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What does resilience and well-being mean to community health workers? An exploratory study in the upper east region, Ghana

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ABSTRACT

Introduction Community Health Workers (CHWs) are critical in achieving universal health coverage, particularly in resource-constrained settings where they often work under demanding social, structural, and health system conditions. However, CHWs' experiences of resilience and well-being in their social and work contexts have received limited attention. Considering the critical role CHWs play in sustaining primary healthcare and understanding their resilience and well-being is vital to workforce sustainability and health system performance. This study explores how CHWs in the Upper East Region of Ghana understand and experience resilience and well-being to gain insight into the multidimensional and culturally grounded nature of these constructs.

Methods A qualitative study was conducted in two districts in the Upper East Region, Ghana using a phenomenological approach. The analysis therefore centres on CHWs' own accounts and interpretations of resilience and well-being as situated within their work and sociocultural contexts. Semi-structured interviews were conducted with 16 CHWs, selected to ensure diversity in gender, experience and geographical location. Interpretative phenomenological analysis was used to capture lived experiences and their underlying meanings.

Results CHWs accounts suggest that resilience is a dynamic process involving cognitive and adaptive strategies, emotional regulation, communal solidarity and spiritual coping mechanisms. They described resilience as shaped by the interplay of individual agency, social support systems and cultural beliefs. Well-being was described as holistic, considering environmental, financial, mental, emotional, physical, social and spiritual aspects, emphasising the interconnectedness of multiple dimensions. While both female and male CHWs described resilience across all dimensions, their coping strategies revealed subtle but important nuances.

Conclusion Resilience and well-being as described by CHWs in Ghana are complex and dynamic experiences shaped by contextual processes. Efforts to understand and support CHWs' resilience and well-being must reflect this complexity, highlighting the relational, communal and spiritual dimensions in addition to individual capacities. Culturally and gender-sensitive, context-responsive strategies are essential for informing policies and practices that promote CHW resilience and well-being, as well as support the sustainability of community health systems.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Community Health Workers (CHWs) are essential to the delivery of primary healthcare in low- and middle-income countries, yet their demanding roles expose them to psychosocial and structural stressors that may negatively affect their resilience and well-being. Existing studies have relied primarily on standardised quantitative measures, while little attention has been paid to how CHWs themselves understand and describe these concepts within their own socio-cultural contexts.

WHAT THIS STUDY ADDS

⇒ This phenomenological study describes how CHWs in the Upper East Region of Ghana conceptualise resilience and well-being as multidimensional processes shaped by cognitive, emotional, communal, financial, environmental and spiritual factors. The findings highlight how resilience and well-being emerge through the interaction of individual coping strategies, social support systems and cultural worldviews.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The findings support the development of CHW support strategies that go beyond individual-level incentives to include culturally responsive supervision, psychosocial support, peer networks and community recognition mechanisms, thereby strengthening workforce sustainability and community health system performance.

INTRODUCTION

In resource-constrained settings, community health workers (CHWs) are a vital part

of the healthcare workforce, delivering essential primary healthcare services and ensuring access for underserved populations.[1–3] In Ghana, the CHW programme is a key component of the Community-based Health Planning and Services (CHPS) initiative. This pioneering primary care approach leverages traditional institutions and support structures to mobilise communities and bring healthcare services to people's doorsteps.[3 4] This paper adopts its definition of CHW from a review of the term 'Community Health Worker', which describes CHWs as 'individuals with an in-depth understanding of the community culture and language, (who) have received standardised job-related training which is of shorter duration than health professionals, and their primary goal is to provide culturally appropriate health services to the community' (p.8).[5] The term 'Community Health Worker' will be used to refer broadly to Community Health Volunteers, Community Drug Distributors, Community Health Navigators and all other formal or informal health workers who fit this definition.

In Ghana, CHWs function as important community liaisons within the healthcare system through their work with community-based healthcare providers, called Community Health Officers (CHOs), to ensure healthcare is both accessible and culturally relevant for the communities they serve.[3 6] Their responsibilities range from essential tasks like delivering routine health services, including preventive and intervention care, and implementing vertical programmes that address specific health concerns, such as vaccine-preventable diseases, malaria and neglected tropical diseases (NTDs).[3 5–7] This has led to improvements in various health indicators, in alignment with the CHPS programme's mission.[3 8] These improvements are seen in Ghana where the collaborative work of CHOs and CHWs has improved child survival, maintained the continuity of care, advanced maternal health and supported mass drug administration (MDA) campaigns.[4 9–11]

