FRAMEWORK FOR A WORKPLACE WELLNESS PROGRAMME FOR HIV AND AIDS AFFECTED AND/OR INFECTED NURSE PRACTITIONERS

by

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31 May 2011

Supervisor: Dr. L. Roets

I, Helena Aletta Basson, declare that this thesis submitted in the fulfilment of the requirements for the degree Magister Societatis Scientae in Nursing at the University of the Free State, is my own independent work. All the sources that were used and quoted have been indicated and acknowledged as complete references. This thesis has not been submitted for any other degree at this or at any other university. I furthermore cede copyright of this thesis in favour of the University of the Free State.

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HELENA A. BASSON

31 May 2011

DEDICATION

I dedicate this work to all my nursing colleagues who daily walk amongst those who carry their own individual burden and need our unconditional care and support. I applaud you!

ACKNOWLEDGEMENTS

I wish to convey my sincere gratitude to:

- my Heavenly Father for giving me the courage, wisdom and health to fulfil my lifelong dream. To Him belongs all the glory!

- my husband, Riaan, for believing in me and giving me all the support he could muster. To him belongs my heart!

- my children, grandsons, family and friends for encouraging me with their laughter and hugs during those lonely days I had to spend inside my study. To them belongs my life!

- my nursing colleagues for sharing their deepest heartache, fear and triumph they encounter daily. To them belongs my loyalty and camaraderie!

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AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment/therapy
CCMA	Commission for Conciliation, Mediation and Arbitration
DOTS	Directly Observed Treatment Short Course
EEA	Employment Equity Act
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICN	International Council of Nurses
IFC	International Finance Corporation
ILO	International Labour Offices
LRA	Labour Relations Act
NSP	National Strategic Plan
OHSA	Occupational Health and Safety Act
PEP	Post-exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
SANC	South African Nursing Council

SCDT   Self-care Deficit Theory

STD   Sexual Transmitted Diseases

STI   Sexual Transmitted Infections

TAG   HIV/AIDS Technical Assistance Guidelines

TB   Tuberculosis

UNAIDS   Joint United Nations Programme on HIV/AIDS

URTI   Upper Respiratory Tract Infections

VCCT   Voluntary Confidential Counselling and Testing

WHO   World Health Organization

CHAPTER 1

Problem statement

1.1 Introduction and problem statement

The effective management of the Human Immunodeficiency Virus and Acquired

Immune Deficiency Syndrome (HIV and AIDS) in the healthcare workplace requires

an urgent integrated strategy that includes an understanding of the impact of HIV

and AIDS (also referred to as HIV/AIDS) on the workplace (Nel, Swanepoel, Kirsten,

Erasmus and Tsabadi, 2005: 326; Van Dyk, 2008: 4).

This statement was supported in The Code of Good Practice on Key Aspects of HIV

and AIDS and Employment (The South African Labour Relations Act No. 66 of 1995,

the South African Employment Equity Act No. 55 of 1998 and the Occupational

Health and Safety Act of 1993) and recommendations were made for the

establishment of a wellness programme for nurse practitioners affected and/or

infected by HIV and AIDS as to possibly deal with the impact of HIV and AIDS in the

healthcare workplace. The HIV and AIDS and STI Strategic Plan for South Africa

2007-2011 (South Africa, 2007: online) endorses involvement of all stakeholders on

creating operational plans and activities to deal with the impact of the disease.

Workplace wellness programmes attempt to enhance organizational wellbeing, not

only in terms of improved attendance patterns, but also in productivity and

profitability (Vass and Phakathi, 2006: 8). It could assist and support newly diagnosed nurse practitioners with HIV to cope with their status, to inform them on measures so that they are able to work productively and to develop positive attitudes towards healthy living principles.

A workplace wellness programme prepares the HIV infected nurse practitioner from being symptom free to falling ill and require care and aids in legal issues such as insurances, joining medical aids, where to receive treatment, prophylaxis, when is antiretroviral therapy (ART) appropriate and qualifications for disability and other social grants (South Africa. Foundation for Professional Development, 2006: 53). It also attempts to move the HIV infected nurse practitioner from a neutral to a higher level of health, focuses on signs of health, and indicates that the key to wellness is self-responsibility and establishing a positive approach (Vass and Phakathi, 2006: 22).

Health promotion, being a positive process emphasizing social and personal resources and physical capacities for every day life, enables nurse practitioners affected by and/or infected with HIV to increase control over, and to improve, their health. To reach a state of physical, mental, and social well-being, an individual has to be able to identify and to realize aspirations, to satisfy needs and to change or cope with the environment. Workplace wellness programmes can enhance awareness, help nurse practitioners make lifestyle changes, and create an environment in the workplace that supports a healthy lifestyle (O'Donnell, 2002: 569).

The healthcare industry and healthcare practitioners, in particular nurse practitioners, experience the impact of HIV/AIDS in a number of ways, such as large numbers of sick people to be taken care of and facing inevitable high death rates amongst colleagues, patients, family and friends. In the workplace nurse practitioners are confronted with additional sick leave, absenteeism and loss of highly qualified staff, fear of job loss, discrimination and stigmatization amongst HIV infected nurse practitioners, additional responsibilities that induces low staff morale and fear of infection (Zuberi, Sibanda and Udjo, 2005: 91; Van Dyk, 2008: 132; Page, Louw and Pakkiri, 2006: 104; Champ, 2006: 50).

Gorman, Sultan and Luna-Raines (1989: 5) described in their study the influence of illness and disability on the self-esteem of the nurse, thus explaining why the HIV infected nurse practitioner may need to alter or abandon her set goals, endeavour to maintain good relations between colleagues and enforce effective coping strategies. It is therefore important that the HIV infected nurse practitioner feel safe and secure when they are amongst colleagues, friends and family who are close to them, have shelter and are employed.

The 2008 mid-year population of South Africa has been estimated at approximately 48.7 million. The HIV-prevalence rate (the proportion of adults who are infected with HIV) of adults 15 - 49 years of age in South Africa, is 18.8%, thus an estimation of 5.35 million HIV-positive adults (Figure 2.1, Page 49), an increase from less than 9% in 2001 to about 11.32% in 2008. The HIV-prevalence rate of 19.6% is estimated for

women 15 - 49 years of age, which is the highest overall prevalence rate (Statistics South Africa, 2008: Statistical release P0302).

In South Africa HIV is spread predominantly via sexual intercourse (Evian, 2003: 20; Van Dyk, 2008: 34) affecting mainly the sexually and economically active members of society (adults between 15 - 49 years of age). Studies have also described that HIV and AIDS have become the leading cause of death amongst working adults in South Africa (Vass and Phakathi, 2006: 7).

Nurse practitioners are directly affected by these occurrences. A total of 212 806 active nurses of all categories were registered on 31 December 2008 at the South African Nursing Council (SANC), not taking the nurses in training and unregistered total of lay care givers into account, of which 139 121 nurses are in the age group between 15 - 49 years (67.4%). The nursing pool in South Africa consists predominantly out of female practitioners, approximately 92.51% (128 700), students and lay caregivers excluded (Figure 2.2, Page 50) (SANC, 2008: online). These statistics emphasise the urgent need for instituting a wellness programme in the workplace whereby nurse practitioners could effectively address their exposure to HIV.

A workplace wellness programme does not only focus on rehabilitation and social assistance, but it provides guidelines of best practices for nursing managers, which includes assistance for nurse practitioners such as retraining for multi-skillship,

compassionate leave, flexible working hours and redeployment. Employers benefit

through lower levels of labour turnover, reduced absenteeism and higher productivity

(Vass and Phakathi, 2006: 12).

Van Dyk (2008: 463) illustrated the development of a wellness programme in the

workplace but a literature search revealed that a wellness programme does not

currently exist for nurse practitioners infected and/or affected by HIV/AIDS in South

Africa. Research is necessary to provide constructive direction to orderly coordinate

and efficiently develop the progression of employee wellness through emphasising

the important role wellness programmes have to play in the workplace (Enslin, 2006:

32).

Given the relative newness of employee wellness as a field, its literature is in a

rudimentary stage, especially where HIV/AIDS are concerned (Fayers, 2006: 19) and

therefore the development of a framework for a workplace wellness programme

would be appropriate to assist nurse practitioners infected and/or affected with HIV

and AIDS in the private healthcare sector.

1.2   Purpose

The purpose of this study is to develop a framework for a workplace wellness

programme for nurse practitioners who are infected and/or affected by HIV/AIDS

(henceforth also referred to as 'subjects') in a private healthcare sector. The study

will be conducted in a private healthcare facility in the city of Bloemfontein, the capital of the Free State, South Africa.

1.3 Research objectives

The objectives of this study are to:

(a) identify components necessary for the development of a workplace wellness programme for nurse practitioners affected and/or infected by HIV and AIDS,

(b) describe components necessary for the development of a workplace wellness programme for nurse practitioners affected and/or infected by HIV and AIDS, and

(c) develop a framework for a workplace wellness programme for nurse practitioners who are infected and/or affected by HIV and AIDS in the private healthcare sector.

1.4 Concept clarification

1.4.1 *HIV and AIDS (HIV/AIDS)*

AIDS is the abbreviation for Acquired Immune Deficiency Syndrome. It is a collection of specific signs and symptoms that occur together to present a particular condition when the human immunodeficiency virus (HIV) enters the body from outside. The immune system is weakened and ceases to defend the body against infection and disease (Van Dyk, 2008: 4).

1.4.2 *HIV infected*

An individual becomes infected with HIV after the virus has entered the person's bloodstream via the body fluids of an infected person. This occurs primarily by sexual intercourse, by HIV-infected blood passing directly into the body and by a mother to her baby during pregnancy or childbirth, or because of breastfeeding. A HIV antibody test confirms the individual's status as HIV positive (Evian, 2003: 40; Van Dyk, 2008: 34).

1.4.3 *HIV affected*

An individual is affected by HIV/AIDS after becoming emotionally involved with an HIV/AIDS infected person and is influenced by the physical, psychological, emotional and/or spiritual needs of such a person (Van Dyk, 2008: 406). For the purpose of this study a HIV/AIDS affected nurse practitioner will be a professional or enrolled nurse that works with HIV/AIDS patients in a hospital or alongside colleagues infected or affected with HIV/AIDS or has any family member, friend or knowledge of such a person or might fear HIV contagion due to occupational exposure or do not feel comfortable in addressing sexual related topics with patients and/or colleagues.

1.4.4 *Nurse*

The nurse is any nurse practitioner who practises nursing and who is registered or enrolled with the South African Nursing Council. The South African Nursing Council is the regulating body for nurses in South Africa (Muller, 2003: 44; SANC, 2008: online).

1.4.5 *Wellbeing*

Wellbeing is a contented positive condition of the body and mind and spirit and social adaptability where social and economical networks and resources exist to encourage and develop and nurture health in all its dimensions (Hawk, 2005: 191; Hall, 2007: 130).

1.4.6 *Workplace wellness program*

A workplace wellness program is a properly developed and designed program in the workplace to promote awareness of positive physical and mental health and supports the modification to healthy lifestyles (O'Donnell, 2002: xxii).

1.4.7 *Framework*

A framework is a theoretical guide of meaning to express views to research findings, evaluate existing knowledge and describe and explain and predict thoughts and behaviours which need to be tested through further research (Lunney, 2008: 28; Doran and Sidani, 2007: 3).

1.4.8 *External factors pertaining to the nurse*

External factors are factors experienced aside from the subjects' mental perception of how the disease influences his or her daily life. External factors influence their ability to apply effective coping strategies. Social resources and environmental influences such as experienced in the workplace and the assurance of being

economical independent are capacities to increase control over everyday life (O'Donnell, 2002: 569).

Social incapacities such as perceived lack of support and avoidance of colleagues and friends should be amongst the issues to be addressed (Hodgson, 2006: 283). Venues to aid the employee to stay economically productive and employed and stay financially independent are important issues that could be addressed in a wellness programme (Gritzman, 2005: 154).

1.4.9 *Internal factors pertaining to the nurse*

Pertaining to the inner self of the nurse are elements resulting in low self-esteem and the lack of applying effective coping skills to deal with the debilitating demands placed on the subjects generated by HIV/AIDS (O'Donnell, 2002: 569; Gorman, Sultan and Luna-Raines, 1989: 5). Physical and psychological factors such as fatigue and burnout has debilitating effects on nursing practitioners and comprehensive education in HIV/AIDS care will have profound influence on their attitudes and levels of care for people living with the disease (Oyeyemi, Oyeyemi and Bello, 2006: 201).

1.4.10 *Managerial factors*

Managerial factors include activities of planning, organizing, directing and control to achieve the objectives in the workplace. The cost-effectiveness, efficiency, problem solving initiatives and the attainment of organizational goals and objectives of a HIV/AIDS workplace wellness programme could be determined by evaluating the results achieved (Muller, 2003: 104 & 107). An ethical and legal obligation rests on the employer to plan, organize and put activities and resources into action to create a safe working environment where policies and programmes are developed to educate and protect employees (Van Dyk, 2008: 440).

1.4.11 *Internal factors pertaining to the workplace*

Internal factors that will have to be taken into account when developing a workplace wellness programme for nurses are company policy on HIV/AIDS issues (Van Dyk, 2008: 429) in the workplace and how the organization comply with the applicable legislation on HIV/AIDS in the workplace. The organizational structure (Booyens, 2004: 208 & 456) will imply the way in which tasks will be divided amongst individuals, units, divisions and departments in a healthcare setting and how it will be co-ordinated to produce successful outcomes.

The organizational culture will play an important role as well, because a firmly established organizational culture that encourages participation of HIV/AIDS infected and/or affected nurse practitioners and involve them in the decision-making process, will influence the workplace wellness programme output positively. Open

communication channels will exist and subjects could function in a safe, caring and friendly environment which accommodates all employees, irrespective of rank, nationality or gender (Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner, 2005: 66, 19 & 91; Van Dyk, 2008: 429 & 462).

1.4.12 *External factors pertaining to the workplace*

External factors that will have to be taken into account when developing a workplace wellness programme for nurses are the enforcement of laws, rules and regulations on all citizens as to ensure basic respect for human rights and dignity of all people and to enforce the running of an orderly and disciplined society.

An un-debatable fact is acknowledged that HIV/AIDS are a workplace issue (Geneva. International Labour Office, 2002: 6) involving important employee welfare, health and social dilemmas as well as significant organizational interests. Not only do legislative requirements insist on equality in the workplace, but also management needs to continuously address the economical and social impact of the disease on business.

Company policy on HIV/AIDS (Van Dyk, 2008: 429) is therefore a document that states in writing how an organization positions itself in dealing with the disease in the workplace and what guidelines are to be adopted to ensure consistent practices and decisions.

The South African Constitution, Act 108 of 1996, includes the Bill of Rights, which

lists basic human rights that apply to all people of South Africa, therefore to people

living with HIV/AIDS as well. For this study the Labour Relations Act No. 66 of 1995,

the Occupational Health and Safety Act of 1993 and the Employment Equity Act No.

55 of 1998, which contains the Code of Good Practice on Key Aspects of HIV and

AIDS and Employment to assist employers and employees in dealing with the impact

of HIV and AIDS in the workplace, will apply (Van Dyk, 2008: 429; Nel *et al.*, 2005:

325).

1.5   Conceptual framework

A conceptual framework will be presented by the researcher (Figure 1.1, Page 13) to

communicate which concepts are associated with the phenomenon to be

investigated after a literature analysis revealed that a wellness programme does not

currently exist for nurse practitioners infected and/or affected by HIV and AIDS in

South Africa and literature explaining this phenomenon is in a rudimentary stage

(Fayers, 2006:19).

The concepts are sets of ideas grouped together, depicting a mutual relationship

with the purpose of this study. The concepts are organized and structured to convey

a useful image of meaning derived from the literature analysis (De Vos, Strydom,

Fouché and Delport, 2009: 28 and 34).
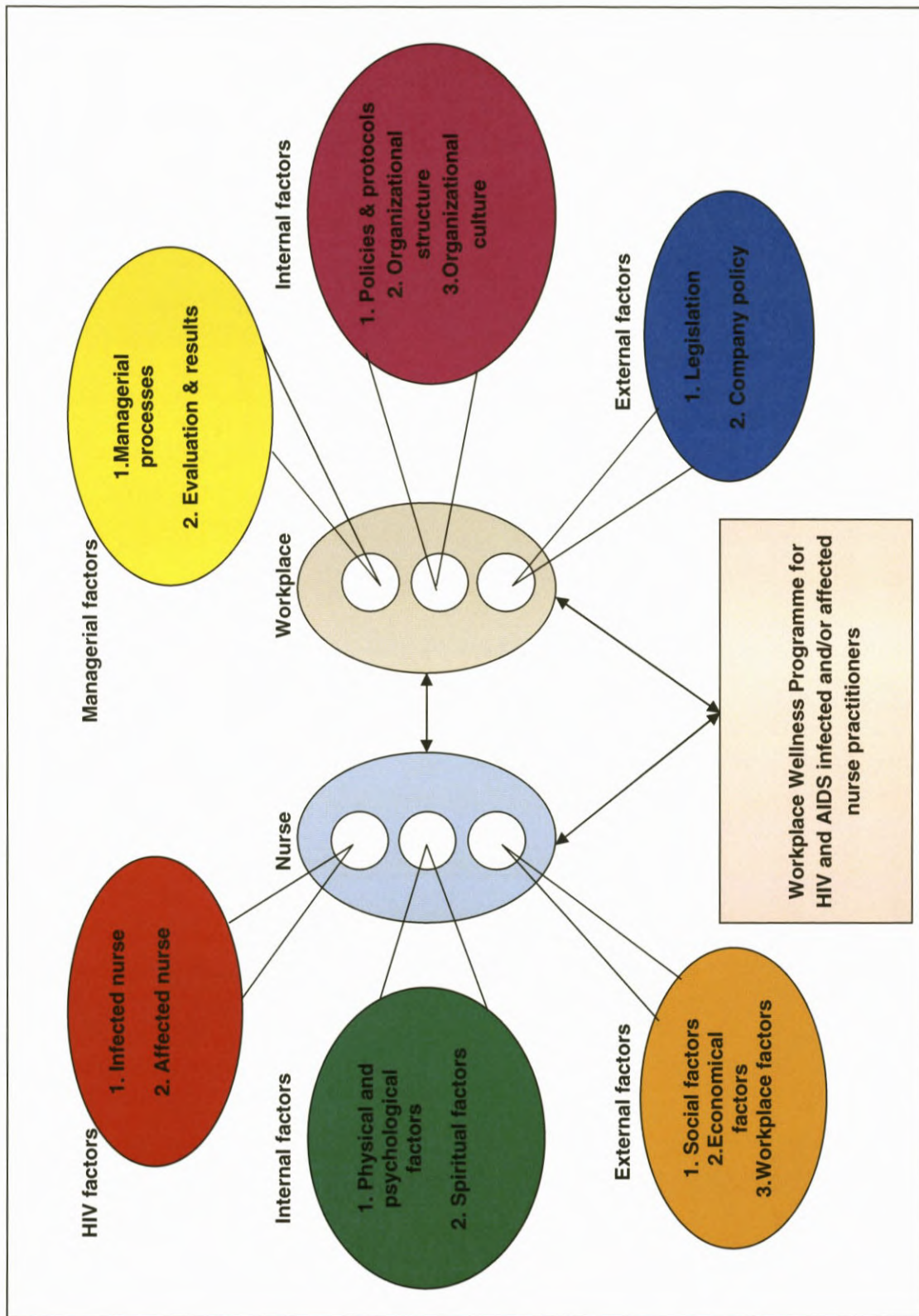
Figure 1.1   Conceptual Framework

1.5.1 The Nurse (light blue circle in the framework)

The nurse is any nurse practitioner who practises nursing and who is registered or enrolled with SANC.

1.5.2 HIV factors and the nurse (red circle in the framework)

HIV/AIDS have become the leading cause of death amongst working adults in South Africa and nurses are directly affected, because the nurse practitioners in the country consist predominantly out of the sexually and economically active members of society (Myslik, 2000: 14; Van Dyk, 2008: 34).

1.5.3 External factors and the nurse (dark green circle in the framework)

The external factors comprising of social, economical and workplace issues have a debilitating effect on the health and wellbeing of the nurse practitioner due to the increasing demands placed on their care-giving role (Holzemer, Uys, Makoae, Steward, Phetlhu, Dlamini, Greeff, Kohi, Chirwa, Cuca, and Naidoo, 2007: 549-550; Booysen and Mafereka, 2006: 2).

1.5.4 Internal factors and the nurse (orange circle in the framework)

The HIV infected and/or affected nurse practitioner is daily confronted with his or her ability to be in control of the quality of life and level of psychophysical wellbeing he or she aspires to. Oyeyemi, Oyeyemi and Bello (2006: 201-203) describe in their study the apprehensiveness and hesitance of individuals to socialize with a HIV/AIDS

infected person due to the perceived stigma associated therewith. The degree of bio-psychosocial and spiritual wellbeing of a HIV affected or infected person enables the individual to redefine their life and find a sense of meaning and purpose as to enhance and maintain a positive approach to human existence (Bosworth, 2006: S3-S4).

1.5.5 The workplace (grey circle in the framework)

The workplace is an environment within which a nurse practitioner conducts his or her daily tasks. This environment has an influence on the physical, psychosocial, spiritual and economical health and wellbeing of a nurse practitioner (Nel *et al.*, 2005: 20 – 21).

1.5.6 Managerial factors and the workplace (yellow circle in the framework)

Educational and prevention strategies in a safe working environment enable employees to address barriers clouding their ability to apply efficient coping skills leading to a productive healthy life. The employer has to apply managerial activities endorsed by internal directives such as policies, protocols and strategic input for mechanisms to combat problems encountered by HIV/AIDS infected and/or affected nurses in the workplace (Page *et al.*, 2006: 112).

1.5.7 External factors and the workplace (deep blue circle in the framework)

Legislation and a company policy on HIV/AIDS put an obligation upon the employer

to ensure basic respect for human rights and dignity of all people. This legislation

and company policy state how an organization should position itself in dealing with

the disease in the workplace and what guidelines are to be adopted to ensure

consistent practices and decisions (Van Dyk, 2008: 454; Nel *et al.*, 2005: 296).

1.5.8 Internal factors and the workplace (purple circle in the framework)

A workplace wellness programme could be a valued venue whereby primary sexual

behaviour change, open communication about HIV/AIDS and people infected and/or

affected by the disease and organizational structures and interventions of support

and contact and care could be managed (Low-Beer, 2005: 478; O'Donnell, 2002:

544).

The Nurse, the Workplace and the Workplace Wellness Programme (light pink box in the framework)

The focus of this study will be to develop a framework for a workplace wellness

programme for nurse practitioners infected and/or affected by HIV and AIDS. The

concepts of meaning are arranged in the conceptual framework (Figure 1.1) to

identify the probable components that needs to be addressed to compose such a

programme.

The researcher will follow a research process (Burns and Grove, 2005: 36) in this study as illustrated in Chapter 3, Figure 3.1 (Page 124) to guide the study through actions, processes or steps (De Vos *et al.*, 2009: 78) to achieve the ultimate goal of acquiring the necessary information to explain the current phenomenon experienced in the nursing population.

The HIV/AIDS infected and/or affected nurse practitioner needs to remain in employment without the fear of the debilitating psychological issues generated by the disease and prejudice from co-workers. Positive attitudes, job performance and productivity are attainable if legal and financial problems could be addressed and effective coping life skills could be acquired (McLean and Moore, 2000: 242).

1.6 Research design

The research design allows the researcher to plan and conduct the study accurately by following a research process (Figure 3.1, Page 124). The objectives of the study could therefore be achieved without compromising the validity and reliability of the study findings (Burns and Grove, 2005: 211).

A quantitative research design will be followed and will be defined as being a formal, objective, systematic process where numerical information will be used to explain an existing phenomenon (Burns and Grove, 2005: 23).

A descriptive research method in quantitative research design will be used to obtain and explore information about the components needed to develop a sustainable and effective wellness program to provide an organized approach to the management of nurse practitioners affected and/or infected with HIV/AIDS (Burns and Grove, 2005: 26). Concepts will be described and relationships could be identified. It will thus provide basic knowledge regarding a specific happening for future research because a literature research revealed that a wellness programme does not currently exist for nurse practitioners infected and/or affected by HIV/AIDS in South Africa given the newness of employee wellness as a field (Fayers, 2006: 19).

1.7 Measurement strategy

The measurement strategy is the process of using an instrument to examine a specific situation by allocating numbers in accord with some rule (Burns and Grove, 2005: 41).

A questionnaire will be developed after the completion of a thorough literature analyses. Questions will be drafted in a consistent and logical order. Registered and enrolled nurse practitioners, as well as enrolled nurse auxiliary practitioners currently practising nursing at the designated institution will be requested to complete the questionnaire in his/her, own time.

The advantage of a questionnaire is the insurance of anonymity and avoidance of researcher bias, because an allocated code will substitute the name of the subject

on each questionnaire to ensure anonymity. The nurse will not be pressurized into

completing the questionnaire in public (Burns and Grove, 2005: 400). It will be a

cheap method to use and would be easy to distribute, because the questionnaire will

be distributed by each unit manager and collected from each unit manager on a

specific appointed date.

It will be borne in mind that a disadvantage of this method is that the response rate

tends to be low and that the researcher has no control over who fills in the

questionnaire (Gerish, Ashworth, Lacy, Bailey, Cooke, Kendall and McNeilly, 2007:

328-338; Burns and Grove, 2005: 402; Paterson, Symons, Britten and Bargh, 2004:

339-349). The researcher will therefore be available on the premises during the data

collection period to assist the nursing staff where problems may arise.

The language policy of the healthcare institution requires that a nurse practitioner

should at least be able to communicate in the English language and writing and

therefore, to enhance a high response rate, the questionnaire will be drafted in

English as to avoid confusion of terminology and explanations of concepts and

statements.

1.8 Reliability and validity of the study

Reliability is defined as the achievement of a measure to be consistent every time a

particular instrument is used. Measuring instruments should be reliable and provide

values with the least possible amount of random error. This will enhance the power

of the study, because significant relationships occurring in a population, will be noticeable detectable (Burns and Grove, 2005: 374).

Burns and Grove (2005: 376) defined validity as the achievement of an instrument to actually reflect the abstract construct being measured. Validity addresses the appropriateness, meaningfulness and usefulness of the specific conclusions made from the instrument scores. No instrument is completely valid, but it demonstrates the truth, strength and value of an instrument and as studies varies, so should a reliable and valid instrument be re-evaluated with every study being done.

To maintain reliability and validity through every step of the research process and to obtain the highest measurement level possible, questions will be derived from the literature search and analyses. The questions to be measured will be described and to the point as to avoid confusion and uncertainty amongst the identified population, i.e. the HIV and AIDS infected and/or affected nurse practitioners (many employed nurse practitioners in South Africa are currently either infected and/or affected by HIV/AIDS). The questionnaire will focus on the proposed topic and will include close-ended, as well as open-ended questions (Lategan and Lues, 2005: 124). Burns and Grove (2005: 404) suggest that all the items in the questionnaire should address an element of the concept being measured.

A blue-print of the questionnaire will be submitted to a panel of experts in instrument developing, research methodology and HIV/AIDS at the School of Nursing of the

University of the Free State in collaboration with the study supervisor, to determine if the questions are consistent, relevant and precise and representing the concepts to be measured (Burns and Grove, 2005: 376 – 380).

1.9 Population

The population consists of all those persons who share similarity in a specific setting and comply with the sampling criteria (Burns and Grove, 2005: 40). Nurse practitioners who are currently practising nursing and are registered as professional or enrolled nurses with the South African Nursing Council will participate in the research study. It is, however, impossible to access the entire nursing population. The target population will thus be 250 professional and enrolled nurse practitioners, as well as enrolled nurse auxiliary practitioners currently practising nursing at the designated private health institution in Bloemfontein, the capital city of the Free State, South Africa, to which the researcher has reasonable access (Burns and Grove, 2005: 341 and 447).

1.10 Sampling

Burns and Grove (2005: 40) define sampling as the process of selecting a group of people, the sample, with which the study has to be conducted.

Due to the character of their nursing function, every professional and enrolled nurse practitioner are directly and/or indirectly involved with HIV/AIDS in the workplace. No

sampling will thus take place at the designated institution because every registered nurse will be asked to take part in the study (Burns and Grove, 2005: 348).

1.11 Pilot study

A pilot study is defined as a smaller version of the proposed study to be conducted in order to test and streamline the research process and identify problems with the data collection instrument and assess the reliability and internal validity of the research instrument to be used (Torp, Hanson, Hauge, Ulstein and Magnusson, 2008: 75-85; Burns and Grove, 2005: 42).

Nurses from a nursing unit in the sister-hospital will be invited to participate in the pilot study. This will enhance the reliability and validity of the research instrument to be used, because the sister-hospital is situated approximately 5 kilometres from the designated hospital. The nursing units in the sister-hospital are not participating in the main research study.

Subjects similar to the target population will be selected by word of mouth and each subject will receive a questionnaire and anonymous envelope from the researcher. They will be required to complete the questionnaire, indicating the amount of time it took to be completed. The respondents will be required to return their completed questionnaire in the sealed envelope to the researcher. The researcher will collect the bundle on the same day, because a nursing unit consists of approximately four registered and enrolled nurses.

The structure and validity of the questionnaire will be determined by means of the way the respondents reacted to the questions. Their perception of the questions and if the expected response was attained will indicate if the questions were concise and clear. The researcher will be able to determine if the duration for the completion of the questionnaire is within a reasonable time. The data obtained from these questionnaires will however not be included in the main study.

Constructive feedback from the participants in the pilot study is valuable to the researcher and will thus be evaluated in collaboration with the study supervisor. Corrections and adjustments to the questionnaire and research plan will be made, where necessary, before the main data collection will commence.

1.12 Data collection

Data collection in quantitative research involves the use of numerical information to explain and describe the research objectives using different methods, such as interviews, observation, scales and as in this study, questionnaires (Burns and Grove, 2005: 42).

After obtaining approval from the Ethics Committee of the Faculty of Health Sciences of the University of the Free State (Addendums E and F, Pages 290 & 291) and written permission to conduct the study at the designated institution and sister-hospital (Halcomb, Davidson, Salamonson, Ollerton and Griffiths, 2008: 9;

Addendums A and B, Pages 286 & 287), the researcher will explain the objectives of the study to each nursing unit manager.

Each nursing unit manager will also be informed which nurses categories to select for participation in the study. The nursing unit manager will be asked to distribute a cover letter with an anonymous questionnaire and envelope to each permanent employed enrolled and professional nurse practitioner on the data collection day determined by the researcher.

The cover letter will inform the subjects of the purpose of the study and what will be expected from them. Voluntary participation and completion of the questionnaire will indicate that consent from the subject participating in the study has been obtained, because no subject will be coerced into completing the questionnaire. Assurance will be given to subjects that their responses will remain anonymous and that the information they provide will be treated as confidential at all times.

The language policy of the healthcare institution requires that a nurse practitioner should at least be able to communicate in the English language and writing and therefore, to enhance a high response rate, the questionnaire will be drafted in English as to avoid confusion of terminology and explanations of concepts and statements. The respondents will be requested to answer the questionnaire as comprehensively as possible and return it in a sealed envelope to the nursing unit manager where-after the researcher will collect each questionnaire bundle after 10

(ten) days as to allow the permanent employed subjects from the different shifts to participate.

The researcher will be available to assist the nursing staff where problems may arise during the collection of the study data by means of dialling a cell phone number that will be supplied in the cover letter. The researcher will however dissociate herself from the subjects taking part in the study. She will maintain an objective and flexible attitude and resolve problems as soon as they arise. This should enhance a high and valid response rate.

1.13 Data analysis

Quantitative descriptive research analysis will be utilized to explore, interpret and organize the crude data. The data analysis will be preformed by a biostatician at the Department of Biostatistics of the Faculty of Health Sciences of the University of the Free State. The categorical data and continuous data will be calculated, analysed and interpreted after the means, standard deviations or medians, percentiles, frequencies and percentages are identified.

1.14 Ethical considerations

Consent to conduct the study will be obtained from the Ethics Committee of the Faculty of Health Sciences of the University of the Free State and the ethical guidelines contained in the code of ethics will be adhered to. Written permission to

conduct the study at the designated institution and sister-hospital will be obtained from the hospital manager and chief nursing manager.

1.14.1 Adherence to excellence and quality

In the introductory letter the identity, qualifications and experience of the researcher will be made known to the participants, as well as the aim and objectives of the research to be conducted. The researcher will attempt to adhere to the highest possible standards and will seek the guidance of an experienced researcher during the research process. The research will be conducted sincerely with the necessary integrity, honesty and confidentiality (Burns and Grove, 2005: 181).

1.14.2 Confidentiality

The information that the participant will reveal, will not be made public or available to other people. The information collected during the research process will be made known by means of a research report and the publication of statistical information and applicable articles. The identity of the participants will not be revealed by the researcher and the participants should regard the utmost trustworthiness of the researcher being a professional nurse registered at the South African Nursing Council and the researcher being sensitive to the needs of HIV and AIDS infected and/or affected persons (Burns and Grove, 2005: 188).

1.14.3 Voluntary participation

Participants will not be coerced to participate in the study and the participant has the right to terminate participation at any stage of the study, despite giving consent to take part in the study. This will be communicated in the introductory letter to each subject (Burns and Grove, 2005: 194).

1.14.4 Remuneration

Financial rewards will not be offered to the participants, because they will not have any expenses during participation in the study. A word of appreciation will be conveyed in the introductory letter to each subject. A research report conveying the results obtained from the research study will be made available to the participants on their request (Burns and Grove, 2005: 194).

1.14.5 Informed consent

The aim and objectives, data collection methods and duration of the study will be explained to the participants. They will be informed that the participation will be voluntarily, held in utmost confidentiality and that no remuneration will be paid. The assurance will be given that the subject will remain anonymous, as well as their responses and data during the data collection stage. The nature of the dissemination of the collected data will be explained to the participants, as well as the value of their participation. Assurance will be given that no deliberate physical, psychological or spiritual harm is intended during this research study (Burns and Grove, 2005: 193).

1.15 Summary and value of the study

An un-debatable fact is acknowledged that HIV/AIDS are a workplace issue (Geneva. International Labour Office, 2002: 6). Research has to prove the urgent necessity for the implementation of a wellness programme in the workplace as supportive tool for the HIV infected and/or affected nurse practitioner in South Africa (Vass and Phakathi, 2006: 12).

A requisite exists for co-responsibility and commitment of the employer to institute workplace wellness programmes to assist in the war against HIV/AIDS (HIV and AIDS and STI Strategic Plan for South Africa, 2007 – 2011: online) and this study will aim to develop a framework for a workplace wellness program for HIV and AIDS infected and/or affected nurse practitioners practising nursing in a private healthcare setting.

HIV/AIDS will remain a serious workplace health issue involving employee welfare, health and social dilemmas as well as significant organizational interests. The need of instituting a comprehensive workplace wellness programme for the HIV/AIDS infected and affected nurse practitioner is emphasized, because legislative requirements insist on equality in the workplace.

Organizations have to continuously address the economical and social impact of the disease on business. The HIV and AIDS affected employee needs to remain in employment without the fear of the debilitating psychological issues generated by the

disease and prejudice from co-workers. Knowledge and assistance on legal and

financial problems and the acquiring of effective coping life skills, will enhance

positive attitudes, job performance and productivity (Vass and Phakathi, 2006: 5 -

15).

"What cannot be talked about must be talked about.

What must not be talked about must be talked about openly.

What cannot and must not be felt must be given its hearing.

We must have the courage to break the spell of our cherished

workplace self-protectiveness."

(Quoted by Margaret H. Vickers (2006: 279) from Stein, 1998: 13 – 14)

CHAPTER 2

Literature review

2.1 Introduction

The purpose of this literature review is to explain the need of a framework for the development of a workplace wellness programme for nurse practitioners who are daily confronted with the realities of HIV/AIDS in the workplace.

A framework is intended to provide an understanding of the relationship between an employee, namely the HIV and/or AIDS infected and/or affected nurse practitioner (henceforward addressed as the 'nurse practitioner') and the employer who represents the organization and the role that a workplace wellness programme could play to promote employee health and wellness through identified activities. A framework furthermore represents a structured and theoretical approach to guide the design of a workplace wellness programme (McCray, 2003: 392 and 393) with the intention to promote awareness of positive physical and mental health, as well as support modifications to healthy lifestyles as its intended outcomes (Frechtling. 2007: 5 and 18; McDavid and Hawthorn, 2006: 15 and 54).

Nurse practitioners have the desire to stay healthy and well (Cavanagh, 1991: 16 & 17) within an environment where they are daily confronted with HIV/AIDS. The 2008 HIV-prevalence rate of Adults 15 – 49 years of age in South Africa is 18,8%, thus an

estimation of 5,35 million HIV-positive adults. Nurse practitioners are especially

affected by the HIV-prevalence rate of 19,6% estimated for South African women in

this age group (Statistics South Africa, 2008: Statistical release P0302) because

approximately 92,51% of registered nurse practitioners in South Africa, students and

healthcare givers excluded, comprise of female adults (South African Nursing

Council, 2008: online).

