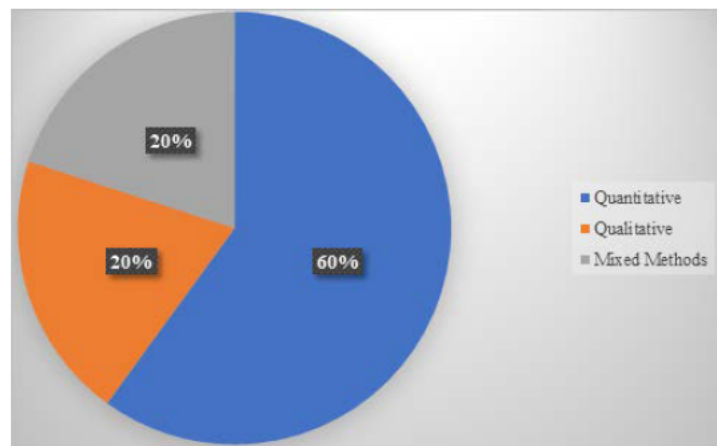


4.2.3.3. Study Design, gender, and Age of Participants

The majority of the articles incorporated a quantitative design (n=3, 60%), whilst others were qualitative (n=1, 20%) and mixed-method design (n=1, 20%) in Figure 5. From the eligible articles, it was evident that most of the articles included more female than male participants. The mean range of participants included (n=4, 80%) was 31.65 years old. However, the age of participants in a study (n=1, 20%) was not reported.

Figure 5

Types of research designs.

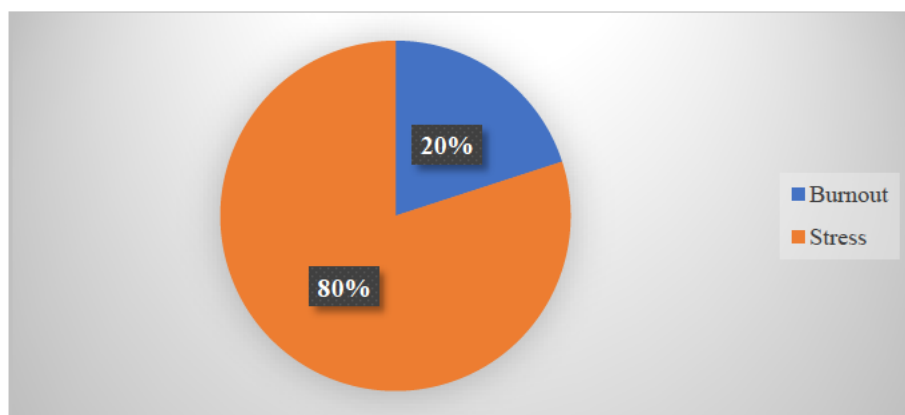


4.2.3.4. Outcome measures

Majority of the included articles reported on measuring the outcome of stress ($n=4$, 80%), such as stress, occupational stress, Secondary Traumatic Stress (STS), and Post-Traumatic Stress Syndrome (PTSS) within health care workers after receiving an emotional coping skills-based intervention. In addition, one article focused on measuring burnout experienced by Emergency Department (ED) nurses ($n=1$, 20%) after receiving an emotional coping skills-based intervention as in Figure 6. Instruments used to measure the outcomes of the included articles provided evidence of the instrument's validity and reliability.

Figure 6

Outcome Measures

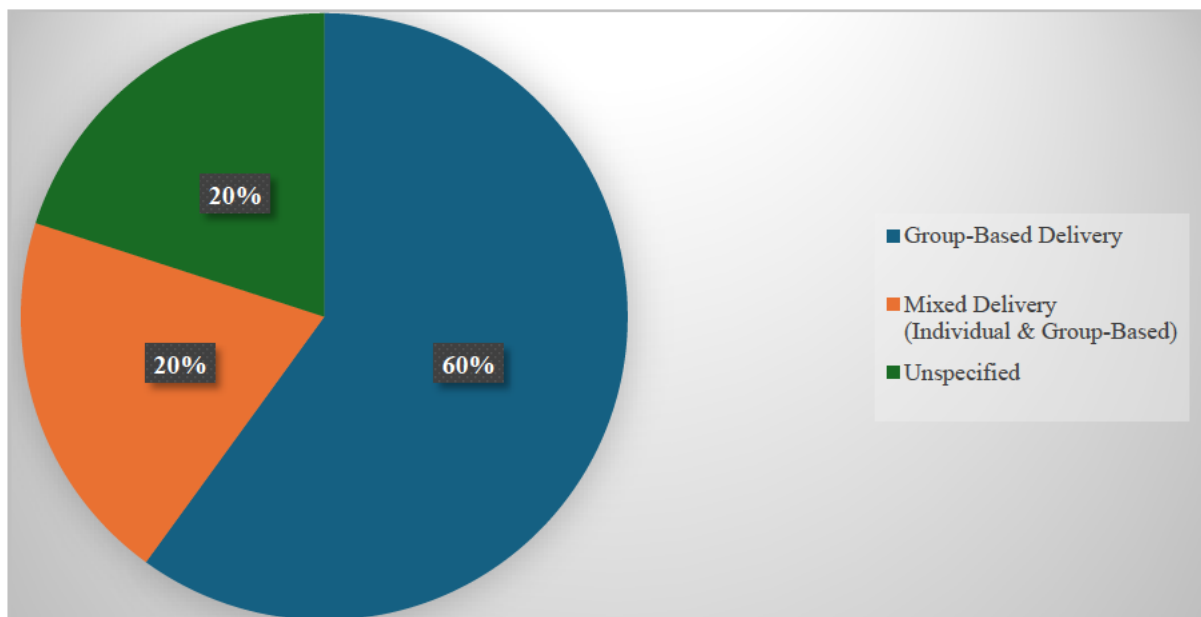


4.2.3.5. Intervention delivery

In terms of the delivery of the intervention, (n=5), all articles delivered face-to-face interventions (n=4) and considered the working times of nurses. However, one article made no mention in relation to the delivery of the intervention. For the method of delivery used in the interventions administered, the majority (n=3, 60%) incorporated a group-based delivery of the interventions. In addition, other articles (n=1, 20%) incorporated a mix of both individual and group-based approaches in the delivery of the intervention as in

Figure 7

Intervention Delivery



4.2.4. Description of Included Studies.

Table 7

Charting of the Extracted Data

Author(s) & Year of Publication	Study Title	Study Location (Country)	Methodology	Aims and Objectives of the Study	Study Population	Intervention Type	Duration of the Intervention	Outcome Measures	Key Findings	Limitations
Wei, Ji, Li, & Zhang, (2017).	Active Intervention Can Decrease Burnout in Ed Nurses	China	Quantitative	To evaluate whether an active intervention can decrease job burnout and improve performance among Emergency Room licensed registered nurses.	Registered emergency room nurses from 8 randomly selected high-level hospitals in Jinan China. (n=102; 88 female; 14 male)	The active intervention consisted of classes pertaining to communication skills approaches to conflict, efficacy elevation, and emotion control, as well as working skills.	6 months	An evaluation questionnaire on job burnout (the revised Maslach Burnout Inventory–General Survey [MBI-GS] by Chaoping Li, which is widely used in China).	The active intervention significantly reduced job burnout experienced by Emergency Room nurses including Emotional Exhaustion and Depersonalization. This study provided emotional coping skills approaches that may assist in decreasing burnout in Emergency Room nurses and may improve their work performance. Reduced EE and DP may help improve their mental and physical status.	The study included a limited number of participants. The study was conducted for a short period.

Author(s) & Year of Publication	Study Title	Study Location (Country)	Methodology	Aims and Objectives of the Study	Study Population	Intervention Type	Duration of the Intervention	Outcome Measures	Key Findings	Limitations
Huang et al., (2018).	Mixed simulation course increases participants' positive stress coping abilities	Taiwan - Republic of Korea	Quantitative	To analyse the effectiveness of mixed simulation-interprofessional education (IPE) courses to enhance coping strategies for inter-professional collaborative practice (IPCP) - associates stress.	Participants (n=54) were selected from the following disciplines, nurses (n=28), physicians (n=12) and pharmacists (n=14).	Mixed simulation-interprofessional education (IPE) courses. This intervention consisted of a pre-course, post-course, and an end-of-study. This intervention aims to provide various health professionals with learning experiences through communication to enhance positive coping strategies amongst health professionals.	3 months	Modified IPCP-specific Cohen's perceived stress scale (PSS) to measure the degree to which the participant perceived events in their life as stressful. Modified IPCP-specific stress coping preference scale (SCPS) was used to measure the ability to cope with difficult, stressful, or upsetting situations.	The IPE/IPCP course resulted in the majority of nurses reporting that they developed positive coping strategies for IPCP occupational stress and conflicts. The positive coping strategies included self-controlling, positive reappraisal approaches for problem-solving and seeking social support. This study found that regular missed simulation-IPE courses that form a part of the discipline's beginner training can enhance positive stress-coping strategies.	The study did not include a control group. This study lacked long-term evaluation, as well as an evaluation of the retention of skills learnt from the intervention to participants' clinical works.