While CHWs have been instrumental in achieving significant health gains, their work is not without difficulty. Community Health Workers often encounter challenges like inadequate resources, unclear workload guidance as well as other stressors within their social ecology, all of which can impact their resilience and well-being.[12–15] The demanding nature of their work has led to a growing recognition of the importance of supporting CHW resilience and well-being.[12 15] Given that CHWs are integral to achieving universal health coverage and the Sustainable Development Goals, their well-being has implications for the healthcare delivered to the communities they serve. Notably, since CHWs often hail from the same communities they serve, their well-being is closely linked to community health outcomes. Thus, addressing their well-being can have broader impacts on community health.[15–17]

Resilience and well-being through CHWs' lived experiences in Ghana

From the inception of the CHW programme in Ghana, several studies have identified challenges faced by CHWs[7 13 14] but none have examined how these challenges offer insights into the contextually meaningful ways resilience and well-being manifest in their work-life situations. Furthermore, despite the increasing acknowledgement of the importance of CHW resilience and well-being, current research approaches have limitations.[12 15] The predominantly quantitative approaches used to explore these concepts in collectivist cultural settings, particularly in Africa, may not capture the nuanced, context-specific processes that shape resilience and well-being.[12 15 18 19] These methods, though valuable, could also reinforce simplified and standardised perspectives that may overlook the complexity and diversity of individual experiences, thereby inadequately capturing the range of unique realities CHWs face.[18–22] Recent research underscores the multidimensional nature of resilience, emphasising that it is a process shaped by a combination of context-specific and normative factors.[23–25]

This study adopts a phenomenological orientation.[26] Accordingly, the aim is to describe how CHWs themselves conceptualise, interpret and narrate resilience and well-being as lived realities in their everyday social and work contexts. Given the importance of context in shaping these experiences, our understanding was particularly influenced by a social-ecological perspective on resilience, which views resilience as a dynamic process shaped through resources operating across multiple levels of an individual's social ecology.[25 27 28] Consistent with this perspective, we drew on Windle's definition of resilience as a process of coping with and adapting to significant adversity through resources located within the individual and the broader life context surrounding them.[27] Similarly, well-being has been conceptualised in a number of ways, with hedonic models emphasising subjective happiness and positive emotional states,[29] and eudaimonic approaches focusing on personal growth, purpose and the realisation of individual potential through meaningful engagement with life.[30] Broader literature, however, suggests that well-being is also shaped by social, cultural, relational and environmental conditions, underscoring the importance of examining how it is understood within specific lived and sociocultural contexts.[19 31 32]

Using a qualitative approach, we examine how CHWs in Ghana describe and experience resilience and well-being within their social and work contexts, with particular attention to the social-ecological conditions through which these experiences are shaped across individual, relational, community and broader sociocultural levels. By focusing on CHWs' perspectives, we illuminate how they navigate, negotiate and find meaning within formal and informal systems while delivering essential healthcare services. Understanding these lived experiences provides insights into culturally meaningful and sustainable ways to support resilience and well-being of CHWs in their work and daily lives. By showing the context-driven nature of resilience and well-being, this study contributes to understanding how CHWs experience and maintain them in their unique settings.

METHODS

Study setting

Data were collected from the Kassena-Nankana Municipal (KNM) and Kassena-Nankana West Districts (KNWD) in Ghana's Upper East Region (UER). The UER lies in the northeastern corner of the country, bordered by Burkina Faso to the north and Togo to the east. Covering an area of 8842 km^2, the region has a population of 1 301 226 according to the 2021 census. It has the lowest urbanisation rate in Ghana, with only 25.4% of its population residing in urban areas.[33 34] The region hosts 395 operational CHPS zones, with a nurse to population ratio of 1:313, and deploys over 2,000 CHWs to meet the healthcare delivery goals under the CHPS programme.[35] The Kassena-Nankana Municipality and Kassena-Nankana West District were instrumental in pioneering the CHPS model, known as the 'Navrongo model'.[3 6] These districts therefore offered a unique and diverse cohort of CHWs for this study, encompassing both long-serving workers who have been part of the programme since its inception and more recent recruits. Participants were sampled from 12 CHPS zones out of approximately 150 across KNWM and KNED, with an equal distribution between the two districts.

Study design and data collection

This exploratory study used qualitative methods to examine resilience and well-being, employing a phenomenological design.[26] According to Langdrige (2007), phenomenology is defined as the study of human experience and how things are perceived as they appear to consciousness.[26] In this regard, the interview guide (online supplemental material 3) was structured to first elicit participants' everyday experiences, roles, challenges and memorable events as CHWs before moving into more explicit questions about resilience and well-being. We explored how CHWs perceive and describe resilience and well-being, capturing their subjective experiences and interpreting the meanings they attributed to these experiences within their everyday social and work contexts. The concepts were not presented to participants as fixed predefined categories; instead, they served as broad entry points for exploring how CHWs themselves understood and described their experiences in context.