This statistical information emphasize the urgent need for instituting a workplace

wellness programme whereby nurse practitioners could effectively address their

exposure to HIV, because early identification of problems associated with HIV/AIDS

could promote timely symptom management through self-care or managerial

interference such as promoting a healthier work environment and optimal health and

wellbeing (Van Dyk, 2008: 90). Nurse practitioners have to be able to identify and

realize their aspirations, satisfy their needs and cope with the environment to reach a

state of physical, mental and social wellbeing. Their social and economical networks

and resources have to exist to encourage, develop, and nurture their health in all its

dimensions (Hawk, 2005: 191; Hall, 2007: 130).

To support and help nurse practitioners reach an optimal level of positive health and

wellbeing, the researcher required to undertake a literature review to explain the

interrelationship of health and wellness and how health and wellness could be

promoted by instituting a workplace wellness programme. Issues that have an

influence on nurse practitioners confronted with HIV/AIDS will be described in the

literature review as external and internal factors that explain the health, psychosocial

and important employee welfare and economical issues that are experienced within the workplace.

Factors that disposition the development of a workplace wellness programme will be explained, as well as the character of a wellness programme that prepare nurse practitioners for all the stages of a chronic disease such as HIV/AIDS, and develop life skills to cope with physical and psychosocial needs by receiving appropriate information, health education, legal assistance and financial direction (O'Donnell, 2002: 544 & 571).

The researcher will furthermore describe the nature of a framework to achieve the intended goals or objectives that support change as well as the value it adds to represent the components that influence the uptake of knowledge and evidence from research to guide the design of a workplace wellness programme for nurse practitioners.

The literature review is concluded with the acknowledgement that a nurse practitioner could experience positive healthy living and wellness if daily health and employment issues are effectively addressed. Positive wellbeing is related to a feeling of being in control of daily living, feeling good about one self and being able to conquer the debilitating effects of HIV/AIDS and experiencing health in all its dimensions (Hildebrandt, 2002: 363 - 368; Smit, 2005: 28).

2.2 Health

Health is defined in the Constitution of the World Health Organization (WHO) as a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity (WHO, 2006: online). Being healthy creates a positive concept with the nurse practitioner emphasizing her social and personal resources and physical capabilities (O'Donnell, 2002: 569). It indicates that the nurse practitioner is functioning completely and fully whilst experiencing sound health and that she (the feminine pronoun of *she* will be used in the literature study and it will refer to both genders) feels good about herself. She is able to maintain herself in her environment such as in her working environment, communicate her ideas, thoughts and actions to others and focus on her own physical, psychological, social and spiritual needs, as well as economical needs, to experience health and wellbeing. She is full vigour and vitality and experiences no signs of morbidity and illness (Orem, 1980: 118).

The health of the nurse practitioner who is affected or infected by HIV/AIDS is confronted with more than one challenge. She requires feeling comfortable and relaxed if she could have access to adequate economic resources such as a consistent monthly income, food and shelter and sustainable resource-use as provided by her employer, because her monthly salary is important in providing the essential household needs and should she be on any medical treatment, this would include the intake of medication, a balanced diet, enough rest and fresh air (Nutbeam, 1998: 351; Van Dyk, 2008: 94). Her concern for herself and her family will affect her ability to care for herself for example maintaining a healthy sexual

relationship with her partner, keeping up the pace at her work and staying sound of mind and spirit (Van Dyk, 2008: 148).

The involvement of her support systems like family members, friends and colleagues, and efforts she makes to address her self-care needs to restore and maintain a high level of health, will promote her dignity and self-worth and emotional stability in a challenging working environment, even in illness or disability (Van Dyk, 2008: 107 & 420; Orem, 1980: 121). Her social interaction and activities in the physical work environment she daily employs have an impact on her health and wellbeing (Nutbeam, 1998: 351) for example perceiving the health state of a person on the judgement of her general appearance fuels the predicament the nurse practitioner finds herself in, because the wasting of body muscle and severe loss of weight exposes her to gossiping, stigmatization and even discrimination in the workplace (Van Dyk, 2008: 83 & 131; Orem, 1980: 121).

Staying healthy enables the nurse practitioner to experience the comfort and security of being in control of her daily living (Orem, 1980: 145). She demonstrates her influence over the debilitating demands that HIV/AIDS place upon her and how she deals with feelings of anxiety, fear and suffering (Van Dyk, 2008: 127 & 167). Her income and social status, education, employment and working conditions, access to health services and health promotional programmes contribute to those living conditions which could be improved or sustained (Hawk, 2005: 191; Hall, 2007: 130). Factors that influence her health that are not modifiable such as age and gender do

exist, but her health behaviours and lifestyle are conditions that could be modifiable as to meet her need to promote her health and wellness (Nutbeam, 1998: 354).

2.3 Wellness

The proposed uniform definition of wellness as adapted from early definitions, state that wellness is "a multidimensional state of being, describing the existence of positive health in an individual as exemplified by quality of life and a sense of wellbeing" (Corbin and Pangrazi, 2001: 1). Wellbeing is a contented positive condition of the body and mind and spirit and social adaptability where social and economical networks and resources exist to encourage and develop and nurture health in all its dimensions (Hawk, 2005: 191; Hall, 2007: 130).

Considering the factors that characterize wellness such as physical, social, intellectual, emotional and spiritual influences, including the working and physical environment of the nurse practitioner, wellness describes the state of being, representing the desire of the nurse practitioner to stay well and enjoy the positive aspects of health (Cavanagh, 1991: 16 & 17; Hartweg, 1991: 16). She would enjoy life and withstand challenges in her daily life as soon as she is able to apply coping strategies contributing to her sense of wellbeing and quality of life (Corbin and Pangrazi, 2001: 2 & 3). Wellness is therefore a continuously active process whereby the nurse practitioner is put before choices to make decisions that would provide a balanced and productive life.

Nurse practitioners are daily confronted with illness, disease and debilitating psychosocial conditions, especially in South Africa where the prevalence of HIV/AIDS is very high and where an estimated one in every three to four patients admitted to some public hospitals, are HIV positive (Van Dyk, 2008: 406). Although the nurse practitioner perceive this state as being a negative notion to health, they accept it as a way of living and choose to adopt the positive concept of health namely wellness, for themselves. The nurse practitioner thus experiences wellness if she is holistically sound and healthy, but acknowledges that her working environment and economical circumstances have a profound influence on her quality of life and sense of wellbeing. Although she is healthy, she may develop symptoms of stress, illness or depression, depending on the work conditions she is subjected to or, on the other hand, a HIV/AIDS infected nurse practitioner can experience a contented, fulfilling 'healthy' life within the boundaries of her disease if she works in a supportive working environment and have a supportive social network (Vickers, 2006: 268).

She has a sense of happiness and satisfaction with her life and how she goes about her working day if her quality of life is improved and she has control over determinants influencing her sense of wellbeing (WHO, 2006: online; Van Dyk, 2008: 418). Adopting healthy lifestyles to promote good health and wellness are important, but it is not a guarantee to holistically sustain wellness in the nurse. Fear, family and cultural pressure such as experiencing in the workplace and potential problems encountered with finances, housing and transport, are but few aspects that may interfere with the nurse practitioner's decision to appeal for help and advice (Cavanagh, 1991: 124).

Illness and absenteeism could decrease and a successful career with good work performance could be attainable in the presence of optimal wellness, as 'optimal' refers to the most favourable degree of physical, psychosocial, spiritual and intellectual health and contentment (Health and Wellness Strategic Initiative – Task Force Summary Report, 2006: online). Therefore, programmes should be designed and initiatives promoted to encourage healthy lifestyles and coping skills with the intention of building positive health, as well as optimal wellness through health promotional activities (Corbin and Pangrazi, 2001: 3 - 4).

2.4 Health promotion

The WHO in the Ottawa Charter for Health Promotion defines health promotion as the process of enabling a person to increase control over, and to improve their health. Health is not the objective of living, but is seen as a positive condition focussing on adequate social, physical, mental and economical capacities the person possess to go beyond a healthy lifestyle to wellbeing (WHO/Europe, 1986: online).

Health promotion represents the intercourse amongst health education, health enhancement and health behaviour with the prevention of disease and illness and the promotion of a higher level of health and wellbeing throughout life on a daily basis (Hartweg, 1990: 36; Kulbok, Baldwin, Cox and Duffy, 1997: 13 & 17). The nurse practitioner undertakes actions where personal habits and environmental issues such as experienced in the workplace are investigated and altered. Nouns

such as growth and improvement, stability and maintenance are used to provide an explanation of the concept of health promotion. Health promotion is a process not only directed to develop skills and abilities of an individual, but it is actions directed to change social, environmental and economic conditions that have an impact on the physical, psychological, social and spiritual health of the nurse practitioner. The nurse practitioner has the ability to improve and sustain a positive health status if she could gain control over those determinants that influence her daily living (Nutbeam, 1998: 351).

The nurse practitioner is capable to promote and protect her health if human and material resources are made available to her (Van Dyk, 2008: 423). Access to education and information are important venues to empower the nurse practitioner and it is therefore essential that she take responsibility for her participation in the health promotional initiatives offered by the employer as to enable her to achieve her full health potential (Nutbeam, 1998: 351). Workplace policies affecting health and mobilizing resources in the workplace by means of a wellness programme will provide the access she needs to information on health, facilitate skills development and support access to economical assistance and health development, resulting in the continuous progressive improvement of the health status of the nurse practitioner (Nutbeam, 1998: 354 - 355).

The nurse practitioner needs however to be empowered to gain greater control over decisions and actions affecting her health and personal life such as maintaining a healthy diet, undertake regular exercise or spiritual sustaining practices, and avoid

negative behaviour like taking excessive alcohol or allow destructive relationships (Kulbok *et al.*, 1997: 19). She needs the opportunity to express her needs, present her concerns, become involved in decision making and gain strategies to achieve her goals in life (Nutbeam, 1998: 361; Allison and Renpenning, 1997:7). Her daily involvement with her patients, family and colleagues, and where she lives and work every day, will influence and determine the quality of life and health status she enjoys (O'Donnell, 2002: 569).

Health promotion will be put into action when nurse practitioners are confronted with the realization of having a need to look for new approaches to face their battle with HIV/AIDS. They will look for different ways to shift their negative approach on HIV/AIDS to an active and conscious pattern of positive health promotional behaviours and habits to sustain their health and wellbeing (Ford-Gilboe, 1997: 207).

Nurse practitioners have the potential to develop intellectual and practical skills that are important to self-care and care for dependant family members and friends with HIV/AIDS. This assigns a duty on the nurse practitioner to obtain the necessary information, abilities, and support she needs from additional resources such as programmes initiated at her workplace. The socio-organizational culture to which she belongs will determine what actions she will choose to meet her needs. The nurse practitioner may however choose not to install efforts to care for herself or her colleagues, family and friends, due to reasons such as anxiety, fear for stigmatization or discrimination. She does however have the knowledge base to determine when she would be in need of support and guidance to apply specific

actions to enhance her confidence and competency when confronted with her health

and wellbeing (Cavanagh, 1991: 5 - 6; Hodgson, 2006: 283 - 290).

These premises are also made on the assumptions in Orem's Model of nursing on

the nature of health and how the nurse practitioner position's herself in relation to

experiencing health and wellbeing. Therefore, to advance efforts towards describing

and explaining and predicting the results of health promotional initiatives, the tested

and validated Self-care Deficit Theory (SCDT) in Orem's model of nursing, is used.

2.5 Orem's Self-care Deficit Theory and the nurse practitioner

In *Nursing: Concepts of Practice* (1980), Orem discussed the theories of self-care,

self-care deficit and nursing systems constituting her model of nursing.

2.5.1 Self-care

In the term *self-care*, the word *self* explains the nurse practitioner as a whole being

and self-care thus indicates that care is given by herself to herself. The nurse

practitioner that provides the self-care is referred to as a *self-care agent*, where

agent applies to herself taking action. Self-care is thus defined as the practice of

activities that the nurse practitioner initiates and performs on her own behalf to

maintain life, health and wellbeing (Orem, 1980: 35; Marriner, 1986: 119). Utilizing

Orem's Self-care Deficit Theory (SCDT) as a nursing framework in health

promotional nursing practice, is indeed relevant and applicable in the constantly

changing work environment of the nurse practitioner. Orem's model brings meaning and information on health, wellbeing and self-care within one framework and in answer to current trends with the focus on wellness (Hartweg, 1991: 32). The SCDT also highlights the nurse practitioner's ability to involve motivation, knowledge and decision making abilities and energy (Hartweg, 1991: 13 &16), to care for her self and her family, irrespective of what her health needs may be, especially within specific diseases and special population groups (Hartweg, 1991: 35), such as nurse practitioners affected by HIV/AIDS.

Self-care is thus the nurse practitioner's continuous contribution to her own existence, health and wellbeing. It is an action where reasoning is used with the deliberate purpose to understand her health condition and contribute to her structural completeness and wholeness, human functioning and human development. Actions of self-care with the purpose to maintain life and health and promote wellbeing are termed *self-care requisites* (Orem, 1980: 36; Marriner, 1986: 119; Hartweg, 1991: 5).

2.5.2 Self-care requisites

Three types of self-care requisites are identified in this model, namely:

1) Universal self-care requisites which address those common needs nurse practitioners have, as to maintain their daily living such as their need for air, water and food, shelter and financial means to maintain sustainable living conditions, as well as elimination, enough activity and rest, solitude and social interaction;

2)   Developmental self-care requisites which address the training and information

nurse practitioners need when they advance from novice hood to full maturity and

how to effectively manage conditions that influence their daily occupational activities

and health, and

3)   Health-deviation requisites which address initiatives to control and alleviate any

change or variation in herself or her family members' normal structural wholeness

and wellbeing, identify health concerns, discomfort or pathology and when to ask for

medical advice or assistance (Orem, 1980: 39).

Each type of self-care requisite represents a group of intentional actions to be taken

by nurse practitioners because of their need as human beings. When all three types

of requisites are met, they will effectively maintain and support human functioning

and human structure, prevent and control injury, illness, disease and contribute to

the cure or correction in any health deviation which may cause a deterioration in their

health and sense of wellbeing (Orem, 1980: 41; Hartweg, 1991: 6).

Nurse practitioners have developed capabilities to identify the self-care requisites of

their patients and which method is to be used to meet the required outcomes. The

assumption is therefore made that the nurse practitioner will also accept herself as

being in need of care or at least be willing to accept the responsibility to contribute to

her own existence, health and wellbeing (Orem, 1980: 38 - 39). She makes a

deliberate choice to decide which method or actions she will follow to support,

promote her normal daily functioning and living, maintain her development and

growth in to maturity, prevent and control any disease or injury and prevent or compensate disabilities. Her motivation and objectives, life goals and available resources will determine how effectively she will care for herself. The urgency to attend to her self is a response to a demand originating from her self, example experiencing a lack of energy and burnout. She will perform a care measure, because she realizes it will promote her health and wellness. She may decide to ignore the demand, but will remain aware of her need of self-care, especially if it is significant to her health (Orem, 1980: 41).

2.5.3 The relevance of self-care requisites to the nurse practitioner

HIV/AIDS have compelled the nurse practitioner to address her universal, developmental and health-deviation self-care requisites as proposed in Orem's model, which are aimed at developing her potential to identify and solve health and wellness issues (Caetano and Pagliuca, 2006: 344) in the following ways:

1) Universal self-care requisites

Nurse practitioners embrace conditions that promote their functioning and development which enhance their feelings of individuality and wholeness, freedom and integrity (Orem, 1980: 44). They have a need to make provision for their daily consumption and physical care to their person and siblings, as well as providing for shelter and safety for their family, including themselves (Orem, 1980: 43 & 74; Hartweg, 1991: 7). Although experiencing an overload of sick people to care for and taking on the duties of absent colleagues that lead to

increasing stress levels and burn-out (Van Dyk, 2008: 407- 417), nurse practitioners foster bonds of affection, friendship, social warmth and acceptance as a social group member (Clark, 1998: 352 & 354). Nurse practitioners need social interaction, perceive their workplace as the ideal area to feel stimulated, and valued (Orem, 1980: 43; Caetano and Pagliuca, 2006: 342). HIV/AIDS do pose as a health and social hazard to the daily functioning and wellbeing of the nurse practitioner (Van Dyk, 2008: 408 - 417), but she accepts the challenge to protect herself from contracting the disease (Orem, 1980: 44; Van Dyk, 2008: 356) as to eliminate the danger to her wellbeing. She has to live and function as normal as possible to enhance positive conditions under which she could effectively address her daily self-care requisites and focus her attention on her own and her family's health and wellbeing (Orem, 1980: 46; Clark, 1998: 354).

2) Developmental self-care requisites

Nurse practitioners face new and specific self-care requisites, such as maintaining effective immunity levels by following a sustainable daily healthy diet and sufficient rest after a day's hard work (Van Dyk, 2008: 418). The specific self-care requisites that address a deviation in a persons' health or wellbeing, are expressed as developmental self-care requisites. Nurse practitioners have to provide proper self-care to prevent deterioration in their daily living, health and wellbeing and achieve a higher level of functioning (Orem, 1980: 46). To effectively address these specific self-care requisites or daily needs, the nurse practitioner has to have education and information on health issues, problem-solving skills, financial planning and how to combat oppressing living conditions.

Social adaptation and living up to her status in the workplace will address her

need to stay accepted by her colleagues and family (Orem, 1980: 47; Hartweg,

1991: 9 - 10). Her loss of relatives, friends, colleagues and patients to HIV/AIDS,

her probable loss of income or health or social standing, poses the need to

address her psychological and spiritual requirements (Caetano and Pagliuca,

2006: 341 & 342; Van Dyk, 2008: 418 - 424).

3) Health-deviation self-care requisites

The nurse practitioner does not only desire the opportunity to find ways and

means to address her daily wants and continue to partake in the daily challenges

she encounters at her workplace, but she needs venues to confront her special

health needs (Orem, 1980: 48). HIV/AIDS affected and/or infected nurse

practitioners have to understand the pathology of HIV/AIDS, as well as the

disabilities and needs people living with HIV/AIDS encounter (Caetano and

Pagliuca, 2006: 337 & 343). They may gradually detect a subtle change in a

persons' behaviour or attendance patterns. The individual may experience health

problems such as frequent bouts of flu, diarrhoea, or unexplained weight loss

(Van Dyk, 2008: 57 - 59) which may cause concern to both her and her family or

friends. A HIV infected nurse practitioners' locus of care therefore changes from

rendering care and assistance to another person to that of a person in need of

care. This activity shift occurred due to a deviation in her health and wellbeing and

it will determine what course of action she will choose to take (Orem, 1980: 49;

Hartweg, 1991: 10 - 11; Caetano and Pagliuca, 2006: 343). She may not

experience any feelings of illness (Van Dyk, 2008: 53) but recognize the fact that

she would have to live with HIV/AIDS and that no time frame of working it through,

is available, because HIV/AIDS infection only terminate with death (Van Dyk,

2008: 300). The disease does not only affect human functioning, but physio-

psychological, sociological, and spiritual functions are also impaired. This could be

disruptive to her daily work performance and interaction with her colleagues

(Orem, 1980: 49 & 50; Caetano and Pagliuca, 2006: 340; Van Dyk, 2008: 266).

It is therefore acknowledged that self-care requisites change and rise according to

the deviation in health levels the nurse practitioner experiences (Orem, 1980: 50).

The nurse practitioner infected and/or affected by HIV/AIDS has to be

knowledgeable of the fundamental facts about the disease, such as how a healthy

immune system functions, the transmission of HIV with the symptoms and diseases

associated with it, diagnosing HIV infection, the management of HIV/AIDS, as well

as the principles and strategies for prevention. Adopting healthy living principles and

life skills up unto experiencing care, support and a positive legal-ethical response to

HIV/AIDS in the work environment empowers the nurse practitioner to be a confident

individual both inside and outside the workplace enjoying a high quality of living and

wellness (Van Dyk, 2008: 406 - 424).

2.6 The nurse practitioner in the wellness continuum

Health promotion, being a positive process emphasizing social and personal

resources and physical capacities for every day life, enables nurse practitioners

affected and/or infected with HIV/AIDS to increase control over, and to improve, their

health and wellbeing (O' Donnell, 2002: 569). To reach a state of physical, mental, and social wellbeing, nurse practitioners have to be able to identify and realize aspirations, satisfy needs and change or cope with the environment. Their social and economical networks and resources have to exist to encourage, develop, and nurture their health in all its dimensions. Workplace wellness programmes could enhance awareness, help nurse practitioners make lifestyle changes, and create an environment in the workplace that supports a healthy lifestyle (Hawk, 2005: 191; Hall, 2007: 130) because the impact of HIV/AIDS has a profound influence on the daily work life of a nurse practitioner.

2.6.1 HIV/AIDS and the nurse practitioner

The 2008 mid-year population of South Africa has been estimated at approximately 48.7 million. The HIV-prevalence rate (the proportion of adults who are infected with HIV) of adults 15 - 49 years of age in South Africa, is 18.8%, thus an estimation of 5.35 million HIV-positive adults (Figure 2.1, Page 49), an increase from less than 9% in 2001 to about 11.32% in 2008. The HIV-prevalence rate of 19.6% is estimated for women 15 - 49 years of age, which is the highest overall prevalence rate (Statistics South Africa, 2008: Statistical release P0302).

In South Africa HIV is spread predominantly via sexual intercourse (Evian, 2003: 20; Van Dyk, 2008: 34) affecting mainly the sexually and economically active members of society (adults between 15 - 49 years of age). Studies have also described that HIV and AIDS have become the leading cause of death amongst working adults in

South Africa (Vass and Phakathi, 2006: 7). A total of 212 806 active nurses of all categories were registered on 31 December 2008 at the South African Nursing Council (SANC), not taking the nurses in training and unregistered total of lay care givers into account, of which 139 121 nurses are in the age group between 15-49 years. The nursing pool in South Africa consists predominantly out of female practitioners, approximately 92.51% (128 700), students and lay care givers excluded (Figure 2.2, Page 50) (SANC, 2008: online).

2008 Mid-year population of South Africa

5.35 million

43.35 million
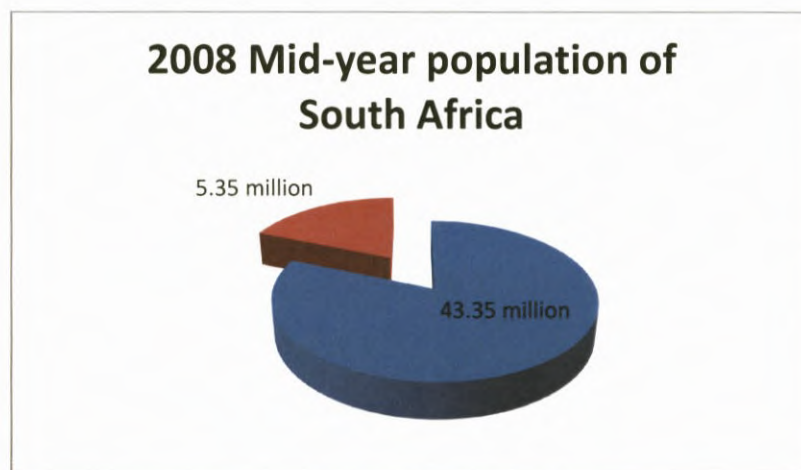
Figure 2.1   HIV-prevalence rate of adults 15 – 49 years of age in South Africa

(From: Statistics South Africa, 2008: Statistical release P0302)

These statistics emphasise the urgent need for instituting a wellness programme in the workplace whereby nurse practitioners could effectively address their exposure to HIV because early identification of problems associated with HIV/AIDS can promote timely symptom management through self-care or managerial interference such as promoting a healthier lifestyle (Van Dyk: 2008: 90). Components necessary

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for the development of a workplace wellness programme have to be identified and described to efficiently develop and coordinate employees' wellness amongst nurse practitioners infected and/or affected by HIV/AIDS in the workplace. Issues that have an influence on nurse practitioners confronted with HIV/AIDS are factors that belong to the nurse practitioner and where they work everyday. These issues are grouped as external or internal factors that describe the health, psychosocial and important employee welfare concerns, as well as the economical impact HIV/AIDS have for nurse practitioners in the workplace.

Nurse gender distribution (age: 15 - 49 years)

Males 10421

Females 128700
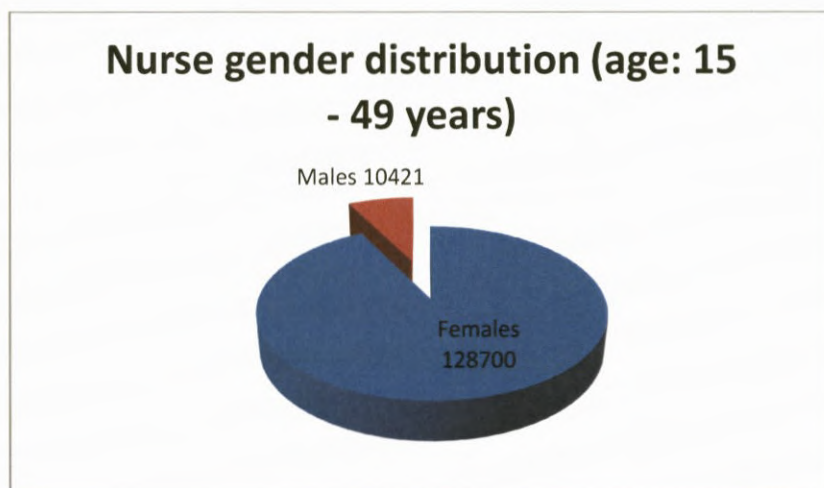
Figure 2.2   Gender distribution of active nurses registered on 31 December 2008 at SANC in the age group 15 – 49 years

(From: South African Nursing Council, 2008: online)

2.6.2 External factors pertaining to the wellness of the HIV affected and/or infected nurse practitioner

External factors are social and environmental factors in the workplace experienced from the nurse practitioners' mental perception of how HIV/AIDS influences his or her daily life and wellbeing. Wellbeing is a positive mode of her existence as exemplified by the quality of life and being she daily demonstrates (Corbin and Pangrazi, 2001: 1) during her association with her employer, fellow colleagues, clients, friends and family. These external factors influence the ability of the nurse practitioner to apply effective coping strategies. Social resources and environmental influences such as experienced in the workplace and the assurance of being economically independent are capacities the nurse practitioner needs for increasing control over her daily exposure to the risks of HIV/AIDS (O'Donnell, 2002: 569).

2.6.2.1 Social factors

Stigmatizing HIV/AIDS affected and/or infected nurse practitioners have a negative consequence on nurse practitioners' daily living. Nurse practitioners knowledgeable on HIV/AIDS issues enhance the belief that all people have the right to equal treatment and care, to be non-judgemental and not to fear HIV/AIDS as a result of adherence to safety protocols. However, nurse practitioners experience hurtful gossiping and a tendency from their colleagues, friends and family to avoid their company if they work in a hospital nursing unit where a large number of persons living with HIV/AIDS are cared for (Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini, Greeff, Kohi, Chirwa, Cuca & Naidoo, 2007: 547).

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This results in a lack of support the nurse practitioners perceive they would receive from their spouse, family, friends and colleagues. Therefore shielding themselves from the prejudice and negative reactions such as disgraceful remarks they receive from other colleagues and their next of kin, nurse practitioners develop exclusive social units in the workplace and avoid involvement to enhance social acceptance amongst their fellow employees (Hodgson, 2006: 283 - 290).

The HIV/AIDS affected and/or infected nurse practitioner fears social rejection and isolation (Hodgson, 2006: 288) because this could result in economical difficulties. The family and friends provide less support due to the stigma associated with HIV/AIDS and the reluctance to disclose their involvement with the disease, especially if a family member has HIV or dies of AIDS (Hodgson, 2006: 534). Should the nurse practitioner be the prime provider for her family or an additional provider in the household, the household spending will eventually move away from food, clothing, education, rent and household services and investments as owing property, to paying for more essential expenditure like medical bills and funeral expenses, ultimately resulting in a deterioration of household income (Selgelid, 2004: 101; Kochar, 2004: 279).

Although a person infected with HIV has an incubation period of approximately 10 to 12 years during which to live a productive life, affected households have a higher level of morbidity (Gritzman, 2005: 162) and does the nurse practitioner need support from family, friends and colleagues to maintain their health and wellbeing due to the increasing demands placed upon their care-giving role (Stetz and Brown,

2004: 534 & 538). Healthcare services should focus on strategies and interventions to enhance the wellbeing of the nurse practitioner by addressing social incapacities such as a perceived lack of support and avoidance of colleagues, family and friends (Hodgson, 2006: 288; Holzemer *et al.*, 2006: 545 & 546). These interventions could play a positive role to enhance social acceptance and involvement amongst nurse practitioners and combat economical hardship originating from their social rejection and isolation (Stetz and Brown, 2004: 533 - 540).

2.6.2.2 Economical factors

The economically productive, middle age-bracket nurse practitioner in South Africa is most affected by HIV/AIDS. As previously mentioned, the highest overall HIV-positive prevalence rate in South Africa is found amongst the sexually and economically active adults between 15 – 49 years of age (Statistics South Africa, 2008: Statistical release P0302).

This statistical evidence implies that 25 225 female nurse practitioners, which is approximately 19.6% of the nursing population in South Africa (SANC, 2008: online), are currently at risk of being infected with HIV, notwithstanding the fact that all nurse practitioners are affected in one way or the other.

A predicament evolves when the co-responsibility of a nurse practitioner and her partner to share labour and income and support household expenditure ("Household" is defined by Statistics South Africa as a person or a group of persons who live

together at least four nights a week (1995: 0317-E)), declines or disappears, because HIV/AIDS has become the leading cause of death amongst working adults in South Africa (Vass and Phakathi, 2006: 7). Thus, the need for the affected nurse practitioner to cope with the psychosocial and economical consequences of HIV/AIDS by staying employed to contribute to the household responsibilities and prevent a decline in the health and material needs of the family, is an enormous strain.

The effects of personal trauma associated with grief due to the loss of a loved one or loss of her own health, as well as stress due to the added responsibilities (Van Dyk, 2008: 420) to make provision for probable loss of income and changes in consumption, renders the nurse practitioner to be more affected by HIV/AIDS (Kochar, 2004: 258 & 279; Booysen and Mafereka, 2006: 10 - 13). Healthcare and funeral expenses become the major expenditure of the nurse practitioner's household resources and she has to rely on elderly caregivers to attend to the sick family members and siblings. The children of affected households often struggle to finish their schooling due to financial constraints, which will most likely lead to unproductive economically unsustainable households (Gritzman, 2005: 154 – 160; Selgelid, 2004: 96 – 105).

The employer could effectively assist the nurse practitioner with advice and support channelled through a workplace wellness programme to promote the welfare of her household and quality of life, therefore rendering the nurse practitioner to be less affected by HIV/AIDS (Van Dyk, 2008: 420 & 470).

2.6.2.3 Factors in the workplace

The following factors, which are found in the work environment, have a profound influence on the wellbeing of the nurse practitioner:

- Patient care and the impact of the mortality rate in South Africa,

- Burnout and stress experienced by nurse practitioners,

- Organisational support and the role of nurse practitioners, and

- Discrimination and stigmatization found in the workplace.

2.6.2.3.1 Patient care and the mortality rate in South Africa

HIV/AIDS have become South Africa's most leading health problem, because there is no cure yet found and it therefore results in a high mortality rate amongst adults in the age group 15 to 49 years, especially amongst female adults (Zuberi *et al.*, 2005: 103 and 155; South Africa HIV & AIDS Statistics, 2008: online). Nurse practitioners experience the impact of HIV/AIDS when having to care for the large number of sick people and facing the inevitable high death rates amongst their colleagues, patients, family and friends.

Approximately 79% of the total South African population constitutes of Africans, approximately 38.6 million (Statistics South Africa, 2008: Statistical release P0302), who embrace strong traditional and cultural beliefs. African patients tend to go into denial when confronted with their HIV status and refuse advice and help from nurse practitioners, but rather seek help from traditional healers, with dire consequences (Van Dyk, 2008: 414). A HIV positive patient's health declines where-after he or she

becomes ill which furthermore leads to a huge amount of people to give care-to. This results into an increase in workload for nurse practitioners (Table 2.1). Nurse practitioners become disillusioned and their morale deteriorates because patients are chronically sick and eventually die (Champ, 2006: 50; Van Dyk, 2008: 407).

Table 2.1 Population per qualified nurse practitioner in South Africa 2008

(Population figures have been rounded off to the nearest 100)

Category	Population : Nurse ratio
Registered Nurse	451:1
Enrolled Nurse	1114:1
Auxiliary Nurse	796:1

(From: South African Nursing Council, 2008: online)

2.6.2.3.2 Burnout and stress

To care for chronically ill HIV/AIDS persons requires significant physical and emotional energy (Mauk and Schmidt, 2004: 331). An additional burden to nurse practitioners is the escalation in the employee absenteeism rate due to the obligation on nurse practitioners to take additional sick leave when they become ill with a HIV-related illness or have to take care of sick relatives or attend funerals (Page, Louw and Pakkiri, 2006: 104; South Africa HIV & AIDS Statistics, 2008: online). This consequently leads to several problems the nurse practitioner is confronted with. Colleagues are absent and cannot work, the workload ultimately increases and their productivity declines due to experienced staff that cannot easily be replaced (Page *et*

al., 2006: 104; Van Dyk, 2008: 407). Investment in training is eroded, especially if nurse practitioners are unable to work or pass away. The loss of highly qualified nursing staff due to HIV/AIDS evokes a reduction in quality nursing care and additional responsibilities escalate in the workplace (Zuberi *et al.*, 2005: 91).

The debilitating influence that a HIV-illness has on the self-esteem of a nurse practitioner, such as severe weight loss with change in body image (Van Dyk, 2008: 83) and disability, explains why she may need to alter or abandon her occupational goals (Gorman, Sultan and Luna-Raines, 1989: 5 & 6). Her health status and wellbeing change due to her loss or serious disruption in financial security and emotional burden (Page *et al.*, 2006: 104). She has feelings of being unable to cope with the overload of work and physical and emotional fatigue she encounters and it is worsened by her perceived lack of social and occupational support (Van Dyk, 2008: 407).

A nurse practitioner will consequently experience a lack of energy and psychological strain at work if symptoms of burnout, such as discouragement, depression and physical symptoms such as headaches go undetected and the need to replenish his or her energy is ignored (Mauk and Schmidt, 2004: 332).

2.6.2.3.3 Organizational support and the role of nurse practitioners

Nurse practitioners experience a lack in organizational support when practising their care-giving and advisory roles, because there is an additional expansion placed upon their daily tasks such as HIV counselling and care. Nurse practitioners are of opinion that they are not adequately trained for their role as HIV/AIDS counsellors, as traditionally giving advice is more acceptable to counselling (Van Dyk, 2008: 413; Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, Van Der Kwaak & Van Der Wilt, 2007: 144). HIV/AIDS counselling provokes resistance amongst Africans, because explicit and sensitive sexual and complicated cultural issues are addressed, especially in the African culture (Mawar, Sahay, Pandit & Mahajan, 2005: 472). Adequate support and supervision are not provided in the workplace to guide nurse practitioners when counselling or caring for HIV infected persons (Van Dyk, 2008: 413; Dieleman *et al.*, 2007: 145).

Their despondency and isolation are fuelled by the secrecy and restriction that confidentiality place upon them, because nurse practitioners are not allowed to discuss their clients (Van Dyk, 2008: 85). They frequently avoid discussing their involvement with HIV persons with their family members, because they are often pressurized to quit their jobs or refuse to take care of HIV-ill patients (Van Dyk, 2008: 407; Mawar *et al.*, 2005: 472 and 475).

2.6.2.3.4 Discrimination and stigmatization

Discrimination, the unjust behaviour towards another person and intolerance for caring for a HIV infected person, is a daily phenomenon the nurse practitioner encounters (Van Dyk, 2008: 407 & 132). Prejudiced language and negative suggestions relating to HIV such as 'she has AIDS', rather than 'she lives with AIDS' compels the nurse practitioner to secrecy should she become infected with or affected by HIV/AIDS. Nurse practitioners refuse to work with colleagues known or believed to be HIV positive, due to the lack of knowledge and fear for being stigmatized (Page *et al.*, 2006: 104).

Stigmatization, the unfair disgraceful branding of people who are HIV positive or care for HIV positive persons, resulted in events where nurse practitioners avoided disclosure of their HIV status or involvement with HIV positive patients and other persons (Page *et al.*, 2006: 107; Van Dyk, 2008: 407). Fear for being exposed to HIV (Champ, 2006: 50) and misconceptions about HIV (Page *et al.*, 2006: 113) affects the daily work life of a nurse practitioner. The often lack of resources to take universal precautions to prevent the risk of being infected, resulted in nurse practitioners to be highly fearful of occupational acquired infection (Van Dyk, 2008: 414; Dieleman *et al.*, 2007: 143). This fear for being infected with HIV is fuelled by family members who prohibit their spouses to work with HIV patients and pressure them to either quit the nursing profession or request them to refuse caring for HIV infected patients (Van Dyk, 2008: 414).

Discrimination and stigmatization amongst nurse practitioners deprive them of much

needed support from their colleagues to combat the physical and emotional

exhaustion they often encounter. They fear that they could loose their jobs should

they become ill with HIV and that no alternative options will be offered in their place

of work to promote healthier living principles and reasonable accommodation of HIV

infected nurse practitioners. Therefore the nurse practitioner needs the assurance

that she could work in a safe and secure working environment where anti-

discriminatory policies are enforced and adhere to (Van Dyk, 2008: 444 - 447;

Dieleman et al., 2007: 144 - 145; Mawar et al., 2005: 472).