Author(s) & Year of Publication	Study Title	Study Location (Country)	Methodology	Aims and Objectives of the Study	Study Population	Intervention Type	Duration of the Intervention	Outcome Measures	Key Findings	Limitations
Sailaxmi, G., & Lalitha, K. (2015).	Impact of a stress management program on stress perception of nurses working with psychiatric patients	India	Quantitative	To evaluate the effectiveness of a stress management program on reducing stress in nursing working in a psychiatric hospital.	Nurses working in a psychiatric hospital in Bangalore (n=53). Using Tippet's Random number table, participants were randomly selected. Nurses were in groups of 10 each during the morning and evening shifts.	Stress management program, which consisted of 10 sessions(1hr). These sessions focused on stress education, time management, taking time off, communication skills, assertiveness training, negotiation skills, humour, problem-solving, and responding to criticism.	2 weeks	To collect socio-demographic data, a semi-structured researcher constructed proforma was used. The DCL (De Villers, Carson & Leary) Stress Scale was used to measure stress levels.	There is a positive impact of stress management strategies on nurses' stress levels.	This study lacked a control group, therefore preventing the generalisation of the study's findings. A stress spill-over could have occurred from the domestic front into the occupational sphere. A follow-up with participants was not conducted after a long period.

Author(s) & Year of Publication	Study Title	Study Location (Country)	Methodology	Aims and Objectives of the Study	Study Population	Intervention Type	Duration of the Intervention	Outcome Measures	Key Findings	Limitations
Iyamuremye, J. D., & Brysiewicz, P. (2015).	The development of a model for dealing with secondary traumatic stress in mental health workers in Rwanda	Rwanda	Mixed-methods Research	To develop a comprehensive model to manage the effects of STS on mental health workers operating in Rwanda.	Cycle 1 - Quantitative Design (n=180). Participants were selected by convenience sampling. Cycle 2 - Qualitative Design (n=30). All participants in the study included professionals who -qualified as a medical health professional such as mental health workers (i.e., psychiatrists, psychologists, social workers, or trauma counsellors.	The Intervention Model to Manage Secondary Traumatic Stress (IMMSTS) was built using an action research design with mixed methodology. This intervention was divided into three components: 1. Preventative interventions (education and training, supervision, debriefing, relaxation techniques, physical exercise, mediation techniques, guided visualisation, and feeling exercises). 2. Assessment interventions (individual and organisational risk assessment. 3. Treatment interventions (individual self-care strategies and therapeutic approaches.	6 weeks	Cycle 1 - Trauma Attachment Belief Scale (TABS) Cycle 2 - 30 unstructured interviews.	The IMMSTS is shown to be an effective framework for dealing with the issue of STS for mental health professionals. The study found preventative, evaluative and curative strategies to help mental health workers manage secondary traumatic stress (STS) with various levels (individual, social and organisational).	The study was conducted in a single site.

Author(s) & Year of Publication	Study Title	Study Location (Country)	Methodology	Aims and Objectives of the Study	Study Population	Intervention Type	Duration of the Intervention	Outcome Measures	Key Findings	Limitations
Pratiwi, A., Hamid, A. Y. S., & Fadhillah, H. (2018).	Effectiveness of Psychological Adaptation Model of Mental Health Nursing for nurse survivors experiencing post-earthquake disaster post-traumatic stress syndrome	Indonesia	Quasi-experimental pre-post-test design	To assess the effectiveness of the psychological adaptation model for mental health nursing for nurse survivors experiencing post-earthquake post-traumatic stress syndrome (PTSS)	Participants were from West Java (n=42) (female=26) (male=16). All respondents were ethnically Sudanese and Muslim.	A PTSS intervention implemented through the psychological adaptation model for mental health nursing.	The article does not state	Instruments: Questionnaires, observation sheets which were used to measure the skills of the PTSS treatment, and an intervention manual (an intervention model and modules)	There was a significant increase in the ability to self-awareness analysis, intrinsic motivation, coping mechanisms, and communication of nurse survivors. The results of the study provided an in-depth understanding of the role of spiritual and cultural aspects in the aftermath of a catastrophe occurrence.	Further research using quantitative and qualitative methodology to gain data in the application of this model for other health professional disaster survivors in various societies.

4.3. Discussion

The main aim of the scoping review was to methodically explore emotional coping interventions within LMICs to capacitate PHC nurses with the tools to manage the stressors that are experienced in their current socio-economic and organisational climate. The discussion reflects the implications and the meaning of the findings concerning the research objectives (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2020; Westphaln et al., 2021; Peters et al., 2022). In reviewing the selected studies of this scoping review the following themes were identified by utilising the three-stage thematic synthesis by Thomas & Harden (2008), to clearly illustrate and relate the study's findings to the research aims and questions postured by the premise of the study. Theme one, discussed the types of emotional coping skills interventions used for the adverse effects of "people work" within LMICs (burnout, stress and compassion fatigue). Thereafter, theme two provides a discussion of the factors of the emotional coping skills interventions that contribute to improved well-being.

4.3.1. Theme 1: Types of emotional coping skills interventions used for adverse effects of "people work" in LMICs.

The first theme consisted of evidence mapping the types of emotional coping skills interventions that were found in LMICs. This theme was further divided into two sub-themes:

- 1) types of emotional coping skills interventions used for burnout in health care providers, and
- 2) types of emotional coping skills interventions used for stress in health care providers.

Table 8

Summary of the findings of the types of emotional coping skills interventions used for adverse effects of “people work” in LMICs

Theme 1 Types of emotional coping skills interventions used for adverse effects of “people work” in LMICs.	Source Author
Types of emotional coping skills interventions used for burnout in health care providers.	Wei, Ji, Li, & Zhang, 2017
Types of emotional coping skills interventions used for stress in health care providers.	Iyamuremye & Brysiewicz, 2015; Huang et al., 2017; Pratiwi et al., 2018; Sailaxmi & Lalitha, 2018

4.3.1.1. Types of emotional coping skills interventions used for burnout in health care providers.

Due to the emotional labour embedded within the PHC profession, burnout is prone to develop (Potter et al., 2010). Additionally, the quality of patient care and a healthy mental state can be negatively influenced by burnout experienced by health care workers (Hamaideh, 2011). Therefore, as detailed in Chapter 2 of this study, there is a obligation to explore emotional coping skills interventions that ameliorated the adverse effects of working with people (i.e., burnout, stress, and compassion fatigue), and approach used to deal with organisational changes of the South African context (HRH reforms, the implementation of NHI Plan & re-engineering of PHC). Of the five selected articles, one emotional coping skills intervention within an LMIC such as China was found to be used for burnout in emergency room nurses.

The article intended to elevate job burnout confronted by 102 licensed registered nurses within a busy emergency room. The emotional coping skills intervention sought to use an active intervention as well as regular management to decrease job burnout and improve the performance of the nurses (Wei, Ji, Li, & Zhang, 2017).

The active intervention incorporated classes that were facilitated by nursing managers. These classes were related to approaches to conflict, communication skills, emotional control, efficacy elevation, and working skills. In addition, this intervention included social support, in the form of the regular management component which included luncheon parties and focus group discussions. The focus groups aimed to create an environment for nurses to talk about issues that they felt caused them stress and thereafter the nurses were offered specific assistance. From this selected study, it was revealed that utilizing an active intervention combined with regular management provided emotional coping skills such as social support, education classes on approaches to conflict, communication skills, emotional control, efficacy elevation, and working skills which substantially decreased burnout in the nurses (Wei, Ji, Li, & Zhang, 2017).

Ahmadi Wei, Ji, Li, & Zhang, 2017 (2013), affirms the benefits of communication skills in reducing burnout in nurses within an educational therapeutic hospital in Iran (LMIC). This notion is further supported by Hamaideh (2011), who proposed that education and training interventions that incorporated personal skills, coping skills, stress management, and an update of knowledge are essential to reducing burnout. Additionally, the study suggests social support be included within interventions that aim to ameliorate burnout experience. Considering the burnout experienced by nurses within the LMIC context, it can be seen that the above-mentioned emotional coping skills are beneficial. In light of the paucity of resources between

urban and rural areas in South Africa, educational materials tend to be limited within outlying rural areas with communication, cultural, and access barriers (Althabe et al., 2008). In addition, due to staff shortages, there are limited or no staff within rural health care facilities (i.e., PHC sectors) to serve as relief for other health care providers to attend training programs. Thus, research needs to be conducted in South Africa, to understand the viability of emotional coping skill interventions and take into consideration the constraints specifically that of the community setting.