Data were collected from a target sample of 16 CHWs between June and August 2023. To select CHWs, the district CHPS coordinators provided a list of all CHWs in their respective districts. The recruitment of participants was done without the involvement of coordinators. A multistage purposive sampling process was used to select CHWs with relevant knowledge and lived experiences of the phenomena under study. Participants were selected to capture variation across districts/municipalities, gender and length of experience, as these characteristics were expected to shape how resilience and well-being are experienced, interpreted and enacted in everyday work and social context.[36] These selection criteria were communicated to the district CHPS coordinators and CHWs during the recruitment process.

Consistent with Boyd's guidelines for phenomenological research, which suggest that two to ten interviews per district are adequate,[36] recruitment continued until sufficient thematic recurrence was observed within the dataset. Saturation was understood pragmatically as the point at which successive interviews yielded recurring patterns and perspectives relevant to the study aims. To support this process, the interviewers had regular team debriefs. At the end of each interview day, interviewers met to review audio recordings and discuss emerging patterns and recurring perspectives related to resilience and well-being. The recruitment was concluded when subsequent interviews largely reinforced existing thematic direction and no substantially new viewpoints were identified.

Semi-structured qualitative interviews were conducted by JS and two male graduate research assistants (RAs) fluent in Kasem and Nankani. Interviews were conducted in English and local languages (Kasem and Nankani) depending on participants' language preferences. Interview guides were translated and verified by a trained bilingual translator fluent in Kasem and Nankani to ensure cultural relevance, linguistic accuracy and consistency. The guides were pre-tested with two CHWs to assess relevance and appropriateness. Interviews were conducted in-person at a time and place that was convenient and private and accommodated the availability of each participant. Community health workers were informed about the study's purpose, procedures, risks, benefits, confidentiality protections and provided written informed consent. The interview began with broader contextual and experience-based questions about participants' everyday lives, CHW roles and work-related challenges. Following this stage-setting discussion, participants were asked more explicit questions about resilience and well-being, with continued probing to elicit reflections grounded in concrete experiences and everyday realities. These included direct questions such as: 1) Can you tell me how you understand resilience? What does this mean to you? 2) What does well-being mean to you? To support a common understanding during interviews, we used brief, non-technical prompts in Kasem and Nankani. For example, resilience was described 'picking oneself up after facing difficulties or challenges', and well-being as 'to possess good health and happiness' only as conversational anchors in the local languages. Participants were then invited to articulate these concepts in their own words and to describe examples from their lived experiences. Additional questions and probes explored challenges, coping strategies, personal and contextual resources for resilience and well-being. Probing questions were used to explore how CHWs navigate and interpret resilience and well-being. Throughout the research process, the research team was mindful of reflexivity and considered how roles as researchers and potential biases could influence the findings. This included reflecting on

how our prior CHW research experience and familiarity with resilience and well-being literature may have shaped the questions asked.

Data management and analysis

All interviews were audio-recorded with participant consent, ranging from 30 to 67 min in duration, based on time-stamped audio recordings. Two interviews lasted 30–44 min, while the remainder exceeded 45 min. Each interviewer took field notes capturing observational insights to help situate each conversation and derive meaning during analysis.[37] All interviewers were male and had prior experience working in community-based health research within the study setting. However, given that all three interviewers were males, we were aware of the gender dynamics between interviewers and both male and female CHWs, and how this can influence rapport, disclosure, and how participants respond to questions. Therefore, as part of the team daily debrief and data analysis process, we discussed and reflected on these positional considerations in order to support reflexive interpretations of CHW narratives.

Interviews conducted in Kasem and Nankani were transcribed into English by a professional transcriptionist and reviewed by the research team for accuracy. This was necessary to enable collaborative analysis among the research team and facilitate consistent coding across transcripts. Acknowledging that translation is inherently interpretive and may involve shifts in meaning, the two data coders who were also native speakers verified the translations to minimise distortion and preserve nuanced meanings, as recommended elsewhere.[38] We used interpretative phenomenological analysis (IPA).[39] This approach entails the combination of a phenomenological 'core' that aims to capture participants' claims, with an interpretive account to uncover the underlying meaning.[39] Accordingly, our analysis considered not only participants' explicit reflections on resilience and well-being but also how these were shaped by, and could be interpreted through, their narrated experiences of work, challenge, coping, support, and everyday life in context. Consistent with the study's social-ecological framing, we examined how these meanings were expressed across interacting individual, relational, community and sociocultural contexts. Building on this analytic orientation, the analysis was grounded in participants' narratives and the resulting themes represent an interpretive analytic synthesis that captures shared patterns of meaning across stories rather than discrete or uniformly articulated coping strategies.[39 40] The thematic labels ((online supplemental material 2) used in reporting largely reflect the researchers' interpretative synthesis of shared patterns across accounts. Following this framework, two coders JS and PA, first discussed the IPA framework and then organised transcripts by unique identifiers and uploaded them into NVivo 14.0. Subsequently, both independently read transcripts multiple times and listened to recordings to deepen familiarity with the accounts and their context. At the initial coding stage, both analysts first generated codes of statements that illuminate resilience and well-being of CHWs with detailed description on portions of each transcript on observations and reflections, with primary focus on literal content, language use and context. Analysts then met to refine the first level codes into well-defined clusters for each transcript by clarifying meanings, identifying relationships and interpreting them within the broader contexts, and eliminating redundant codes. There were a few cases where clusters overlapped, so the analysts reviewed the recordings together to ensure the meanings were accurately captured. Finally, common themes were grouped across all interviews based on conceptual similarities and connections established to develop sub-themes and overarching themes to provide a structured framework within which the data can be explained. Attention was also given to patterns of convergence and divergence across accounts. In the process, we also identified some counterpoints that were different from the majority of perspectives, so we met to discuss and to ensure that we accounted for all diverse views on resilience and well-being as per the descriptions of CHWs. An intersectional lens was applied to explore how sex and gender influenced resilience and well-being. This included the exploration of differences in meaning and interpretations between male and female CHWs, which were informed by variations in socio-cultural responsibilities, community expectations, work burden, and access to social support and opportunities. These gendered intersections were integrated into the analytic process to inform theme development and strengthened the interpretation of CHWs' understandings and lived experiences of resilience and well-being.