2.6.3 Internal factors pertaining to the wellness of the HIV affected and/or infected nurse practitioner

Regarding the inner self of the nurse practitioner is physical factors, psychosocial

factors and spiritual factors influencing the wellness of a nurse practitioner that could

result in a low self-esteem and a lack of applying effective coping skills to deal with

the debilitating demands placed on her generated by HIV/AIDS (Gorman et al., 1989:

5; O'Donnell, 2002: 569).

2.6.3.1 Physical factors influencing the wellness of the nurse practitioner

The HIV/AIDS infected and/or affected nurse practitioner is daily confronted with his

or her ability to be in control of the quality of life and level of psychophysical

wellbeing she aspires to. The unique characteristics of HIV and how to avoid HIV

infection pose a challenge to all nurse practitioners, especially female nurse

practitioners in South Africa. Due to their 'biological vulnerability' (Van Dyk, 2008: 35) they are more at risk of being infected with HIV (Statistics South Africa, 2008: Statistical release P0302).

In the different levels of society and cultures in South Africa, many women have little or no control over their sex life and in some cases, are not allowed to negotiate safer sex practices for fear of abandonment and poverty. Unprotected sex (sex without a condom), dry sex, rough sex, genital mutilation, anal sex, rape and female genital organ conditions such as erosions, open sores, infections and uterine lining exposure during menstruation, are ways through which HIV is transmitted to enter her bloodstream via the body fluids of an infected individual (Van Dyk, 2008: 34 – 36).

HIV attacks and weakens the immune system, which means that the body is unable to protect itself against other diseases. The progression of HIV infection is divided into the first primarily HIV infection stage namely the pre-clinical stage, where after the four clinical stages appear. The stages do not necessarily appear in sequential order, because the development of HIV-related symptoms and opportunistic diseases will depend on the health, namely the CD4 count and viral load of the immune system (Van Dyk, 2008: 52; Evian, 2003: 28). The five stages comprise as follows:

(a) Pre-clinical stage. The primary HIV infection or acute sero-conversion illness

When a person becomes infected with the HI-virus, non-specific flu-like signs and symptoms are experienced which may persist for 1 to 2 weeks such as a sore throat, headache, mild fever, fatigue, muscle and joint pains, swelling of the lymph nodes, gastrointestinal symptoms like diarrhoea and occasional oral ulcers (Van Dyk, 2008: 52; Evian, 2003: 28).

This pre-clinical condition is referred to as the sero-conversion illness during which the HIV antibody test converts from being negative to positive, also termed as the window period. The HIV test becomes positive 4 to 6 weeks after infection. The body develops antibodies to HIV and the high virus levels decreases as the virus is collected into the lymph nodes (Van Dyk, 2008: 51 and 52; Evian, 2003: 28; Page *et al.*, 2006: 21).

(b) Clinical stage 1. The asymptomatic latent stage

A HIV positive person could remain healthy and asymptomatic for at least 10 years and continue with their normal daily activities although the virus is active and progressively damaging the immune system. Persistent generalised lymphadenopathy is the chronic swelling of the lymph nodes and presents in some people as an only symptom of HIV infection (Van Dyk, 2008: 53; Evian, 2003: 29). The CD4 lymphocyte cells (helper T cells) are measured to predict to which extent the immune system is compromised. A normal CD4 cell count in healthy non-

infected individuals ranges between 600 to 1500 cells/mm³. A CD4 cell count between 500 and 800 cells/mm³ is associated with the HIV asymptomatic latent stage (Van Dyk, 2008: 14 and 53; Evian, 2003: 7 and 26 – 29).

(c)   Clinical stage 2. The minor symptomatic stage

The minor symptomatic stage refers to the onset of minor HIV-related symptoms such as persistent generalized lymphadenopathy, Herpes Zoster, fever, skin rashes such as seborrhoeic dermatitis and chronic dry skin, fungal nail infections, recurrent oral ulcerations and upper respiratory tract infections (URTI). Persons are however able to pursue with their normal daily activities. A CD4 cell count between 350 and 500 is cells/mm³ associated with the minor symptomatic stage (Van Dyk, 2008: 54; Evian, 2003: 30).

(d)   Clinical stage 3. The major symptomatic stage

During the major symptomatic stage of HIV, the immune system becomes weaker because the viral load increases and the CD4 cell count drops to between 200 and 350 cells/mm³. More frequent and severe opportunistic infections appear such as recurrent oral or vaginal candida infection and herpes simplex infection, which are the first clinical signs of advanced immune-deficiency, skin infections and Herpes Zoster, persistent diarrhoea, weight loss, lymphadenopathy, episodes of fever and fatigue. A person will be more bedridden, usually up to 50% of the day during a month (Van Dyk, 2008: 54 and 55; Evian, 2003: 23 and 30 - 31).

(e) Clinical stage 4. The severe symptomatic stage, AIDS, also referred to as AIDS defining illnesses

During the major symptomatic stage, HIV develops into AIDS within 12 to18 months. A high viral load is present with severe immune-deficiency resulting in opportunistic infections, which are referred to as AIDS defining illnesses (Van Dyk, 2008: 55; Evian, 2003: 31).

Although symptoms of AIDS defining illnesses vary from one person to another person, he or she is often sick due to the deterioration of the immune system. Severe infections present it selves such as bacterial infections (Mycobacterium Tuberculosis and Pneumococci), viruses (Herpes Simplex and Herpes Zoster), fungal infections (Candida) and protozoa (Pneumocyctis carinii). Cancer (Kaposi's sarcoma) and organ damage of especially bone marrow and respiratory organs occur as well (Van Dyk, 2008: 55; Evian, 2003: 33).

A person may present with numerous signs and symptoms of AIDS depending on which infection, cancer or organ is infected. He or she experiences severe skin rashes, respiratory tract infections with fever, ongoing diarrhoea, oral or genital thrush, neurological conditions with severe mental deterioration and immense tiredness, fatigue and weakness (Evian, 2003: 32; Page et al., 2006: 23).

A person is bedridden more than 50% of the day during the preceding month. The use of ART can however influence the progress of HIV/AIDS but death usually

occurs within 6 months to 3 years after developing signs of AIDS (Evian, 2003: 35).
A CD4 cell count less than 200 cells/mm³ and low lymphocyte count are found during
AIDS (Van Dyk, 2008: 55; Evian, 2003: 31).

The infected nurse practitioner therefore initially experiences good health with no
symptoms of ill health and is able to continue her profession for an estimated 10
years (Statistics South Africa, 2008: Statistical release P0302). Persistent
generalised lymphadenopathy (swollen lymph glands) does occur in some cases.
However, experiencing occasional fevers, recurrent respiratory tract infections such
as pneumonia, chronic diarrhoea, skin diseases such as shingles, headaches and
ultimate weight loss, induce her feelings of fatigue, malaise and lethargy which
results in her being more absent from work (Van Dyk, 2008: 76 & 461; Evian, 2003:
28 – 35).

It is during the major symptomatic stage, clinical stage 3, where the HIV symptoms
become more acute and persistent, that the infected nurse practitioner should be
introduced to antiretroviral treatment (ART)(University of Cape Town (UCT). PALSA
Plus, 2006: 17). The persistency and severity of the opportunistic infections changes
according to the body's response to ART, but will re-occur and become more
frequent with the progressive deterioration of her health and wellbeing. The infected
nurse practitioner experiences a wasting of her body tissue with remarkable weight
loss and poor energy levels (Van Dyk, 2008: 57).

The subjective experience of HIV-associated fatigue on the normal activities of daily living for nurse practitioners reveals symptoms of diminishing activity levels, lack of motivation, lack of control over daily requirements and a general feeling of weakness. The HIV infected nurse practitioner perceive their levels of fatigue as an indicator to illness severity and the progression towards the debilitating effects of AIDS. Their ability to stay employed, maintain positive activity levels, avoid isolation and enhance a positive lifestyle, is a daily concern and challenge to nurse practitioners (Rose, Pugh, Lears and Gordon, 1998: 295 & 298; Smit, 2005: 25) and eventually obliges her to apply for work dismissal due to incapacity or for the adapting of duties to accommodate her disability to function at optimal level (Van Dyk, 2008: 447).

The use of ART poses its own unique difficulties for the nurse practitioner. To improve the quality of her life and minimise the impact of HIV on the immune system, highly active antiretroviral therapy (HAART) is recommended to achieve the most effective results (Van Dyk, 2008: 94). Her choice of an antiretroviral drug regime will depend on her financial ability to obtain the drugs such as being registered on a medical aid programme or does she have to obtain it from a governmental health clinic, where the availability of antiretroviral drugs are more often lacking due to financial constraints in South Africa (Van Dyk, 2008: 95 & 98).

However, the importance of adhering to the South African Department of Health's national antiretroviral treatment guidelines, allows the nurse practitioner to use an appropriate antiretroviral regime that eliminates treatment failure and prevent any

drug resistance (Van Dyk, 2008: 99; Evian, 2003: 79). Side-effects such as diarrhoea, nausea, skin rashes, headaches and dizziness, weakness, tiredness and lethargy, do occur during the first few weeks of ART, because antiretroviral drugs are potentially toxic (Evian, 2003: 88), but it has changed the character of HIV infection from a lethal acute disease to a manageable chronic disease.

2.6.3.2 Psychosocial factors influencing the wellness of the nurse practitioner

Being diagnosed with HIV induces severe emotional responses in both the infected nurse practitioner as well as the affected nurse practitioner who in particular is involved with such persons on either regular intervals or prolonged periods. HIV being an incurable disease emphasizes the futility of caring for very sick patients who when being discharged from hospital, will still be ill (Smit, 2005: 25; Van Dyk, 2008: 266) and eventually die (Hayter, 1999: 988).

The nurse practitioner is daily confronted with a host of emotions that renders her desponded, tired and stressed (Smit, 2005: 25). Symptoms of diminishing activity levels, lack of motivation and feelings of despair and sadness when dealing with HIV has inimical affects on the quality of life she experiences (Rose *et al.*, 1998: 296). Challenging factors that contribute to high levels of stress and burnout amongst nurse practitioners are the judgemental and discriminatory reactions from fellow colleagues, although sometimes identified as a perceived stigma (Hayter, 1999: 990 & 992).

The nurse practitioner frequently experiences moments of ambivalent emotions such as relief, then anger and frustration due to her exhaustive working environment within which she daily performs her duties, but then she has feelings of fear for being stigmatized, discriminated against and eventually isolated when disclosing either her status or intimate involvement with HIV (Van Dyk, 2008: 267). Due to the compelling enhancement of strict confidentiality and social isolation of the nurse practitioner, nurses harbour negative attitudes towards HIV/AIDS infected people. This could also be attributed to fear of contracting HIV while interacting with the HIV infected individual (Oyeyemi, Oyeyemi and Bello, 2006: 201; Hayter, 1999: 990).

Although adhering to the universal precautions to prevent the risk of HIV transmission from accidental occupational injuries such as needle prick incidents or exposure to infected bodily fluids such as exposed to during the delivery of a baby, nurse practitioners are continuously fearful and concerned for being exposed to most probable infectious bodily fluids and products (Van Dyk, 2008: 413; Smit, 2005: 25).

Apprehensiveness and a hesitance to socialize with an infected individual due to the perceived stigma associated therewith, exists (Oyeyemi *et al.*, 201 & 203; Hayter, 1999: 990). Her anxiety escalates when her family pressures her into quitting her job or prevent her from socializing with her children or friends due to the perceived risk of exposure to HIV should she interact with them or in her personal relationship with her spouse or friends (Van Dyk, 2008: 414; Hayter, 1999: 989).

The lack of occupational support from nurse managers and organizational administrators justifies nurse practitioners' anger and feelings of frustration (Smit, 2005: 26). The reluctance to provide affordable ART to all HIV positive persons on all levels of society and the continuous overload of HIV-related patients that have to be cared for in hospitals and clinics (South Africa HIV & AIDS Statistics, 2008: online) poses nurse practitioners to become unmotivated due to the struggle to force the focus on their plight and strenuous energy tapping caring role (Smit, 2005: 26).

The reluctance of managers to address the shortage of trained counsellors to support the more than often overworked and underpaid nurse practitioners (Smit, 2005: 23) and hesitance and uncommitted will to support comprehensive HIV treatment and educational programmes, may render the nurse practitioner exposed to negative attitudes, depression and isolation with no hope of improvement in their daily work conditions (South Africa HIV & AIDS Statistics, 2008: online; Van Dyk, 2008: 414 – 416; Smit, 2005: 27).

Therefore, nurse practitioners involved with HIV/AIDS need supportive venues whereby mutual problems and concerns could be addressed. Nurse practitioners, irrespective of rank and age and field of specialization, will have to be continuously subjected to comprehensive education in HIV/AIDS care, because updated knowledge proves to have profound influence on their attitudes and level of care for persons with HIV/AIDS (Oyeyemi *et al.*, 2006: 203; Hayter, 1999: 992; Van Dyk, 2008: 132).

2.6.3.3 Spiritual factors influencing the wellness of the nurse practitioner

Spirituality is the core of a person's being and describes an important facet of health, because it involves the search for meaning and purpose in one's life. It is a perceived personal relationship with a supreme being, such as God and the involvement with other people (International Council of Nurses (ICN): online; Callaghan, 2006: 183; Mauk and Schmidt, 2004: 2). Feelings of compassion derives from sensing God's love, while ill-health due to illnesses such as AIDS, harbours anger and blame towards God for their misfortune, resulting in impatience and feeling irritated towards other people (Mauk and Schmidt, 2004: 3).

Issues such as feeling connected to nature or searching their souls for deeper meaning when meditating or applying faith to hold onto beliefs that cannot be observed directly, such as having faith that God will heal them, are co-key concepts related to spirituality focussing on suffering, hope, forgiveness and grace (Callaghan, 2006: 183; Mauk and Schmidt, 2004: 2 – 7).

Nurse practitioners experience a range of emotions varying from blaming, punishment and disgust to confusing feelings of fear for people and God and the course that HIV and AIDS take, hopelessness, remorse, stigmatization, isolation and even suicide (Smit, 2005: 25), and are daily confronted with HIV-positive persons who in particular experience these spiritual issues. Burdensome questions such as "Why me?" and viewing their infection with HIV or involvement therewith as God's

punishment to a sinful or wrongful lifestyle (Mauk and Schmidt, 2004: 8 – 9) emphasize their suffering.

Allowing nurse practitioners living with HIV/AIDS to hope, helps them to endure suffering and it has a profound influence on their spiritual wellbeing, such as hope in an after life that helps terminally ill AIDS persons come to terms with death, while others will hope for the discovery of a cure to the disease (Akinsola, 2001: 162). Their fight for survival reinforce nurse practitioners' hope for things to which they were previously denied to, such as the unavailability of ART due to a lack in political initiatives (South Africa HIV and AIDS Statistics, 2008: online) and non-discriminative compassionate care from colleagues and friends (Van Dyk, 2008: 131) which they accept as a gift of grace bestowed upon them. To be unconditionally loved by her partner or family and accepted amongst her colleagues, despite the nurse practitioner's involvement with HIV/AIDS, alleviates the negative feelings of despair and isolation (Mauk and Schmidt, 2004: 11).

Nurse practitioners, infected and/or affected by HIV/AIDS, need to abandon grudges towards others and forgive past wrongdoing, especially if they experience severe disruptive situations in their life, such as financial or occupational incapacities and particularly if a partner, next of kin or self, become infected with HIV. Resolving differences, forgiving one self for weaknesses and making wrong choices, are important to promote spiritual healing and positive wellbeing (Mauk and Schmidt, 2004: 12).

Listening with empathy to her spouse, family or colleagues and patients, to help her explore her feelings about suffering, illness and death, sharing of non-judgemental love and compassion, taking the values, cultural beliefs and attitudes of a person into consideration, enhances a sense of belonging, security and caring (Mauk and Schmidt, 2004: 13).

Taking care of chronically ill, disabled or dying persons or vulnerable people such as children who are suffering from HIV/AIDS, require an extreme pool of energy and endurance from nurse practitioners. Their frustration, fatigue and disappointment with their support systems, pressures related to economic changes in health care such as budget cuts and shortages in the provision of adequate drugs and resources, leaves nurse practitioners disillusioned and overwhelmed with depleted emotional and spiritual energy (Mauk and Schmidt, 2004: 331). They work long hours, feel indifferent and isolated, because caring for AIDS-patients are an ongoing and emotional sapping task (Van Dyk, 2008: 406 & 407).

The devastating and profound effects of HIV/AIDS on the bio-psychosocial and spiritual wellbeing of the nurse practitioner, underpin the appropriateness of religion as a defence strategy (Callaghan, 2006: 183). Religion enables nurse practitioners to redefine their life and find a sense of meaning and purpose to life experiences, personal health, illness and death as to enhance and maintain a positive approach to human existence (Callaghan, 2006: 183; Bosworth, 2006: S3 – S4). Religion is a core expression of spirituality involving an organized existence with beliefs, rituals and practices with which a person identifies and wishes to be associated with. It

involves worshipping a Supreme Being or power, such as God and gathering with those in agreement or has similar beliefs (Callaghan, 2006: 183; Mauk and Schmidt, 2004: 3). Nurse practitioners providing care for terminally ill AIDS patients need the familiarity of prayer and communion with their fellow worshipers or chaplain or spiritual leader (Mauk and Schmidt, 2004: 15).

Nurse practitioners have to feel confident and experience positive health and wellbeing to deliver quality nursing care that is beneficial to the HIV infected and/or affected person. They need to understand and accept the limitations of their caring role and divert their positive attitudes and energy into their own personal life. They have to apply methods to re-energize and keep their body, mind and spirit healthy (Mauk and Schmidt, 2004: 333).

Activities of adequate rest and relaxation, such as time for leisure, vacation and exercise, are necessary for her sense of wellbeing. Changing health habits such as following a healthy diet, spending time with family and avoiding risky habits such as substance abuse or practicing unsafe sex, will improve the quality of her life (Van Dyk, 2008: 418). Humour, friendship, counselling and support groups help solve personal and interpersonal problems, resolve past issues, deal with current and future obstacles and challenges, such as bereavement and issues with death (Mauk and Schmidt, 2004: 346). Building relationships with fellow colleagues and friends, meditating and pray, worshiping and exercising religious rituals allow nurse practitioners to rebuild their lives, identify their strengths and make wise decisions. Nurse practitioners need to feel safe in the presence of people living with HIV/AIDS

and embrace a spirit of wholeness and completeness (Mauk and Schmidt, 2004: 352; Van Dyk, 2008: 417).

Support programmes should therefore facilitate professional spiritual guidance to aid nurse practitioners (Akinsola, 2001: 163; Mauk and Schmidt, 2004: 15) in their ability to cope with the difficult demands HIV/AIDS imposes on them. A positive outlook on life and a sense of hope and achievement could be promoted and established to guide them to set realistic goals and be future driven, focus on their family's needs and engage in meaningful activities (Van Dyk, 2008: 417).

2.7 The workplace and factors that disposition the development of a workplace wellness programme

Components necessary for the development of a workplace wellness programme as strategy to enhance the wellbeing of nurse practitioners are not only found in the external and internal factors influencing the wellness of HIV infected and/or affected nurse practitioners. The employer has an obligation to efficiently develop and co-ordinate employee wellness to promote a supportive environment where the quality of life is improved and morbidity and mortality amongst HIV infected nurse practitioners is reduced (Van Dyk, 2008: 470). Managerial processes and activities are used to achieve this objective when considering the internal and external factors pertaining to the workplace to disposition, namely regulate and plan, the development of a workplace wellness programme for nurse practitioners.

2.7.1 Managerial factors in the workplace

The approach of managers or persons governing a healthcare organization, hospital, healthcare centre or unit in creating a culture of wellness to enhance optimal health and wellbeing amongst nurse practitioners in the workplace, is of utmost importance as to better comprehend, assess and respond to the impact of HIV/AIDS in the health sector (Janse van Rensburg, 2008: 63).

Assessment of the risk profile of the work environment and the impact it has on the nurse practitioner are the initial step in designing strategies to improve the wellness in the workplace (Lowe, 2002: 49; Janse van Rensburg, 2008: 63). To ensure that productive high quality of care is available, the health needs of its nursing corps have to be taken into account and support systems instituted (Holzemer *et al.*, 2007: 545 & 546; Stetz and Brown, 2004: 533 – 540) to address the obstacles they daily encounter.

Management should recognize the value of shared governance, input and decision-making with nurse practitioners. To sustain the efforts in creating a supportive environment for optimal health and wellbeing, nurse practitioners have to be involved when decisions are taken in the workplace that influence their health and coping abilities (Nutbeam, 1998: 351), because keeping them informed will ultimately enhance a sense of partnership and self-assertiveness. This will strengthen the employment relationship that depends on trust, respect for their significant culture, commitment, communication and the influence of decision-making that determines

the balance in their work-life, securing a healthy and safe work environment and their relationship with their colleagues, clients and social network (Lowe, 2002: 51).

Orem's model on nursing underlines the importance of managerial input that address the development and management of systems, programmes and initiatives to address the ever changing needs and requirements of nurse practitioners such as the influence of South African legislation for example the 'Code of Good Practice on Key Aspects on HIV/AIDS and Employment' of 2000, published under the Labour Relations Act (Act 66 of 1995) and the Employment Equity Act (Act 55 of 1998) addressing issues such as pre-employment HIV-testing and confidentiality (Janse van Rensburg, 2008: 3; Van Dyk, 2008: 443).

Management should identify potential self-care deficits such as work overload and discrimination in the nursing population and promote executive capabilities of the nurse practitioner to effectively address her concerns when confronted with HIV and AIDS (Renpenning, 1997: 7). On this premise rests an ethical and legal obligation on the employer to plan, organize and identify activities and resources necessary to create a safe and conducive environment in the workplace that supports a healthy lifestyle and optimal wellbeing. Positive health and wellbeing could result in a probable decline in the rate of absenteeism, as well as the promotion of employee productivity (Janse van Rensburg, 2008: 3 & 10) and preventing an increased nursing staff turnover (Lowe, 2002: 49 & 50; Nutbeam, 1998: 351).

Managerial processes such as planning, organizing, directing and control (Muller, 2003: 104) are applied to manage HIV/AIDS in the workplace, such as:

- undertaking an impact study on HIV/AIDS in the specific work environment before the disposition of a workplace wellness programme;

- employ measures to address the outcome of such an impact study;

- adhere to legislative requirements by instituting

   ❖ a non-discriminatory HIV/AIDS workplace policy,

   ❖ a prevention programme such as a Voluntary Confidential Counselling and Testing (VCCT) programme,

   ❖ a HIV/AIDS workplace wellness programme that address positive living principles and medical treatment, and

   ❖ management strategies that are concerned with the direct and indirect costs of HIV/AIDS, such as benefit packages, recruitment, absenteeism and work performance.

   (Janse van Rensburg, 2008: 3 & 4; Versteeg, 2004: 12 & 34)

Management needs to estimate the quality or worth and consequence that a workplace wellness programme have on the workplace and its nursing population (Janse van Rensburg, 2008: 61). Evaluation and monitoring strategies need to be applied to determine:

- if the planned activities were completed and the goals and targets were met,

- the outcome and results of the workplace wellness programme, and

- if strategies need to be adapted where necessary (Booyens, 2004: 597 & 637).

Monitoring will measure the daily progress to ensure that the activities and the implementation of a workplace wellness programme are matching the set plans, goals and objectives. The input of resources, service delivery and quality attained, as well as budget goals, enhances management's accountability to the company shareholders and the workforce.

Evaluation will assess the impact that the activities and wellness programme had and allow management to identify and improve on any deficiencies such as financial over expenditure or policy gaps (Muller, 2003: 107; International Finance Corporation (IFC), 2000: online). Possible evaluation methods could be as simple as basic opinion polls to more involved and accurate measurement of statistical outcomes (Hollingsworth, 2008: 1108) like technological productivity measurement.

Feedback results, trend analyses and performance measurements are useful management tools to determine the extend of attendance patterns and productivity or profitability in the workplace and if a workplace wellness programme prove to be a useful venue of support and guidance to nurse practitioners confronted with HIV and AIDS (Janse van Rensburg, 2008: 53 & 62).

2.7.2   Internal factors in the workplace

Internal factors in the workplace that have to be taken into account when dispositioning, namely regulate and plan, a workplace wellness programme for nurse practitioners are policies on HIV/AIDS issues in the workplace and how an

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organization comply with the applicable South African legislation on HIV/AIDS. The organizational structure and organizational culture will determine in how far the nurse practitioner will be allowed to become involved in the organizational decision-making process when developing a proposed workplace wellness programme. Their involvement in this process will benefit the degree of acceptance by nurse practitioners of a proposed workplace wellness programme (Booyens, 2004: 208 & 456; Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner, 2005: 66, 19 & 91; Van Dyk, 2008: 429 & 462).

2.7.2.1 The organizational structure

The way in which persons are ranked according to their function and amount of authority vested in them (the hierarchical order) and communication lines through which the management of an organization distributes any information and responsibilities and convey decisions for optimum functioning in the workplace, are channelled through the organizational structure (Booyens, 2004: 210). The organizational structure therefore implies the way in which information and tasks are divided amongst nurse practitioners, units, departments and divisions in a healthcare setting and how this information and tasks are co-ordinated to produce successful outcomes concerning HIV/AIDS issues (Booyens, 2004: 208).

Accepting the challenge which HIV/AIDS pose in the workplace, signifies that the authoritative body of an organization, consisting of appointed managers and supervisors (Nel *et al.*, 2005: 11), could contribute to the fight against the debilitating

effects of HIV/AIDS by adopting a strategic lead in utilizing and promoting awareness, training and education on HIV/AIDS. They could combine their capabilities and competencies such as supplying resources and exert their influence, to create a more fluent and health conducive work environment, as suggested by The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (2000) (Van Dyk, 2008: 443; Nel *et al.*, 2005: 584).

The management of an organization has to realize that to retain and keep highly trained and skilled nurse practitioners motivated, nurse practitioners need to know how each position in the organizational structure relates to the next position and where they fit into an organization (Nel *et al.*, 2005: 581 & 136). The person to which they report or to whom they convey their concerns to has to be clearly identified, because any information runs along these established formal communication line or channels, also referred to as the formal organizational structure (Booyens, 2004: 208). Any confusion between the nurse practitioners and the management of an organization and how the formal structure works, need to be avoided, as this could promote bad communication and conflicting interests (Nel *et al.*, 2005: 136; Booyens, 2004: 213).

The management of an organization will however be able to motivate the nurse practitioners and improve the wellbeing of their nursing corps if they demonstrate their commitment to support change and wellness enhancement (Hodgson, 2006: 288; Holzemer *et al.*, 2007: 545). Managers have to listen to their concerns and problems, give them timely feedback, rectify wrong distorted information and allow

the nurse practitioners to give their opinion and advice on HIV/AIDS issues (Nel *et al.*, 2005: 136).

The informal structure of the organization plays a vital role in achieving the goals and objectives in the workplace. The informal structure is the unwritten, unofficial relationships and traditions, norms and informal communication (Nel *et al.*, 2005: 363; Booyens, 2004: 208), such as the strict adherence to confidentiality and closure (Van Dyk, 2008: 261 & 445) found amongst the nurse practitioners when confronted with HIV/AIDS in a workplace. Rumours are usually commuted at this level and unofficial spokesmen are selected amongst the nurse practitioners to convey their problems, grudges and concerns (Booyens, 2004: 209).

The informal structure uses the 'grapevine'-method to communicate information, especially if the information needs to reach all the nurse practitioners within a limited time frame. The prevailing mood amongst the nurse practitioners is detectable within the grapevine and the management of an organization should not ignore the power of the informal structure, but listen to the problems that nurse practitioners convey, especially if it concerns their working conditions, health and wellbeing (Nel *et al.*, 2005: 363).

Nurse practitioners should thus be encouraged to become involved in decision-making processes in the workplace and contribute input for mechanisms to combat

problems encountered by HIV/AIDS when developing and executing a workplace wellness programme for nurse practitioners (Page *et al.*, 2006: 112).

2.7.2.2 Policies on HIV/AIDS

A policy is a written guideline or directive to guide decision making during specific actions or interventions (Booyens, 2004: 200), such as during the dispositioning of a workplace wellness programme. It is also classified as a written standard (Muller, 2003: 129) or statement describing what level of work performance is expected from employees and what needs to be done.

A structured policy describes what is required from an action to take place such as a policy or standard describing how an organization should comply with a non-discriminative environment, such as the South African Labour Relations Act, No. 66 of 1995 (LRA) (Grossett, 2002: 125). A process policy, which describes how things should be assessed, planned, implemented and evaluated are found as procedure manuals, such as when conducting voluntary confidential counselling and HIV testing. An outcome policy explains what results could be expected and if the goals and objectives were achieved, such as the absenteeism rate amongst the nurse practitioners in an organization (Muller, 2003: 204 – 206).

A company statement and policy on HIV/AIDS is a document that states in writing how an organization positions itself in dealing with HIV/AIDS in the workplace and what guidelines are to be adopted to ensure consistent practices and decisions

(Page *et al.*, 2006: 110; Van Dyk, 2008: 466). A company statement and policy on HIV/AIDS in South Africa has to comply with the South African LRA and Employment Equity Act, No. 55 of 1998 (EEA) to coincide with policies on national and provincial level such as the directives of the South African Department of Health (Nel *et al.*, 2005: 84 and 91; Van Dyk, 2008: 462).

Policies on HIV/AIDS ensure that employees act in a similar way in response to HIV-related health and occupational issues (Booyens, 2004: 28; Hartwig, Pashman, Cherlin, Dale, Callaway, Czaplinski, Wood, Abebe, Dentry and Bradley, 2008: 216). These policies should coincide with the national policies, laws and guidelines relevant to the nurse practitioner's tasks and their work environment, such as the National Policy on Testing for HIV, published by the South African Department of Health in August 2000 and the South African Code of Good Practice on Key Aspects of HIV/AIDS and Employment of 2000 (Van Dyk, 2008: 429 & 431). A document called *HIV/AIDS Technical Assistance Guidelines* (TAG) was published by the South African Department of Labour to support South African labour legislation and policies addressing HIV/AIDS (TAG: online) and help develop policies that reflect the specific needs of an organization.

Both nurse practitioners and the management of an organization should have a clear understanding of how an organization intends dealing with employees who either are infected with HIV/AIDS or are affected by it. The company policy of an organization should inform nurse practitioners of their rights and responsibilities, but emphasize the organization's responsibilities and obligations to maintain employee equity and

confidentiality and what measures to put in place to promote a safe and conducive health environment in the workplace. The organizational policies addressing HIV/AIDS should be reviewed and revised periodically as new epidemiological and scientific information appears and evaluation results request that the current policies should be adapted to promote more favourable outcomes, such as the morbidity and mortality rates due to HIV/AIDS (Booyens, 2004: 200; Van Dyk, 2008: 467).

Knowledge of the contents of these policies and the implementation thereof is required to advise and assist nurse practitioners. The policies should therefore be written in clear, understandable language and communicated to all nurse practitioners in the workplace via electronic mail, posted notices or flyers and postings in visible locations, such as on notice boards in nurse workstations (Booyens, 2004: 201; Van Dyk, 2008: 466).

2.7.2.3 The organizational culture

The organizational culture in a healthcare environment mirrors the collateral assumptions, values, views and beliefs found between the management of an organization and nurse practitioners (Booyens, 2004: 195; Berson, Oreg and Dvir, 2008: 617). The mission statement of an organization which indicates the direction it follows to address service delivery and explain their attitude towards issues such as HIV/AIDS, represent the cultural values and norms found in an organization. These cultural values, beliefs and understanding of how tasks and actions should be

undertaken are found in the policies formulated by the management of an organization or institution, the social behaviour amongst the workforce, the character of the physical work environment, communication structure, vision for the future and support structure to enhance the wellbeing of the employees (Booyens, 2004: 195; Nel *et al.*, 2005: 19; Berson *et al.*, 2008: 616).

The success of any workplace intervention, such as the disposition of a workplace wellness programme, relies on the acceptance of the cultural views and opinions found in an organization, especially as found between a healthcare organization and nurse practitioners on HIV/AIDS (Booyens, 2004: 196).

An organizational culture could influence a workplace wellness programme positively and yield a positive outcome to goals which effectively address the impact of HIV/AIDS in the workplace, because a firmly established organizational culture promotes empowerment and involvement of the nursing corps, as well as ownership of the proposed workplace wellness programme should nurse practitioners be allowed to express their views and give input on HIV-related issues influencing their daily wellbeing in the workplace (Berson *et al.*, 2008: 619 – 620; Booyens, 2004: 197).

2.7.3 External factors in the workplace

External factors in the workplace that have to be taken into account when developing a workplace wellness programme for nurse practitioners are the adherence of

business to national legislation that has an impact on HIV/AIDS in the workplace as well as national and international statements and policies on HIV/AIDS (Van Dyk, 2008: 429).

2.7.3.1 National legislation

National legislation is the enforcement of laws, rules and regulations on all citizens in a country as to ensure basic respect for human rights and dignity of all people and to enforce the running of an orderly, disciplined society. The South African Constitution, Act 108 of 1996, includes the Bill of Rights which lists the basic human rights that apply to all people of South Africa, therefore to people living with HIV and AIDS as well (Van Dyk, 2008: 454; Grossett, 2002: 125). The following South African legislation applies for HIV/AIDS in the workplace:

(a) The Labour Relations Act, No.66 of 1995

All employees have to be protected against unfair labour practices in South Africa. Persons with HIV/AIDS should therefore receive protection against any kind of discrimination and stigmatization in the workplace. They should be treated as any other employee with a chronic life threatening disease, such as diabetes. The rights of a person living with HIV/AIDS are specified in the Labour Relations Act and addresses issues on promotion, sick leave, benefits, confidentiality and dismissals. Employees will be treated equal and not be coerced into any form of employment related HIV testing. Employees are encouraged to participate in managerial decisions affecting them as to prevent disputes between workers and employers.

The Labour Relations Act therefore instituted the Commission for Conciliation, Mediation and Arbitration (CCMA) to resolve disputes resulting from any form of victimization, coercion or unfair labour practice (Grossett, 2002: 15 & 127; Van Dyk, 2008: 429; Nel *et al.*, 2005: 92).

(b) The Employment Equity Act, No. 55 of 1998, which contains the Code of Good Practice on key aspects of HIV/AIDS and Employment (the Code), also published on 1 December 2000 under the Labour Relations Act.

The Employment Equity Act and the Code have been instituted to assist employers and employees in dealing with the impact of HIV/AIDS in the workplace. The Code however, is not intended to be legally binding on all employers and organizations may apply the Code voluntarily (Van Dyk, 2008: 443) in the workplace. Unfair discriminatory issues that affect people living with HIV/AIDS in the workplace are identified in the Code and measures on dealing with HIV/AIDS in the working environment are provided. Topics that are dealt with in the Code comprise of:

i.   the development and implementation of HIV/AIDS policies and programmes for different organizations, as well as the recommendation of a workplace wellness programme for employees affected by HIV/AIDS (Van Dyk, 2008: 470);

ii.   promoting a non-discriminatory work environment based on treating all employees equal and fair;

iii. HIV testing, confidentiality and disclosure;

iv.   promoting a safe work environment to prevent the risk of occupational HIV-transmission, as found in a healthcare setting amongst nurse practitioners (Van Dyk, 2008: 441);

v.   compensation for occupationally acquired HIV should an employee become infected with HIV as result of an occupational accident, such as found when nurse practitioners become infected with HIV as result of infectious bodily fluids like blood and amniotic fluid found in a maternity unit (Van Dyk, 2008: 446);

vi.   employee benefits, example medical aid benefits and pension benefits;

vii. dismissal on grounds of incapacity, and

viii. grievance procedures and confidentiality during such proceedings.

(Van Dyk, 2008: 443; Grossett, 2002: 128; Nel, Swanepoel, Kirsten, Erasmus and Tsabadi, 2005: 326)

(c) The Occupational Health and Safety Act of 1993

The Occupational Health and Safety Act (OHSA) insures that no person will be allowed to do work in unsafe conditions or be subjected to unsafe conditions such as the collection, transportation and disposal of any articles or substances like potential HIV infectious bodily fluids that may endanger the health or safety of any employee or person (Nel et al., 2005: 135; Grossett, 2002: 5). The OHSA places an obligation on all healthcare employers to designate at least one health and safety representative for every 50 employees (South Africa. Occupational Health and Safety Act 1993, sec. 17(5): online) and the OHSA imposes a responsibility on employees to care for their own health and safety, adhere to the safety regulations of

an organization and the universal precautionary measures as to prevent the risk of HIV transmission in the workplace (Nel *et al.*, 2005: 137; Nel *et al.*, 2005: 113).