The selected article by Wei, Ji, Li, & Zhang (2017), further demonstrated a combination of emotional coping skills within the intervention to reduce burnout in emergency nurses. Moreover, Hamaideh (2011) affirms an integration of diverse types of emotional coping skills within the intervention to decrease burnout in nurses. In light of the current socio-economic disparities faced by the LMIC context, such as scarcity of human and financial resources in HRH reforms, incorporating a multifaceted emotional coping skills intervention has the potential to be beneficial to the LMIC context. In that, a myriad of burdens faced by health care providers can be dealt with simultaneously through the implementation of multifaceted interventions. Conversely, while multifaceted interventions are portrayed as a reasonable solution, Althabe et al. (2008), speculate that such interventions tend to not be cost-effective to fit the disparities of the LMIC context. Furthermore, Althabe et al., 2008 state that there is a lack of evidence that demonstrates the effectiveness of multifaceted interventions. Hence, multifaceted interventions must require further study to ensure that the best interventions are curated to the South African context as well as the LMIC context.

HRH reforms, the NHI Plan and the re-engineering of PHC within the LMIC health care system calls for nurses to be well-equipped to effectively communicate in a person-centred manner and achieve high levels of engagement to gain an authentic knowledge of the patient (Moore et al., 2017). The active intervention with regular management establishes a base for

future interventions, in that it can be curated to the needs of the temperamental LMIC health care sector. Providing health care providers with education on approaches to conflict, communication skills, emotional control, efficacy elevation, and working skills will assist with adapting to the requirements placed by the re-engineering of PHC. In addition, the emotional coping skill-based intervention would assist in capacitating PHC nurses to cope with burnout.

A gap in the existing literature on types of emotional coping skills interventions used for burnout in nurses was identified. Only one study was identified and provided evidence of emotional coping skills interventions for nurses with LMICs. Furthermore, no studies were qualified to provide an implementation of emotional coping skills intervention used for burnout in nurses within the African context. As evident from the literature review in Chapter 2, there is an array of comprehensively researched emotional coping interventions that exist in HICs that aim to reduce burnout (Jenkins & Elliott, 2004; Khamisa et al., 2017; Payne, 2001). Moreover, a study conducted by Dubale et al. (2019), systematically reviewed burnout among nurses in sub-Saharan Africa, intended to grow awareness and coping with burnout symptoms through resilience enhancement and stress management training. Therefore, there is a myriad of emotional coping skill interventions that lack implementation in the LMIC socio-economic climate.

To elaborate, a systematic review and meta-analysis study of seventeen HIC articles conducted by Suleiman-Martos et al. (2020), provided comprehensive research on mindfulness interventions that intend to tangibly reduce burnout in nurses. Mindfulness interventions, allow nurses to overcome and address cases of acute emotional impact through body-mind training. However, the majority of mindfulness interventions involve a lot of time from the nurse. The LMIC context limits the time nurses have to participate in time-consuming interventions due to human resource shortages that are embedded in the fragmented health care system and more importantly in PHC. Despite this, mindfulness interventions should be researched in the LMIC

context as through the research, the benefits can be harnessed and such interventions can be structured so that best practices can be identified for the LMIC context, especially locally (i.e., Africa/South Africa).

4.3.1.2. Types of emotional coping skills interventions used for stress in health care providers.

Stress experienced by nurses is among the highest when compared to other professions and is related to a decrease in patient satisfaction, quality of care, as well as psychological health (Burton et al., 2017). From the eligible articles, a majority (n=4) focused on emotional coping skills interventions used for stress in health care providers in LMICs (Huang et al., 2017; Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018; Sailaxmi & Lalitha, 2018). Of the four eligible articles only one study was conducted in the African context (Iyamuremye & Brysiewicz, 2015).

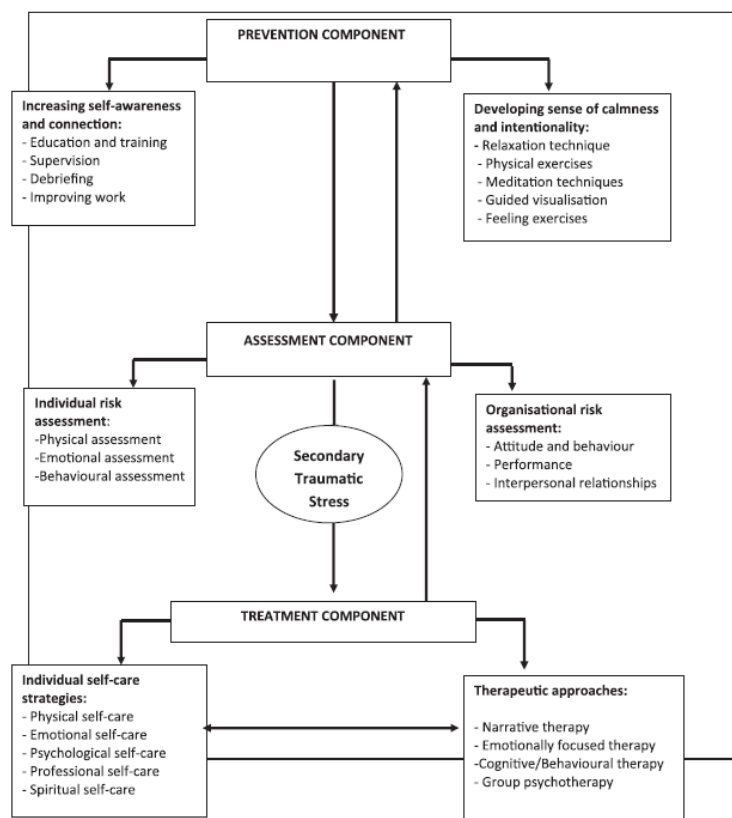
Out of the four articles, two articles incorporated emotional coping interventions that were guided by a model (Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018). The selected study conducted by Iyamuremye & Brysiewicz (2015), used action research designed with a mixed methodology to develop the Intervention Model to Manage Secondary Traumatic Stress (IMMSTS) to reduce secondary traumatic stress (STS) experienced by mental health workers in Rwanda. The model was divided into three key components, the first entailed providing STS preventive, such as improving connection and self-awareness through emotional coping skills interventions such as supervision, education, and training, debriefing, as well as improving the working environment of health care providers. Additionally, providing health care providers with a sense of calmness and intentionality by using relaxation techniques, feeling exercises, mediation techniques, physical exercises, and guided visualization.

The second component incorporated an assessment component, individual STS risk assessment which included an emotional, behavioural, and physical assessment of the health

care professional. In addition, organisational STS assessment included assessments such as work performance, attitude and behaviour of staff, and interpersonal relationships. The third component of IMMSTS is treatment, through an individual self-care strategy such as emotional, spiritual, psychological, physical, and professional self-care. In addition to therapeutic approaches that incorporated group psychotherapy, emotionally focused therapy, narrative therapy, and cognitive/behavioural therapy. Furthermore, the IMMSTS indicates directional relationships between the components which are demonstrated through uni-directional arrows as in Figure 8 (Iyamuremye & Brysiewicz, 2015).

Figure 8

Intervention model to manage secondary traumatic stress. (Iyamuremye & Brysiewicz, 2015, p. 62)



The selected article by Iyamuremye & Brysiewicz (2015), was implemented at a mental health facility for six weeks. During the evaluation phase of the intervention, participants

reported a change in coping with stress when they dealt with psychiatric and/or traumatized patients. Furthermore, the article concluded that the IMMSTS model provided an effective intervention when addressing STS in health care providers. This article provides a base for future interventions that aim to incorporate a holistic approach at the individual, group, and organisational levels.

The selected article by Pratiwi et al., (2018), aimed to address post-traumatic stress (PTSS) in nurses in Indonesia using a PTSS intervention based on a psychological adaptation model. Participants received educational training on topics such as self-concept, treatment of PTSS, the function and role of supervisor, as well as interdependence. This emotional coping skills intervention provided an improvement in the participant's ability to analyse self-awareness, communication, intrinsic motivation, and coping mechanisms. Thus, assisting participants with skills to cope with PTSS. This article reported that the use of a psychological adaptation model in training programs in the form of nursing expertise certification (i.e., continuous development points) is beneficial in coping with the challenges faced in vulnerable areas or nursing for disaster relief and response.

van Meijel et al., (2004), advocate for the application of models and frameworks to develop, guide the design, as well as the testing and/or evaluation of the interventions. This guide provides an outline of how the intervention will be actioned (i.e., the where what, how and by whom). The findings from the selected articles suggest that both studies can assist future emotional coping skills interventions that are to be tailored to the South African context.