RESULTS

A total of 16 interviews were conducted with CHWs. Female CHWs accounted for 63% of the CHW interviews (table 1). Results are presented as thematic descriptions of how CHWs in the study articulated and made sense of resilience and well-being. They also reflect the broader experiential narratives through which these understandings were expressed and made meaningful within their everyday work and social contexts. Themes are grouped as follows: (A) CHWs' understandings and experiences of resilience; and (B) CHWs' understandings and experiences of well-being. We applied the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist designed for interviews and focus groups (Supplementary Material 1).[41]

CHWs' understandings and experiences of resilience

Participants' accounts of resilience were organised into four interrelated themes: cognitive and adaptive resilience, collective or communal resilience, emotional resilience, and spiritual and faith-based resilience.

Cognitive and adaptive resilience

When reflecting on resilience in the context of their CHW roles and everyday responsibilities, participants

Table 1 Distribution of CHW by selection criteria

	District		Sex		Experience	
Participant	KNE Municipal	KNW District	Male	Female	< 5 years	> 5 years
# CHPS Zones	6	6	12		12	
CHWs	8	8	6	10	8	8
% CHW	50	50	37.5	62.5	50	50

CHW, Community Health Worker.

frequently described cognitive and adaptive processes that shaped how they navigated their volunteer work alongside livelihood demands. CHWs' accounts suggested cognitively **adaptive processes in resilience**, including **remaining resourceful and finding alternative ways** to fulfil their responsibilities when faced with setbacks. Instead of dwelling on disappointment, they redirected efforts towards productive activities that enhanced well-being and focus as expressed here:

> A challenge in my own life is about my school. I wanted to further it but couldn't. What I did at the time was, I got a small job to do so…at the end of the month, I will get something small…this helped me move on. Later I got married and at my husband's house is where I learnt the machine work (seamstress). That has made me forget because I have taken that to be my education. (Female CHW005)

Although this quote (Female CHW005) illustrates a broader life experience, participants often described applying similar adaptive strategies when navigating competing livelihood demands along with CHW responsibilities, such as maintaining household visits, participating in outreach campaigns or maintaining engagement with supervisors despite personal constraints.

Further, CHWs described resilience as avoiding overthinking and sometimes suppressing emotions in situations that were beyond their control, recognising that persisting with overwhelming tasks can lead to unnecessary mental strain. Instead, they deferred those tasks that seemed insurmountable at the moment, in preservation of their well-being. These coping responses were often shaped by financial strain, competing livelihood demands and work-related constraints that limited their capacity to respond immediately to emerging challenges.

> If you are pushing yourself to do it (a task), you will suffer without doing it…then that will lead you to too much thinking. So personally, whenever you want to do something and there is a problem…you should forget of it, because it is not time to do it. (Male CHW008)

For others, the internal resources they drew from allowed CHWs to have **personal agency** to endure throughout challenges. CHWs achieved this by working to improve their circumstances by adapting to difficulties, showing a strong determination and a sense of responsibility to fulfil their duties, as highlighted below:

> How I understand resilience is that when you have a problem, and you try not to allow the problem weigh you down, but you force yourself to improve and survive…I had an accident and I was seriously injured…(yet) I went and distributed all the medicines till the end of the week…So, you must keep doing what keeps you moving by every means. (Male CHW004)