2.7.3.2 National and International statements and policies on HIV/AIDS

National and International statements and policies on HIV/AIDS are documents that state in writing how organizations in South Africa and others world wide could position themselves in dealing with HIV/AIDS in the workplace and what guidelines are to be adopted to ensure consistent practices and decisions (Van Dyk, 2008: 461 & 466). Such statements and policies provide valuable information that could influence South Africa's stance on HIV/AIDS in the workplace, such as statements from

- The South African National Strategic Plan (NSP) 2007 – 2011 that is aimed at reducing new infections by 50% and reducing the impact of HIV/AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV (South Africa. National Strategic Plan 2007 – 2011: online), and

- UNAIDS, the Joint United Nations Programme on HIV/AIDS, involving several United Nations Agencies, the World Health Organization (WHO), the World Bank and the International Labour Offices (ILO) in providing a vision and specific guidance to policy makers and decision makers to prevent HIV transmission in the workplace and to mitigate the impact of HIV (UNAIDS, 2002: online). An example is the ILO 'Code of Practice on HIV/AIDS and the World of Work' which encourages employee assistance by means of

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programmes in the workplace, especially for women workers, because they are identified as the major caretakers for people living with AIDS related illnesses (ILO, 2002: online). An outline is given of the most important topics that should be contained in a workplace wellness programme as well (see: 2.8.4.2, Page 106).

2.8   A workplace wellness programme

Wellbeing is a contented positive condition of the body, mind and spirit and social adaptability where social and economical networks and resources exist to encourage and develop and nurture health in all its dimensions (Hawk, 2005: 191; Hall, 2007: 130). A workplace wellness programme is an embracement of a prearranged plan and course of actions to properly develop and design a programme in the workplace to promote awareness of positive physical and mental health and wellbeing and supports modification to healthy lifestyles. A workplace wellness programme support employee development such as assisting nurse practitioners living with HIV/AIDS in the workplace to prepare themselves for all the stages of a chronic disease and develop life skills to cope with physical and psychosocial needs by receiving appropriate information, health education, legal assistance and financial direction (O'Donnell, 2002: xxii, 19 & 544 & 571).

2.8.1   A workplace programme addressing health and wellness

Health is a mode of existence that indicates complete physical, social and mental wellbeing and not only the absence of an illness or disability (WHO, 2006: online).

Wellbeing is thus a contented positive condition of the body, mind and spirit and social adaptability where social and economical networks and resources exist to encourage and develop and nurture health in its entire dimension (Hawk, 2005: 191; Hall, 2007: 130).

This state of wellbeing where a person experiences positive health as demonstrated by the quality life he or she lives, typifies wellness (Corbin & Pangrazi, 2001: 1). However, wellness puts a responsibility on a person to use self-evaluation and self-assessment to determine and acknowledge his/her need for assistance, information and confirmation that his or her self-care needs are met (Orem, 1980: 36; Hartweg, 1991: 5).

Wellness therefore encompasses seven areas of self-care requisites to promote the wellbeing and quality of life of a person, namely physical (body), intellectual (mind), emotional (feelings), social (family, friends and colleagues), occupational (professional and care-giving roles and skills), environmental (air, water, food, safety) and spiritual (religion, values and beliefs, purpose and vitality) areas or requisites (Health and Wellness Strategic Initiative – Task Force Summary Report 2006: online), that influence each other, are interchangeable and to be successful, depend on each other for someone to live life to the fullest in and outside the workplace (Wang and Laffrey, 2001: 123).

A workplace is made up of people who work to give meaning to an organization. People have many needs and different organizations exist to deliver the goods necessary to satisfy these needs. People use their mental and physical abilities and skills, labour and the resources provided by an organization, to deliver the demand (Nel *et al.*, 2005: 9). The South African Labour Relations Amendment Act (RSA 2002e), Section 200A, defines an employee who finds her-/himself in a work environment as:

"A person who works under supervision or control, and forms part of an organization, and is economically dependent on the person for whom she/he works, and is provided with the resources to do the work, and is in a work arrangement or agreement" (Nel *et al.*, 2005: 91).

Therefore, a workplace is where a worker who is the employee, and an organization that supplies the work, the employer, concludes an employee-employer relationship by agreeing in which way the work should be organized and executed (Nel *et al.*, 2005: 10) in exchange for employee equity and stability, employee development and wellbeing as provided with a properly developed and designed health and wellness programme (O'Donnell, 2002: 544 & 571).

A programme addressing health and wellness issues in a workplace focus on

- creating an awareness of health topics that pose a hazard in the workplace and has an affect on a person's wellbeing,
- health education and behaviour modification to promote lifestyle changes and optimal health and wellbeing, and

- creating a supportive work environment that encourages persons to obtain and maintain positive health and wellness.

A health and wellness programme in a workplace could result in improved health with ultimately reduced medical problems and reduced medical expenses for the employee, with improved attendance and productivity levels witnessed by an employer (O'Donnell, 2002: xxii – xxiv).

The organizational policies and organizational culture has to be adapted and changed to accommodate a wellness programme. The content of a proposed programme has to include sustainable health programmes that could enhance and encourage employee ownership, because if employees acknowledge that a workplace wellness programme serves their best interest and is continually accessible, they would most probably accept ownership. This feeling of ownership could be fostered by maintaining confidentiality on all information relating to an employee and to involve employees in the managing and delivering of a programme (O'Donnell, 2002: xxiv). Ongoing structures need to be put in place when a workplace wellness programme are dispositioned to make it an integrated stable part of an organization, such as

i.   appointing a programme manager to oversee all the managerial activities, especially during the planning, implementation and evaluation of such a workplace wellness programme;

ii.   the provision of resources, for example promotional material, manpower, equipment, stock, finances and a proper communication structure;

iii.   an allocated office or venue;

iv.   sustainable activities or projects, for example support groups and peer

counselling sessions;

v.   health screenings and a referral system with other health services, for

example HIV/AIDS VCCT;

vi.   the organizing of special events, for example World Aids Day;

vii.   ongoing marketing and promotion on the benefits of a workplace wellness

programme and employee involvement.

(O'Donnell, 2002: xxiv, 211, 460, 571 & 545; Van Dyk, 2008: 469)

2.8.2   A workplace wellness programme and HIV/AIDS

The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (the

Code) was published on 1 December 2000 under the South African Labour Relations

Act No. 66 of 1995 and the Employment Equity Act No. 55 of 1998 to guide

employers and employees with the intent to ensure that people with HIV are not

unfairly discriminated against in the workplace and how to manage HIV/AIDS within

the workplace.

The Code emphasizes the importance for the creation of a supportive environment in

order that employees living with HIV/AIDS could continue their work under normal

circumstances, especially female employees. Employers are encouraged to develop

and implement HIV/AIDS health promotional programmes in the workplace, such as

a workplace wellness programme that address the following:

i.   the promotion of a supportive and acceptant environment for employees living with HIV/AIDS in the workplace;

ii.   medical management of HIV infected employees, especially employees on ART;

iii.   accessible ongoing counselling and support such as a VCCT programme;

iv.   interaction with other healthcare providers and specialized agencies such as referrals to psychologists, nutritionists and medical aids;

v.   family assistance programmes;

vi.   reasonable accommodation of HIV infected employees to improve their health and productivity and

vii.   the monitoring, evaluation and reviewing of a workplace wellness programme (Van Dyk, 2008: 470).

The universal building blocks of HIV prevention and care in a workplace wellness programme are primary sexual behaviour change, open communication about HIV/AIDS and people infected and/or affected by the disease, and organizational and community-level structures and interventions of support and contact and care (Low-Beer, 2005: 478). A wellness programme is therefore an important venue to assist and support newly diagnosed employees with HIV to cope with their status, to inform them on measures so that they are able to work productively and to develop positive attitudes towards healthy living principles. It prepares a HIV infected employee from being symptom free to falling ill and require care, and aids in legal issues such as insurances, joining medical aids, where to receive treatment, prophylaxis, when is ART appropriate and qualifications for disability and other social grants (South Africa. Foundation for Professional Development, 2006: 53).

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A workplace wellness programme also attempts to move an employee from a neutral to a higher level of health, focuses on signs of health, and indicates that the key to wellness is self-responsibility and establishing a positive approach. Acquiring timely medical assistance and embracing a healthier lifestyle can extend the asymptomatic phase of HIV. Emotional, social and economical deprivation adds to the HIV/AIDS affected employee's perplexing predicament and the hostility of co-workers fuels this state of desolation. Thus, to defuse these harmful attitudes, the need for implementing a comprehensive HIV/AIDS workplace wellness programme, is acknowledged (Evian, 2003:12; Smit, 2005: 25 & 28; Vass and Phakathi, 2006: 22).

2.8.3 A workplace wellness programme and the HIV/AIDS infected and/or affected nurse practitioner

The development of a workplace wellness programme is a valid mode of helping the nurse practitioner to cope with her confrontation with HIV/AIDS and address her complex and well-concealed conceptions and attitudes about sex, death and the myths, stigma and prejudice surrounding the disease. She needs to develop her attitude, knowledge and coping skills necessary to motivate and empower her to address her daily occupational challenges in an appropriate and successful manner (Orem, 1980: 55; Van Dyk, 2008: 122).

The factors that contribute to her realization that she is in need of assistance and has to span the limitations set to her daily wellbeing, contributes of feeling at risk due to her profession, vulnerability to HIV infection and the consequences and effect it

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has on her life (Holzemer*et al.*, 2007: 546 & 547). Her concern about her exposure to HIV and personal contact with somebody who is HIV positive or who has AIDS, on her health and wellbeing, puts her in need of specific modes of health care to be able to live and work with the consequences of HIV/AIDS (Orem, 1980: 51; Van Dyk, 2008: 123).

A workplace wellness programme creates the opportunity to holistically address the needs of the nurse practitioner who is confronted with debilitating health and living issues (Van Dyk, 2008: 470). It enables her to form or change her attitudes and values, creatively use her abilities to overcome life-sapping situations and adjust her self-concept. It creates an opportunity for her to interact and communicate with other people and give her the guidance and support she needs to address her daily tasks and functioning (Orem, 1980: 66: Van Dyk, 2008: 470).

The nurse practitioner strives to earn respect and trust from her colleagues and friends and she needs to pursuit her goals and professional career (Orem, 1980: 66; Smit, 2005: 26 & 27). She is able to achieve her goals if she successfully combats the negative consequences of HIV/AIDS, such as discrimination and stigmatization in the workplace (Holzemer*et al.*, 2007: 547) or work overload due to high absentee levels amongst her colleagues (Hodgson, 2006: 284). A nurse practitioner is able to effectively accomplish self-care if she has acquired the necessary knowledge to apply her skills in making sound judgements, involve her colleagues in her daily life

namely accepting friendship, trust and loyalty and use the resources made available to her, such as a wellness programme run in the workplace (Orem, 1980: 82).

A pre-requisite for a workplace wellness programme is the involvement and application for recall of a body of knowledge about:

- the fundamental facts about HIV/AIDS such as the transmission of HIV, symptoms of infection, prevention and treatment of HIV/AIDS, counselling and care and support;
- the economic impact of HIV/AIDS on nursing and the workplace or organization,
- management of an organization's response to HIV/AIDS and nursing on business, and
- legal, ethical and policy issues and what it communicates (Van Dyk, 2008: 461 & 466).

The influence of selected basic conditioning factors such as age, gender, level of education, health state, life style, family profile, socio-cultural and environmental factors such as to which social group a person belongs and work related issues on self-care and health promotion is of value when health promotional interventions such as a workplace wellness programme, are to be developed and implemented (Callaghan, 2006: 178).

Orem's self-care deficit nursing theory underpins the importance of taking basic conditioning factors into consideration when interventions are planned for promoting health and self-care to a higher level of wellbeing in adult populations such as nurse practitioners (Hartweg, 1991: 31). An example is found where the more mature and experienced female nurse practitioner with an adequate income to care for herself and her family, exploits venues to increase her health and wellness to maintain her position in the workplace (Callaghan, 2006: 183).

An understanding of these basic conditioning factors presented information about conditions necessary to address the health and healthcare needs of the nurse practitioner in the workplace. This information extends for further consideration because the identified needs of the nurse practitioner and what actions to take to meet these needs, depend on which self-care actions or behaviours she requires to attain a satisfactory level of health and wellbeing (Orem, 1980: 212; Van Dyk, 2008: 467).

She however requires learning activities to develop her knowledge of HIV/AIDS, guide her attitude and perception of the disease and its victim as well as how to apply the necessary skills to address her needs holistically. Applying her knowledge to initiate, perform and control activities of care to herself and others, and how to interpret and manage her emotional and spiritual hurdles, will enable her to monitor and evaluate her own or her other's condition or response to self-care, illness and wellbeing (Van Dyk, 2008: 467).

A workplace wellness programme should therefore purposefully utilize resources and activities whereby the nurse practitioner could address her self-care requisites (Orem, 1980: 213). Supplying her with knowledge through printed material or discussion and information sessions on self-care issues such as health, wellness and social adaptability and introducing her to appropriate resources to address her daily maintenance such as financial aid, planning and provision for future economical needs or medical assistance through VCCT and the provision of ART, are but few activities to be implemented and maintained in a workplace wellness programme (Van Dyk, 2008: 469). These activities tend to be need-fulfilling actions, which focus on the collaboration between the management or the human resources department of an organization and the nurse practitioner. These actions prompt the nurse practitioner to engage in promoting positive healthcare habits and activities and promote the desire to make sound judgements about living principles, how to inter-relate to family, friends and colleagues and how to achieve her occupational and personal goals (Orem, 1980: 214; Van Dyk, 2008: 470 - 472).

Taking Orem's model of nursing into consideration to offer physical and psychological, as well as economical and occupational assistance with the necessary education and information to the nurse practitioner, well considered planning has to be undertaken when developing a workplace wellness programme (Cavanagh, 1991: 28). Orem's model underlines the importance of an appropriate timeframe to identify the nurse practitioner's needs and goals, what support to give, which resources are to be used and after evaluation, would the nurse practitioner's needs be addressed.

The environmental conditions such as an area where she could feel at ease without any interruptions from other persons have to be taken into account. Manpower to achieve the goals of a workplace wellness programme has to comply with a sufficient number of qualified staff and the availability of necessary equipment and supplies. Orem's model also suggests a feedback mechanism to evaluate the outcomes of such a programme, because there will be a need to decide if a workplace wellness programme should be continued in the current way or whether changes or modifications should be done to it (Cavanagh, 1991: 29 – 37).

The purpose of a workplace wellness programme is thus to create a system whereby the nurse practitioner could address her health needs and healthcare limitations and the amount of intervals she would need to arrive at a satisfactory level of self-care and maintenance. She would be able to identify the level of contribution the employer makes to demonstrate its partnership to provide information and open discussion on prevention methods, providing compassionate care and support, as well as providing venues towards reducing stigma and discrimination both inside and outside the workplace (Van Dyk, 2008: 470).

Formulating a design for a workplace wellness programme therefore relies on two actions, namely:

(1)   determining and organizing the components of the nurse practitioner's self-care requirements such as a need to be accommodated at work should illness prevent her from being productive, and

(2)   determining and selecting the appropriate expertise and resources to

successfully address the nurse practitioner's self-care deficits and requirements such

as providing a referral system with other healthcare providers to address her

physical or social or spiritual needs (Orem, 1980: 210; Van Dyk, 2008: 470).

Limitations to a workplace wellness programme should however be borne in mind as

to the voluntary participation of the nurse practitioner. She has to acknowledge her

responsibility to maintain positive health and wellness and make the willing choice to

accept the help and support available to her in the workplace. Her willingness to

participate in a wellness programme will rely on the urgency of the self-care

demands she encounters and the sense of motivation she experience. She may

experience bouts of reluctance and unwillingness to seek support to resolve her

problems. A well-designed workplace wellness programme could therefore prompt

and assist the nurse practitioner to make satisfactory decisions (Orem, 1980: 211).

2.8.4   Components of a workplace wellness programme

Components of a wellness programme constitutes of the elements of being that

describe the existence of positive health in an individual namely the physical, social,

intellectual, emotional and spiritual aspects, as well as the economical and daily

working environment (Corbin and Pangrazi, 2001: 1 – 3). Each component is

dependent on the other to achieve a positive outcome. It is therefore imperative that

a workplace wellness programme should have an impact on awareness in a specific

topic or area of need to help employees make lifestyle changes that enhance

positive health and wellbeing, as well as create environments that support healthy

lifestyle choices where health hazards are addressed and coping skills of

employees can be developed (O'Donnell, 2002: xxii, 544 & 571).

2.8.4.1 Integrated strategy to effectively manage HIV/AIDS in the workplace

The backbone of a sustainable HIV/AIDS workplace wellness programme depends

on an integrated strategy to effectively manage HIV/AIDS in the workplace (Van Dyk,

2008: 462) of which should address the following:

- good leadership and the appointment of a representative HIV/AIDS
  management team;
- a study to determine the nature and effect of HIV/AIDS on the workplace and
  its employees;
- a HIV workplace policy with applicable goals and objectives, and
- monitoring and evaluation strategies.

2.8.4.1.1 Leadership and the appointment of a representative HIV/AIDS management team

Good leadership and the appointment of a representative HIV/AIDS management

team to serve as a focal point for co-ordinating the organization's HIV related

activities should be made. A HIV/AIDS management team has to be vested with

authority over such activities and have a direct line of communication with senior

management. Good leadership should encourage managerial support for a

workplace wellness programme, because the management of an organization has the authority to allocate financial aid and staff resources to a programme (International Finance Corporation (IFC), 2002: online; Van Dyk, 2008: 462; Thomas, Colvin, Rosen and Zuccarini, 2005: online). To save time and money and avoid duplication, a HIV/AIDS management team could involve partnerships with other role players, such as medical aids or service supplier's namely clinical medical staff at local clinics to help with biometric screening or human resources departments to assist with employment issues (Van Zyl, 2009: online).

2.8.4.1.2 Impact study

The nature and effect of HIV/AIDS on the operations of an organization and the impact that the disease has on the workforce should be established. An impact study could determine an organization's risk with respect to HIV/AIDS. The statistical data available on the rate of HIV infection for a population should be used as a guideline to determine the rate of HIV infection in the workforce, as well as absenteeism rates, staff turnover and the general perceptions of employees in the workplace. Risk factors to which the workforce is exposed to in their daily work operations have to be identified as well (IFC, 2002: online; Van Dyk, 2008: 462; Thomas *et al.*, 2005: online).

2.8.4.1.3 HIV/AIDS workplace policy with applicable goals and objectives

A HIV/AIDS workplace policy with applicable goals and objectives should be instated. A HIV/AIDS workplace policy should communicate an organization's

position on HIV/AIDS and address the responsibilities and rights of both the employer and employees. A HIV/AIDS workplace policy emphasizes the commitment of the management of an organization to fulfil their legal obligation in avoiding any discriminative actions and health hazardous practices in the workplace (Van Dyk, 2008: 466; IFC, 2002: online).

Goals that limit the incidence of new infections amongst staff and manage the impact of existing HIV/AIDS infections on both the employer and employee, should support the objectives to (1) change negative behaviour, (2) promote the advantages of applying preventative measures to improve healthy lifestyles and medical care such as ART, as well as (3) render support to employees affected and/or infected with HIV/AIDS. The goal of a workplace wellness programme should therefore be to encourage employees to establish their HIV status through testing and support employees who are HIV negative to stay that way, as well as promoting access to ART and healthy living principles for employees who are HIV positive (IFC, 2002: online; Thomas et al., 2005: online).

2.8.4.1.4 Monitoring and evaluation strategies

Monitoring and evaluation strategies should be developed to enable an organization to measure its progress against the stated goals and objectives and make informed decisions on the effectiveness of a workplace wellness programme and the HIV activities. A workplace wellness programme could therefore be adapted accordingly

after the results have been reviewed. A monitoring system could comprise of the following:

i. statistical reports relating information on employee absenteeism rates and occupational accidents with blood and bodily fluids to the management of an organization;

ii. collecting feed-back evaluation reports of service users;

iii. condom use rates;

iv. number of requests for VCCT service;

v. number of peer educators and counsellors in an organization;

vi. staff morale, general awareness and attitude towards HIV surveys; and

vii. satisfaction with organizational health promotion programmes and activities surveys (IFC, 2002: online; Van Dyk, 2008: 470; Thomas *et al.*, 2005: online).

2.8.4.2 Component content of a workplace wellness programme

Component content of a workplace wellness programme addressing HIV/AIDS could comprise of the following:

- educational and prevention programmes;

- promotion of prevention and self-care;

- care and treatment programmes; and

- wellness and support initiatives (IFC, 2002: online;Thomas *et al.*, 2005: online; Van Zyl, 2009: online; ILO, 2002: online).

2.8.4.2.1 Educational and prevention programmes

Educational and prevention programmes should promote awareness on HIV issues through the provision of information, education, communication and activities that address the facts and myths on HIV transmission and how to apply preventative measures to avoid infection with HIV (Van Dyk, 2008: 122). This is attainable should flyers and posters be displayed on billboards and condoms placed in high-traffic areas. A workplace HIV policy could be posted in prominent places and World AIDS Day activities could be initiated (Thomas *et al.*, 2005: online; Van Dyk, 2008: 139).

Training should involve professional training on personal safety, Universal Safety Precautions during staff induction programmes, as well as HIV/AIDS education to employees (Van Dyk, 2008: 356).

De-stigmatize HIV/AIDS and stop discrimination and fear for others and being infected with HIV by dispelling the myths on HIV/AIDS, enforcing workplace anti-discriminative policies and programmes and encouraging support groups for employees and peer education (IFC, 2002: online; Thomas *et al.*, 2005: online).

Peer education is a most widely used strategy to raise awareness on HIV/AIDS, because it trains and supports employees to affect change among their colleagues (Van Dyk, 2008: 193 & 470).

Employees need specific HIV-related information on:

a) the HI-virus and its affect on the body and cues to recognize the signs of opportunistic infections, how to treat these infections promptly, how to enjoy optimal health and stay healthy for as long as possible (Van Dyk, 2008: 25 & 136; Thomas *et al.*, 2005: online);

b) ART and where to obtain prophylactic drugs that prevent opportunistic infections such as TB (tuberculosis) and pneumonia and measures to prevent the risk of being infected with HIV (Van Dyk, 2008: 61,100 – 107; Thomas *et al.*, 2005: online);

c) emotional health, emotional support, stress and coping management and how to live with HIV/AIDS (Van Dyk, 2008: 423);

d) spiritual health and the value of religion (Van Zyl, 2009: online; Van Dyk, 2008: 320);

e) social health and the support and value of family, friends and colleagues (Van Zyl, 2009: online; Van Dyk, 2008: 419);

f) health education on personal hygiene with adequate nutrition, rest and recreation, protection against occupational hazards and promoting a safe and healthy work environment, as well as developing good interrelationships within the workplace, medical screening and examinations and referral possibilities (Van Zyl, 2009: online; Van Dyk, 2008: 418).

2.8.4.2.2 Promote prevention and self-care

HIV prevention strategies in the workplace rely on the involvement and commitment of a management team to scrutinize an organizations' stance to HIV health promotional activities by conducting the following actions:

- review the occupational health and safety procedures of an organization,

- review the equipment, stock and objects used by employees in an organization for their safety and hazardousness in doing tasks with, and

- establish what occupational health and safety protocols and work procedures are to be put in place to prevent the risk of HIV infection from blood borne infectious diseases through bodily fluid transmission (IFC, 2002: online; Van Dyk, 2008: 440 – 441).

HIV prevention strategies in the workplace that could promote self-care within the employee consist of condom distribution actions, a VCCT programme and addressing Sexual Transmitted Diseases (STD's) (IFC, 2002: online; Thomas *et al.*, 2005: online; Van Dyk, 2008: 69).

Condom use should be encouraged as to assist in the prevention of all sexually transmitted diseases. Condom distribution should be readily available and free of charge or at least affordable to all employees. A condom should be of high quality and placed in strategic areas or available at the company clinic or at self-service dispensers in bathrooms (Van Dyk, 2008: 131; Thomas *et al.*, 2005: online).

Voluntary confidential counselling and testing (VCCT) should be initiated whereby an employee undergoes confidential pre- and post-test counselling to enable him or her to make an informed decision about being tested for HIV (Gruskin, Ahmed & Ferguson, 2008: 24; Van Dyk, 2008: 134). VCCT for HIV is aimed toward helping an employee know his or her HIV status, because knowing one's status is instrumental in promoting behaviour change and adopting safer sex practices (Mayer and Pizer, 2009: online).

VCCT is applied to discuss and access an individual's risk behaviour, explain the HIV test process, obtain permission to conduct the HIV test, discuss coping strategies and prevention strategies after receiving the test results during pre-test counselling. During post-test counselling the HIV test result is relayed to the individual where-after risk reduction strategies are discussed and he or she is encouraged to disclose their status (Mayer and Pizer, 2009: online; Van Dyk, 2008: 134). Appropriate referrals for care and support are provided as well, because the counsellor induces self-awareness from within the person to make decisions on actions to be taken resulting from his or her needs and concerns (Orem, 1980: 35 – 36).

Healthcare providers in South Africa provide HIV testing and counselling to persons who attend formal healthcare institutions by initiating the Provider Initiated Testing and Counselling (PITC) process (Gruskin *et al*, 2008: 24; Heunis, Engelbrecht, Kigozi, Pienaar & Van Rensburg, 2009: online; Mayer and Pizer, 2009: online). PITC is recommended in areas where high-risk populations are found and where clients

exhibit symptoms of HIV. It is an effort to involve HIV infected persons in HIV care and treatment after identifying them in a clinic setting.

Counselling plays a less dominant role in PITC because the core requirement exists in pre-test information. The clients are provided with an opt-in and opt-out decision. An opt-in decision occurs when a person clearly and without any doubt agrees to an HIV test to be done by the healthcare provider. An opt-out decision implies that a person clearly and without any doubt declines to have an HIV test done, despite it being a routinely performed procedure at the healthcare provider (Mayer and Pizer, 2009: online; Heunis *et al*, 2009: online).

A workplace wellness programme could therefore be appropriately utilized as an effort to bring VCCT to nurse practitioners who may not seek the service at a formal healthcare setting such as a clinic. Nurse practitioners could therefore decide to avoid being infected with HIV or prevent infecting other people with HIV after they have received the results of their HIV test. VCCT services should however be made available, accessible and affordable to the employee. Where nurse practitioners are at risk of being discriminated against and fear stigmatization and isolation, VCCT should be offered, but the results supplied to a medical officer who could counsel, support and refer the individual to a support service identified by an organization (IFC, 2002: online; Van Dyk, 2008: 134; Thomas *et al.*, 2005: online).

Prevention and treatment of STD's are to be implemented, because a strong

relationship exists between sexually transmitted diseases and HIV transmission.

STD's indicate high-risk sexual behaviour and it is therefore important to create

awareness of HIV transmission due to sexual promiscuity, educate persons on

sexual abstinence, having a sexual relationship with only one non-infected partner or

use condoms. Employees identified to suffer from a STD should be referred to their

local clinic or medical practitioner who could prescribe antibiotics to cure the disease

(IFC, 2002: online; Van Dyk, 2008: 69 – 70; Thomas *et al.*, 2005: online).

2.8.4.2.3   Care and treatment programmes

(a)   HIV care and treatment

An organization should determine which options it poses to offer an employee when

ARV-drug therapy are to be commenced and such employees be medically

monitored for example:

- the initiation of post-exposure prophylaxis (PEP) with antiretroviral therapy
  after accidental exposure to HIV infected blood and/or bodily fluids (Van Dyk,
  2008: 110),
- assigning an employee to his/her medical aid HIV programme when put on
  antiretroviral drugs or
- referring an employee to his/her private medical practitioner.

An organization could appoint service providers aimed at ensuring equitable

healthcare packages for all employees or a referral strategy to a local clinic (IFC,

2002: online; Thomas *et al.*, 2005: online).

b) TB (Tuberculosis) prevention and treatment

TB is a leading opportunistic infection fuelled by HIV infection and it is the most frequent cause of death in people living with HIV/AIDS. It is therefore important that a referral strategy is imposed in the workplace for the testing and treatment of TB at a local TB treatment clinic or at an employee's medical practitioners of choice (IFC, 2002: online; Van Dyk, 2008: 62; Thomas *et al.*, 2005: online). A support programme for TB prevention and treatment could address medication adherence by implementing the DOTS (directly observed treatment short course) strategy, weight management, advice on nutrition and support to uphold consistent productive job performance (Van Dyk, 2008: 66).

2.8.4.2.4 Wellness and support programmes

Wellness information could comprise of awareness and educational classes, interactive counselling or support groups on important issues such as stress management and depression, lifestyle change initiatives such as practicing safer sex and abstain from risk behaviour (Van Zyl, 2009: online; Van Dyk, 2008: 423), as well as spiritual guidance and emotional self-care (Van Zyl, 2009: online).

Support programmes should address employee assistance where counselling is provided regarding his/her personal concerns and help with critical incident stress debriefing such as found when a nurse practitioner is confronted with a HIV test result (Van Zyl, 2009: online; Van Dyk, 2008: 219). Guidance to effectively manage finances and economical implications resulting from an incurable disease such as

HIV/AIDS (Van Dyk, 2008: 26), as well as job and career issues that have to be addressed, constitutes a supportive working environment (Van Dyk, 2008: 461 – 462).

The social health of an employee could thus be promoted through the promotion of team work and the development of his/her listening skills, life coping skills, encouraging disclosure and discussion on HIV related topics such as family care, self-care and communication enhancement between colleagues within the workplace (Van Zyl, 2009: online; Van Dyk, 2008: 419 – 420).

Nurse practitioners need to be knowledgeable about reliable current information on how to achieve positive health outcomes (Cavanagh, 1991: 123; Luney, 2008: 28). The health outcomes refer to the nurse's response to treatment or participation in activities and programme initiatives. The programme initiatives are any action, based on the knowledge possessed by nurse practitioners who are taken to enhance employee health outcomes (Doran and Sidani, 2007: 5 & 6). For nurse practitioners to make well-informed decisions about appropriate self-care requisites that could address their self-care needs, as well as the needs of their colleagues and next of kin, they have to be made aware of methods to assess their need for assistance (Orem, 1980: 36; Doran and Sidani, 2007: 3).

2.9 A Framework

A framework is a theoretical guide of meaning to express views to research findings, evaluate existing knowledge and describe and explain and predict thoughts and behaviours which need to be tested through further research (Lunney, 2008: 28; Doran and Sidani, 2007: 3).

A framework helps to organize ideas, reach conclusions and understand an event through the abstract and valid clarification and careful structuring of knowledge developed inductively from theoretical work and theories (Burn and Grove, 2005: 121; Lunney, 2008: 28). A framework that may be developed after having done research of the literature should be well accommodated within the study methodology, because to understand the meaning of the study findings, the researcher needs to understand the logic within a framework and how the findings will be used (Burns and Grove, 2005: 121).

2.9.1 Components influencing the disposition of a workplace wellness programme

A prerequisite for the development of a framework is the clarification of the components that have an influence (Hjørland, 2009: 1519-1521) on the disposition of a workplace wellness programme. The theoretical support for a framework will be furthermore obtained from the literature study that concluded that the major components of a workplace wellness programme framework are based on four concepts, namely (1) health, (2) wellness, (3) health promotion and (4) a proposed

wellness programme (Figure 2.3). The wellness programme will focus on promoting purposeful activities towards a specific health goal to increase the level of wellbeing and health (Hartweg, 1990: 38) of the HIV/AIDS infected and/or affected nurse practitioner.
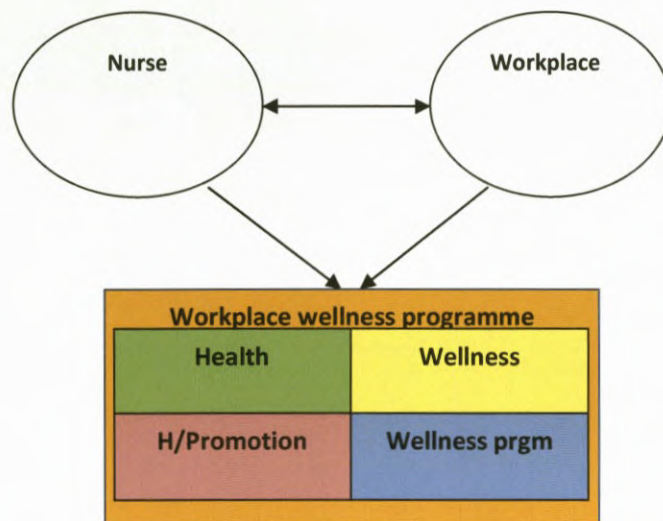
Figure 2.3   The four concepts underpinning a workplace wellness programme

- Health is defined as a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity (WHO, 2006: online).

- Wellness is understood per definition as being a contented positive condition of the body, mind and soul, as well as social adaptability where social and economical networks and resources exist to encourage and develop and nurture health in all its dimensions (Hawk, 2005: 191; Hall, 2007: 130).

- Health promotion is defined by the WHO as the process of enabling a person to increase control over, and to improve his or her health that goes beyond a

healthy lifestyle to a high level of wellbeing (WHO/Europe, 1986: online) and this definition is endorsed in Orem's model of nursing (Orem, 1980, 55).

- A workplace wellness programme is understood to mean the mode of selective proceedings instituted in the workplace with the sole intention to motivate and promote, empower and enhance an employee's ability to achieve and maintain a high level of health and wellbeing (Orem, 1980: 55; Van Dyk, 2008: 122).

The researcher will therefore firstly identify and illustrate the interaction and interdependence of components that influence the uptake of knowledge and evidence from research to guide the design of a workplace wellness programme for nurse practitioners. The researcher will apply research evidence acquired from the literature review and the feedback data received from a quantitative research methodology to describe, integrate, and connect the theorized relationships amongst the components (Figure 5.1(a), Page 217). Thereafter secondly, the researcher will discuss the logic model, hence describing the theory of change underpinning a framework for the development of a workplace wellness programme.

2.9.2 Steps guiding the formulation of a framework

The following steps will guide the researcher in formulating the framework:

(1)   the identification of concepts or variables and components after having done an extensive literature study and supplying the conceptual definitions (Chapters 1 & 2);

(2) identify components after yielding the opinions of nurse practitioners and make

relational statements, which means to develop statements relating to the

components (Chapter 4);

(3) apply the theory of change logic model to support and develop a framework

(Chapter 5).

2.9.3 Framework for a workplace wellness programme

The formulation of a framework for a workplace wellness programme relies on a

clear understanding of the interaction and interdependence of components that

influence the uptake of knowledge and evidence from research to guide the design

there-of (Lunney, 2008: 28; Doran and Sidani, 2007: 3).

It furthermore depends on the application of tested models or theories to explain how

a proposed programme could successfully achieve its desired goals or objectives

(Frechtling, 2007: 5 and 18). The logic model is identified to describe the intended

theory of change supporting the framework of a workplace wellness programme.

2.9.3.1 Logic model and theory of change

A logic model is a tool that describes the theory of change supporting a programme.

Theory of change is defined as an explanation of the causal links that connect the

programme activities to the expected outcomes. It consists of elements and

connections, as well as context for planning and managing activities in the

programme where evaluation is important (Frechtling, 2007: 1- 2; Julian, 2005: 162).

A logic model renders a visual image or picture of how a programme is expected to

achieve its intended outcomes (W.K. Kellogg Foundation, 2002: 1). A logic model

guides concepts and components underlying a programme. It furthermore describes

the causal linkages from the start of a programme up until achieving the programme

objectives, clearly defining as well as describing the theory of change that supports a

programme. Hereto a programme depicts a group of projects or activities to achieve

the desired goals or objectives (Frechtling, 2007: 5 and 18; McDavid and Hawthorn,

2006: 15 and 54).

A logic model explains how a programme will work under certain environmental

conditions to solve the identified problems. It furthermore communicates the

intentions of a programme to persons outside the programme in a short, to the point

and compelling way (Wholey, Hatry and Newcomer, 2004: 8 and 11). In other words,

a logic model organizes the information of a programme in a comprehensible and

logical flow of events allowing the reader to determine which activities lead to what

outcomes (Wholey *et al.*, 2004: 19).

The theory of change logic model underpinning the framework of this research study

will be discussed and visually presented in Chapter 5.

2.10 Summary

Health is put on the agenda of all policy makers and promoting the health and wellbeing of nurse practitioners in the workplace is therefore an obligation put upon all employers in the health industry (O'Donnell, 2002: 563). This literature study attempted to identify the inter-relating and inter-acting factors between the nurse practitioner and his/her place of employment

With the emphasis on the promotion of health and wellbeing of people in the workplace, the World Health Organization (WHO) endorsed the importance of the improvement of health and wellbeing of all employees in the workplace (Hartwig *et al.*, 2008: 1) by instituting the WHO's Global Healthy Work Approach in 1997. It is therefore imperative that the factors pertaining to the nurse practitioner and the workplace respectively should be taken into account when proposing a framework for the development of a workplace wellness programme (Israr and Islam, 2006: 321).

A HIV and AIDS infected and/or affected nurse practitioner could arrive at a state of positive wellbeing if the daily situations like health issues, domestic problems and job related demands are creatively solved and dealt with, because he/she has a subjective perception of his/her physical, mental and social wellness, prosperity and context in which their life is being lived. Positive wellbeing is embossed in the feeling of being in control of their daily living, feeling good about themselves and being able

to overcome energy tapping situations and avoid social biases and isolation

(Hildebrandt, 2002: 363 – 368; Smit, 2005: 28).