Given the fast-evolving nature of the current working conditions posed on South African health care providers, namely the re-engineering of PHC and the NHI plan, can benefit from utilizing the above-mentioned models and can provide a starting point for future emotional coping interventions to be structured to the demands of the health care provider. In addition, models take into consideration the urban or rural area the health care provider is placed within.

Given that urban and rural areas, specifically within the South African context, provide different challenges and barriers to the health care provider (Kakuma et al., 2011; Mohale & Mulaudzi, 2008; Mokoka et al., 2010). For instance, the implementation of emotional coping skills interventions in rural areas requires additional curations to the barriers of heterogeneous cultural context, staff working shifts, material resources, higher patient intake, budget constraints, and lack of staff support.

Of the four articles, only two articles incorporated emotional coping interventions that emphasize providing education and training for health care providers to reduce the stress experienced by health care providers (Huang et al., 2017; Sailaxmi & Lalitha, 2018). The selected article by Huang et al. (2017), in particular, used a mixed simulation-IPE (interprofessional education) course to enhance coping strategies for inter-professional collaborative practice (IPCP) associated stress. The IPE/IPCP is a multidimensional approach program that incorporates simulation workshops with nurses, physicians, and pharmacists. The emotional coping skill interventions were facilitated by other professional peers and included education and training, debriefing, and social support to reduce stress and conflict experiences in the collaborative practice of the health care sector. Furthermore, participants exposed to the IPE/IPCP intervention reported that they established positive coping strategies for occupational stress and IPCP conflict. The emotional coping skills strategies that were incorporated by participants were seeking social support, and self-controlling (Huang et al., 2017).

In the selected article by Pratiwi et al., (2018), social support for PTSS includes group meetings that tend to be detrimental to health care providers. Introducing new members who share their traumatic experiences in a group meeting can cause flashbacks that may affect the progress of existing members. However, Rezaee et al., (2006), endorses the implementation of social support for interventions that aim to reduce stress in nurses, given that social support provides a buffer in the stressful situation faced by the participants, especially that colleagues

and nursing management. From these articles, it is evident to ensure that emotional coping skills interventions are tailored to the context and that the outcomes that are to be addressed.

Due to the health care reforms within South Africa, namely the re-engineering of PHC to provide holistic patient care, nurses are placed in a position to collaborate with all disciplines of health care providers (Moore et al., 2017). Subsequently, an emotional coping skills intervention such as IPE/IPCP intervention would be practically suitable for the needs of South African PHC nurses. In that nurses, would have the opportunity to develop positive emotional coping skill strategies for IPCP occupational stress and conflicts that tend to occur in emotionally demanding health care climates.

The selected article by Sailaxmi & Lalitha (2018), aimed to use a stress management program to decrease stress for nurses working in a psychiatric hospital in India. The session within the intervention included emotional coping skills interventions such as stress education, communication skills, time off work, negotiation skills, responding to criticism, humour, and assertiveness training which was implemented for two weeks. These sessions incorporated a myriad of teaching strategies such as role-playing, behaviour rehearsals, group work, brainstorming, and lecture cum discussions and worked within the participant's working schedules. Within the intervention, participants prepared case scenarios built on stress experiences and discussed how stress management techniques could be applied through these stressful situations. This stress management program reported a significant decrease in stress perceived by nurses. Given the drive of person-centred care and demands of re-engineering of PHC, the South African health care provider experiences an elevated level of strain. The evidence provided by the selected article suggests that stress management interventions would place nurses in a position that capacitates their ability to manage their stress and teach patients, as well as family members to manage and improve their stress.

The findings on the types of emotional coping skills interventions suggest an absence of detail in the interventions implemented, as well as limited long-term effects of the interventions. As a result, there is complexity in establishing a substantial foundation for the future implementation of LMIC emotional coping skills interventions. In addition, there is an indication of a need for variety in emotional coping skills interventions to ameliorate stress in health care providers as opposed to the myriad types of interventions that exist in HICs. Given that HICs include detailed emotional coping interventions relaxation techniques, mindfulness training, and self-care strategies (Kravits et al., 2010; Köse & Murat, 2022; Spinelli et al., 2019; Veiga et al., 2019;). In that, a variety of emotional coping interventions supports the flexibility to curate context-specific interventions that capacitate nurses in varying socio-economic LMIC conditions. LMICs need to generate context-specific interventions to understand the applicability of emotional coping skills interventions.

4.3.2. Theme 2: Factors of the emotional coping skills interventions that contribute to improved well-being.

The second theme entails factors of evidence mapping the types of emotional coping skills interventions that were found in LMICs. This theme was further divided into the following sub-themes namely, education and training, communication, debriefing/venting, religion and spirituality, social support, humour, and duration of interventions and working hours that contribute to improved well-being.

Table 9.

Summary of the findings for the factors of the emotional coping skills interventions that contribute to improved well-being

Theme 2: Factors of the emotional coping skills interventions that contribute to improved well-being.	Source Author
Education and Training	Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017; Huang et al., 2018; Pratiwi et al., 2018
Communication	Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017; Huang et al., 2018; Pratiwi et al., 2018
Debriefing	Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Huang et al., 2018
Religion and Spirituality	Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018
Social Support	Huang et al., 2018; Pratiwi, Hamid, & Fadhillah, 2018
Humor	Sailaxmi & Lalitha, 2015
Duration of Intervention	Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017; Huang et al., 2018

4.3.2.1. Education and Training.

All selected articles included an educational and training component within the emotional coping skills interventions in order to reduce stress and burnout experienced by nurses in LMICs (Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017; Huang et al., 2018; Pratiwi et al., 2018). The selected article by Pratiwi et al., (2018), utilised education and training to reframe the perspective of mental health nurses' interpretation of their self-concept, interdependence, function, their role through supervision, and communication to decrease PTSS in Indonesia. It was evident that this factor improved nurses' self-awareness, intrinsic motivation, and communication and reduced PTSS experienced. Due to the improved well-being, the nurses were capacitated to perform their role better, given that the heightened motivation generated feelings of being valued, and happiness.

Education and training in the selected article by Wei, Ji, Li, & Zhang (2017), entailed education classes such as communication skills, emotional control, approaches to conflict, working skills, and efficacy elevation. In addition, the intervention established improved well-being in the nurses by reducing burnout, more specifically, a reduction in emotional exhaustion and depersonalization. A subsequent finding was the reduction in burnout experienced correlated with nurses providing better quality care to their patients. Furthermore, the selected article by Huang et al. (2017), utilised education and training as an intervention and incorporated an interpersonal education course (IPE). The course was facilitated by well-trained health care providers of various health care professions (nurses, physicians, pharmacists, social workers, dieticians, occupational therapists, etc.). In addition, included a preliminary information session that informed the management of patients with acute or chronic illnesses and the family of the patients. Thereafter, participants were exposed to interactive simulations to practically apply management strategies. It was discovered after the

implementation of IPE, participants established positive coping strategies to cope with experienced stress, patient-centred care, and the frustration of inter-professional care.

The selected study by Iyamuremye & Brysiewicz (2015), incorporated the factor of education and training within the preventive component of their IMMSTS intervention to address, secondary traumatic stress. The intervention aimed at improving mental health workers' connection within themselves and others, as well as their self-awareness to assist those who experienced feelings of isolation on a personal and social level. Additionally, it revealed that there was a modification in coping with the stress experienced when dealing with traumatized and psychiatric patients. The participants demonstrated greater acknowledgement of the realism of secondary traumatic stress within their context, furthermore, the intervention reframed how to manage work-related stress and highlighted the shortcomings of mental health services and their own.

The emotional coping skills intervention by Sailaxmi & Lalitha (2015), included educational training which entailed teaching strategies such as lecture discussions, role play, behaviour rehearsal, brainstorming, and group work. Equally important, the educational training sessions considered working times and were conducted during working hours to ensure the best results of the emotional coping skills intervention. The sessions were interactive to encourage participation to incorporate life experiences provided by the nurses. The intention of utilizing life experiences assists in educating participants on how to implement stress management techniques in their everyday working lives. Sailaxmi & Lalitha (2015) found that the sessions conducted were a tailor-made, practical, cost-effective, realistic approach to reducing stress and equipping nurses to manage stress and impart teachings to patients and families.

From the evidence provided on emotional coping skills interventions, education and training are essential factors that support improved well-being of health care providers. In that nurses are capacitated to improve their emotional coping skill techniques to combat a myriad of stressful experiences and burnout, equipped to effectively perform and manage within their profession, as well as to impart coping teachings to patients and affected families to provide holistic person-centred care.