Collective or communal resilience

CHWs' accounts highlighted the important roles that family, community and professional networks play in their resilience. Some believed in future reciprocity from the community members, especially children. These elements helped CHWs to persevere through challenges, reinforcing their resilience through a shared purpose and mutual support. For instance, CHWs viewed their social networks as vital sources for their resilience during difficult times. **Family and friends** provided assistance, encouragement as well as social and spiritual support. These social connections often intervened and addressed CHW concerns, ensuring stability and alleviating stress as noted here:

> …receiving advice from friends and loved ones is important…if it is left with you alone, you may not know what to do. When I am not around and I have task to accomplish, they help me do it. And what I want to do, and I am not able to do, they give me some advice or show me how… They let me know that there is still a second chance…what they tell you, if you apply it, it will work…they come to help me, or they advise me…in a spiritual way, they pray for me… (Male CHW004).

Furthermore, support and positive reinforcement from **social and community networks** were essential to CHWs' resilience:

> If I want to go and do rounds, there are people in the community that I can go to for a bicycle or transport…We have a women's group and we come together to support ourselves…that group is one of the sources of my motivation… if I'm bereaved, or I'm supposed to go to my father's house and I don't have money, they contribute money, and come to my father's house and support me through the mourning." (Female CHW013).

For some CHWs, resilience was rooted in **community solidarity** and a commitment to the health and well-being of their community, even if they felt they were not compensated enough for their work. Resilience came from genuine care for the well-being of

the people, especially the health and well-being of children in the community:

> Why I am encouraged to do the work and I know it has no payment is that I like the people. If the children are healthy, that is why I devote time to volunteer. It is the reason I try to invite everyone or child to come for treatment. If I am given medicines…I go and treat the children for the benefit of (community name). (Male CHW008).

Encouragement and support from health professionals and supervisors further bolstered CHWs' resilience and a sense of purpose, especially during work-related challenges. CHWs recognised the positive impact of being part of a supportive work environment where challenges can be shared with co-workers and supervisors, helping them cope with work demands:

> This our work is full of disappointments, but I always tell myself that if I leave this work out of someone insulting me it's like I'm punishing the entire community…the nurses encourage us and always tell us to share any challenge or problems with them in our line of work. (Female CHW001).

Shared experiences with other volunteers during meetings and training sessions were important ways CHWs built personal and collective resilience in their work-life environment. These interactions fostered a sense of solidarity and mutual support, strengthening their individual and collective resilience. For some, hearing and sharing experiences with fellow volunteers were meaningful ways to create a sense of community to reduce feelings of isolation and offer emotional strength to continue their work:

> When they call us for training and our colleague share their stories of what they are going through in their communities, the problems and the challenges…then you know you're not alone. Hearing experiences like that of yours gives you more strength to do [the] work. (Female CHW001).

Some CHWs described their resilience as sustained by **reciprocal altruism**,[42] whereby their current voluntary service was perceived to be an investment for future community support. For these CHWs, resilience came from knowing that if they are helping a child today, they are hopeful the child will reciprocate in the future. This perspective helped to balance work-related challenges like insufficient pay with intrinsic motivation, driven by a commitment to community benefit and future reward, as expressed by this CHW:

> When this SMC [Seasonal Malaria Chemotherapy] came, we were part…they will call me and I always say you make me suffer like this how much do you pay me? But the reason I am not worried is that it is my community and they are our children, if you help your child, in future you wouldn't send them and they say no (Female CHW016)

CHWs also benefited from their efforts and work in the community in terms of knowledge and experience, as expressed below:

> What I will say has encouraged me to support the community…there is a saying that when you wash someone's clothes your hands too are washed clean. As I made up my mind to also help the community, there are many issues with the health centre or about the health work that I should also know and can teach community members and even it could also help me. So, it is also a reason I said let me involve myself. (Male CHW004).

Emotional resilience

Community health workers described navigating emotional challenges through processes such as **emotional regulation, self-reflection** and **positive reinforcement** from the community. In this context, emotional regulation refers to CHWs' deliberate efforts to manage distressing emotions, such as anger, frustration or resentment, in order to maintain functional relationships and carry out their duties. Some CHWs coped with negativity through emotional regulation as illustrated by Male CHW002:

> There are things in life that you should ignore…if you don't ignore them, you will not get any improvement. If you want to harbour things people say you will die early, even your BP (Blood Pressure) will rise. (Male CHW002.)

Further, the emotional reward derived from receiving **positive feedback** and appreciation from community members enhanced CHW resilience and motivated them to continue their duties despite challenges.

> …. we gave a woman the SMC [seasonal malaria chemotherapy] medicines and she always says we did very well because ever since we started giving the medicines to her children, the season will end without her children being sick of malaria. She is so impressed that you also feel very happy…it made me feel that I have offered something in someone's life…and you are encouraged to do the work. (Male CHW004).