CHAPTER 3

Methodology

3.1 Introduction

The purpose and objectives of this study were to identify and describe components necessary for the development of a workplace wellness programme for nurse practitioners who are infected and/or affected by HIV/AIDS in the private healthcare sector. The plan, structure, and process with which this study was conducted are explained by describing the methodology that was followed (Burns and Grove, 2005: 211). The methodology discusses the researcher's choice of research design, which research technique was used, the population and sampling, data collection, data analysis, validity and reliability and ethical considerations taken into account. The information derived from the results obtained during the data analysis, would be used to underwrite a framework for the development of a workplace wellness programme for the population (De Vos, Strydom, Fouché and Delport, 2009: 159).

The researcher followed a research process to guide the study through the methodology phase as to avoid any error or weakness in the research design, the sampling, statistical analysis and generalization of the findings (Burns and Grove, 2005: 23 – 25; De Vos *et al.*, 2009: 72) to the applicable population, because a disciplined attitude and adherence to detail and accuracy were important.

The research process consisted of actions, processes or steps (De Vos *et al.*, 2009: 78) that guided the researcher to achieve the ultimate goal of acquiring information and investigate an area of concern that explains a current phenomenon experienced in the nursing population. The research process (Burns and Grove, 2005: 36) followed in this study is illustrated in Figure 3.1 (Page 124).

The processes, actions or steps relied on each other and could flow back and forth between each other during the clarification of each step (Burns and Grove, 2005: 35; De Vos *et al.*, 2009: 78-79). Two-way arrows connected and illustrated this movement between the actions indicated in Figure 3.1. A feedback arrow indicated that the research process was cyclical, implying that the study generated additional research in any given field at any given time (Burns and Grove, 2005: 36).
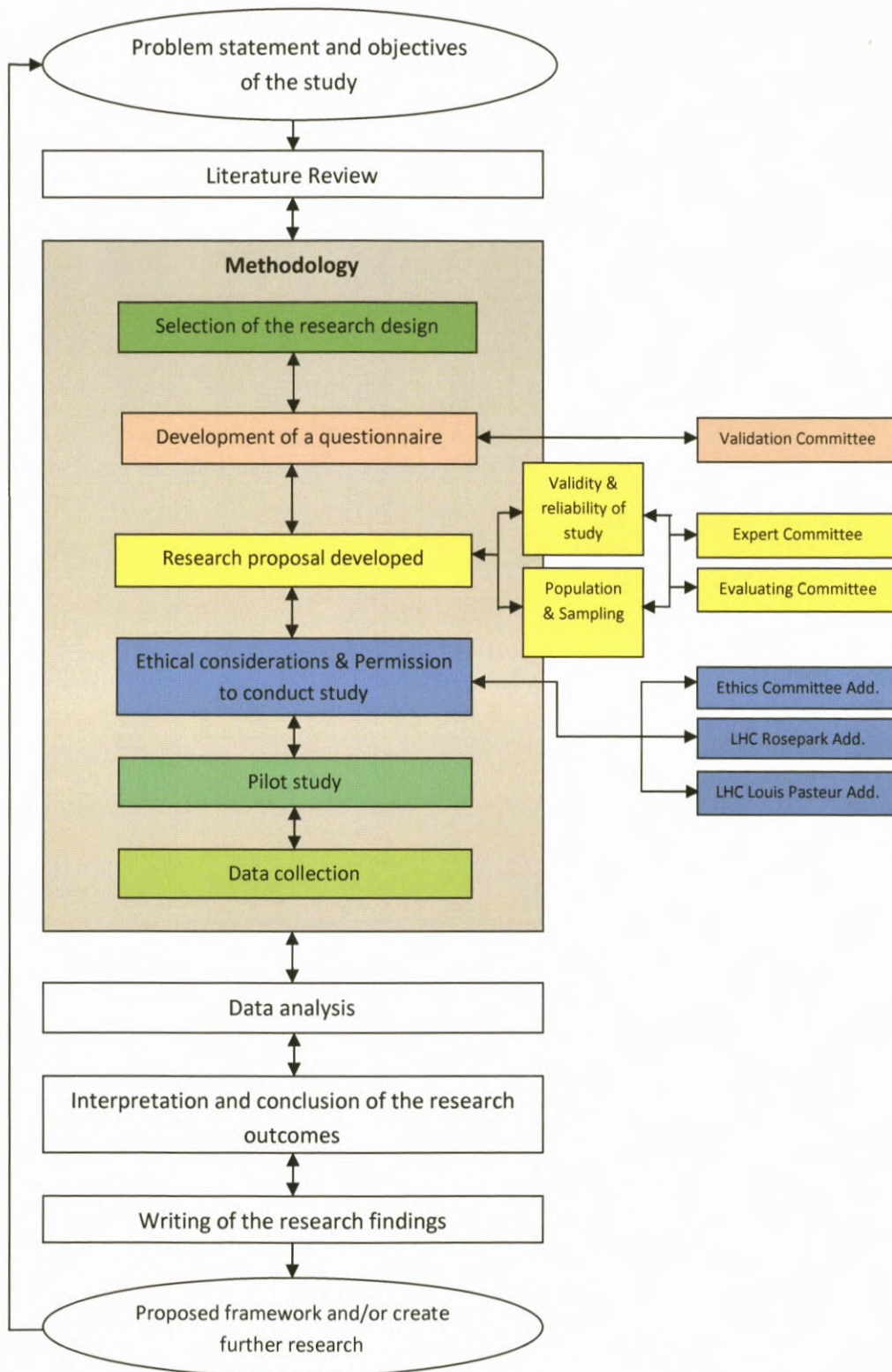
Figure 3.1 Research process

A descriptive research method in quantitative research design was used in this study. The research design of a study allows the researcher to plan and conduct the study accurately and achieve the objectives without compromising the validity and reliability of the study findings. It enables the researcher to conduct the research for the purpose of explaining the research problem (Burns and Grove, 2005: 211; De Vos *et al.*, 2009: 133).

3.2 Quantitative descriptive research design

Quantitative descriptive research is defined as being a formal, objective, systematic process where numerical information is used to explain an existing phenomenon (Burns and Grove, 2005: 211; De Vos *et al.*, 2009: 134). This study design therefore enabled the researcher to obtain, identify and explore information about components (Burns and Grove, 2005: 26) found in the workplace that have a direct impact on the physical, social, spiritual and economical wellbeing of the nurse practitioner affected and/or infected with HIV/AIDS that could be addressed by means of a workplace wellness programme.

The components that could have an influence on the wellbeing of nurse practitioners could be identified as particular relevant to the evaluation of the existing work environment the subjects encounter. This information provided the basic knowledge regarding components necessary for the development of a workplace wellness programme because the literature research revealed that a wellness programme does not currently exist for subjects in South Africa given the newness of employee

wellness as an area of concern and importance (Burns and Grove, 2005: 26; Fayers, 2006: 19).

Due to the limited information that currently exists on wellness programmes for HIV/AIDS subjects, new knowledge had to be generated (Fayers, 2006: 19). This was done through descriptive reasoning of discovering new meaning of current events that exist in the workplace and the determination of the frequency with which these incidents occurred. No dependent and independent variables were used (De Vos *et al.*, 2009: 134 and 149), because no attempt was made by the researcher to establish causality, which is to determine a situation that may have served as the cause of an effect in the study (Burns and Grove, 2005: 168 and 232), as no manipulation of variables was involved.

The information obtained through the descriptive reasoning and analysis of the study literature and responses from the sample could then be categorized into internal components inherent to the nurse practitioner and external components in the workplace influencing the nurse practitioner. The researcher could thus make decisions that may solve problems that occur in the nursing environment. Although research findings may not always be directly useful in practice, the results can be generalized to various settings where problems in the place of work exist (Burns and Grove, 2005: 44 and 232).

The researcher displayed responsibility by adhering to a strict code of conduct which involved rules of meticulous logic and absolute truth, believing that all human behaviour has a reason of being self-existent and could thus be defined by careful measurement (Burns and Grove, 2005: 23; De Vos *et al.*, 2009: 56). The researcher endeavoured to remain detached and attempted to stay objective and not allow personal values, emotions and perceptions to influence the study.

The focus of the researcher was to identify patterns and trends in the workplace, portray and explain these occurrences and then break the whole picture into parts so that the parts could be examined. A measuring instrument was utilized to identify and describe these components or occurrences and it demanded continuous control of the study (Burns and Grove, 2005: 24).

3.3 Measurement strategy

The measurement strategy is the process of using an instrument to examine a specific situation or concepts by allocating numbers to the concepts or areas of concern in accord with some rule (Burns and Grove, 2005: 41; De Vos *et al.*, 2009: 160). The measurement strategy followed during this study was the development of a structured questionnaire with close-end questions, an open-end question and the application of the Likert scale of measurement. The ampleness of the results obtained depended on the reliability and validity of the measurement process and the questionnaire.

3.3.1 The questionnaire

A questionnaire is a printed self-statement form designed to gather information from a large sample of individuals from a specific population (Sandelowski, Barroso and Voils, 2007: 103; Van Zyl, 2009: online) after responding to printed questions on the form (Burns and Grove, 2005: 398; Lategan and Lues, 2005: 121). The questionnaire (Addendum D, Page 289) was developed after the completion of a thorough literature analyses.

The researcher made use of a structured questionnaire with close-ended questions to yield data with a narrower range of responses. One open-end question was asked to ascertain the opinion of the respondents (De Vos *et al.*, 2009: 170 and 174). A valid and reliable data collection scale, the Likert scale, was applied. The Likert scale attempts to prevent bias and generate numerical data to achieve the necessary control of the study and decrease the possibility of error in the research process (Burns and Grove, 2005: 32 – 34; Sandelowski, *et al.*, 2007: 103). The researcher used the Likert scale to attain a more accurate reflection of the target population.

The subjects of the sample were questioned on how they experienced their work environment and what they identified their needs to be. Thereafter statistical analyses and interpretation (De Vos *et al.*, 2009: 218) were done to reduce and organize the data as to arrive at a meaningful conclusion. This contributed to a truer account of the existing reality (Burns and Grove, 2005: 369) and could the research findings be applied to the population from which the research sample was drawn.

The language policy of the healthcare institution required that a nurse practitioner should at least be able to communicate in the English language and writing. Therefore, to enhance a high and accurate response rate (De Vos *et al.*, 2009: 170), the questions and cover letter were drafted in English as to avoid confusion of the terminology and explanation of concepts and statements.

The questionnaire was presented to each respondent with the initial cover letter (Addendum C, Page 288) explaining the purpose of the study, the name of the researcher, the approximate amount of time required to complete the questionnaire and the most important concepts of meaning. The respondent was reminded of the strict adherence to confidentiality and the respondent was encouraged to respond to the questions in an honest and thorough fashion. The cover letter included instructions on the data collection method as to avoid any confusion of how and where to send the completed questionnaire to (De Vos *et al.*, 2009: 170).

The researcher endeavoured to construct an uncomplicated questionnaire to avoid confusion and omitted questions from the respondents. The questionnaire therefore consisted of four sections, grouping questions related to a specific topic, together. Biographical information was dealt with initially and with progression to more specific items focussing on the nurse practitioner and the workplace in sections 2 (two) and 3 (three) and concluding with questions of a sensitive nature in the fourth section (Halcomb, Davidson, Salamonson, Ollerton and Griffiths: 2008: 9).

Each section explained what the respondent could expect with clear and easy-to-follow instructions as guide (De Vos *et al.*, 2009: 171). The respondent was required to place a check mark, which was illustrated in section A, in the appropriate box of choice. The pages were numbered and the respondents were reminded to complete all the pages.

The questionnaire consisted of clear, concise and concrete close-ended questions for the relatively large sample to prevent any confusion in the subject, elicit research results faster and avoid researcher bias (De Vos *et al.*, 2009: 171 and 175). The answers in the close-end questions were direct and derived from a specific list of alternatives from which to select, with the simplest response of 'yes' or 'no' arranged vertically to reduce errors and yield data with a narrower range of response (Van Zyl, 2009: online; Burns and Grove, 2005: 399; Lategan and Lues, 2005: 124; Halcomb *et al.*, 2008: 9).

An open-end question was included in section B, question 2.1(4), to determine the opinion of the respondents on the importance of a workplace wellness programme (Sandelowski, 2000: 252; De Vos *et al.*, 2009: 174). The response of the respondents to the open-end question allowed the researcher to examine the feasibility of a workplace wellness programme more critically.

Leading and value-laden words were avoided in the questions to prevent the respondents of being influenced in his or her response. Double questions were

omitted as well. Section C included a response option to yield all the possible answers to questions 3.1 to 3.3, 3.7 and 3.9, by using a check (√) mark. The Likert scaling method was used to portray a more precise means of measurement.

3.3.2 The Likert scale

The Likert scaling method was used in sections B and C of the questionnaire to measure the opinions or attitudes from the nurse practitioners infected and/or affected by HIV/AIDS in the workplace. Both sections addressed an element of the concept being measured. Question 2.1(3) of section B and questions 3.4 to 3.6 and 3.8 of section C included four response categories. Each category was assigned a value, with a value of 1 given to the most negative response and a value of 4 to the most positive response (Burns and Grove, 2005: 402).

The response choices addressed agreement and evaluation (Burns and Grove, 2005: 404; De Vos *et al.*, 2009: 184). The response choices addressed agreement options such as not at all interested, not so interested, fairly interested and very interested to encourage declarative statements from the subjects. Response choices of evaluation included options such as not important, slightly important, important and very important. A neutral category was omitted in all the questions to coerce the subject into making a choice. This enabled the researcher to avoid data of little value and difficult interpretation (Burns and Grove, 2005: 404). The values of each item in the questionnaire were summed to obtain a single score for each section.

The advantage of the Likert measuring scale used in this study was the possible repetitive usage of the instrument after a useful set of statements had been set up. It was easy to implement and easy to aggregate the results from a large group of subjects (Burns and Grove, 2005: 402-404; Lategan and Lues, 2005: 124).

3.3.3 Advantage and disadvantage of the questionnaire

An advantage of the questionnaire was the insurance of anonymity (Lavoie-Tremblay, Wright, Desforges, Gélinas, Marchionni and Drevniok, 2008: 295 - 296) because a questionnaire number substituted the name of the respondent of each questionnaire. The respondent completed the questionnaire voluntarily and was not pressurized into completing the questionnaire in public.

Respondents could complete the questionnaire in their own time. A disadvantage was however the risk of the response or return rate tending to be low. The researcher had no control over who completed the questionnaire as well (Gerish, Ashworth, Lacy, Bailey, Cooke, Kendall and McNeilly, 2007: 328 - 338; Paterson, Symons, Britten and Bargh, 2004: 339 - 349). Due to the rotation of subjects doing shift work, the questionnaire could be completed where-ever the respondent preferred and which could therefore increase the risk of the misplacement of questionnaires (De Vos *et al.*, 2009: 168 and 169).

The probable compromised degree of reading and comprehension abilities (De Vos *et al.*, 2009: 169) of the respondents whose mother tongue is not English, posed a

challenge during the drafting of the questionnaire. Although English is the language of preference at the designated hospital, terminology and sentence construction had to be carefully considered by the researcher.

Facts about a large sample and their knowledge and their needs could be determined and analysed and errors greatly reduced (Burns and Grove, 2005: 398 - 399). The respondents were acquainted with the issues (De Vos *et al.*, 2009: 170) which were addressed in the questionnaire. This created the opportunity to draft a questionnaire that could contain the most necessary questions that focus on the objectives of the study and yield the most relevant information.

The challenge then presented itself to prevent any important information to be skipped or disregarded. Careful planning therefore went into the format of the questionnaire. Clear and accurate directions in bold printing accompanied each section. The potential risk of respondents omitting a question or becoming confused in the method of answering a question, however continuously existed (De Vos *et al.*, 2009: 171).

The researcher was available on the premises during the data collection period to assist the respondents where problems could arise (Burns and Grove, 2005: 402). It was a cost effective method to use and was easy to distribute, because the questionnaire was distributed by each unit manager and collected by the researcher from each unit manager on a specific appointed date.

The researcher was challenged to eliminate any deviation in the data results yielded from the questionnaire. Leading and value-laden words were avoided to prevent a respondent from being influenced in his or her response. Double-questions were omitted to prevent any confusion. The researcher had an obligation to prevent own emotions and preconceived notions to influence the method of conceptualizing the questions (Lavoie-Tremblay *et al.*, 2008: 295 and 296; Burns and Grove, 2005: 213). Researcher bias could pose a serious threat to the validity of the results obtained from the respondents and the reliability of the measurement tool to consistently yield the same results (Burns and Grove, 2005: 213 and 400; De Vos *et al.*, 2009: 160 and 190).

3.4 Validity of the study

Validity is defined as the achievement of a measurement instrument to actually reflect the abstract construct or concept being measured (Burns and Grove, 2005: 376). The questionnaire therefore implies that the concepts or items under investigation are measured correctly.

Validity furthermore addresses the appropriateness, meaningfulness and usefulness of the specific conclusions made from the instrument scores. The concepts or constructs should have only one meaning at the same time to the respondents and have to be numerically represented (Sandelowski, 2000: 253; De Vos *et al.*, 2009: 160).

To maintain validity through each step of the research process and to obtain the highest measurement level possible, questions were derived from the literature research and analyses. All the items in the questionnaire addressed an element of the concept being measured (Burns and Grove, 2005: 404) to enhance content validity. The questions were described and to the point as to avoid confusion and uncertainty amongst the target population and therefore promote face validity. The questionnaire focussed on the proposed topic and included relevant close-ended, as well as one open-end question and the Likert scale.

A blueprint of the questionnaire was submitted to a validation committee and a panel of experts in instrument developing, research methodology and HIV/AIDS at the School of Nursing of the University of the Free State. This was done in collaboration with the study supervisor, to determine if the questions were valid, consistent, relevant and precise and representing the concepts to be measured (Burns and Grove, 2005: 376 - 380; Van Zyl, 2009: online). Thereafter final approval to the ethicality of the measurement instrument was granted from the Ethics Committee of the Faculty of Health Sciences at the University of the Free State (Addendums E and F).

3.5 Reliability of the study

Reliability is defined as the achievement of a measure to be consistent every time a particular measurement instrument is used (Burns and Grove, 2005: 374). Measuring instruments should generate equal numerical results when applied in

similar circumstances and provide values with the least possible amount of random error. This will enhance the power of the study, because significant relationships occurring in a population will be noticeable detectable (Van Zyl, 2009: online; De Vos *et al.*, 2009: 163). The questionnaire was therefore pilot tested before applying the final instrument to determine to what extend each concept is consistently measured (Lategan and Lues, 2005: 124; De Vos *et al.*, 2009: 161 and 163).

No questionnaire is completely valid, but it should demonstrate the truth, strength and value of a measurement instrument. As the studies varies, so should a reliable and valid measurement instrument be re-evaluated with each study being done (Lavoie-Tremblay *et al.*, 2008: 296; Van Zyl, 2009: online).

3.6 Population

A population consists of all those individuals who share similarity in a specific setting and comply with the sampling criteria of a research study (Burns and Grove, 2005: 40; Lategan and Lues, 2005: 117; Van Zyl, 2009: online).

Nurse practitioners who are currently practising nursing and are registered with the South African Nursing Council participated in this study. It was, however, impossible to access the entire nursing population. The target population was thus the 250 registered and enrolled nurse practitioners, including enrolled nurse auxiliary practitioners, (n= 250). They were currently practicing nursing at a private healthcare institution in Bloemfontein, the capital city of the Free State which is a province of

South Africa, to which the researcher had reasonable access (Burns and Grove, 2005: 341 and 447; De Vos *et al.*, 2009: 193).

3.7 Sampling

Sampling is the process of selecting a group of people or subset, the sample, with which the study has to be conducted, mathematically denoting a ratio of the total target population (Burns and Grove, 2005: 40 and 341; Lategan and Lues, 2005: 117; Van Zyl, 2009: online). The findings obtained from a sample of the accessible population are then abstractly made to the entire population or known individuals. These conclusions enable the researcher to estimate some unknown characteristics of the population (Van Zyl, 2009: online; De Vos *et al.*, 2009: 194) from which the sample is drawn.

Due to the character of their nursing function, every registered and enrolled nurse practitioner are directly and/or indirectly involved with HIV/AIDS in the workplace. The researcher thus decided that probable sampling based on randomisation (De Vos *et al.*, 2009: 196) would be done at the designated institution.

Probability sampling is directed towards selecting a large group of subjects that statistically represent the target population (Burns and Grove, 2005: 346; Sandelowski *et al.*, 2007: 103) therefore ultimately the whole nursing population, as every registered and enrolled nurse at the designated institution would be invited to take part in the study. The researcher bore the risk of subject mortality (De Vos *et*

al., 2009: 195) in mind due to the subjects doing shift work. Each unit manager was therefore involved in the collection of the questionnaires as each unit manager controlled the movement of the subjects.

The inclusion of all the nurse practitioners in the study should reduce sampling error (Lategan and Lues, 2005: 118; De Vos *et al.,* 2009: 195) because the findings should provide a more precise picture of the population, making the data findings and conclusions more representative (Lavoie-Tremblay *et al.,* 2008: 295 - 296). Reducing the sample error would therefore increase the power of the study and enhance validity to the data analyses and data conclusions (Sandelowski, 2000: 248).

Two hundred and thirty two (n=232) registered and enrolled nurse practitioners were asked to anonymously and voluntarily complete a questionnaire in their own time. They were assured that their responses would remain anonymous and that their input would be treated confidentially. The respondents were also assured that the research would be conducted with the necessary integrity and honesty.

3.8   Pilot study

A pilot study is defined as a smaller version of the proposed study to be conducted (Burns and Grove, 2005: 42; De Vos *et al.,* 2009: 205) in order to test and streamline the research process, identify problems with the data collection instrument and

assess the reliability and validity of the research instrument to be used (Torp, Hanson, Hauge, Ulstein and Magnusson, 2008: 75 - 85).

Piloting a study implies that the researcher undertakes a trial run of the main study by exposing the measurement instrument to a few subjects representative of the target population (Burns and Grove, 2005: 400; De Vos *et al.*, 2009: 209). Their feedback is of invaluable worth, because the questionnaire could be edited and modified before finalizing the instrument to be used in the main study.

After obtaining permission (Burns and Grove, 2005: 83 and 193; Addendum B) from the Ethics Committee of the Faculty of Health Sciences of the University of the Free State, the pilot study was done at a nursing unit in the sister-hospital of the designated hospital, 5 kilometres from each other. Subjects used in this pilot study, as well as the data yielded, were not included in the main study.

Four permanent employed subjects similar to the target population, were invited to voluntary participate in the pilot study. They represented the different nursing categories of the target population and complied with the sampling criteria of the research study.

The researcher explained the objective of the pilot study to them. Each subject received an information letter clipped to the questionnaire and a sealable envelope

from the researcher (Burns and Grove, 2005: 400). They were required to complete the questionnaire, indicating the amount of time it took to be completed. Their responses to the questionnaire, questions, as well as queries were documented. Any verbal input that was brought to the fore was appreciated and noted. The respondents were required to return their completed questionnaires in the envelope to the researcher on the same day.

Each respondent spent approximately 15 (fifteen) minutes reading the information letter and completing the questionnaire. The researcher was therefore able to determine if the duration for the completion of the questionnaire was within a preferable period acceptable to the respondents (Lategan and Lues, 2005: 125; De Vos *et al.*, 2009: 214).

The structure and validity of the questionnaire could be determined by means of the way the respondents reacted to the questions. Their perception of the questions and if the expected response was attained could indicate if the questions were concise and clear (De Vos *et al.*, 2009: 209). Every respondent participating in the pilot study remarked that the questions were clear, concise and easy to answer. The data obtained from these questionnaires was not included in the main study (Lategan and Lues, 2005: 125).

However, one respondent omitted all three questions on one particular page. The pages of the questionnaire were thereafter numbered to prevent a similar

occurrence. The prospective participants were reminded in bold letters in the introductory section to complete all the pages of the questionnaire.

Constructive feedback was derived from the completed questionnaires. The researcher, in collaboration with the study supervisor, scrutinized and evaluated the questionnaires for any content deviations. Corrections and adjustments to the questionnaire and research plan could be made, where necessary, before the main data collection would commence (Halcomb *et al.*, 2008: 9; Burns and Grove, 2005: 435).

3.9 Data collection

Data collection in quantitative research involves the use of numerical information to explain and describe the research objectives through the use of different methods, such as interviews, observation, scales and as in this study, questionnaires (Burns and Grove, 2005: 42; Sandelowski, 2000: 250 - 252).

After obtaining approval from the Ethics Committee of the Faculty of Health Sciences of the University of the Free State (Addendums E and F) and written permission to conduct the study at the designated institution and sister-hospital (Halcomb *et al.*, 2008: 9; Addendums A and B), the researcher explained the objectives of the study to each nursing unit manager.

A questionnaire bundle was handed to each nursing unit manager. The questionnaire bundle consisted of pre-packed sealable envelopes containing a cover letter and an anonymous number-coded questionnaire with clear instructions on how to complete the questionnaire (Lavoie-Tremblay et al., 2008: 292). The nursing unit manager was instructed to distribute such a pre-packed envelope to each permanent employed enrolled and registered nurse practitioner in her unit on the specific data collection day.

The cover letter to the questionnaire informed the subjects of the purpose of the study and what would be expected from them (Lategan and Lues, 2005: 123). Voluntary participation and completion of the questionnaire would indicate that consent from the subject participating in the study, had been obtained, because no subject would be coerced into completing the questionnaire. Assurance was given to the subjects that their responses would remain anonymous and that the information they provided would be treated as confidential at all times. The questionnaire was drafted in English to enhance a high response rate and avoid confusion of terminology and explanations of concepts and statements.

The respondents were informed that the data conclusions would be made known by means of a research report (Van Zyl, 2009: online). They could also terminate their participation at any time, despite giving voluntary consent to complete the questionnaire. They were instructed to hand the completed questionnaire back to their unit manager after replacing it in the sealable envelope. The questionnaires

were collected by the researcher after the termination of two work shifts, namely 10 (ten) days (De Vos *et al.*, 2009: 168).

The respondents were encouraged to voluntary participate in the research study and were requested to answer the questionnaire as comprehensively as possible and return it in the sealable envelope (Lavoie-Tremblay *et al.*, 2008: 292) to the nursing unit manager. The researcher collected the completed and sealed questionnaire bundles from each unit manager after 10 (ten) days as to allow the permanent employed subjects from the different shifts to participate.

The researcher was available to assist the respondents where problems could arise during the collection of the study data by means of dialling a cell phone number that was supplied in the cover letter (Lategan and Lues, 2005: 125). The researcher however dissociated herself from the respondents taking part in the study. She posed to maintain an objective and flexible attitude and resolve problems as soon as they should arise. This raised the expectation of a high and valid response rate and reduce potential researcher bias (Burns and Grove, 2005: 213 and 435; Lategan and Lues, 2005: 123). A sixty-one percent (61%; n= 141) response rate was elicited from a sample (n=232) of the target population (n=250).

3.10 Data analysis

Quantitative descriptive research analysis explains the conversion of original data into comprehensible information (Sandelowski *et al.*, 2007: 103). It begins by

describing and analysing the responses from a large number of respondents in questionnaires. The ultimate aim of descriptive research is to describe the characteristics of a population or phenomenon and obtain answers to the research problem in question.

Descriptive research analysis endeavours to determine answers to whom, what, where and how questions (Van Zyl, 2009: online; De Vos *et al.*, 2009: 218) where-after conclusions could be drawn and explained. The biostatician therefore calculated the descriptive statistics namely the means and standard deviations or medians and percentiles, for continuous data. Frequencies and percentages were calculated for categorical data (Aston, Shi, Bullôt, Galway and Crisp, 2006: 60; Hallcomb *et al.*, 2008: 10).

This allowed the researcher to interpret the data that was yielded from the sample that was drawn from the target population. The researcher was therefore able to find meaning in the conclusions that was arrived at. Components that were identified after all the data had been analysed by the biostatician could be categorized to be included in the preliminary content compilation of a workplace wellness programme.

The content of the open-ended question in 2.1(4) was analysed. The objective was to describe the message that was communicated in the open-ended question. The researcher could hence study the message in itself and identify terms and clarify their meaning (Burns and Grove, 2005: 554; Sandelowski *et al.*, 2007: 100; De Vos

et al., 2009: 174). The respondents were asked to explain or motivate why they thought that it is important to have a workplace wellness programme. The response was coded, recorded and analyzed to identify the specific information, content and the characteristics of the explanations.

Data analysis was done by a biostatician at the Department of Biostatistics of the Faculty of Health Sciences of the University of the Free State.

3.11 Ethical considerations

Ethical considerations had to be taken into account that could result in obstacles in obtaining access to data that could limit and influence the validity, reliability and generalization of the research study. Ethical adherence also refers to the researcher's quest to protect the rights of everyone involved with the study (Burns and Grove, 2005: 83; De Vos *et al.*, 2009: 84 and 118). Therefore ethical issues pertaining to the sample's participation had to be addressed by the researcher in a proper manner.

3.11.1 Consent

Consent to conduct the study and apply the questionnaire was obtained from the Ethics Committee of the Faculty of Health Sciences of the University of the Free State (Addendum E and F) and the ethical guidelines contained in the code of ethics were adhered to. Written permission to conduct the study at the designated

institution (Addendum A) and sister-hospital (Addendum B) were obtained from the

hospital manager and chief nursing manager (Burns and Grove, 2005: 83 and 193).

3.11.2 Adherence to excellence and quality

In the cover letter (Addendum C) the identity, qualifications and experience of the

researcher was made known to the participants, as well as the aim and objectives of

the research to be conducted. The researcher attempted to adhere to the highest

possible standards and seek the guidance of an experienced researcher and study

supervisor during the research process. The research was conducted sincerely with

the necessary integrity, honesty and confidentiality (Burns and Grove, 2005: 181;

Van Zyl, 2009: online; De Vos *et al.*, 2009: 62 and 170).

3.11.3 Confidentiality

The information that the respondents revealed, would not be made public or

available to other people. The information collected during the research process

would however be made known by means of a research report and the publication of

statistical information and applicable articles (Addendum C).

The researcher (De Vos et al., 2009: 62) would not reveal the identity of the

respondents. The subjects could hence regard the utmost trustworthiness of the

researcher being a professional nurse registered at the South African Nursing

Council, as well as the researcher being sensitive to the needs of HIV and AIDS

infected and/or affected persons (Burns and Grove, 2005: 188; Van Zyl, 2009: online).

3.11.4 Voluntary participation

Respondents were not coerced to participate in the study and the subject had the right to terminate participation at any stage of the study, despite giving consent to take part in the study. This was communicated in the cover letter to each subject (Burns and Grove, 2005: 194; De Vos *et al.*, 2009: 59 and 63).

3.11.5 Remuneration

Financial rewards were not offered to the participants, because they had no expenses during participation in the study. A word of appreciation was conveyed in the introductory letter to each subject. A research report conveying the results obtained from the study would be made available to the participants on their request (Burns and Grove, 2005: 194; Lategan and Lues, 2005: 125).

3.11.6 Informed consent

Informed consent infers that the aim and objectives, data collection methods and duration of the study were explained to the participants. They were informed that the participation would be voluntarily, held in utmost confidentiality and that no remuneration would be offered. The assurance was given that the subjects would remain anonymous, as well as their responses and data during the data collection

stage. The nature of the dissemination of the collection data was explained to the participants, as well as the value of their input. Assurance was given that no deliberate physical, psychological or spiritual harm was intended during this research study (Burns and Grove, 2005: 193; Van Zyl, 2009: online; De Vos *et al.*, 2009: 59). The voluntary participation of the subjects therefore implied that the researcher obtained that informed consent.

3.12   Limitations of the study

Limitations are barriers or obstacles found in a study that may hinder data findings being generalized to a population. Methodological limitations refer to deficiencies in a study design that may breach the validity of the findings and the generalization of the data results (Burns and Grove, 2005: 40; Sandelowski *et al.*, 2007: 102).

Combating threats to the validity of the study findings posed a continuous challenge to the researcher. The mortality threat due to subjects withdrawing from the study before the data collection could be completed or the omission of subjects during the changeover of shifts could have reduced the power of the study and restrict the representation to the entire population. A reduction in the power of the study was however prevented due to the response rate of 61% (Burns and Grove, 2005: 216, 345 and 401).

This study determined components necessary for the development of a workplace wellness programme for nurse practitioners confronted with HIV/AIDS in a private

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healthcare institution. The generalization of the study findings was therefore restricted to the private healthcare nursing population (Burns and Grove, 2005: 343). However, similar research could assist in establishing if mutual results are to be found in the public healthcare sector.

3.13 Summary

The methodology discussed the quantitative descriptive research design followed to yield accurate and valid study results with the purpose of identifying and exploring information about components in the workplace that could be addressed by means of a workplace wellness programme for nurse practitioners infected with and/or affected by HIV/AIDS with HIV/AIDS.

The objective of the methodology followed was to avoid error in the research design, enhance the power of the study and arrive at acceptable answers and solutions to problems encountered by the nursing population.

A research process was followed in this study, which encompassed a methodology process entailing a discussion on the selected research design. The measurement instrument, population and sampling, validity and reliability, data collection and data analysis and ethical considerations taken into account, were explained. Limitations of the study were addressed as well.

CHAPTER 4

Data analysis, interpretation and application

4.1 Introduction

A workplace wellness programme depicts components that describe the existence of positive health and wellbeing in an individual as well as the economical and daily work environment (Corbin and Pangrazi, 2001: 1 - 3). Components necessary for the development of a workplace wellness programme therefore needs to be identified and described to efficiently develop and co-ordinate employees' wellness amongst nurse practitioners infected and/or affected by HIV/AIDS in the workplace.

The researcher conducted an in-depth literature study and henceforth poses to explain the relevance and inference between the literature study and the results of the following accumulated data:

- the biographical data,
- the needs and perceptions of the subjects about the workplace and a wellness programme,
- which interventions are considered important in a workplace wellness programme, and
- to what extend is the subject affected and/or infected with HIV/AIDS.

In this study, quantitative descriptive research analysis was utilized to explore, interpret and organize the crude data. The data was collected by means of a

structured questionnaire from a sample (n= 232) of the target population (n = 250), into comprehensible and useful information (Burns and Grove, 2005: 452; De Vos, Strydom, Fouché and Delport, 2009: 220) with the aim to determine which components should be included in a workplace wellness programme. A response rate of 61% (n=141) was elicited from the sample which enhanced the power of the study (Burns and Grove, 2005: 401).

The crude data was entered into a computer and numerically coded and organized by a biostatician (De Vos *et al.*, 2009: 221) at the Department Biostatistics in the Faculty of Health Sciences of the University of the Free State.

The categorical data such as sex, gender, race, marital status as well as the nursing classification and continuous data, namely where variables are measured on a ratio or interval scale such as the Likert scale, were calculated after identifying the means, standard deviations or medians, percentiles, frequencies and percentages (Aston, Shi, Bullôt, Galway and Crisp, 2006: 60; Halcomb, Davidson, Salamonson, Ollerton and Griffiths, 2008: 10; De Vos *et al.*, 2009: 219).

The content of the open-ended question in 2.1(4) was analysed. The objective was to describe the message that was communicated in the open-ended question. The researcher could hence study the message in itself, identify terms, and clarify their meaning (Burns and Grove, 2005: 554; Sandelowski, Barroso and Voils, 2007: 100; De Vos *et al.*, 2009: 174). The respondents were asked to explain or motivate why

they thought that it is important to have a workplace wellness programme. The response was coded, entered into a computer by the biostatician, there after analyzed, and organized to identify the specific information, content and the characteristics of the explanations.

The researcher there-after presented a summary of the data analysis to explain the relevance and inference (Van Zyl, 2009: online) of each specific variable or concept under investigation. Relevant characteristics of the sample such as age, race, gender and nursing category, marital status and financial responsibilities were compared in the summary. The different needs, perceptions and attitudes could be established and demonstrated as well. The results explained in the summary could provide evidence of similarity for representation from the sample to the target population, thus the nursing population (Burns and Grove, 2005: 454; De Vos *et al.*, 2009: 138).

The summary was visually represented in a tabular or graphic display by means of a doughnut graph, histograms and bar charts. The type of display depended on the type of variable the researcher was summarising, namely a bar chart was used for categorical data and histograms for continuous data.