Addressing the educational and training needs of health care providers in LMICs requires affordable and effective educational strategies with limited financial resources (Karim et al., 2021). In light of the historical antecedents that are enveloped within the South African context such as resource allocation, social injustice, and fiscal constraints to funding mental health expenditure health care (Docrat et al., 2019; Couper et al., 2018). Equally essential, a requirement develops to consider the vast financial disparities between the South African provinces in the curation of context-specific emotional coping skills interventions. Subsequently, due to high financial demands that are embedded in organisational changes in Human Resources for Health (HRH), the re-engineering of PHC, and the NHI plan. Moreover, there are limited financial resources for well-being initiatives to cope with the strain of organisational changes, especially with the pre-existing emotional burden placed on nurses (Almeida & Miclos, 2022; Bhayat et al., 2021; Dhai, 2023). In addition to the poorly organized health systems, there is a myriad of challenges in terms of language barriers, shortage of staff to step in as relief, and high patient loads, and that exist within community settings, as well as urban and rural areas within South African provinces.

The incorporation of cost-effective interventions proposed to be a major benefit, such as the emotional coping skills intervention as found by Sailaxmi & Lalitha (2015) that was built upon

by education and training. Therefore, despite an intervention's success and effectiveness within an urban area of South Africa, in contrast to a rural area, the socio-economic conditions would render the intervention ineffective. Therefore, the context and health priorities must be considered before implementation to attain positive results.

In addition, the majority of the selected articles do not stipulate whether the interventions are implemented by health care providers. However, the article by Huang et al., (2018), demonstrates the use of health care providers in the facilitation of training to break professional silos between health care providers and create a support system to improve well-being. Consequently, the shortage of health care workers in South Africa constrains health care providers that are involved in the implementation of interventions (Malatji et al., 2022).

Furthermore, the mapped evidence on education and training is limited to face-to-face delivery, therefore, a gap is found in the implementation of emotional coping interventions delivered through e-learning educational practices. In that e-learning provides an alternative method to education and teaching, in terms of being easier to access more so to those in a disadvantaged resource setting and can provide supportive and stable productive teaching outcomes (Lahti, Hätönen, & Välimäki, 2014; Patrick et al., 2021). Moreover, due to the nature of undergraduate education courses, nursing students have recurrent contact with pain and suffering (Mathias & Wentzel, 2017). A study conducted by Mathias & Wentzel (2017), advocates that nursing training incorporates the knowledge of compassion fatigue and burnout together with coping strategies through studying nursing students in KwaZulu-Natal South Africa.

Thus, the provided evidence calls for further research to be conducted to isolate the factors in education and training of the existing emotional coping skills interventions in LMICs. These

factors include the facilitation of training, cost-effectiveness, and context-specific subject matter that are curated to improve health care providers' well-being. Given that such research will be crucial for developing a practical application that is contextually relevant to the application within the South African nursing context.

4.3.2.2. Communication.

A core professional skill is communication, which is crucial in providing quality health care, especially in person-centered care (Li et al., 2021; Tetteh et al., 2021). Furthermore, nurses can extract information on pain management, advocate for health, and plan for discharge through the means of communication with patients (Tetteh et al., 2021). Out of the 5 selected articles communication was an essential contributor to emotional coping skills intervention towards the improvement of well-being (Huang et al., 2018; Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017;).

Pratiwi et al., (2018), found that incorporating communication skills both interpersonal and intrapersonal within the emotional coping skills intervention, assisted nurses in developing alternative perspectives and the ability to openly express feelings to better comprehend unpleasant and emotionally demanding experiences. The article by Wei, Ji, Li, & Zhang (2017), incorporated communication skills in the intervention to reduce burnout and contribute to improving the well-being of nurses.

In addition, Huang et al. (2017), utilised communication through inter-professional education, to collaborate between health care professionals to break down the professional silos that exist. It was found through sharing valuable learning experiences through communication, there was a development of non-hierarchical relationships, enhanced use of multiple skill sets to deliver high-quality and well-organized care, person-centered care, and seeking social support from colleagues. Ultimately, communication demonstrated to be beneficial in assisting with

stress and conflict that is embedded within collaborative care. Thus, the reduction in stress experiences is a contributing factor to improving the health and well-being of nurses. Iyamuremye & Brysiewicz (2015), facilitated debriefing and supervision within the intervention through both interpersonal and intrapersonal communication in order to improve the self-awareness and connection of nurses experiencing secondary traumatic stress in Rwanda. In the article by Sailaxmi & Lalitha (2015), communication skills placed nurses in India in a better position to teach patients and the patient's support structure stress management techniques and impact the improvement of stress management skills. As a result, patients received higher levels of communication and care.

Conversely, from the selected articles there is a lack of information regarding an account for dysfunctional communication that could occur in LMICs. The key role of the nurse is to perform primary care duties to their patients, however, they simultaneously serve as patient advocates or translators. Thus, it is essential to maintain effective communication between the nurse and the patient. There is an array of barriers that exist in communication to provide holistic care to patients such as institutional and health care systems, environmental, as well as personal and behavioral. In terms of institutional and health care systems, the shortage of health care providers prevents health care providers from having adequate time with patients and thus resorting to task-oriented care. Therefore, a patient's turnaround time to seek treatment is quicker and infers a higher patient load to attend. Equally important, lies in the organisational level of communication between staff and management, in that when staff personal challenges and mental health is not accounted for the delivery of patient care is hindered. In terms of personal and behavioural, due to the array of linguistic backgrounds, cultures, and demographic characteristics that exist in South Africa, communication with patients face many hurdles. Given that due to a patient's cultural background, they may refuse to be treated by a nurse of a contrasting cultural background, furthermore, PHC nurses in rural communities may not have

an available translator to effectively communicate the requirements of the patient (Kwame & Petrucka, 2021). Hence, it suggested that future research accounts for barriers of communication to maintaining effective communication between the PHC nurses and patients in LMICs.

The findings on the factor of communication within emotional coping skills intervention provided evidence of an improvement in well-being in nurses. The tool of communication skills facilitates PHC nurses to express experiences and with suitable implementation provides an outlet to cope with the adverse effects in people work. In addition, improved listening to the valuable learning experiences with other professionals created a reduction in negative emotions and reactions that are caused by the work pressure that impacts mental and physical health (Li et al., 2021).

Hence, the benefits of communication in South African interventions would ameliorate stress, burnout, and compassion fatigue that arises within a person-centred care environment that nurses experience daily. Furthermore, due to the HRH reforms producing organisational changes within the health care sector, an improvement in nurses' communication skills will address the professional silos that exist within the health care sector. It will promote improved communication with all levels of care within the person-centred care health environment as desired by the Ministry of Health (Rispel & Barron, 2012; WHO, 2008). Specifically, in the case of ensuring a collective health care workforce to effectively and efficiently execute the NHI plan and re-engineering of PHC and simultaneously ensure optimum health and well-being of PHC nurses.

4.3.2.3. Debriefing

Debriefing entails a structured approach in which participants share their actions, thoughts, and feelings within a group setting. This space intends to reduce the impact of an experienced event (to grieve or to resolve stress) and assist in identifying individuals who require additional support (Dietz, 2009). According to Yun & Kang (2022), debriefing after simulation practice education allows for the integration of learning and transfer with practice. The process of debriefing allows for re-evaluation and utilizes reflection and performance analysis to enhance the effect of learning. Additionally, debriefing allows learners to develop the capacity to analyse their approach to a situation and correct their approach.

The majority of the selected articles identified debriefing as a contributory factor that improved the well-being of nurses (Huang et al., 2018; Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015). Articles that included debriefing, employed debriefing after the simulation practice education in relation to the article. Huang et al. (2017), found that skilfully facilitated debriefing assists nurses with integrating and clarifying previous knowledge on managing real-life challenges of patients with complex conditions through the simulations. That after simulating real-life complex conditions, debriefing allowed nurses to reflect on pitfalls and successes that occurred during the simulation. Therefore, by debriefing with other health care providers, nurses were able to develop improvement in emotional coping skill strategies when managing various situations through shared experiences and inter-professional support.

Iyamuremye & Brysiewicz (2015), demonstrated the use of debriefing within the emotional coping skill intervention to provide suitable support within debriefing sessions to improve self-awareness and connection among health care providers in Rwanda. The article by Sailaxmi & Lalitha (2015), incorporated debriefing through discussions within the intervention. Discussions were based on real-life experiences provided by nurses within the stress

management intervention sessions. Furthermore, nurses were requested to share how the stress management techniques taught can be implemented in the stressful situations that are encountered in their health care environment.

The evidence suggests that debriefing would be integral to improving the well-being of South African nurses. Jacobs et al., (2021), supports debriefing for health care providers in managing stressful situations and preventing secondary traumatic stress.