Others engaged in **self-reflection** to assess their own reaction to conflict which helped them reflect on conflict situations and their role to be able to manage it properly and continue their duties as volunteers.

> …in context to the SMC [seasonal malaria chemotherapy] drugs we distribute to children, the work needs a lot of courage because some of the people, the way they talk to you, you feel very bad going to them next time. If you go there and you are not careful, you are likely to retaliate to their actions, which will lead to events that are not good" (Female CHW013).

Spiritual and faith-based resilience

Community health workers emphasised the role of spirituality and faith as important to their resilience. These were regarded as essential tools for overcoming challenges, providing strength and motivation. Beliefs and seeking guidance from a higher power became a way of coping with disappointment, maintaining inner peace and persevering through adversity with a sense of purpose and gratitude. For instance, one male CHW

(Male CHW008) underscored the power of **prayer and seeking divine guidance** as central to addressing and resolving problems, highlighting a spiritual approach to resilience. Traditional practices, such as consulting soothsayers, were utilised to seek insights and guidance for overcoming challenges in their day-to-day endeavours:

> If I want to do something and I am not able to do it, I ask God, he would do it for me. I pour libation or go to consult the soothsayer to find out what to do to solve this problem… The soothsayer too will show you some things to do…and later the problem will be solved (Male CHW008).

Belief in **divine support** allowed CHWs to remain calm and steadfast in the face of adversity, trusting that outcomes would be guided by God's will, whether to endure suffering or experience deliverance. Through this faith, they sustained a sense of peace and resilience.

> I was sick and could not stand up. I couldn't talk. Is there a challenge more than this one? But I recovered and I am alive, and my wife was sick I didn't know whether she would recover or not, but she is alive, is there a challenge more than this one?… God has helped me out. If I encounter a problem I don't panic and the reason I don't panic, is I know it's God's work and if God wants me to suffer it, I will suffer it and if God wants to deliver me, he will deliver me (Male CHW008).

CHWs' understandings and experiences of well-being

CHWs commonly described well-being in holistic terms, referring to environmental, financial, mental, emotional, physical, functional, social, and spiritual dimensions. These aspects were viewed as interconnected, harmonised through a mind-body-spiritual relationship as suggested by this female CHW:

> One who wakes up, you are not sick, you are strong, and you eat well, and you are happy, wouldn't you say you are well? When you wake up…thank your God and go out, what is destined for you, he will give you. So, all these things are important for well-being, it is about happiness, and if you are happy, you are well. (Female CHW016).

Environmental well-being

Maintaining a clean and safe living environment was essential to overall well-being. Practices such as keeping the surroundings tidy, eliminating stagnant water and eating clean, nutritious food are proactive well-being measures as one CHW noted:

> For me, it (well-being) is about keeping your environment clean, eating clean food, disposing your bowels in the right place, keeping your compound clean and doing away with stagnant water…and eating well. (Female CHW001)

Financial well-being

For many CHWs, financial hardship was intertwined with well-being. Limited access to proper nutrition and healthcare due to economic constraints increased stress and hindered their ability to care for themselves. Some noted that economic pressures often compelled them to prioritise work over personal health, thus neglecting their well-being to meet financial demands. As one CHW shared, financial challenges such as housing issues directly impacted their blood pressure. They explained:

> …they came and asked me what was wrong, and I told them I have a headache…when they checked it was BP. They asked me what was wrong, and I explained… have you seen these block rooms? That is for my husband's first son, but I am sleeping in this room; have you not seen how it has cracked? I cannot even maintain it. After my husband's death and all that I am experiencing, what will you do? So, the problem is that you come to check on our condition, but that condition, when you wake up and you don't eat, it will attack. So, we need support. (Female CHW016)

Mental and emotional well-being

Community health workers also recognised that mental and emotional well-being were important for achieving their goals, maintaining stability and finding fulfilment in their work. To most, negative feelings can harm both mental and physical health, while cultivating positive emotions and managing anger were essential for overall well-being.

> …if you have peace of mind and you are not sick, that is well-being…. If you are happy… and you are not sick, that is also good health…Don't be angry always…if you are always happy your well-being is there forever (Female CHW005)

Physical well-being

Participants viewed physical well-being as a consequence of preventive health practices, proper nutrition and functional physical activity. For many, maintaining well-being was closely linked to engaging in preventive measures that safeguard and enhance overall health. This included actions like sleeping under a mosquito net to prevent illness, as one CHW noted:

> Mosquitos give us big sickness, if you don't sleep under a net, you cause yourself a big sickness. So, in that regard it is something that supports well-being. (Male CHW011)

For others, nutritional awareness and fitness were critical aspects of well-being:

> The well-being of a child depends on the parent and that means you have to give the child food that has no problem. Adults or elderly and young people, need to exercise our body and eat good food…we shouldn't do work that will be more than our body can contain… (Male CHW002)