4.2 Health, wellness and health promotion of the HIV/AIDS infected and/or affected nurse practitioner

4.2.1 Biographical data

4.2.1.1 Nursing category

The respondents comprised of ninety five (95) Registered Nurses, twenty nine (29) Enrolled Nursing Auxiliary Nurses and seventeen (17) Enrolled Nurses, a sample (n=141) of the target population (Figure 4.1).
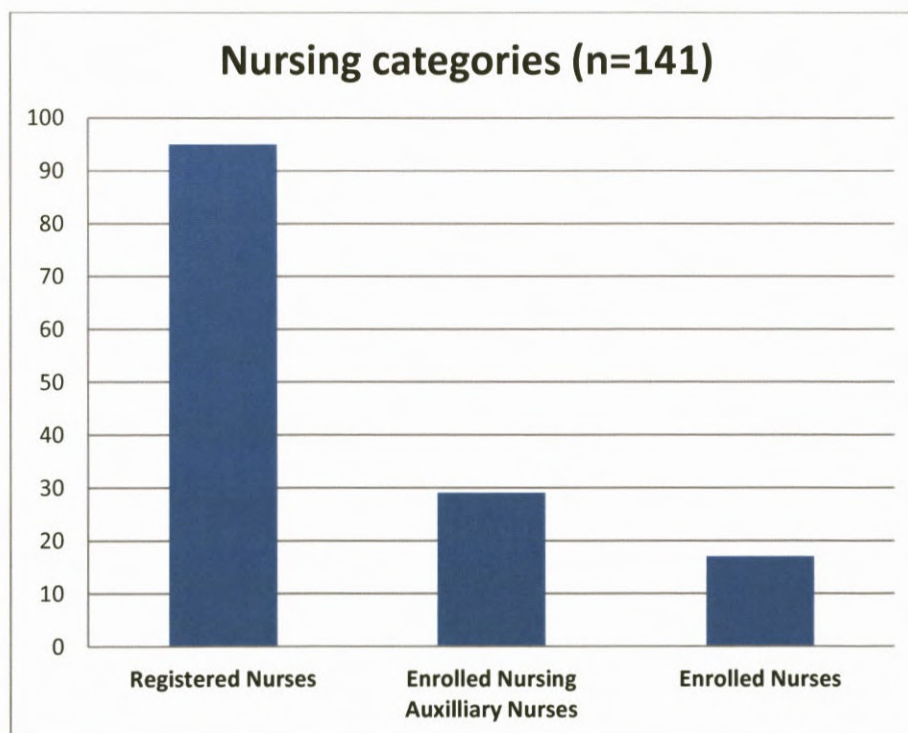
Figure 4.1 Nursing categories

4.2.1.2 Gender

Six males, representing four percent of the sample and one hundred and thirty five
females, a majority representation of 96 percent of the sample, completed the
questionnaire (Figure 4.2).
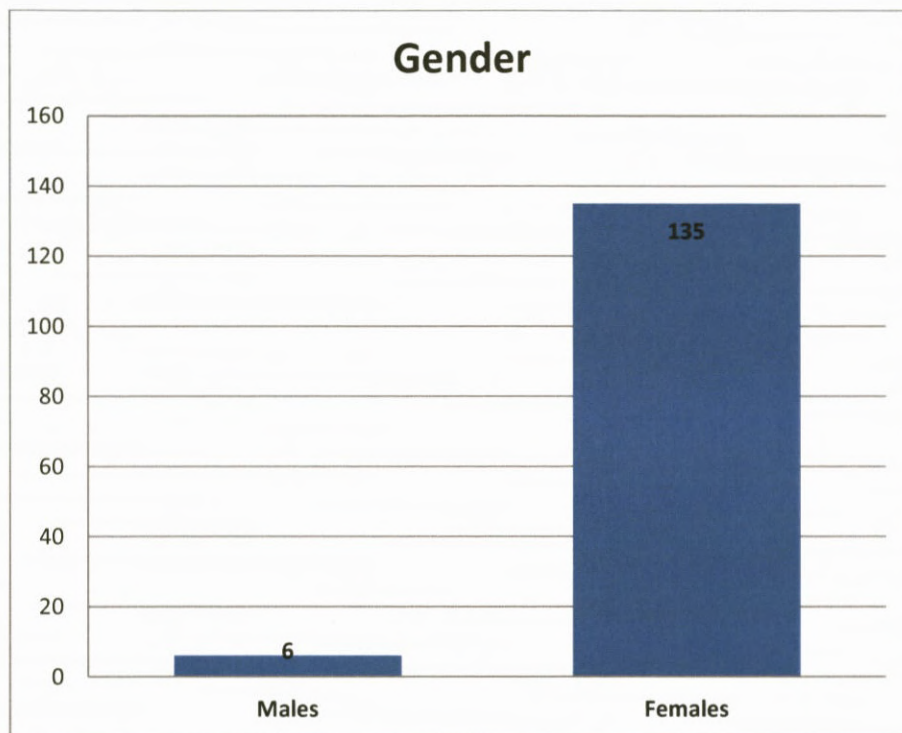
Figure 4.2   Gender

4.2.1.3 Age

Seventy-seven percent (n=108) of the respondents were between 19 and 49 years of age (mean= 41.9yrs), representing the childbearing labour force of the target population (Figure 4.3).
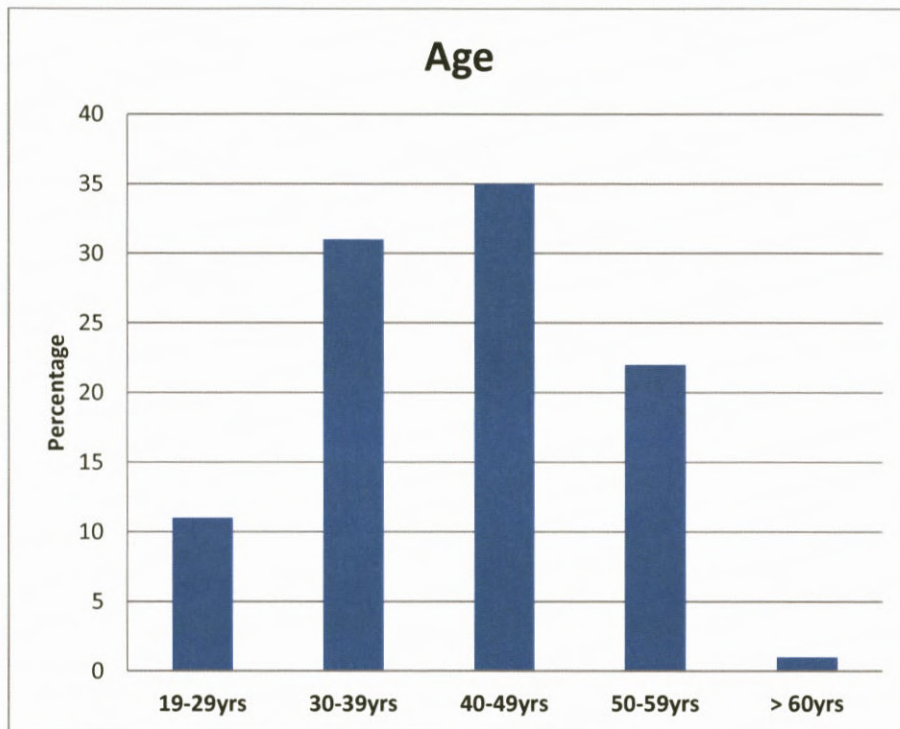
Figure 4.3 Age groups

4.2.1.4 Race

White nurse practitioners (n= 95) represented sixty seven percent of the racial grouping, which was the highest. Black and coloured respondents (n= 46) constituted the remaining thirty three percent of the racial grouping of the sample (Figure 4.4).
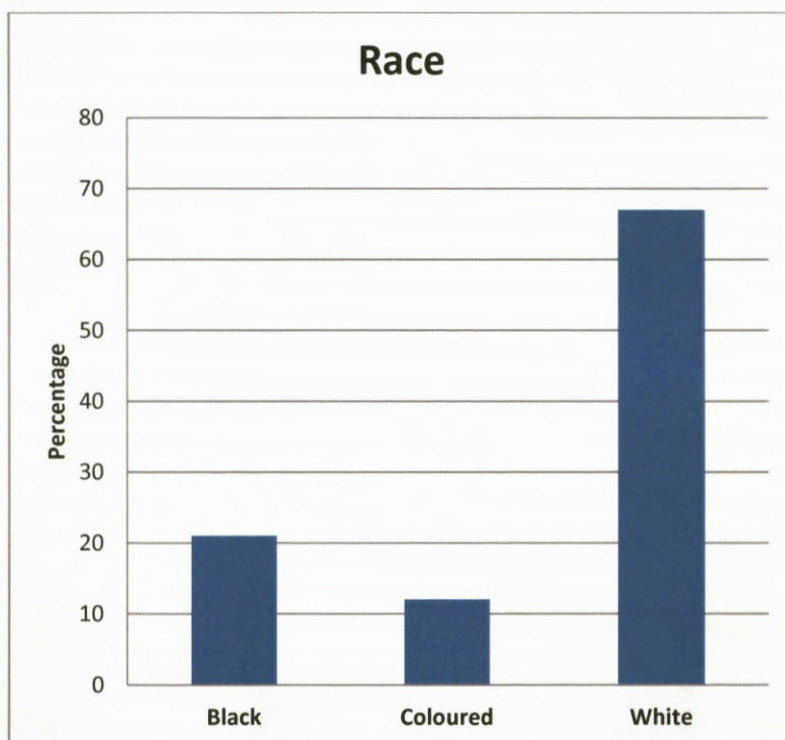
Figure 4.4   Racial grouping

4.2.1.5 Marital status

Sixty-one percent (n= 86) of the respondents were married, while thirty-eight percent (n= 53) indicated that they were single. Only two respondents indicated that they were living together (Figure 4.5).
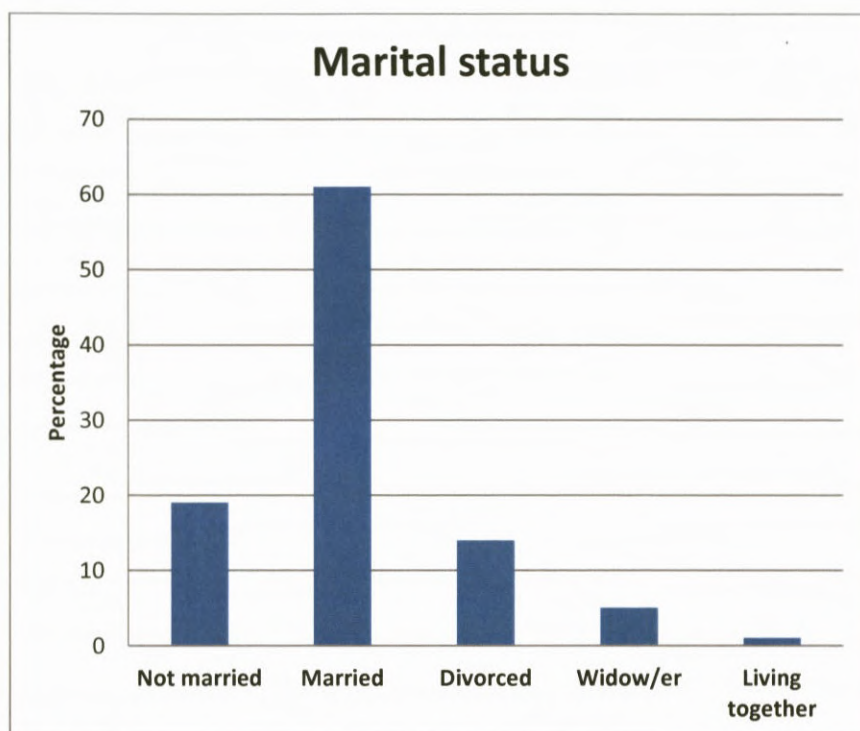
Marital status

Figure 4.5   Marital status

The majority of nurse practitioners in this study comprised of economically and sexually active females within the 19 to 59 years age group. The 2008 highest overall HIV-prevalence rate of 19.6% in South Africa is determined for women 15 – 49 years of age which affects the mainly sexually and economically active adults in South Africa (Statistics South Africa, 2008: Statistical release P0302). The nurse

practitioners in this study confirmed their relationship with this statistical information, because they represented a target population of the approximately 92.5% female nurses that were registered or enrolled with the South African Nursing Council (SANC) on 31 December 2008 (SANC, 2008: online).

The six males, representing four percent of the sample, coincides with the nurse gender distribution results of 7.5% active male nurses registered on 31 December 2008 at SANC in the age group 15 – 49 years (Illustrated in Figure 2.2, Page 50).

4.2.1.6 People per household

Fourteen percent (n=19) of the respondents declared that they do not share their households with another person. Where-as eighty-six percent (n=122) indicated that they share their households with someone (Figure 4.6).

People per Household
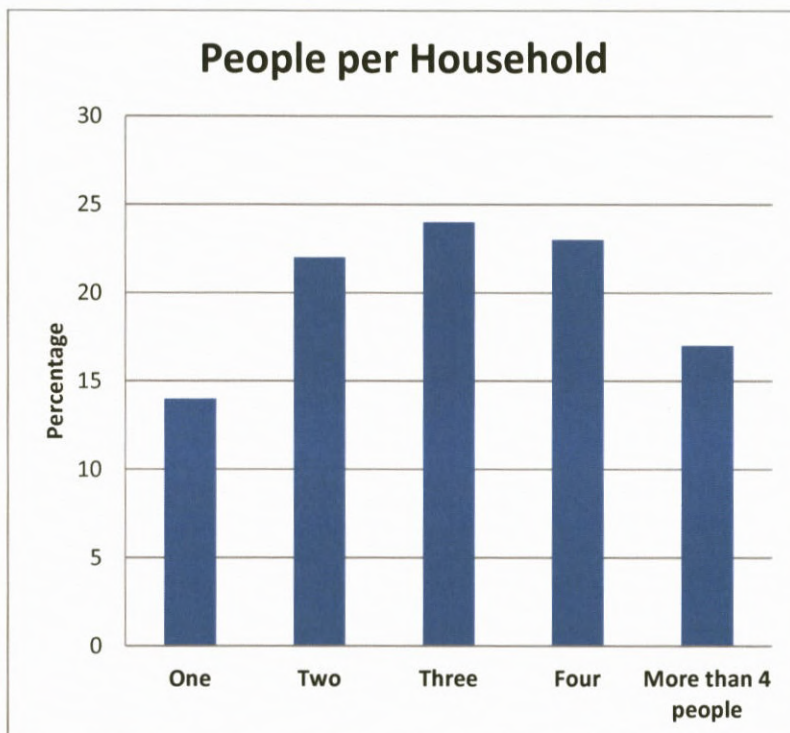
Figure 4.6   People per household

4.2.1.7 Children

Seventy-four percent (n=105) of the respondents indicated that they had between one and more than four children. Thirty-six respondents (26 percent) had no children (Figure 4.7).
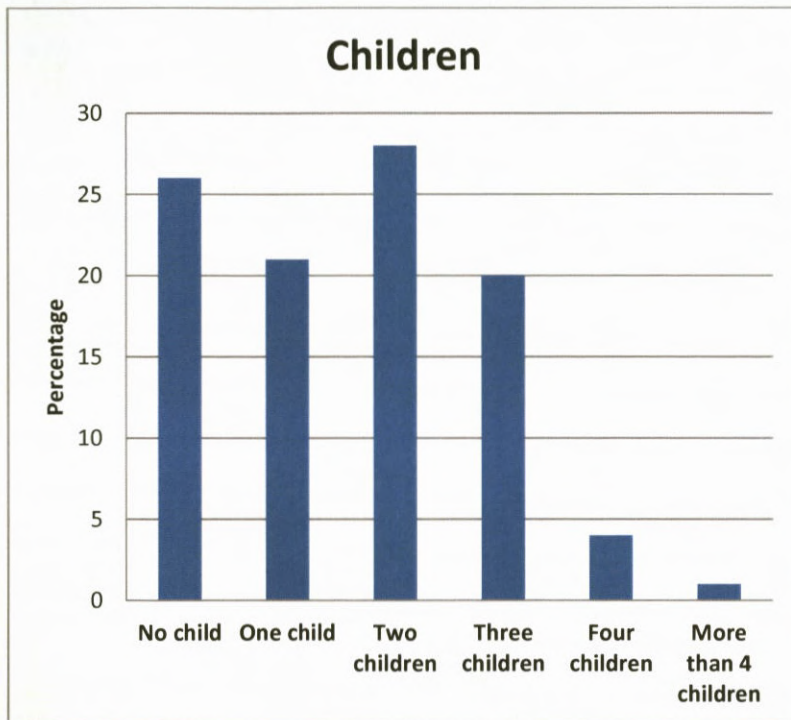
Children

Figure 4.7 Children per respondent

4.2.1.8 Financial support to other

Ninety respondents (64 percent) indicated that they do not financially support anyone else besides their children and spouse or partner. Thirty-six percent (n= 51) however do financially support others besides their children and spouse or partner (Figure 4.8).

Financial support to other
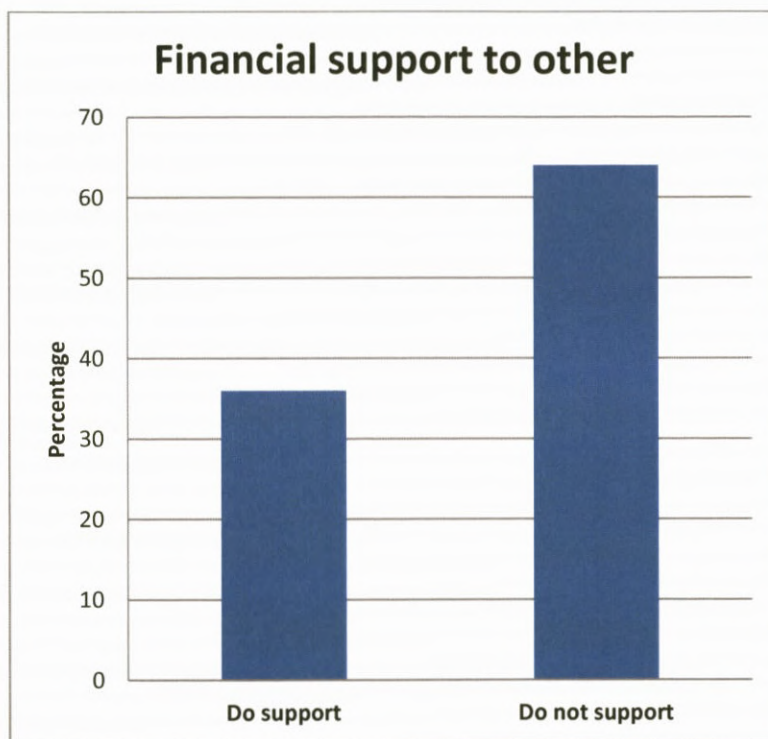
Figure 4.8 Financial support to other

4.2.1.9 Health insurance/Medical aid insurance

Ninety-three percent (n=131) of the respondents declared that they have access to medical aid or health insurance (Figure 4.9).

Health insurance/Medical Aid
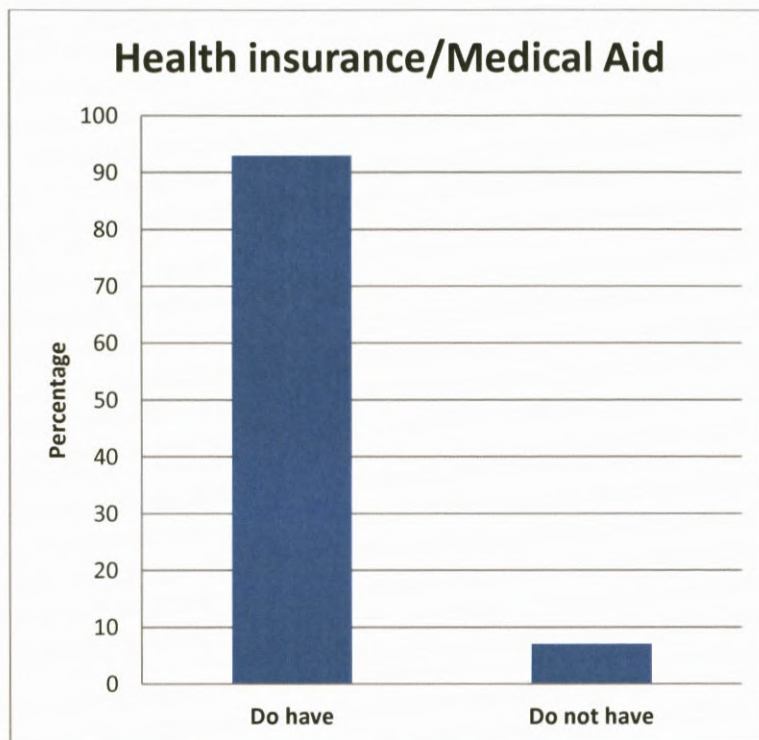
Figure 4.9   Access to health insurance/medical aid

The majority of respondents in this study indicated that they were married and had a financial obligation towards their family. They furthermore expressed their need to stay healthy and well and they had access to medical health insurance. These results coincide with the findings yielded from the literature study that claimed that the health and wellness of a nurse practitioner affected by and/or infected with HIV/AIDS depend on the following:

1) an adequate monthly financial income, food and shelter to provide in the essential household needs, sustainable medico-physical nurturing, such as medical treatment should it be requested, enough rest and fresh air, as well as recreational activities (Nutbeam, 1998: 351; Van Dyk, 2008: 94) and

2) compliance to the daily employment and family demands whilst staying sound of mind, emotions and spirit (Van Dyk, 2008: 148).

Nurse practitioners are daily confronted with external and internal factors within themselves and the workplace that explain the health, psychosocial and employee welfare, as well as the economical issues that influence them. This assumption is very relevant after the statistical results of South Africa on HIV/AIDS were being compared to the study data yielded by the researcher and should be considered when developing a framework for a workplace wellness programme.

4.2.2   The HIV/AIDS affected and/or infected nurse practitioner and the need for a workplace wellness programme

4.2.2.1   Response of nurse practitioners on HIV/AIDS in the workplace

Due to the sensitivity of disclosure, the respondents were encouraged to answer all the questions posed to them in this section of the questionnaire, as honest and complete to their ability.
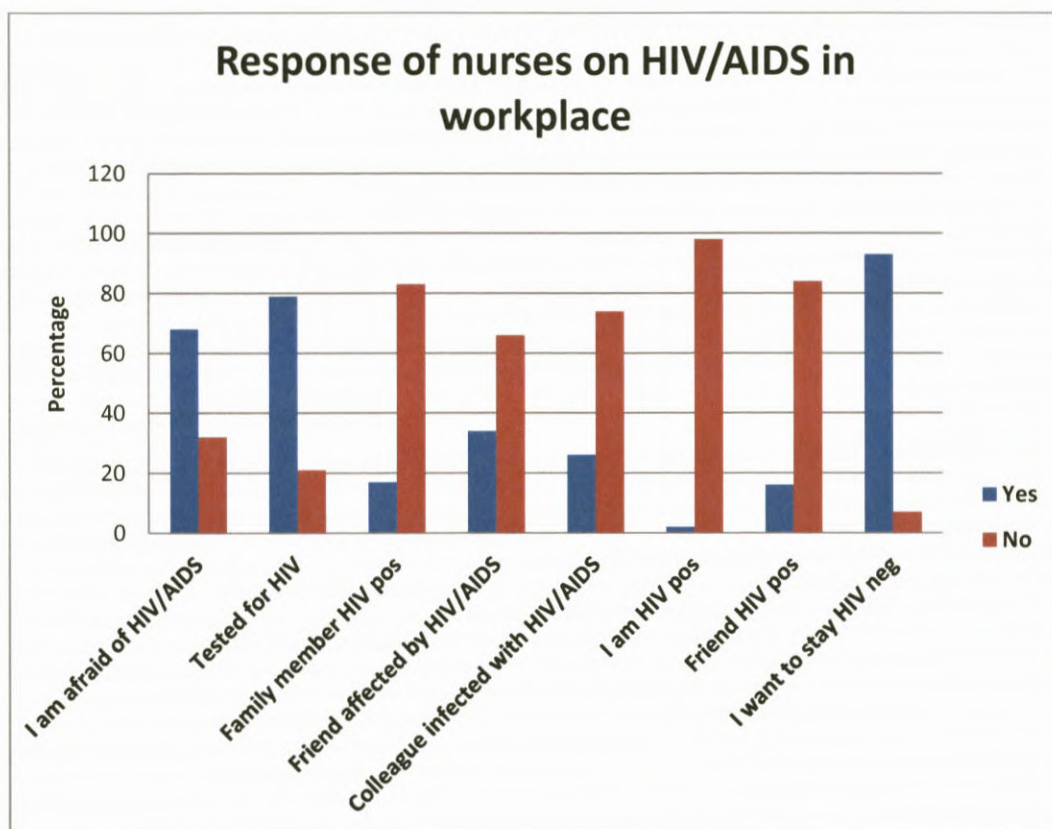
Figure 4.10   Response of nurse practitioners on HIV/AIDS in the workplace

Sixty-eight percent (n= 92) of the respondents indicated that they were afraid of HIV/AIDS (Figure 4.10). Five abstained from answering.

Seventy-nine percent (n=108) indicated that they have been tested for HIV before. Four respondents abstained from answering.

Eighty-three percent (n=114) of the respondents declared that they do not have a family member or friend diagnosed with HIV/AIDS. Four respondents abstained from answering.

Sixty-six percent (n= 91) did not know of a friend who is affected by HIV/AIDS (four abstainers). Seventy-four percent (n=100) of the respondents did not know of a colleague who is infected with HIV/AIDS.

Ninety-nine percent of the respondents (n=135) declared that they were HIV negative (four abstainers) and ninety three percent of the respondents (n=126) indicated that they wanted to stay HIV negative.

The majority of respondents in this study declared that although they had been tested for HIV and were diagnosed HIV negative, they were afraid of being infected with the disease. They were also of opinion that HIV/AIDS poses a serious threat to nurse practitioners in the workplace.

The data findings of this study confirmed that although the majority of the respondents indicated that they had no knowledge of an immediate associate

infected with or affected by HIV/AIDS, they themselves wanted to maintain an HIV negative status.

The respondents in this study indicated that it was impelling that they acquire information and knowledge on HIV/AIDS and work related issues if the serious threat, which HIV/AIDS pose to the nurse practitioner, are considered. They furthermore indicated in this study that although they experienced good health and wellbeing, they intend staying healthy and HIV negative. They also considered workplace health promotional activities important and were convinced that active participation in the decision-making processes could play a decisive role in their overall wellbeing.

4.2.2.2 HIV/AIDS presents as a serious threat in the workplace

Eighty-six percent (n=120) of the respondents were of opinion that HIV/AIDS poses a serious threat to nurse practitioners in the workplace. Two respondents abstained from any opinion whilst nineteen respondents (14 percent) were of opinion that HIV/AIDS pose no threat (Figure 4.11).
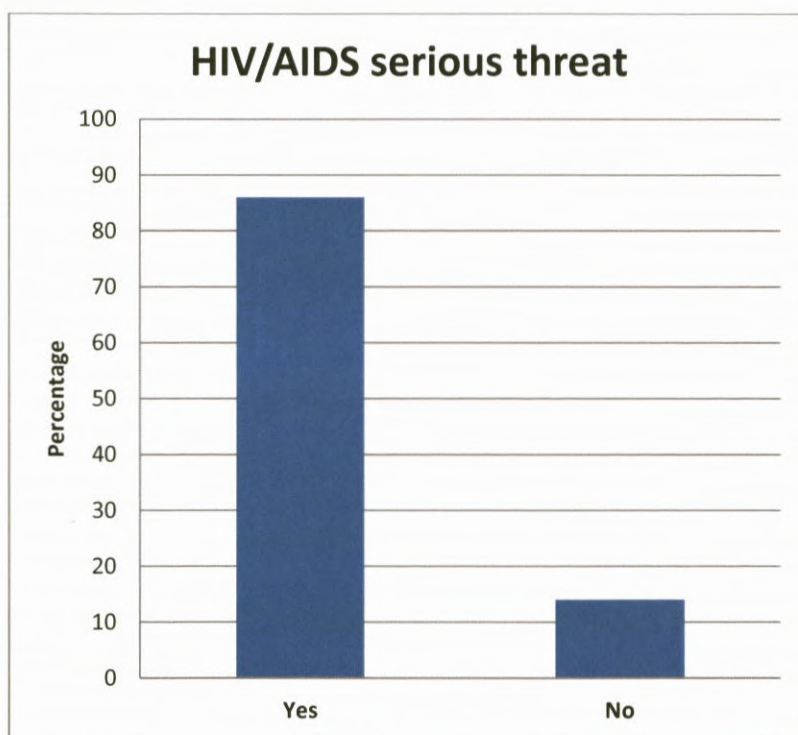
Figure 4.11 HIV/AIDS threat in workplace

Fear for exposure to HIV (Champ, 2006: 50) and misconceptions about HIV (Page, Louw and Pakkiri, 2006: 113) affects the daily work life of a nurse practitioner. Thereby are nurse practitioners highly fearful of occupational acquired infection

(Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, Van Der Kwaak and Van Der Wilt, 2007: 143).

4.2.2.3 Current knowledge of a wellness programme operating in the workplace

Sixty-one percent (n= 85) respondents had no current knowledge of a workplace wellness programme operating in their workplace, whereas thirty-nine percent (n= 54) indicated that they were aware of an operating workplace wellness programme (wwp)(Figure 4.12).
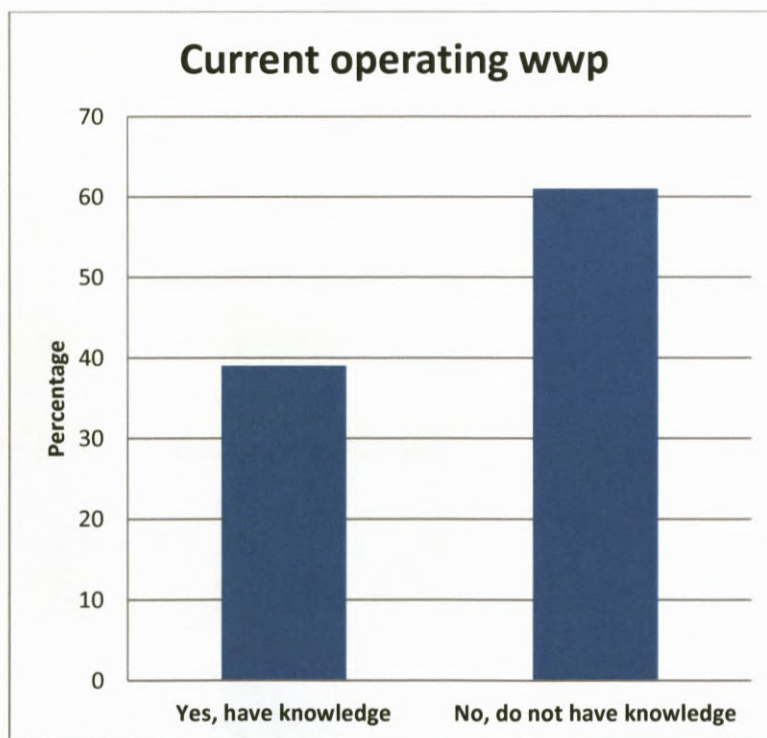
Figure 4.12   Knowledge of current operating workplace wellness programme

4.2.2.4 Importance of a workplace wellness programme for HIV/AIDS infected and/or affected nurse practitioners

Seventy two percent (n=100) of the respondents, which were the biggest grouping, indicated that it was very important to have a wellness programme in the workplace for nurse practitioners infected with and/or affected by HIV/AIDS (Figure 4.13).
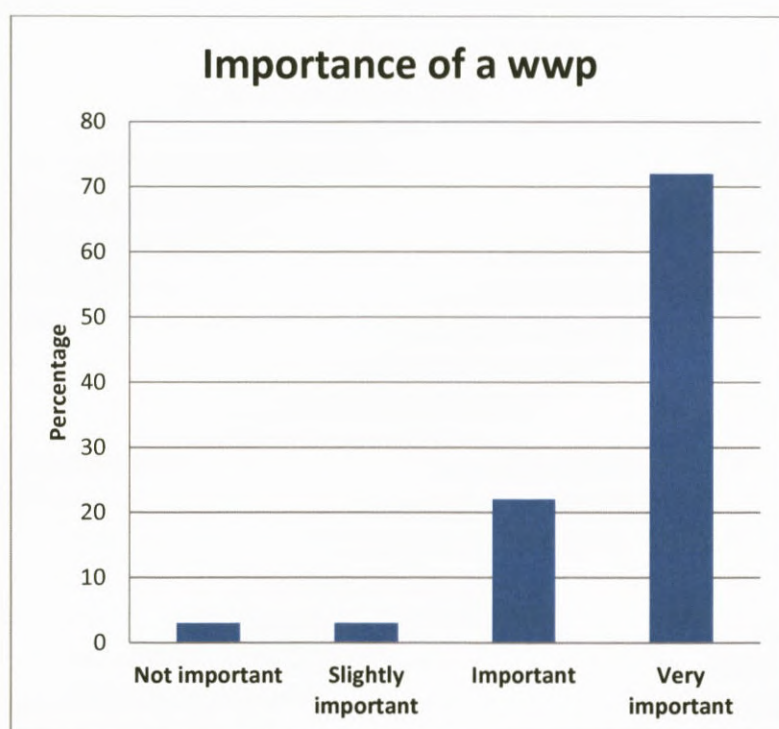
Figure 4.13   Importance of a workplace wellness programme

Caetano and Pagliuca (2006: 344) stated that HIV/AIDS has compelled the nurse practitioner to address her universal, developmental and health-deviation self-care requisites which are aimed at developing her potential to identify and solve health and wellness issues.

Nutbeam (1998: 351, 354 - 355) continued to explain that providing education and information were important venues to empower nurse practitioners. Workplace policies affecting health, skills development initiatives, economical assistance and health development in the workplace such as VCCT services, promote a continuous progressive improvement of the health status of nurses.

4.2.2.5   Explanatory information of the importance of a workplace wellness programme (Figure 4.14)
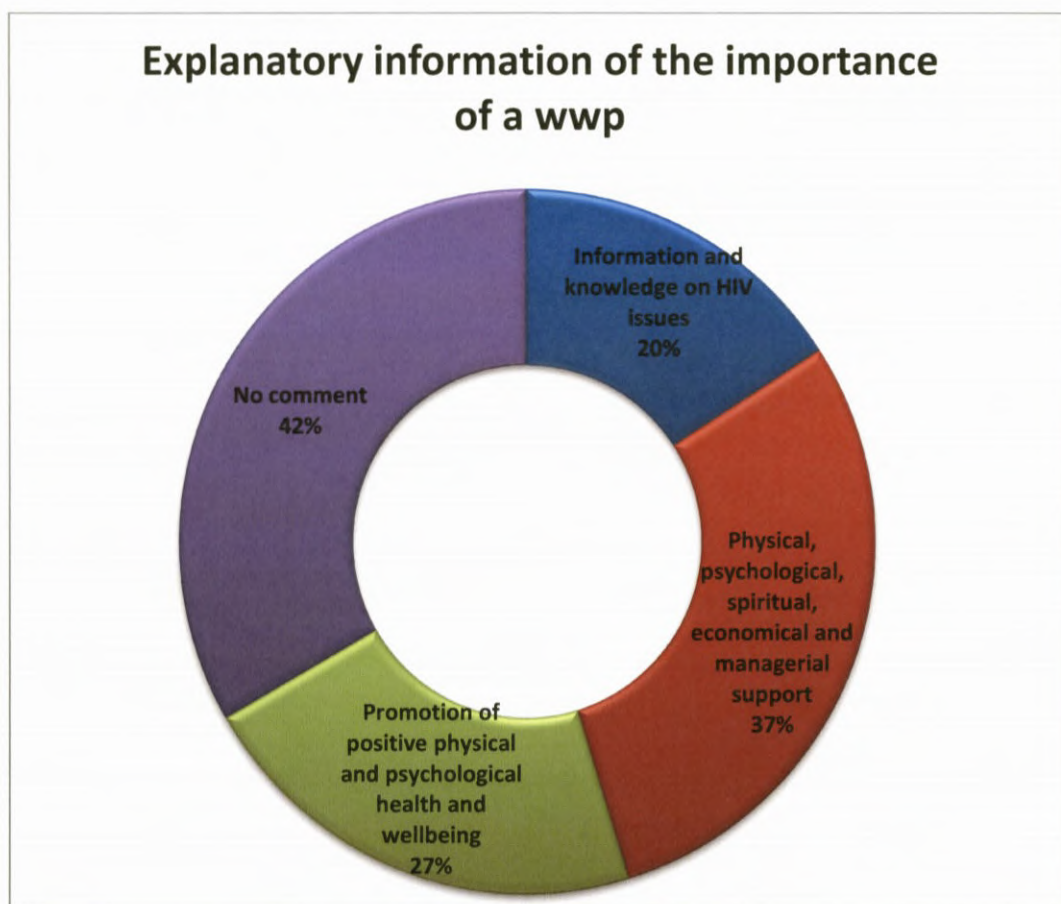
Explanatory information of the importance of a wwp

- Information and knowledge on HIV issues 20%
- No comment 42%
- Physical, psychological, spiritual, economical and managerial support 37%
- Promotion of positive physical and psychological health and wellbeing 27%

Figure 4.14   Explanatory information of the importance of a workplace wellness programme

The majority (n=100) of respondents considered a workplace wellness programme to be very important. However, as illustrated in Figure 4.14 forty-two percent (n= 58) abstained from any explanation or motivation why they considered a workplace wellness programme as very important.

Thirty-seven percent (n= 51) explained that physical, psychological, spiritual, economical and managerial support could be given through means of a workplace wellness programme.

Furthermore, twenty-seven percent (n= 37) of the respondents explained that a workplace wellness programme could be utilized to promote positive physical and psychological health and wellbeing in a confidential, but stigma and discrimination free environment.

Twenty percent (n= 28) explained that it is very important that information and knowledge are channelled through a workplace wellness programme on HIV related issues such as the disease itself, ARV treatment, care for the self and others, including work related issues such as financial and legal advice.

According to Orem (1980: 118) a nurse practitioner has to be able to uphold her-self in the work environment, communicate her ideas, thoughts and actions to others, focus on her own physical, psychological, social and spiritual needs, as well as

economical needs, to experience positive health and wellbeing. She would as result experience ample vigour and vitality, as well as no signs of morbidity and illness.