Furthermore, a study conducted in the Tshwane district of the Gauteng Province by Thobane et al., (2022), demonstrated that South African nurses voiced the need for regular debriefing in that nurses felt that sharing ideas and experiences will ameliorate their stress. Subsequently, context-specific coping strategies are strengthened through shared experiences and inter-professional support. Therefore, debriefing influences improvement in professional practice such as allowing nurses to reflect on the approach to stressful circumstances and through shared learning improve on the future approach. This creates confidence for nurses when overcoming prior situations that they would perceive as stressful and doubt their ability to cope. More importantly, debriefing creates an enhancement to person-centered care and better physical and mental well-being through creating a self-care supportive environment.

However, the evidence is limited in providing a structured guideline for the implementation of debriefing within emotional coping skills interventions. Given that a study conducted by Jacobs et al., (2021), asserts that logistical challenges and high patient volumes hindered the implementation of debriefing in PHC facilities. In those logistical challenges, the lack of private spaces to conduct debriefing sessions, as well as high patient volumes contributed to health care providers focusing on attending to patients over debriefing sessions. Hence, there is a call for additional research into this limitation and to ensure that the existing nursing shortage, due to the NHI plan, re-engineering of PHC and current HRH reforms are accounted for the implementation of debriefing within emotional coping skills interventions.

4.3.2.4. Religion and Spirituality

Spirituality and religious practices increase well-being and decrease burnout in nurses. Harris & Tao (2022) expresses that through spirituality and religion, nurses reconnect to their purpose and meaning in work, self-compassion, stress recovery, and resilience. In addition, the development of spirituality in nurses extends to patient care, through the ability to detect and respond to patients' spiritual requirements and provide pre-emptive spiritual care to patients (Rykkje et al., 2022). Of the five selected articles, only two demonstrated using either religion or spirituality in coping to improve the well-being of nurses (Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018).

The article by Pratiwi et al., (2018), included nurses in Jordan, who practiced Islam and prayed to seek closeness to God. This was to cope when dealing with a traumatic situation and experience a higher level of serenity, which assists in reducing stress. This practice allowed nurses to enhance their intrapersonal communication to overcome their PTSS. Similarly, Iyamuremye & Brysiewicz (2015), found that spirituality for nurses plays a role in improving well-being in practising self-care to treat trauma-related stress. However, it is noted that the selected articles lack a distinction between religion and spirituality.

Few articles provide evidence on the role of religion and spirituality in improving the well-being of nurses in LMICs. However, published work focuses on the insight gained towards the role of spiritual and religious aspects and the trauma experienced. Muehlhausen (2021), affirms that religion and spirituality allow nurses coping with trauma to process, determine the meaning and ultimately reconnect to a sense of purpose to aid the advancement of vicarious growth.

In a study conducted by Rothmann et al., (2011), South African employees turned to religion which served to provide emotional support to actively cope and the capacity to reinterpret stressful conditions positively. However, the evidence provided by Pratiwi et al., (2018), is confined to the use of Islam and does not consider the diversity of religions that exist. In

contrast, the South African environment is diverse in its practice of religion and spirituality (Rothmann et al., 2011). Thus, the application of religious and spiritual factors to emotional coping skill interventions requires the inclusivity of all nurses. The aforementioned benefits of religion and spirituality to the improving well-being of nurses promote the necessity for religion and spirituality to be included in emotional coping skills interventions for LMIC nurses. Therefore, there is a call for an understanding of applying inclusive religion and spirituality within South African based emotional coping skill interventions.

4.3.2.5. Social Support

Social support entails receiving support from family, colleagues, and friends that positively influences an individual's psychological well-being when exposed to stressful and adverse circumstances (Fronza & Labrague, 2022). Specifically, two articles itemized social support concerning emotional coping skills interventions (Huang et al., 2018; Pratiwi et al., 2018). Pratiwi et al., (2018), incorporated group meetings and discussed traumatic experiences after the earthquake in Indonesia to increase self-awareness analysis and improve nurses' well-being. The article found that the group meetings brought flashbacks that affected the progress of nursing survivors when new nurses joined the meetings. According to Huang et al. (2017), nurses utilize seeking social support after participating in the IPE /IPCP course to cope with stress.

According to the scoping review, there was limited reporting on social support concerning emotional coping skills interventions. Furthermore, little evidence of social support implementation at an organisational level through means of communication and encouragement to assist in the maintenance of well-being during stressful experiences. Labrague & De Los Santos (2020), state that organisational support includes nursing managers providing timely and correct information and training on new diseases, a safe working environment, as well as quality protective personal equipment. Similarly, other works such as

Velando-Soriano et al., (2020), posit that the support nurses' colleagues and supervisors assist in the amelioration of burnout, by reducing the feeling of isolation from emotional day to day work, creating a social network for the exchange of learning coping strategies and experience to cope with stress-inducing situations.

In addition, the findings are inconclusive on the factor of social support contributing to the improved well-being of nurses. However, studies found in HIC countries demonstrate that social support relates to the improved well-being of health care providers (Labrague & De los Santos, 2020; Velando-Soriano et al., 2020). The above findings suggest for implementation of social support interventions within the LMIC context that consider organisational, community-based, and interpersonal interventions. Given that a substantive base for the development of emotional coping skills interventions can be curated to the socio-economic climate of South African PHC nurses.

4.3.2.5. Humour

Humour is a form of non-therapeutic stress management, that aims to evolve enthusiasm from fatigue, modify perspective on health conditions, reframe burdensome situations, increase motivation and job satisfaction, increase values, and creativity, encourage trust, hopelessness, overcome sadness and teach responsible and ethical behaviour (Wulandari & Wardani, 2022). Chelly et al. (2022) affirm that humour supports nurses in relieving anxiety and stress and in turn, allows nurses to use humour to humanize the nurse/patient relationship. Wulandari & Wardani (2022) advocates through systematically reviewing publications of the past 10 years that one of the most effective stress management tools in the reduction of stress is humour, as well as the implementation of humour, which is deemed cost effective.

In this study, only one article found that humour played a role in contributing to improved well-being among health care providers (Sailaxmi & Lalitha, 2015). Sailaxmi & Lalitha,

(2015), incorporated humour as a factor that was integrated into the overall emotional coping intervention. This single article is indicative that there is limited evidence existing on humour-based interventions in LMICs. Arguably, multifold HIC reviews explore the humour in emotional coping skills interventions of nurses (Chelly et al., 2022; Sousa et al., 2019; Wulandari & Wardani, 2022). Given that a scoping review conducted in Portugal found 17 articles from various HICs, which promote the benefits of utilizing humour-based interventions in health care for nursing care. The study demonstrated that humour was an integral tool in facilitating communication, creating relationships, alleviating anxiety, reducing stress, and quality of life improvement, assisting to cope with difficult and unpleasant situations and humanizing care (Sousa et al., 2019).

To illustrate, other HIC works systematically explore easy-to-implement and affordable laughter-inducing interventions, such as spontaneous and simulated laughter which include interacting with clowns or watching funny videos and produce immense positive effects on nurse's mental health (Stiwi & Rosendahl, 2022). Thus, diverse scholarly works of humour in emotional coping skills interventions in HIC that contribute to improved well-being in health care providers, yet this is not the case in the LMIC context.

Conversely, Chelly et al. (2022) infer that other elements influence the application of humour, mostly personal such as age, gender, and personality, hence, probing into conditions conducive to the benefits of humour. Concerning the South African context, the benefits of humour interventions would alleviate the emotional burden experienced by nurses. Taking into consideration the make-up of diverse South African nurses as mentioned in Chapter 2, it would be beneficial to probe into conducive conditions for humour and extract the discussed benefits for nurses.

4.3.2.6. Duration of Intervention and working hours.

Only four articles reported on the duration of the implemented interventions (Huang et al., 2018; Iyamuremye & Brysiewicz, 2015; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017). According to Huang et al. (2018), the intervention was conducted for a duration of 3 months. It was found that regular exposure to the IPE intervention, reduced conflict, and stress, as well as the impact of a reduction in conflict, improves the quality of patient care. The article by Iyamuremye & Brysiewicz (2015), was conducted for a period of 6 weeks, and findings suggested that the duration of the intervention limited the impact of the reduction of secondary traumatic stress. According to Wei, Ji, Li, & Zhang (2017), the intervention was conducted over 6 months, however, it was found that a longer duration could have provided additional time for other facets to be explored. The article by Sailaxmi & Lalitha (2015), conducted stress management over 2 weeks. However, there was no follow-up after the intervention to provide an understanding of the prolonged impact. From the evidence on the duration of the intervention, there is no specified period to imply the golden standard for intervention duration.

In addition, all articles considered the working times of nurses when scheduling the interventions (Huang et al., 2018; Iyamuremye & Brysiewicz, 2015; Pratiwi et al., 2018; Sailaxmi & Lalitha, 2015; Wei, Ji, Li, & Zhang, 2017). This is a beneficial factor in the South African context, in that due to the high patient intake due to HRH reforms and the embedded shortage of staff as referenced in Chapter 2, the selected articles support the notion of incorporating working times that facilitate higher feasibility of the intervention.