Additionally, well-being was described as the physical capacity to actively engage in daily tasks and community responsibilities. Participants emphasised that good health enabled them to remain productive, sustain their livelihoods and fulfil routine obligations, whereas poor health was perceived as a major barrier to participation in everyday life and work-related activities:

> Our forefathers have a saying that if you have good health, you farm the best valleys…this shows that good health is

everything. If you are not healthy you cannot partake in everyday life. (Female CHW001)

Social or relational well-being

This dimension of well-being emphasised the interconnectedness of personal well-being with the well-being of social connections, particularly family. One CHW expressed the deep emotional bond they share with their family, explaining how a loved one's illness affects them more profoundly than their own:

> You are my son… when I wake up and you are not well that is something that disturbs me. I have to do all that I can do for God to give you good health so that you will recover… if it is I myself who is sick, it is better than if you are sick. If you are sick, it rather affects me than if I am sick myself. (Female CHW009)

Spiritual and Faith-based Well-being

Well-being was also viewed as a divine gift, obtained through spiritual practices and reliance on divine grace. Participants highlighted the importance of prayer, rituals and seeking divine guidance to ensure health and well-being for themselves and their families. As one CHW explained, traditional spiritual practices play a central role in their pursuit of well-being:

> As for me I am a traditionalist, I don't go to church I pour libation so when I go to the soothsayers, I am looking for health I am searching to know what to do so that God will give me and my family good health. (Male CHW008)

DISCUSSION

The purpose of this study was to explore resilience and well-being within the social and work context of CHWs in the Upper East Region of Ghana, emphasising how these constructs are conceptualised and experienced. Using a phenomenological approach, the study revealed nuanced descriptions of how these concepts were experienced by CHWs. Importantly, the findings reflect how CHWs themselves articulate their resilience and well-being in relation to their roles.

Community health workers' Understandings and Experiences of Resilience

The findings revealed that resilience among CHWs was expressed in four dimensions as CHWs navigate work-life challenges: cognitive and adaptive resilience, collective or communal resilience, emotional resilience and spiritual and faith-based resilience. These dimensions align with multisystem frameworks, which view resilience as shaped by the dynamic interplay of individual traits and contextual experiences and norms.[25 28]

At the personal level, CHWs used various strategies to manage adversity, demonstrating cognitive flexibility, emotional regulation and personal agency. They showed cognitive and adaptive resilience by remaining resourceful and finding alternative ways to fulfil responsibilities, often reframing challenges and redirecting efforts toward productive activities to protect their well-being. This reflects problem-focused coping, where individuals take constructive actions to minimise the impact of challenges rather than becoming overwhelmed by frustration or helplessness.[43] CHWs also used avoidant strategies like emotional suppression and cognitive deferral,[44] recognising that dwelling on overwhelming tasks could strain their mental health. Deferring insurmountable tasks helped preserve their well-being, consistent with findings that emotional suppression[45] and personal resourcefulness[22 46] are key to navigating adversity.

Beyond the individual, resilience is manifested through shared purpose and interconnectedness, through community solidarity, reciprocity and collective support. To CHWs, relationships provide emotional support and practical assistance. This aligns with studies demonstrating that interpersonal relationships enhance resilience.[12 22] For most CHWs, resilience is intrinsically evident in relationships with family, colleagues and the broader community, serving both as a protective buffer against adversity and a source of strength. CHWs also see their roles as a duty to their communities, although this responsibility may be more than altruistic. While they expect their work to improve community health, they remain hopeful that those they help will reciprocate in the future. This can be explained by what Trivers[42] describes as human reciprocal altruism**,** where individuals engage in altruistic acts at a small cost to themselves but with a significant benefit to the receiver, with the expectation of future returns.[42]

Even so, collective or communal resilience depends on the availability and responsiveness of social resources. When CHWs are unable to access such social supports in times of adversity, this creates a social vacuum, which negatively impacts resilience. In some circumstances, CHWs felt they had no support or were not appreciated enough by the community. Hence, fostering team cohesion, peer support initiatives, and broader community engagement efforts is essential for CHW resilience.[12 47]

In addition to individual coping strategies and social resources, many CHWs drew strength from their faith which shaped their understanding of adversity and guided their responses. Thus, spiritual and faith-based resilience emerged as a foundational layer both a personal coping resource and a reflection of broader cultural values. This aligns with African perspectives on resilience, where spirituality is integrally woven into coping strategies and meaning-making processes.[18]

While both female and male CHWs described resilience across all dimensions, their coping strategies revealed subtle but important nuances. Some female CHWs framed their resilience through caregiving responsibilities and relational support. These nuances may reflect the influence of broader cultural expectations and socially constructed gendered roles, particularly in normative cultural contexts, where norms, values, and beliefs shape individual and collective experiences of resilience.[22 28]

It is challenging to disentangle how CHWs perceive and experience resilience, which illustrates how fluid the concept is and how difficult it is to define as a single term, phrase or even a sentence. CHWs often moved fluidly between describing their reliance on individual and community supports as well as their spiritual beliefs, highlighting how all processes work in tandem to sustain resilience. Together, these findings highlight that CHW resilience is not confined to individual traits or isolated strategies but emerges from the dynamic interaction between internal capacities, social connections, and cultural belief systems.[22 28] Those interested in understanding CHW resilience should adopt a multidimensional and context-sensitive approach, considering the cognitive, emotional, communal and spiritual processes that influence their daily lives.