Therefore, the nurse practitioner has to be knowledgeable on the fundamental facts about HIV/AIDS and adopt healthy living principles and life skills up unto experiencing care, support and a positive legal-ethical response to HIV/AIDS in the workplace. This procurement would empower the nurse practitioner to be a confident individual enjoying a high quality of living and wellness in the work environment (Van Dyk, 2008: 406 - 424).

Issues that influence nurse practitioners confronted with HIV/AIDS in the workplace discern between external and internal factors describing the health, psychosocial, and important employee welfare concerns, as well as the economical impact there-of.

The respondents in this study were of opinion that an operational and sustainable workplace wellness programme should focus on physical, psychological, spiritual, economical, as well as managerial issues that could influence their health and wellbeing in the workplace.

4.2.2.6 Health status

Sixty-nine percent (n= 95) of the respondents indicated that they experienced good health and wellbeing (Figure 4.15).
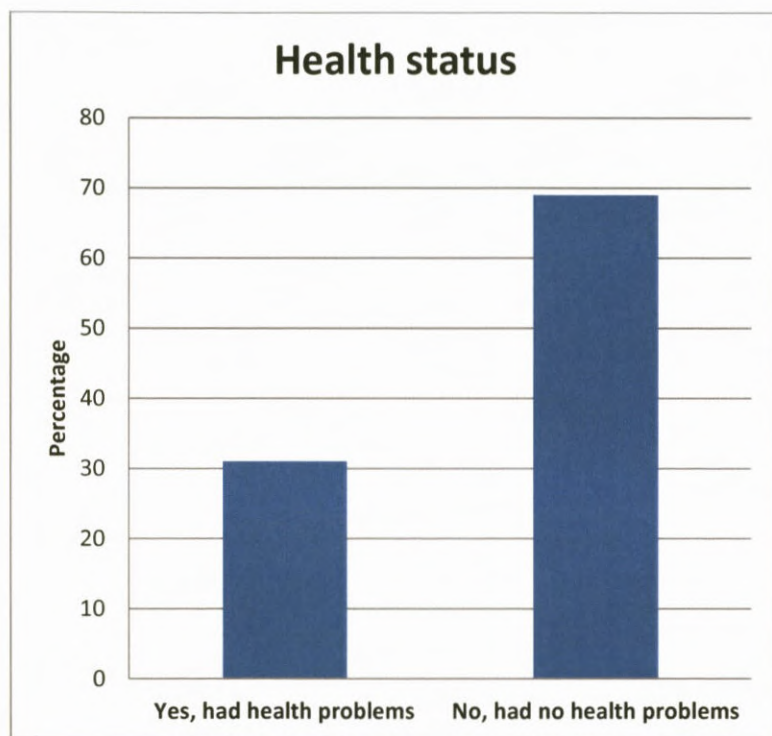
Figure 4.15   Health status

Corbin and Pangrazi (2001: 2 and 3) exclaimed that nurse practitioners have a desire to stay well, enjoy life and incorporate their coping strategies while withstanding their daily challenges. A nurse practitioner experiences wellness if she is holistically sound and healthy and acknowledges that her work environment and economical circumstances have a profound influence on her quality of life and sense of wellbeing. Vickers (2006: 268) went further to say that despite being healthy, she

may develop symptoms of stress, illness or depression whilst on the other hand, she could experience a contented, fulfilling healthy life within the boundaries of her limitations should she function within a supportive working environment and have a supportive social network.

4.2.2.7 Physical and psychological health (Figure 4.16)

The respondents in this study indicated that their ability to sustain their health and
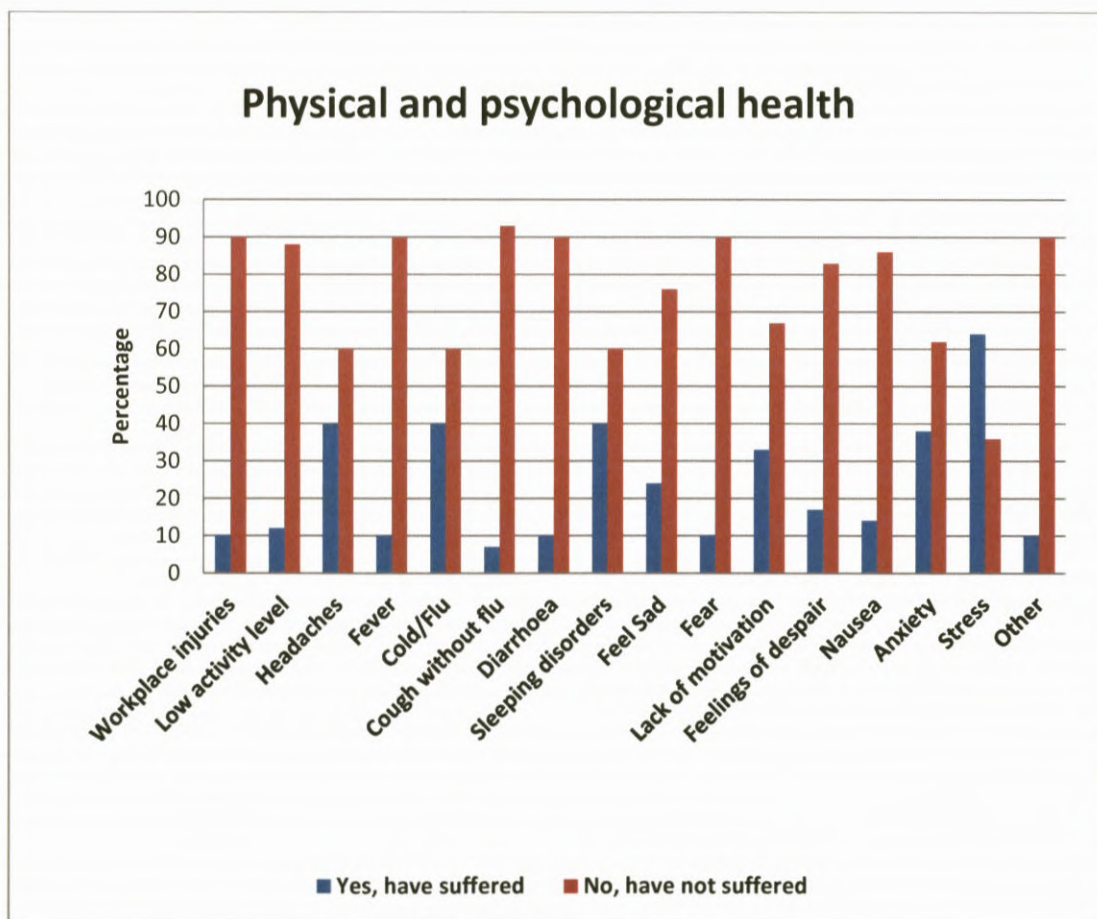
Figure 4.16 Physical and psychological health

wellbeing was often compromised by symptoms of poor physical and mental health, especially stress related symptoms.

Thirty-one percent (n= 42) of the respondents stated that they experienced ill health and poor wellbeing within the three (3) month period prior to the investigation (Figure 4.16).

Forty percent (n=17) of the respondents experienced symptoms of flu or a common cold. Thirty-five percent (n=15) of the respondents indicated that they suffered from frequent headaches, sleeping disorders, feelings of sadness, lack of motivation and anxiety. Though these feelings do indicate probable symptoms of depression or tension and pressure (Kneisl and Trigoboff, 2009: 406), sixty-four percent (n= 27) of the respondents experiencing ill health and poor wellbeing considered themselves to suffer from specifically, stress.

4.2.2.8 Absenteeism

Adopting healthy lifestyles to promote good health and wellness are important, but Cavanagh (1991: 124) warned that it was not a guarantee of holistically sustaining wellness in the nurse. Fear, family and cultural pressure, financial and economical problems could interfere with a nurse practitioner's appeal for help and advice.

During a three (3) month period twenty-three percent (n= 32) of the respondents declared that they were absent from work due to ill health (Figure 4.17).
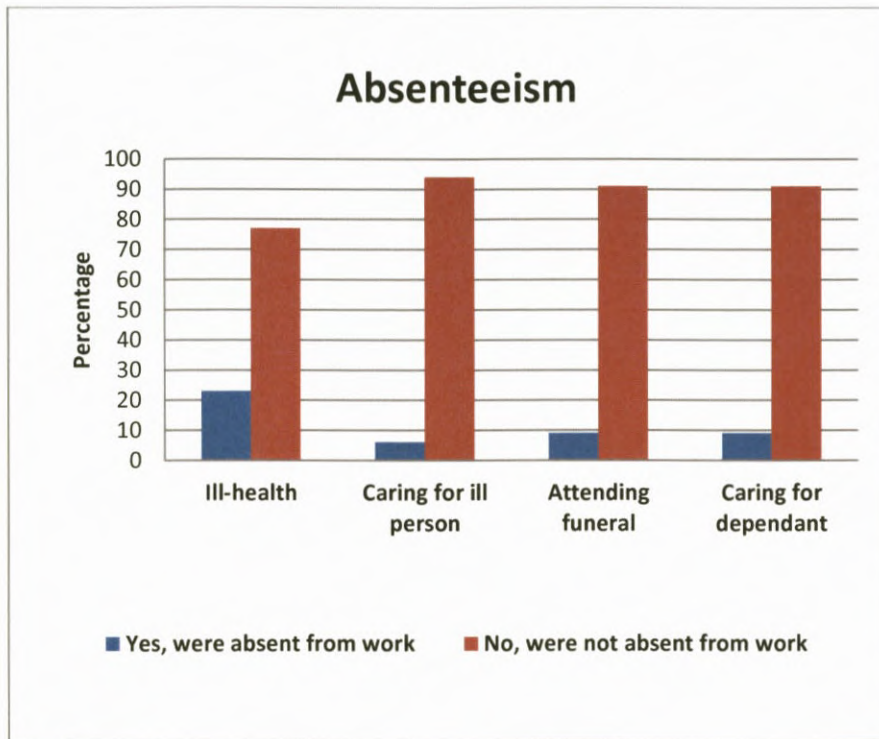
Absenteeism

Figure 4.17   Absenteeism

Six percent (n= 8) respondents had to care for an ill person, whilst nine percent (n=13) of the respondents had to care for a dependant person. Nine percent (n=13) of the respondents had to attend a funeral during the three (3) month period prior to the inquest.

The Health and Wellness Strategic Initiative: Task Force Summary Report (2006: online) found that illness and labour absenteeism decreased in the presence of optimal wellness and that a successful occupational career was attainable.

Coinciding was the suggestion of Corbin and Pangrazi (2001: 3 - 4) that health promotional programmes should be designed and initiatives promoted to encourage healthy lifestyles and coping skills with the intention of building positive health and gaining optimal wellness in a workplace.

4.2.3   Important interventions to enhance positive health and wellbeing

As illustrated in Figure 4.18 (Page 178) eighty-seven percent (n=120) of the respondents stated that protection against safety risks in the workplace was very important. Eighty-two percent (n=112) of the respondents declared that a medical aid or appropriate health insurance was very important.

Seventy-nine percent (n=108) of the respondents indicated that a workplace wellness programme for HIV/AIDS affected and/or infected nurse practitioners was very important. A market related monthly salary (78 percent; n=104) and agreeable working conditions (77 percent; n=102) were also rated as being very important to the respondents.

Seventy-three percent (n=101) of the respondents stated that they consider attention to their personal hygiene to be very important.

To a lesser degree did sixty percent (n= 81) of the respondents indicate that family orientated activities pose as very important to enhance their health and wellbeing.

Sex education also elicited a lesser response of forty-seven percent (n= 65) from the respondents as being very important to enhance positive health and wellbeing.

Important interventions to enhance positive health and wellbeing
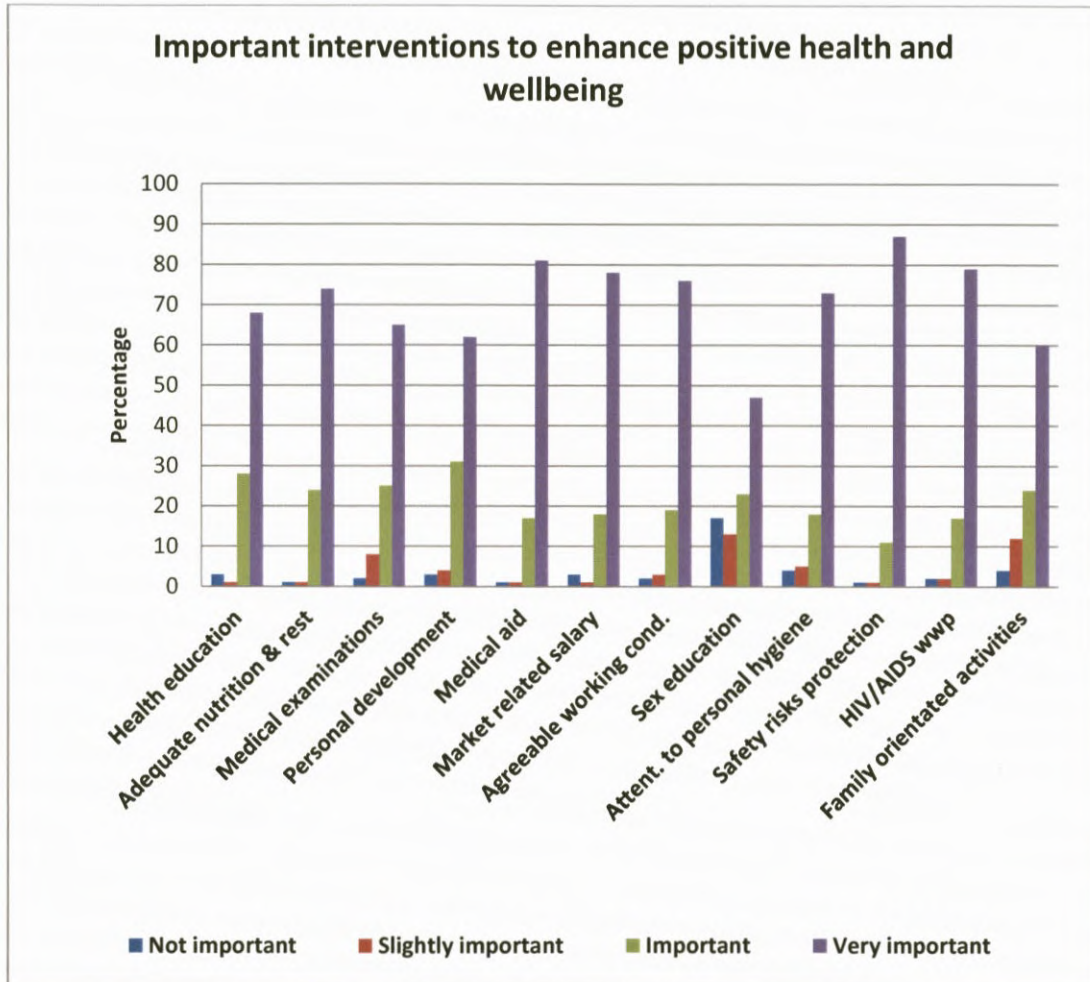
Figure 4.18   Important interventions to enhance positive health and wellbeing

External factors are social, economical and factors inherent to the workplace experienced from the nurse practitioner's mental perception of how HIV and/or AIDS influence their daily life and wellbeing. Van Dyk (2008: 420 and 470) pointed out that the employer could effectively assist the nurse practitioner with advice and support to

promote the welfare of her household and equality of life such as complying to appropriate legislation on equity and fair labour practice in a workplace.

Therefore, a nurse practitioner needs to stay employed to contribute to the economy and family needs and responsibilities. Preventing a decline in the health and material needs of the family and making provision for funeral expenses are but few important priorities, because HIV/AIDS has become the leading cause of death amongst working adults in South Africa (Vass and Phakathi, 2006: 7; Kochar, 2004: 258 and 279; Booysen and Mafereka, 2006: 10 - 13).

Regarding the inner self of the nurse practitioner is physical, psychosocial and spiritual elements resulting in low self-esteem and the lack of applying effective coping skills to deal with the debilitating demands placed on her generated by HIV and AIDS (Gorman, Sultan and Luna-Raines,1989: 5; O'Donnell, 2002: 569).

Van Dyk (2008: 35) stated that the unique characteristics of HIV and avoiding HIV infection, pose a challenge to all nurse practitioners. Rose, Pugh, Lears and Gordon (1998: 298) and Smit (2005: 25) agreed therewith by expanding that maintaining high immune levels through initiating a healthy and positive life style with sound sexual practices, staying employed and maintaining positive activity levels, is a daily concern and challenge to nurse practitioners.

Considering that seventy-nine percent (n=108) of the respondents indicated that a workplace wellness programme for HIV/AIDS affected and/or infected nurse practitioners was very important, the promotion of awareness of positive physical and mental health and wellbeing, as well as providing support to modify lifestyles, are clearly motivated by O'Donnell (2002: xxii, 19, 544 and 571).

4.2.4 HIV/AIDS awareness initiatives (Figure 4.19)

HIV/AIDS awareness initiatives

Legend:
- Not at all interested
- Not so interested
- Fairly interested
- Very interested
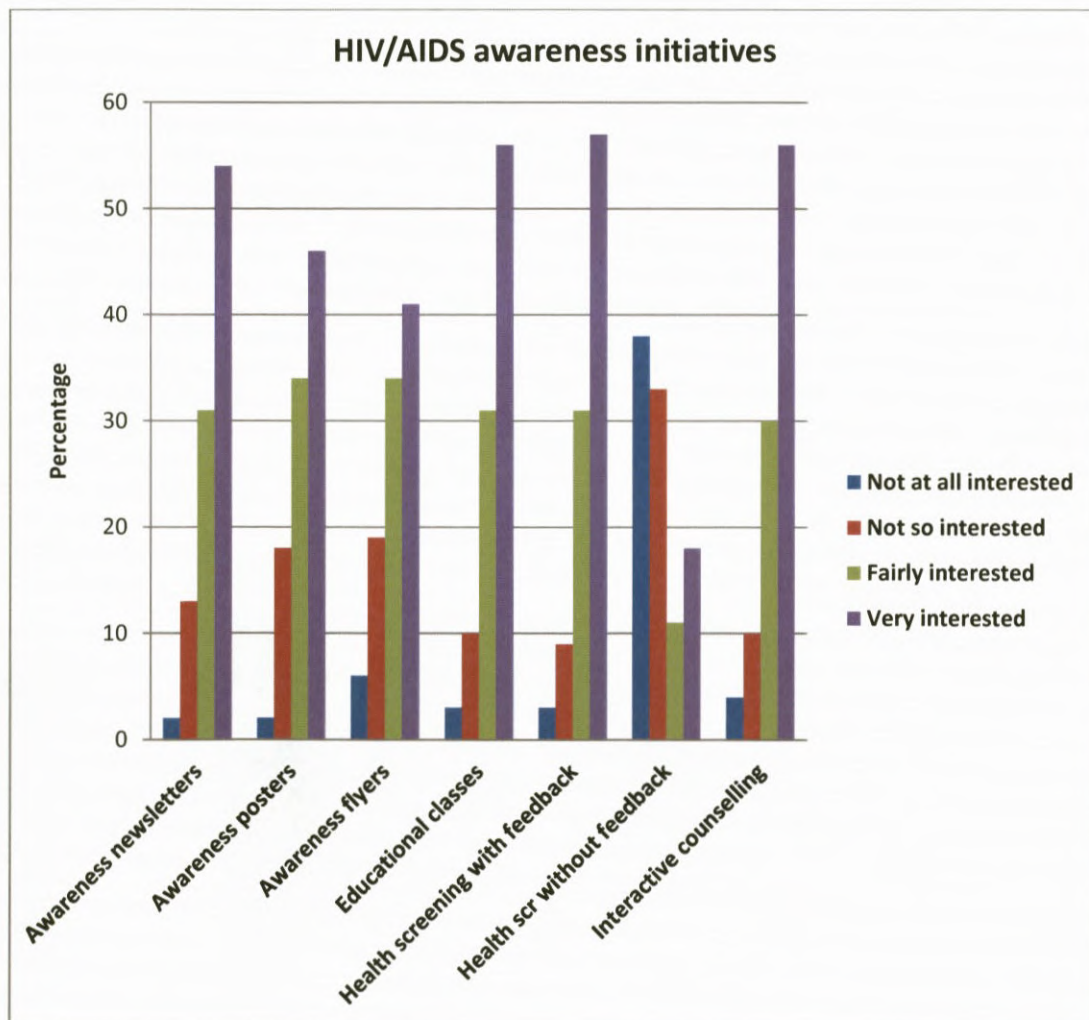
Figure 4.19   HIV/AIDS awareness initiatives interested in

Fifty five percent of the respondents (n= 75) indicated that they would be very interested in educational classes and interactive counselling initiatives. The respondents (n= 74) equally indicated that they would be very interested to receive an awareness newsletter. Forty-six percent (n= 61) of the respondents were very interested in awareness posters. Forty-one percent (n= 55) stated that they were very interested in awareness flyers.

Awareness initiatives that the respondents (57%; n= 79) indicated that they were very interested in were health screening such as Voluntary Confidential Counselling and HIV testing (VCCT) **with** feedback. Thirty-eight percent of the respondents (n= 49) stated that they were not at all interested in health screening where feedback is not given.

4.2.5 Information on HIV/AIDS that should be addressed in a workplace wellness programme (Figure 4.20)

'How to stay healthy and well if one is HIV positive' – instruction elicited an overwhelming ninety-two percent (n=130) response from the respondents.

HIV/AIDS information to be addressed in wwp

Category	
Family support	
Emotional preparedness	
Care for others	
Financial planning	
Spiritual preparedness	
Employment options	
Disclosure if HIV pos	
Stay HIV negative	
Stay healthy if HIV pos	
Getting HIV test	
HIV/AIDS origin	
Other STD's	
Infection symp & signs	
Treatment options	
Prevention strategies	

Percentage
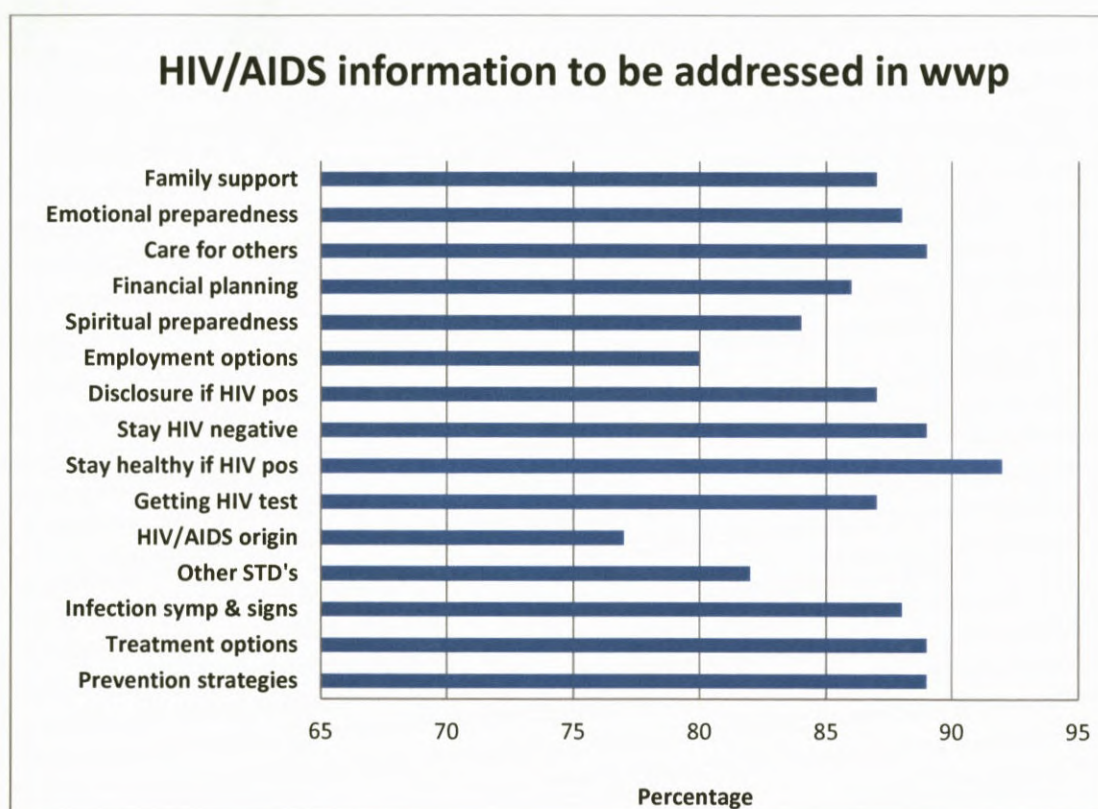
Figure 4.20 HIV/AIDS information to be addressed in a workplace wellness programme

As illustrated in Figure 4.20 eighty-eight percent of the respondents (n=124) indicated that the following HIV/AIDS information should also be addressed in a workplace wellness programme in no particular order of importance:

- Prevention strategies (89.4%)

- Treatment options (89%)

- Symptoms and signs of infection (87.9%)

- Getting a HIV test (87.2%)

- How to stay HIV negative (88.7%)

- How to tell a husband/wife/partner/friend if I am tested HIV positive (86.5%)

- Financial planning (85.8%)

- How to care for my family/partner/husband/wife should I be affected by or infected with HIV/AIDS (88.7%)

- How to prepare myself emotionally should I be affected by or infected with HIV/AIDS (87.9%)

- How to involve my family in supporting me should I be affected by or infected with HIV/AIDS (87.2%)

Eighty-two percent (n=116) of the respondents stated that the following information should be addressed in a workplace wellness programme as well (in no particular order of importance):

- How to prepare myself spiritually should I be affected by or infected with HIV/AIDS (83.7%)

- Other sexually transmitted diseases (83.3%)

- Employment options (80.1%)

Seventy-seven percent (n=108) of the respondents indicated that information on the origin of HIV/AIDS should be addressed as well.

4.2.6 Lifestyle initiatives (Figure 4.21)

Trying to determine the level of interest in lifestyle initiatives that could be addressed
through means of a workplace wellness programme evoked mixed reactions from
the respondents.
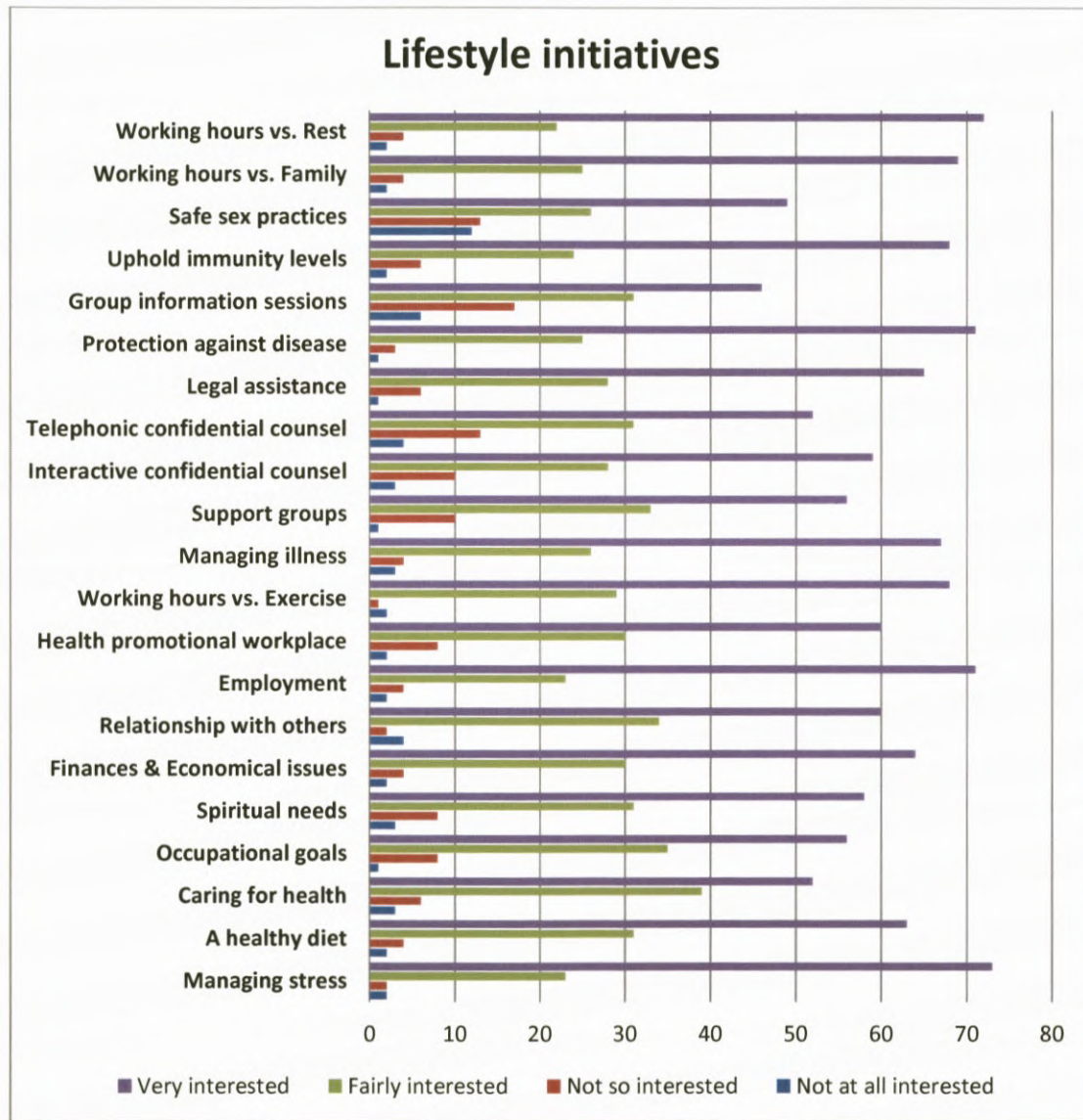
Figure 4.21   Lifestyle initiatives interested in

As portrayed in Figure 4.21 seventy-four percent (n=102) of the respondents indicated that they were very interested in how to manage stress. Seventy-two percent (n= 98) of the respondents were very interested in working hours that allow you to have enough rest periods. Likewise, seventy two percent (n= 98) of the respondents were very interested to know how to stay employed, whilst seventy-one percent (n= 97) indicated that protection against life threatening diseases such as HIV/AIDS were a very interesting lifestyle initiative.

However, only forty-six percent (n= 60) of the respondents indicated that they were very interested in group information sessions and forty-nine percent (n= 66) of the respondents stated that they were very interested in how to practice safe sex.

4.2.7 Health and wellness promotional services provided in a workplace

Eighty-two percent (n=115) of the respondents indicated that a psychology service to address emotional health such as depression and stress or anxiety related issues should be provided in a workplace (Figure 4.22).
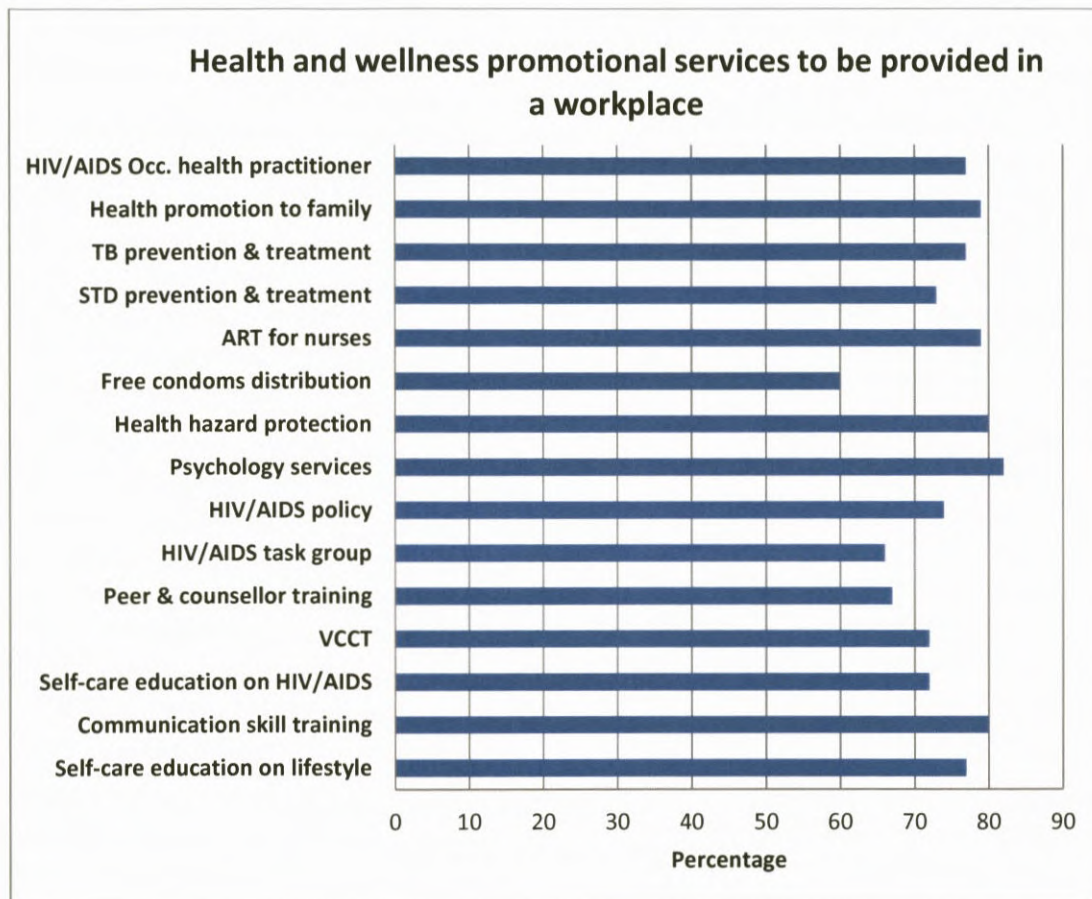
Figure 4.22 Health and wellness promotional services to be provided in a workplace

Eighty percent (n=113) of the respondents stated that training in communication skills and protection against health hazards in the workplace such as the provision of personal protective equipment, should be addressed as well.

Seventy-six percent (n=107) of the respondents indicated that the following health and wellness promotional services should be rendered in a workplace (in no particular order of importance):

- Availability of Antiretroviral Therapy or medication for HIV positive nurses (78.7%),

- A HIV/AIDS policy addressing issues such as discrimination, stigmatization, sick leave and retrenchment (73.8%),

- Self-care education on issues such as hygiene, nutrition, sexual health, exercises, sleep and rest (76.6%),

- Self-care education on HIV/AIDS (72.3%),

- VCCT services (72.3%),

- Prevention and treatment services for Sexually Transmitted Diseases (73.1%), and

- Prevention and treatment services for Tuberculosis (77.3%).

Seventy-nine percent (n=112) of the respondents were of opinion that the health and wellness promotional programmes should include the family members. Seventy-seven percent (n=109) of the respondents indicated that an occupational health nurse practitioner skilled in HIV/AIDS issues, should be available in the workplace.

Sixty-seven percent of the respondents (n= 94) stated that peer and counsellor education to raise awareness on HIV/AIDS issues should be implemented, as well as an operational HIV/AIDS workplace task group.

Sixty percent of the respondents (n= 65) indicated that although rated the lowest amongst the health and wellness promotional services to be rendered in a workplace, the distribution of free condoms should receive attention as well.

The respondents in this study indicated that it is important for a workplace wellness programme to focus on thorough information on the workplace HIV policy and employment related HIV/AIDS concerns, as well as the support from the management and colleagues with open discussions and disclosure enhancement.

Smit (2005: 25 and 28) and Vass and Phakathi (2006: 22) supported the South African Foundation for Professional Development (2006: 53) for suggesting the application of a workplace wellness programme to attempt moving an employee from a neutral to a higher level of health. This posed to be procurable by acquiring timely medical assistance, holistically prepare a person to cope with all the challenges HIV/AIDS yield, how to maintain financial and economical stability and conserve her participation in the labour market.

Low-Beer (2005: 478) furthermore emphasized that the building blocks of HIV prevention and care in a workplace wellness programme are primarily

- sexual behaviour change,
- open communication about HIV/AIDS and people infected and/or affected by the disease, as well as

- organizational and community level structures and interventions of support, contact and care.

With regard to the enhancement of positive health and wellbeing in a workplace wellness programme, the respondents in this study agreed to the following important provisions:

- sex education to promote behaviour change,

- family orientated activities and involvement,

- open discussion with disclosure enhancement,

- thorough information on the workplace HIV policy and other HIV self-care requisites, as well as

- attention to personal hygiene and development.

However, Orem (1980: 55) and Van Dyk (2008: 122) agreed that a nurse practitioner needed to develop her attitude, knowledge and coping skills to motivate and empower her to address her daily occupational challenges.

Callaghan (2006: 178) on the other hand explained the value of selected basic conditioning factors in the development of health promotional interventions such as a workplace wellness programme. Factors denoting age, gender, level of education, health status, life style and family profile are valuable. Included are socio-cultural and environmental factors such as to which social group does a person belong and work related issues on self-care and health promotion.