As aforementioned in Chapter 2, the implementation of the NHI plan, re-engineering of PHC and entailed that South African nurses cope with higher patient volumes, hence, emotional coping skills interventions that are implemented incorporate a well-researched golden standard on intervention duration. In order to ensure fairness in intervention duration and working times

for nurses situated in both urban and rural areas, as well as consideration of the overall socio-economic disparities that exist.

4.4. Summary.

To conclude, this chapter collated, summarized, reported on the findings, and lastly discussed the findings of the scoping review. The first objective was to map the existing evidence of emotional coping skills interventions in health care settings which revealed interventions catered to burnout and stress. The findings revealed that the emotional coping skills intervention to address burnout demonstrated a paucity of existing evidence in LMIC health care settings. Furthermore, this chapter examined the deficiency in the range of emotional coping skills interventions available to the overall health care providers in the LMIC context in relation to the multitude of offerings within the HIC context.

The second objective was to explore the factors of emotional coping skills interventions that contribute towards improved well-being. The findings revealed that education and training, communication, debriefing, religion and spirituality, social support, humour, and the duration of intervention and working times are essential to influence improved well-being in health care providers. Simultaneously bearing in mind the role of organisational changes such as the implementation of the re-engineering of PHC, the NHI plan, that call for HRH reforms, and the pre-existing background of the South African health care system. The factors of emotional coping skills intervention that were found to improve are to be viewed through the lenses of their deployed context. The chapter to follow will comprise the conclusion, and limitations and establish the recommendations that can be drawn from this study for future research.

Chapter 5: Conclusion, Limitations and Recommendations

5.1. Introduction

The previous chapter presented the results and discussion of the study's findings in relation to the objective of the study. This last chapter provides a conclusion, presents the limitations, and lastly, the recommendations for future research.

5.2. Conclusion

The literature presented in Chapter 2, details the inherent contextual challenges encountered by PHC nurses within the current health care system in LMICs. In addition, it included the impact of the current system/organisational changes experienced by the South African health care system such as the re-engineering of PHC and the implementation of the NHI plan that call for HRH reforms. Moreover, pre-existing stress, burnout, and compassion fatigue due to adverse effects of "people work" were presented. Therefore, this study broadly scoped the existing research to map emotional coping skill interventions for health care providers, in particular nurses, to achieve improvement in well-being and the best quality of work-life for PHC nurses in the South African context. In addition, it included the tools utilised for emotional coping skill interventions to address promoting and maintaining well-being for PHC nurses. This affords optimising person-centred care for PHC nurses.

This study followed the tenets of the scoping review methodology by adhering to the five-step framework by Arksey & O'Malley (2005), the expansion by Levac et al., (2010) as well as the guidance by Joanna Briggs Institute (JBI) re-viewers guidelines (Peters et al., 2020). In addition to the recommendations by Westphaln et al., (2021) & Peters et al., (2022). In addition the Arksey & O'Malley (2005), served as the conceptual framework that guided this study. The present study yielded 8 747 records through the search term 'emotional coping skill

interventions for nurses. From rigorously searching the larger ambit of research in LMICs for existing emotional coping skill interventions for health care providers, five articles met the eligibility criteria. The articles found within the scoping review were published between the years 2015 to 2018. In addition, an important finding that emerged was only one article was conducted within Africa while the majority of research was conducted in Asia. Furthermore, the interventions aimed to ameliorate stress and burnout experienced by nurses in various LMICs health care settings. The results revealed two major themes in relation to the study's research objectives and questions:

5.2.1. Types of emotional coping skills interventions used for adverse effects of “people work” in LMICs.

The first objective of the study addressed the first theme presented in this study. The first sub-theme (n=1) reviewed the single emotional coping skill intervention aimed at decreasing burnout of nurses within an emergency ward in China. The active intervention combined with regular management incorporated education and training on approaches to conflict, communication skills, emotional control, efficacy elevation, working skills and social support which aimed to alleviate burnout. However, it was evident that there is a paucity of interventions in LMICs, specifically in the greater African context. This revealed a gap in the literature for context-specific emotional coping skill interventions.

Yet, the literature indicates that HICs hold a wide variety of rigorously researched interventions at their disposal to ameliorate high burnout levels experienced by health care providers. It can be concluded, that given the supporting literature, there is a myriad of factors specific to the South African health care climate that need to be accounted for in the curation of emotional coping skill interventions to promote the best quality of work-life for PHC nurses. Factors such as socioeconomic constraints faced by the implementation of HRH reforms due

to the NHI plan and re-engineering of PHC, such as the HRH workforce shortages, and urban and rural resource disparities.

The second sub-theme explored the types of emotional coping skills interventions used for stress in health care providers (n=4). The overall findings add to the body of knowledge on utilizing emotional coping skill interventions to decrease stress in LMIC PHC nurses. The evidence explored model-based interventions that demonstrate the potential to provide a baseline for building emotional coping skill interventions that are tailored to the South African context such as IMMSTS and the PTSS intervention based on the psychological adaptation model. It was evident in the literature that future interventions consider the demanding working times, shortage of staff, and material resources, and higher patient intake due to the current organisational/system changes which are placed on South African PHC nurses.

Furthermore, this sub-theme explored evidence of interventions that have the potential to be suitable for the South African context such as IPE/IPCP intervention and a stress management program. The linkage between IPE/IPCP intervention and improving collaboration between health care providers demonstrates a benefit to the South African PHC nurse that is experiencing organisational/system changes that require collaboration between all health care professionals to provide holistic person-centered care. In addition, the presented stress management program proposes to capacitate PHC nurses' ability to cope with their experienced stress while simultaneously using their acquired skills to upskill their patients and patient's families. Thus, aligning with the intentions set forth by the health care reforms of re-engineering PHC, implementation of the NHI plan, and to provide optimum person-centered care within the South African health care sector.

Lastly, the theme establishes the criticality to developing conscientious research of emotional coping skill interventions for the improvement of PHC nurses' well-being in conjunction with cultivating enhanced person-centered care. Furthermore, utilizing research to

explore the myriads of emotional coping skill interventions that exist in HIC such as relaxation techniques or mindfulness interventions within a context-specific setting to provide additional approaches to PHC nurses in LMICs. The above findings are critical to be understood by policymakers and health care managers in the South African health care sector to inform future emotional coping skill interventions.

5.2.2. Factors of emotional coping skills interventions that contribute to improved well-being.

The second theme addressed the second research objective, which explored the factors of the emotional coping skill intervention that contribute towards the experience of improved well-being. The sub-themes explored each factor that contributed to improved well-being namely, education and training, communication, debriefing/venting, religion and spirituality, social support, humour, and duration of interventions and working hours. The factors were extensively discussed in relation to other works, thus, it is apparent that though factors revealed to improve well-being in health care providers there exists the need to explore further the tenets that lead to improvement. An important finding that emerged in this study was that the factor of education and training, communication, and debriefing was a salient component of all emotional coping skill interventions. In addition, though limited selected articles utilised religion and spirituality, social support, and humour within the interventions, literature from HICs demonstrates instrumental benefits to improved well-being and quality of person-centred care.

The findings of the best practice in the duration of emotional coping skill interventions established no specified time frame. The findings noted that it is essential to consider the working times of nurses given the rotation of shifts due to the entrenched shortage of PHC nurses to increase the feasibility of the interventions. The findings within the sub-themes established that it is necessary to incorporate the context to leverage the benefits of each factor

discussed. Furthermore, the study revealed that further research is required to propose a standard of best practice, cost-effectiveness and inclusiveness to shape subsequent emotional coping skill intervention in LMICs.

Hence the findings within this theme demonstrated benefits to assist South African PHC nurses to cope with the organisational/system changes. In addition, it considers the inherent heterogeneity and the pre-existing burden placed on health care providers.

In conclusion, there is a palpable shortage of articles found in Africa and especially in the South African health care setting. However, the findings substantiated that emotional coping skill interventions exist in LMICs and are beneficial to the well-being of PHC nurses. Notwithstanding, the discussed collective of factors demonstrates immense benefits that cater to a variety of needs of the PHC nurse. Moreover, the findings within this study provide essential points to policymakers and health care organisation managers for the development of research-based emotional coping skill interventions. From an organisational perspective, the findings demonstrate that the existing emotional coping skill interventions propose a basis in which the PHC nurses can be capacitated with the necessary tools to cope with the current organisational/system changes. Furthermore, align PHC nurses to achieve holistic goals of person-centred care and, simultaneously cope with the daily pre-existing burden of stress, burnout, and compassion fatigue experienced.