Community health workers' understandings and experiences of well-being

Well-being was described by CHWs as encompassing environmental, financial, mental and emotional, physical, social, and spiritual dimensions. These dimensions often emerged as precursors and central to the experience of well-being, which aligns with the Afrocentric view of the concept, inherently holistic, rooted in group identity, communal responsibilities, kinship ties and spiritual harmony.[19 31 32] As Idemudia and Adedeji[19] suggest, in African contexts, the self is not defined in isolation but through relationships with the environment, relationships and spiritual entities, a holistic notion also described by CHWs.[19] This integrated perspective can be seen in how CHWs perceive peace of mind, good health, proper nutrition, financial stability, supportive relationships and spiritual guidance as essential to overall well-being. This is consistent with studies showing that mental and emotional competencies, including the ability to recognise, express, and nurture positive emotions[48 49]; physical health, particularly preventive health practices[50]; food security and financial stability[16 51]; social connectedness in both work, family and community life[16 51]; environmental quality[52] and spiritual harmony[17 49] collectively shape how CHWs subjectively experience and describe well-being.

Alternative perspectives of well-being, such as eudaimonic and hedonic models, offer differing interpretations of well-being. For instance, the hedonic model centres well-being around pleasure, happiness, and the avoidance of pain, focusing on subjective emotional experiences.[29] This perspective contrasts with our findings, where CHWs experience and describe their well-being in a broader, socially embedded manner. The eudaimonic model, on the other hand, describes well-being as the realisation of personal potential, emphasising self-actualisation and mastery over one's environment.[30] While CHWs valued professional growth, their well-being was rooted in community belonging, resources and connection to a higher existence, than in individual fulfilment, reflecting a cultural emphasis on holistic functioning. Thus, for individuals interested in CHW well-being in the Ghanaian context, considerations should be made to the sum of these experiences, rather than relying solely on individualistic measures of success or satisfaction.

Our findings reiterate well-being as a multidimensional, relational and culturally grounded phenomenon. As suggested elsewhere, the development of context-sensitive understanding and experiences of well-being is essential for accurately capturing the lived realities of African populations and informing responsive health policy and social interventions.[19 31] For CHWs, supporting well-being requires holistic approaches that recognise and integrate environmental, financial, mental and emotional, physical, social and spiritual needs rooted in the values and worldviews that define their everyday lives.

Strengths, limitations and future research

By identifying a range of manifestations and meanings of resilience and well-being among CHWs in Ghana, this study contributes to the literature on CHW resilience and well-being within culturally grounded and communally oriented contexts. However, despite these contributions, several limitations should be acknowledged. Despite a diverse sample across two districts, the findings may not reflect CHWs in other regions with different contextual challenges. Well-being and resilience may vary depending on how they are understood across contexts.[24 53] Future studies should include more regions to capture wider perspectives and context-specific nuances. In addition, although the interview guide first elicited participants' experiences before asking directly about resilience and well-being, the inclusion of explicit concept-based questions may still have encouraged reflective accounts. The findings should therefore be read as an interpretative account of how CHWs related resilience and well-being to lived experience in their everyday social and work contexts, rather than as a purely descriptive account of experience alone. Finally, the cross-sectional nature of the study limits our ability to examine how resilience and well-being evolve over time. Given that these are dynamic processes influenced by changing life circumstances, work environments and seasonal patterns, future research should adopt longitudinal designs to explore how these constructs shift across time, particularly in response to seasonal variations, policy changes and life events as observed in other studies.[54]

CONCLUSION

This study shows that CHW resilience and well-being are the result of interrelated cognitive, emotional, social and spiritual processes embedded in local cultural contexts. The findings may interest policymakers and health system stakeholders by highlighting the importance of context-sensitive, culturally and gender-attuned approaches to understanding the diverse experiences of resilience, well-being and synergies among CHWs. Consequently,

it is imperative to move beyond narrow incentive-based approaches to develop more holistic workforce strategies that emphasise peer support systems, community recognition structures, psychosocial support mechanisms and culturally sensitive supervision practices. Incorporating these dimensions into CHW programme design may improve retention, motivation and long-term sustainability.

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