In addition, this study provided insight into existing evidence in emotional coping skill interventions as well as contributory factors in improving the well-being of health care providers, specifically nurses. Hence, the need to foster further specific research to enrich the curation of future context-specific interventions and contribute to providing improved health care outcomes aligned with global trends.

5.3. Limitations

The current study presented is not without limitations. The review was confined to all articles published up to February 2018, hence articles published after the database search date were not included in the scoping review. Furthermore, the final yield of selected articles was limited due methodological approach carried out, specifically the eligibility criteria. In that the review did not include articles that were not translated into English, non-peer-reviewed research, other forms of information such as reports, and books were excluded as well as articles that were inaccessible by the utilised databases resulting in limiting the yield of selected articles. The methodological approach intended to streamline the review to work within the ambit of the scoping review's objectives regarding the mapping of existing emotional coping skill interventions to improve the well-being of PHC nurses.

In addition, the study used five specific databases to search for articles that met the eligibility criteria. Hence, articles found beyond the selected database that meet the eligibility criteria it was not included within the ambit of this scoping review. Though the study aimed to focus on all genders, the participants within the selected articles were skewed towards females, this could be attributed to the tendency of the nursing profession to consist of more females than males (Durand et al., 2022). Subsequently, the presented limitations are to be considered due to the impact generalisability of the outcomes from this study.

5.4. Recommendations

The current dynamic structural changes within the South African health care sector places immense strain on the PHC nurses who are expected to adapt and perform optimally. Non-technical techniques for preparing a workforce to adapt to structural changes such as emotional coping skill interventions, lead the path towards capacitating PHC nurses to effectively cope and adapt to HRH reforms, the implementation of the NHI plan, and the reengineering of PHC. The literature presented in this study depicts the strain placed on the PHC nurse at an

organisational level through both the adverse effect of “people work” and the current HRH reforms. At an organisational level, informing policymakers and health care organisation managers of the use of emotional coping skill interventions that allow PHC nurses to cope with system changes (HRH reforms), high-patient loads, holistic person-centred care, workforce shortages, and limited health care resources. Hence, it is a necessity to continue to advocate, support and develop emotional coping skill interventions to capacitate PHC nurses to improve and provide stability to their health and well-being. According to McInnes et al. (2020), the PHC nursing profession entails high levels of psychological job demands. These demands ultimately impact their lives, thus, advocating for the progression of research in this area, would improve overall person-centred care within the health care system.

The following recommendations for future research are worthy of consideration:

The findings provide existing evidence of emotional coping skill interventions for the overall health care provider within LMICs which play a critical role in aiding well-being. There is an absence of emotional coping skill interventions emanating from the African region for PHC nurses in particular. Hence a necessity for further primary studies to explore the implementation of emotional coping skill interventions within LMICs and more specifically the South African context.

Considering the socio-economic disparities that have permeated through the rural and urban health care facilities in South Africa, primary research needs to be conducted on trial community-based interventions that are cognisant of the contextual environment. This will have implications for coherent and comprehensive implementation.

In particular factors of emotional coping skill interventions which contributed to the improved well-being of health care providers such as education and training, communication, debriefing/venting, religion and spirituality, social support, humour, and duration of

interventions and working hours should be specifically included within the scope of future studies.

With regard to the education and training component of emotional coping skill interventions, there is a need for research to explore integration aligned with community-based nursing curricula. Given that it allows for emotional coping skills to be tailored to the specific needs of the PHC nurses, as well as the socio-economic barriers faced in the implementation of an intervention.

Current research has engaged minimally on alternative methods to intervention delivery other than face-to-face delivery. Moreover, to consider logistical and socio-economic challenges embedded within rural health care settings. Therefore, it is recommended to explore alternative intervention delivery methods such as e-learning for the delivery of emotional coping skill interventions. The various benefits such as accessing disadvantaged settings, flexibility in adapting to the extensive working times and staff shortages should be emphasised.

Although the present study revealed the present emotional coping skill interventions a more detailed, and comprehensive plan inclusive of logistics on how to articulate these plans should be explored. Current research reveals that factors such as education and training, social support, communication, religion & spirituality, and debriefing that are included within the intervention did not elaborate on the method of implementation. For example, the study's findings mention that communication skills as a component of the intervention, however, there is little evidence on how communication was implemented for the health care provider. Hence, it is recommended that future primary studies expound on providing detailed implementation steps on emotional coping skill intervention to offer easily implementable programmes in context-specific environments. The guidance in designing and executing future interventions can be more deliberately focused on

The models such as Intervention Model to Manage Secondary Traumatic Stress (IMMETS) and the PTSS intervention based on the psychological adaptation model hold a significant finding of this study. The model provided a structure for the designing of future emotional coping skill interventions for health care providers in LMICs in terms of guiding intervention design development as well as testing and evaluation (i.e., prevention, assessment, and treatment). Being cognisant of the heterogeneous nature of the South African context and Africa, it is recommended that future research call for inclusivity of the models that focus on socio-economic backgrounds, cultures, language, spiritualities, religions and demographics in the development of emotional coping skill interventions to increase generalisability and contextual relevance.

High patient volumes, staff shortages and socioeconomic disparities as well as the organisational/system changes (i.e., the implementation of the NHI plan and re-engineering of PHC) in South Africa pose a further restraint on the working hours PHC nurses have to offer for emotional coping skill interventions. Considering the current study demonstrated a range of intervention durations, there is a need for future research to explore an acceptable standard to effectively integrate into the dynamic working times that exist specifically within the South African context.

In addition, there was an absence of longitudinal studies that ascertained the long-term effects of the interventions. Hence, further studies should consider generating longitudinal studies to provide evidence on the long-term effects of emotional coping skill interventions as a tool to cope for LMIC health care providers.

Moreover, to expand the scope of further studies it is recommended that selected articles of foreign languages should be included, to establish enhanced reliability and validity.

From the study, it was evident that multifaceted interventions were posed as an inclusive approach. These nonetheless have financial implications in their implementation as well as

health care resources (i.e., manpower and material resources). Hence, it is recommended that research within the South African health care sector should focus on the cost-effectiveness of the interventions that consider the LMICs' contextual financial environment.

The current study found limited types of emotional coping interventions researched in LMICs for health care providers. Chapter 2 of this study outlined the types of emotional coping skill interventions that were widely researched by HICs such as mindfulness interventions, relaxation techniques and self-care interventions. Yet, the existing types of emotional coping skill interventions researched in LMICs for health care providers pose a limited variety. Hence, researchers are required to undertake primary research that explores the implementation of the myriads of emotional coping skill interventions in HICs within the LMIC context and understand the conducive conditions required to improve the well-being of PHC nurses.

Humour, social support, religion and spirituality are extensively researched by HICs and establish an immense contribution to the health care provider's well-being. Yet, the current study revealed few interventions that reference the contribution of these factors. Therefore, future research should be conducted to explore these pertinent implications of the LMIC's context.

Lastly, the current study identified that existing emotional coping skill interventions conducted in LMICs focused on ameliorating burnout and stress of PHC nurses. Yet, there is an absence of emotional coping skill interventions that focus on the other adverse effects of "people work" such as compassion fatigue. It is therefore recommended for future research to advocate for the curation of emotional coping skill interventions that allow health care providers to cope with the myriads of other adverse effects of people work.

5.5. Summary

The findings of the scoping review addressed the intended research objectives and highlighted several implications for future research in emotional coping skill interventions for

PHC nurses in LMICs to contribute to academic knowledge. It is acceptable that nurses within the PHC sector are confronted with a multitude of challenges to perform optimum person-centred care while simultaneously maintaining their health and well-being. Therefore, the current study advocated for fostering the development of inclusive, flexible, and context-specific emotional coping skill interventions that are aligned with the needs of PHC nurses in the South African context.

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Appendices

Appendix 1: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	i
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	iv
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	1
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	8
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	50
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	46
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	48
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	43
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	51
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	53

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	53
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	58
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	59
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	64
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	61
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	69
Limitations	20	Discuss the limitations of the scoping review process.	101
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	96
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A

JBIG = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med.* 2018;169:467-473. doi: 10.7326/M18-0850.

Appendix 2: Ethical Clearance Certification



08 November 2018

Ms Alison Teneal Andrew (214547723)
School of Applied Human Sciences – Psychology
Howard College Campus

Dear Ms Andrew,

Protocol reference number: HSS/1790/018M

Project title: Mapping emotional coping interventions for health care providers: A scoping review

Full Approval – No Risk / Exempt Application

In response to your application received on 04 October 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. **PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shamila Naidoo (Deputy Chair)

/ms

Cc Supervisor: Dr Ruwayda Petrus and Ms Cynthia Zandile Madlabana
cc Academic Leader Research: Dr Maud Mthembu
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

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Appendix 3: Turnitin Similarity Report

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