Van Dyk (2008: 467) continued to urge the purposeful utilization of resources and activities whereby a nurse practitioner could address her self-care requisites. Van Dyk (2008: 469) recommended the implementation and maintenance on but few activities in a workplace wellness programme such as:

- supplying her with knowledge through printed material or discussions,

- presenting information sessions on self-care issues such as health, wellness and social adaptability,

- introducing her to appropriate resources to address her daily maintenance such as financial aid, planning and provision for future economical needs, and

- medical assistance through VCCT, the provision of ART and medical aid programmes.

The HIV/AIDS awareness initiatives that elicited a positive response from the respondents in this study included:

- educational classes supplying information and education on HIV/AIDS origin, prevention and treatment options,

- interactive counselling initiatives supplying self-care strategies to promote positive health, wellbeing and life styles for the self and others infected with and/or affected by HIV/AIDS,

- receiving an awareness newsletter, awareness posters and awareness flyers on health and wellness inducing activities,

- VCCT facilities with feedback counselling, as well as PEP treatment and ART provision,

- information and education on HIV/AIDS, other sexually transmitted diseases, as well as Tuberculosis,

- employment options addressing working hours and work overload, how to stay employed, sick leave, retrenchment, promotions and study aid, as well as

- protection initiatives within the workplace against life threatening diseases such as HIV/AIDS.

The need for group information sessions and information on safe sex practices did not however elicit a positive response from the respondents in this study.

The respondents furthermore indicated that health and wellness promotional services provided in a workplace should also focus on:

- psychology services to address emotional health obtainable from outsourced healthcare facilities,

- communication and coping skills development and training,

- the provision of personal protective equipment,

- the inclusion and involvement of family members through family counselling services and activities,

- the availability of an HIV/AIDS skilled and trained occupational health nurse practitioner,

- peer and counsellor training and development with the support of an operational HIV/AIDS workplace task group, and

- the continuous distribution of free condoms in a workplace.

Subsequently to the information derived from the respondents in this study, well-considered planning should be undertaken when developing a workplace wellness programme, as petitioned by Cavanagh (1991: 28). Cavanagh based his opinion on Orem's model of nursing where physical and psychological, as well as economical and occupational assistance with necessary education and information to the nurse practitioner were examined.

4.3 The workplace and a workplace wellness programme

4.3.1 Current interventions in the workplace
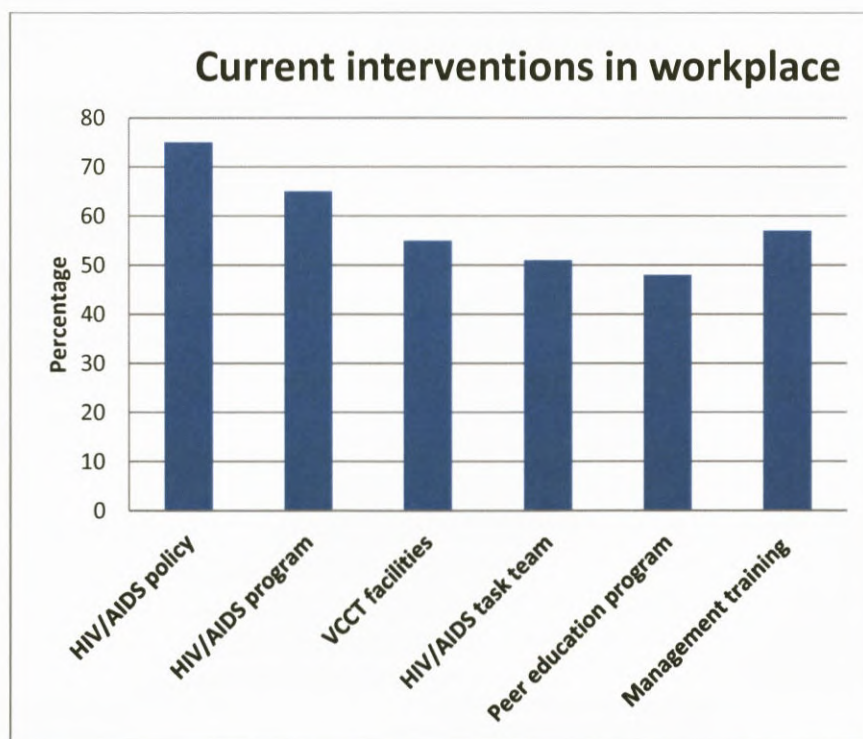
Figure 4.23   Current interventions in the workplace

As illustrated in Figure 4.23 seventy-five percent (n=106) of the respondents were aware of an existing HIV/AIDS policy in their place of work.

Sixty-five percent (n= 91) of the respondents were also aware of a HIV/AIDS prevention and awareness programme in the workplace. Fifty-seven percent (n= 81) of the respondents indicated that the management team do receive training on how to manage HIV/AIDS in the workplace.

The respondents indicated that VCCT facilities (fifty-five percent of respondents), a HIV/AIDS task team (fifty-one percent of respondents) and a peer education programme (forty-eight percent of the respondents) were not as much in the forefront.

Smit (2005: 23 & 26 - 27) and Van Dyk (2008: 414 - 416) stated that nurse practitioners become unmotivated due to the lack of organizational support and a reluctance of managers to address the shortage of trained counsellors. A hesitance and uncommitted will of the employer to supply comprehensive HIV informative, educational support and treatment programmes eventually render the nurse practitioner exposed to negative attitudes with no hope of improvement in their daily work conditions.

The respondents furthermore stated that although they were aware of a workplace HIV/AIDS prevention and awareness programme, they considered the managerial support inadequate. They were of opinion that the inadequacy could be addressed through means of an involved HIV/AIDS task team, VCCT facilities, as well as peer educational programmes and counsellor training.

4.3.2 Directors of the HIV/AIDS strategy and policy in the workplace (Figure 4.24)

Forty-one percent (n= 57) of the respondents indicated that either nobody is responsible to direct the HIV/AIDS strategy and policy in their place of work or they just do not know who is directing it.
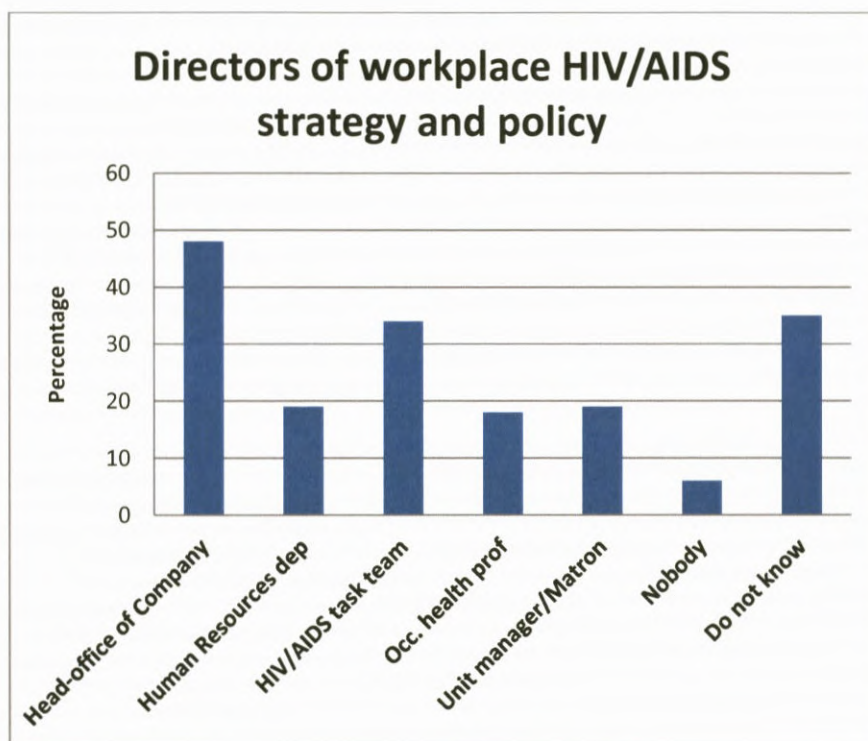
Figure 4.24   Directors of the workplace HIV/AIDS strategy and policy

Forty-eight percent (n= 67) of the respondents stated that the HIV/AIDS strategy and policy are directed by the Head Office of the Company. Thirty-four percent (n= 48) of the respondents believed that the HIV/AIDS task team were responsible for their workplace HIV/AIDS strategy and policy.

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4.3.3 Proposed parties to be involved in the development of a workplace HIV/AIDS strategy and/or policy (Figure 4.25)
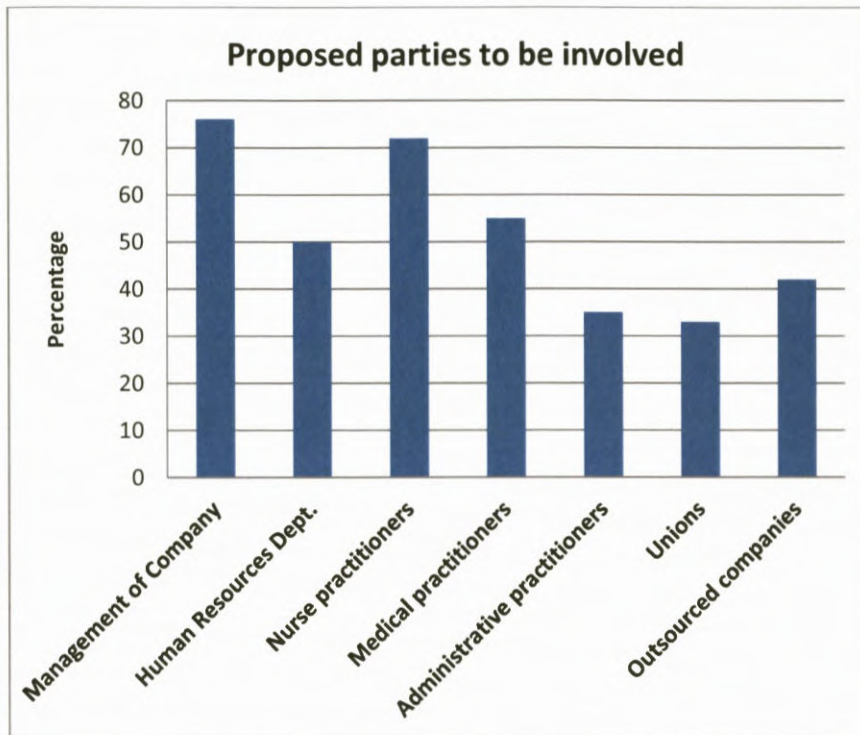
Proposed parties to be involved

Figure 4.25 Proposed parties to be involved in the development of a

workplace HIV/AIDS strategy and/or policy

Seventy-six percent (n=107) of the respondents believed that the management of the company should be involved in the development of a HIV/AIDS strategy and policy.

Seventy-two percent (n=101) of the respondents indicated that nurse practitioners should be allowed to be involved with the process as well. Fifty-five percent (n= 78) of the respondents believed that medical practitioners could be more involved than the Human Resources Department (50 percent; n= 70).

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A mere thirty-four percent (n= 48) of the respondents indicated that administrative practitioners and the unions should be involved in the development of a workplace HIV/AIDS strategy and/or policy.

Thus emphasising that the employer has an obligation to develop as well as co-ordinate employee wellness to promote a supportive environment where the quality of life is improved, and morbidity and mortality amongst HIV infected and/or affected nurse practitioners are reduced (Van Dyk, 2008: 407).

Janse van Rensburg (2008: 63) explained that managerial processes and activities necessitate the creation of a culture of optimal health and wellbeing within a work environment. A recommendation for the assessment of a workplace risk profile and an impact study as the initial step in designing strategies to improve the wellness in a workplace was submitted by both Lowe (2002: 49) and Janse van Rensburg (2008: 63).

Janse van Rensburg (2008: 3 and 10) continued to emphasise the ethical and legal obligation that rest on the employer to identify, plan and organize activities and resources necessary in creating a safe and health conducive work environment. Lowe (2002: 49 and 50) and Nutbeam (1998: 351) agreed that these actions should result in a probable decline in the rate of employee absenteeism as well as the promotion of employee productivity.

Nutbeam (1998: 351) furthermore recommended that nurse practitioners had to be involved in the assessment and decision making process that could influence their health and wellbeing. Keeping them informed would ultimately enhance a sense of partnership and self-assertiveness. Management should therefore recognize the value of shared governance, input and decision-making with nurse practitioners to sustain the efforts in creating a supportive environment for optimal health and wellbeing.

According to the findings of this study, the respondents agreed that the employer had an obligation to develop as well as co-ordinate employee wellness. According to the subjects, the objective should be the promotion of an environment where the health and wellbeing of employees could be enhanced.

The respondents in this study assumed that the Company head-office took responsibility in directing the workplace HIV/AIDS strategy and policy. They however indicated that the power to direct the HIV/AIDS strategy should be vested in a HIV/AIDS task team and the managerial team of the institution with mutual involvement of the nurse practitioner. The inclusion of an occupational health nurse practitioner skilled in HIV/AIDS issues were highly recommended by the respondents.

4.3.4 Important HIV/AIDS issues in the workplace

As portrayed in Figure 4.26 seventy six percent (n=106) of the respondents stated that it is very important that nurse practitioners should be well informed about the company's or employer's HIV/AIDS policy. Seventy-three percent (n=101) of the respondents agreed that it is very important for them to be well informed about HIV/AIDS issues.
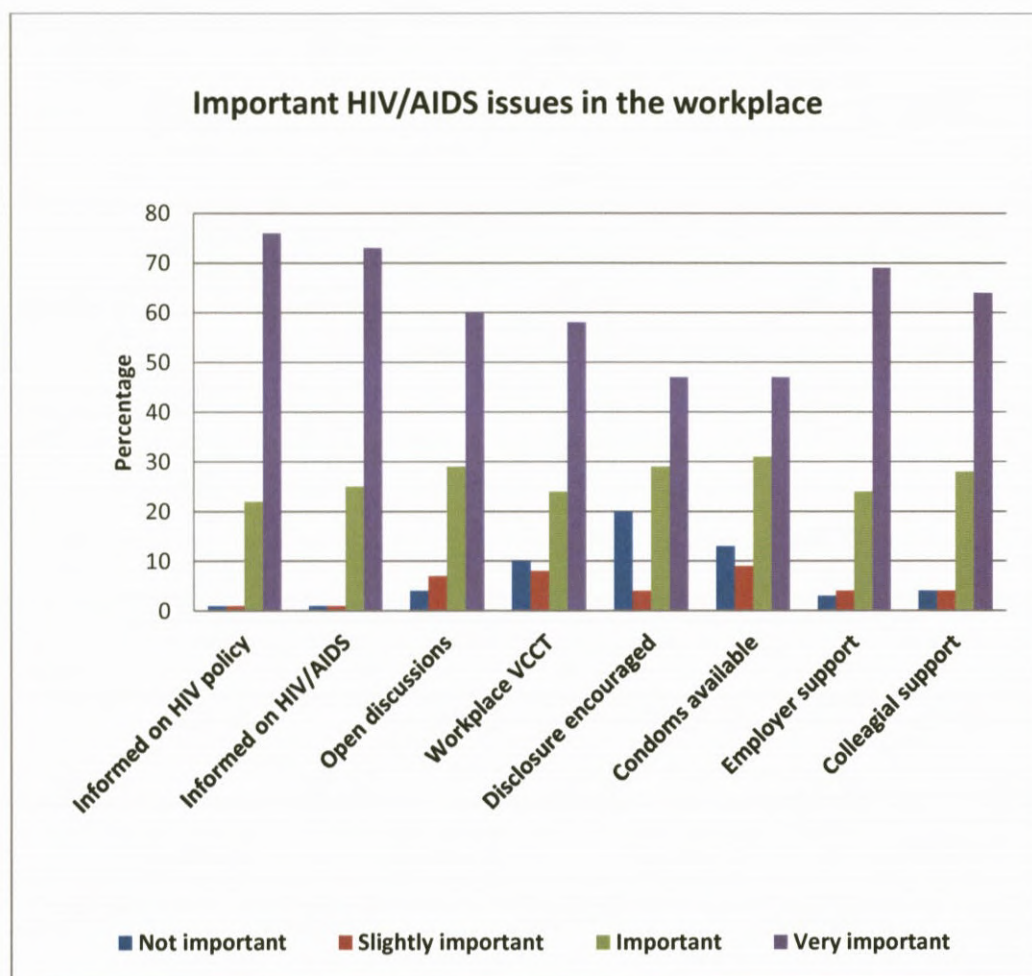
Figure 4.26   Important workplace HIV/AIDS issues

The HIV/AIDS policy of a company informs nurse practitioners about their rights and responsibilities, as well as the organization's responsibilities and obligations to maintain employee equity and confidentiality (Van Dyk, 2008: 466 and 467). It provides an insight to which measures are put in place to promote a safe and conducive health environment in the workplace. Knowledge of the contents of these policies and the implementation there-of is required to advise and assist nurse practitioners.

Hartwig, Pashman, Cherlin, Dale, Callaway, Czaplinski, Wood, Abebe, Dentry and Bradley (2008: 216) confirmed that policies on HIV/AIDS ensure that employers and employees act in a similar way in response to HIV-related health and occupational issues. Booyens (2004: 28 and 200) furthermore explained that a HIV/AIDS policy poses as a written directive to guide decision making during specific actions or interventions such as found during the disposition of a workplace wellness programme.

The respondents insisted on a transparent and well formulated, as well as informative, and well-communicated workplace HIV/AIDS policy.

The respondents (n= 72) indicated that it was very important that subjects should frequently and freely discuss HIV/AIDS as a subject, undergo VCCT at their place of work and feel comfortable to disclose their HIV status. Accessibility of condoms was also identified as being very important in the workplace.

Sixty-seven percent (n= 92) of the respondents agreed that it was very important that a subject on antiretroviral therapy (ART) should be emotionally supported by their employers and fellow colleagues.

The respondents in this study stated that a workplace wellness programme should operate in a stigma and discriminative free environment. Although the majority of respondents, which were of the white racial grouping, indicated that they were not aware of any family member, friend or colleague infected with or affected by HIV/AIDS, they were of opinion that it was very important that they frequently and freely discuss HIV/AIDS as a subject. They furthermore declared that they should feel comfortable to disclose their HIV status to their social occupational grouping.

As previously discussed, the majority of respondents in this study declared that HIV/AIDS poses a serious threat to nurse practitioners in the workplace and that they were afraid of being infected with HIV. The respondents agreed that disclosure was a sensitive topic, because it could elicit stigmatization and discrimination. They however indicated that there should be a focus on open discussions and disclosure enhancement.

4.4 Components of a workplace wellness programme

Reiterating what Corbin and Pangrazi (2001: 1 – 3) stated in the introductory passage of this chapter, components necessary for the development of a workplace wellness programme should address the health and wellbeing of nurse practitioners, as well as their economical and occupational requisites.

O'Donnell (2002: xxii, 544 and 571) continued explaining that each component is dependent on the other to achieve a desired outcome. It is therefore imperative that a workplace wellness programme should have an impact on awareness in a specific topic or requisite to help nurse practitioners make lifestyle changes that enhance positive health and wellbeing. A workplace wellness programme for nurse practitioners furthermore creates an environment that supports healthy lifestyle choices addressing health and wellness issues, as well as the development of appropriate coping skills.

4.5 Limitations and recommendations

Limitations to a workplace wellness programme should be borne in mind as to the voluntary participation of the nurse practitioner. Orem (1980: 211) warned that a nurse practitioner has to acknowledge her responsibility to maintain positive health and wellness. She will subsequently make a willing choice to accept the help and support available to her in the workplace. Her willingness to participate in a workplace wellness programme will rely on the urgency of the self-care demands she encounters and the sense of motivation she experiences. She may experience

bouts of reluctance and unwillingness to seek support and advice to resolve her

problems and requisites.

The majority of respondents in this study comprised of white female nurse

practitioners. Approximately 79 (seventy-nine) percent of the total South African

population constitutes of Africans (Statistics South Africa, 2008: Statistical release

P0302) who embrace strong traditional and cultural beliefs. African persons tend to

go into denial when confronted with their HIV status and tend to refuse advice and

help from persons outside their framework of reference (Van Dyk, 2008: 414). The

opinion of nurse practitioners from this racial grouping should be further investigated

as to ascertain their willingness to seek advice and help from the employer by means

of a workplace wellness programme.

Research has determined that HIV/AIDS counselling provokes resistance amongst

Africans (Mawar, Sahay, Pandit and Mahajan, 2005: 472), because explicit and

sensitive sexual and complicated cultural beliefs are addressed (Van Dyk, 2008:

413). Traditionally giving advice is more acceptable to counselling (Dieleman *et al.*,

2007: 144). Further research in this occurrence needs to be investigated, because it

will have a profound outcome on the sustainability of counselling services rendered

in a workplace wellness programme.

Research was limited to one private healthcare facility in one city in the province of

The Free State, South Africa. The study findings are limited to one sample and could

not be appropriately generalized to the complete nursing population represented in the private healthcare sector. It would therefore be of value if the study could be expanded to include all nurse practitioners practicing in the private healthcare sector of South Africa. Value could also be added to the research study with the inclusion of the public healthcare sector. Expanding the study to include the public service nurse practitioners is commendable.

4.6 Summary

The objective of the questionnaire was to obtain and explore information about the components needed to develop a sustainable and effective wellness programme in the workplace for nurse practitioners infected with and/or affected by HIV/AIDS in South Africa.

A nurse practitioner would be able to manage the challenges of daily living, feel good about her self and surmount the debilitating effects of HIV/AIDS whilst experiencing physical, social and mental wellbeing, not merely experiencing the absence of an illness or infirmity, if she receives adequate support from the employer.

Basic knowledge and an explanation were yielded from a sample of the target population concerning:

1) How nurse practitioners considered their current mode of health and wellbeing,

2) How nurse practitioners regarded the current management of HIV/AIDS in their place of work, and

3) What health and wellness promotional interventions do nurse practitioners consider necessary to support a sustainable and effective workplace wellness programme.

The respondents were registered SANC nurse practitioners representing the mainly sexually and economically active female adults within the 19 - 59 years of age range.

The white respondents represented the predominant racial grouping. The majority of respondents were married and had families to financially take care for.

A relationship was found between HIV/AIDS, health, wellness and wellbeing, as well as the importance of Orem's self-care deficit theory and the nurse practitioner in the workplace.

Due to the sensitivity of disclosure, the respondents were encouraged to indicate honestly in so far as how HIV/AIDS affected them. Although the majority of respondents declared that they had been tested for HIV and were diagnosed HIV negative, a large percentage of respondents indicated that they were afraid of being infected with the disease. They also indicated that they wanted to stay HIV negative.

The majority of respondents indicated that they were not aware of any family member, friend or colleague infected with or affected by HIV/AIDS.

The respondents were however of opinion that HIV/AIDS poses a serious threat to nurse practitioners in the workplace. They indicated that although they were not aware of an operational workplace wellness programme, they considered such a programme of considerable importance to nurse practitioners infected with/or affected by HIV/AIDS with specific relegation to:

- physical, psychological, spiritual, economical and managerial support,
- promotion of positive physical and psychological health and wellbeing in a confidential, but stigma and discriminative free environment, and
- the acquirement of information and knowledge on HIV/AIDS and work related issues.

The majority of respondents indicated that although they experienced good health and wellbeing and their absenteeism profile proved it, it was often compromised by symptoms of depression, tension or stress, as well as symptoms of flu or a common cold.

The external factors that influence the wellbeing of a nurse practitioner in the workplace were determined as social factors, economical factors and factors inherent to a workplace.

The internal factors that influence the wellbeing of a nurse practitioner in the workplace were furthermore determined as physical factors, psychosocial factors and spiritual factors.

The literature study as well as the research data yielded recommended an integrated managerial strategy for effective management of HIV/AIDS in the workplace.

The respondents indicated that they were aware of

- an existing workplace HIV/AIDS policy,
- a workplace HIV/AIDS prevention and awareness programme, and
- a HIV/AIDS training programme for the management team of the institution.

The respondents were however, of opinion that a HIV/AIDS task team, VCCT facilities and a peer educational programme were not adequately promoted.

The respondents assumed that the head-office of the Company took responsibility to direct the HIV/AIDS strategy and policy in the workplace, although many respondents indicated that it could be a HIV/AIDS task team as well. Even though satisfied with the involvement of the managerial team of the Company, the respondents indicated that nurse practitioners should be allowed to be involved with the process as well. Administrative practitioners such as found in Human Resources

departments, should be less involved in the development of a workplace HIV/AIDS strategy and policy applicable to nurse practitioners.

The respondents indicated that it is important to focus on (in order of importance):

- thorough information on the workplace HIV policy,

- information on HIV/AIDS issues,

- managerial or employer and colleague's support,

- open discussions with disclosure enhancement, and

- VCCT facilities with free distribution of condoms.

The proposal was therefore made that the physical and psychosocial, as well as economical and occupational requisites with necessary education and information to the nurse practitioner be purposefully addressed by means of a workplace wellness programme.

The obligation of an employer to develop as well as co-ordinate employee wellness to promote and enhance positive health, positive daily living principles and wellbeing amongst nurse practitioners, were determined as proposed managerial factors, internal as well as external workplace factors that disposition the development of a workplace wellness programme.

With regard to the enhancement of positive health and wellbeing, the respondents indicated that they considered the following interventions as being important (in order of importance):

- protection against safety risks in the workplace,

- appropriate health insurance or medical aid,

- an operational and sustainable workplace wellness programme,

- a market related monthly salary with agreeable working conditions,

- attention to personal hygiene and development,

- family orientated activities and involvement, and

- sex education.

Concerning HIV/AIDS awareness initiatives, the respondents indicated that they are interested in:

- educational classes,

- interactive counselling initiatives, and

- receiving an awareness newsletter, awareness posters and awareness flyers.

It is of importance to remark that a large percentage of the respondents stated that they were not interested in undergoing health screening such as VCCT where feedback is not given.

Information on HIV/AIDS issues that should be addressed in a workplace wellness programme elicited from the respondents included:

- self-care strategies if diagnosed HIV positive or negative,

- information on HIV/AIDS origin, prevention and treatment options,

- information on physical, mental, psychological and spiritual care for the self and others if infected with or affected by HIV/AIDS,

- other sexually transmitted diseases, and

- employment options.

Trying to determine the level of interest in lifestyle initiatives that could be addressed through means of a workplace wellness programme evoked mixed reactions from the respondents. They indicated that they were very interested in:

- how to manage stress,

- working hours that allow you to have enough rest periods,

- how to stay employed, and

- protection initiatives against life threatening diseases such as HIV/AIDS.

However, to a lesser degree were the respondents interested in group information sessions and information on safe sex practices.

Concerning health and wellness promotional services provided in a workplace, the respondents indicated that there should be a focus on:

- a psychology service to address emotional health such as depression and stress or anxiety related issues,

- communication skills training, and the

- provision of personal protective equipment.

The respondents indicated that health and wellness promotional services that are to be rendered in a workplace included (in no particular order of importance):

- ART or medication for HIV positive nurses,

- A HIV/AIDS workplace policy,

- Self-care education on issues such as hygiene, nutrition, sexual health, exercises, sleep and rest,

- Self-care education on HIV/AIDS,

- VCCT services

- Prevention and treatment services for Sexually Transmitted Diseases and Tuberculosis.

The respondents indicated that the health and wellness promotional programmes should include the family members. They also highly recommended the availability of an occupational health nurse practitioner skilled in HIV/AIDS issues in the workplace.

The respondents stated that peer and counsellor education should be implemented, as well as an operational HIV/AIDS workplace task group.

The distribution of free condoms was also indicated as a health and wellness promotional service to be rendered in a workplace.

The nurse practitioners in this study effectively indicated that:

1) they propose to stay healthy and well,

2) they regard the current management of HIV/AIDS in their workplace to be reconsidered, and which

3) health and wellness promotional interventions and services should be implemented to support a sustainable and effective workplace wellness programme.

The literature findings and research data procured finally identified the objectives and components necessary for a disposition of a workplace wellness programme. The disposition should focus on the following:

- creating an awareness of health and occupational topics that pose a hazard in the workplace and have an effect on nurse practitioners' wellbeing such as HIV/AIDS,

- health education, information and behaviour modification strategies to promote lifestyle changes and optimal health and wellbeing, as well as

- creating a supportive work environment that encourages nurse practitioners to obtain and maintain positive health and wellness (O'Donnell, 2002: xxii – xxiv, 211, 460, 545 and 571; Van Dyk, 2008: 469).

The respondents therefore provided important information about components

necessary for the development of a sustainable and effective workplace wellness

programme for nurse practitioners in South Africa.

CHAPTER 5

Framework

5.1 Introduction

Nurse practitioners have the appetency for being healthy and well within an environment where they daily face HIV/AIDS, taking the HIV-prevalence rate of 19.6% estimated for South African adult women between 15 – 49 years of age (Statistics South Africa, 2008: Statistical release P0302; Cavanagh, 1991: 16 and 17) into consideration. Thence the recommendation in the South African Employment Equity Act, No. 55 of 1998, which contains the Code of Good Practice on key aspects of HIV/AIDS and Employment (The Code), for the development and implementation of a workplace wellness programme for employees affected by HIV/AIDS.

According to the WHO (2006: online) a mode of existence that indicates complete physical, social and mental wellbeing and not merely the absence of an illness or disability, is defined as health. There-to conjoining is wellbeing explained as a contented positive condition of the body, mind and spirit and social adaptability where social and economical networks and resources exist to encourage, develop, and nurture health in all its dimensions (Hawk, 2005: 191; Hall, 2007: 130). This state of wellbeing where a person experiences positive health as demonstrated by the quality life he or she lives, typifies wellness (Corbin and Pangrazi, 2001: 1).

A workplace wellness programme is furthermore considered a valuable venue, as confirmed with the study results, where through an awareness of positive physical and mental health and wellbeing could channel to support modification to healthy lifestyles. It assists employees who encounter physical and psychosocial needs through providing appropriate information, health education, legal assistance and economical direction (O'Donnell, 2002: xxii, 19, 544 and 571).

The researcher therefore developed a framework (Figure 5.9, Page 243) that represents a structured approach to the interaction and interdependence of components that influence the uptake of knowledge and evidence from research to guide the design of a workplace wellness programme for nurse practitioners affected by HIV/AIDS.

The researcher applied research evidence acquired from a literature study and the feedback data received from a quantitative research methodology to offer a mode of reference to describe, integrate, and connect the theorized relationships amongst the components of the proposed framework (McCray, 2003: 392 and 393). The researcher furthermore utilized the logic model to demonstrate the theory of change underpinning this framework for the development of a workplace wellness programme.

5.2 A framework

5.2.1 Definition

A framework is a theoretical guide of meaning to express views to research findings, evaluate existing knowledge and describe and explain and predict thoughts and behaviours which need to be tested through further research (Lunney, 2008: 28; Doran and Sidani, 2007: 3).

A framework helps to organize ideas, reach conclusions and understand an event through the abstract and valid clarification and careful structuring of knowledge developed inductively from theoretical work and theories (Burns and Grove, 2005: 121; Lunney, 2008: 28).

A prerequisite for the development of the framework was the clarification of the components that have an influence (Hjørland, 2009: 1519 -1521) on the disposition of a workplace wellness programme. This was accomplished after conducting a literature review (Chapter 2). The framework was furthermore developed and concluded on a justifiable logic model describing the theory of change (Frechtling, 2007: 1 – 18; McDavid and Hawthorn, 2006: 15 and 54; W.K. Kellogg Foundation, 2002: 9) it endeavoured to achieve.

5.2.2 The formulation of the framework

The following three (3) steps guided the researcher in formulating the framework for a workplace wellness programme for nurse practitioners infected with and/or affected by HIV/AIDS:

STEP 1:

- Components that influence the development of a workplace wellness programme were identified after having done an extensive literature study (Chapter 2) and are illustrated in Figure 5.1(a) (Page 217).

STEP 2:

- Components necessary for the development of a workplace wellness programme were identified after yielding the opinions of nurse practitioners by means of a structured questionnaire. Thereafter relational statements were made, which means statements were developed relating to the identified components (Chapter 4). The components that should hence be addressed in a workplace wellness programme are illustrated in Figure 5.1(a) (Page 217) as well.

STEP 3:

- The theory of change logic model (Frechtling, 2007: 1 – 2; W.K. Kellogg Foundation, 2002: 9) was utilized to explain, develop and illustrate the framework for a workplace wellness programme (Figures 5.2 – 5.9).
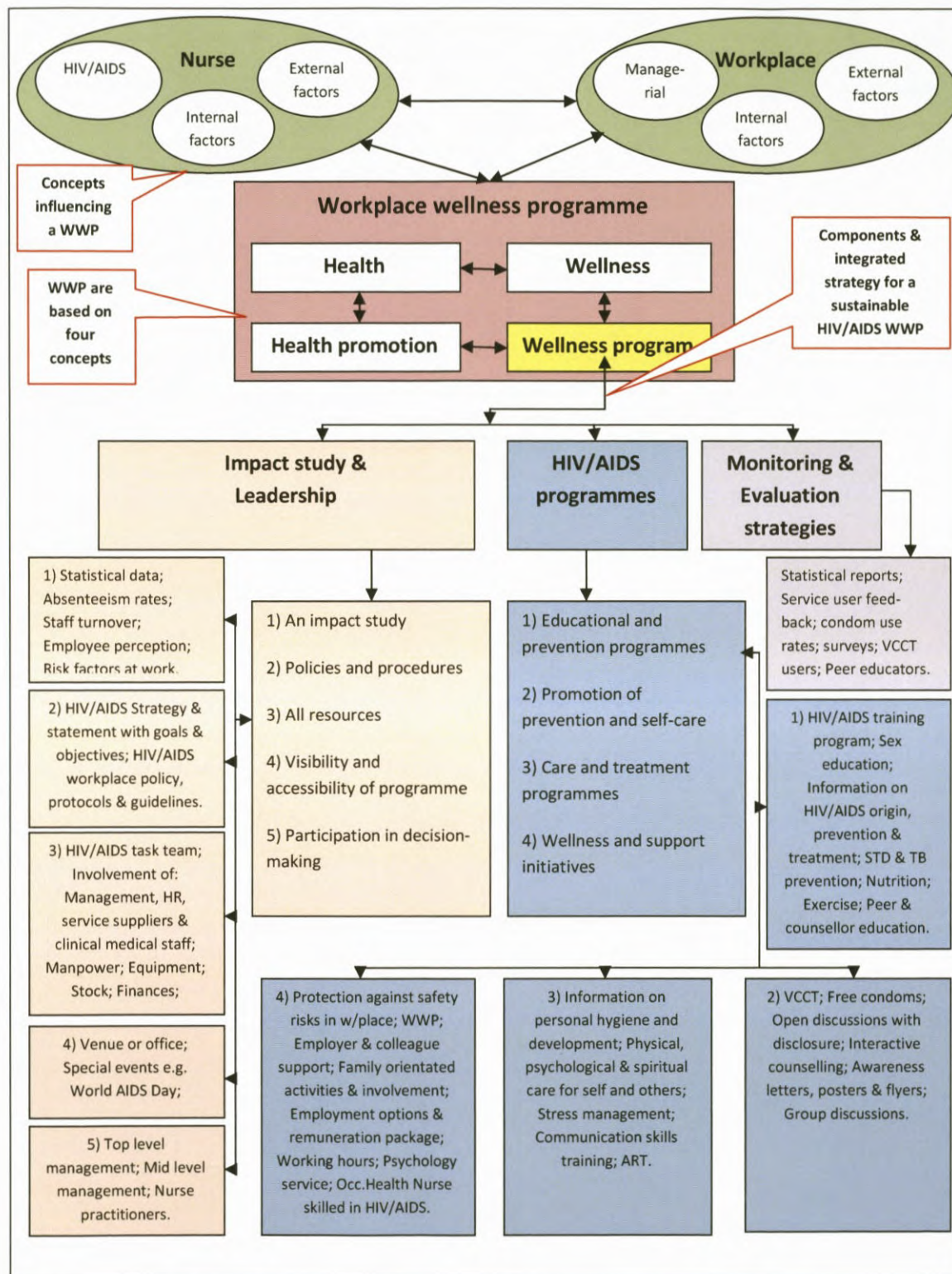
Figure 5.1(a)   Components to be addressed in a workplace wellness programme for nurse practitioners (Illustration)

5.2.3 Framework for a workplace wellness programme

5.2.3.1 Logic model

A logic model is a tool that renders a visual image or picture of how a programme is expected to achieve its intended outcomes (W.K. Kellogg Foundation, 2002: 1) and guides the components underlying a programme. It furthermore describes the causal linkages from the start of a programme up until achieving the programme objectives (W.K. Kellogg Foundation, 2002: 11), clearly defining as well as describing the theory of change that supports a programme. Hereto a programme depicts a group of projects or activities to achieve the desired goals or objectives (Frechtling, 2007: 5 and 18; McDavid and Hawthorn, 2006: 15 and 54).

A logic model explains how a programme will work under certain environmental conditions to solve the identified problems (W.K. Kellogg Foundation, 2002: 15).It furthermore communicates the intentions of a programme to persons outside the programme in a short, to the point and compelling way (Wholey, Hatry and Newcomer, 2004: 8 and 11). In other words, a logic model organizes the information of a programme in a comprehensible and logical flow of events allowing the reader to determine which activities lead to what outcomes (Wholey *et al.*, 2004: 19).

Hence, the logic model produces effective programming that describes which strategies should be implemented and what resources are important to arrive at the intended goals and objectives of a programme. It furthermore sets the platform to

clearly explain and illustrate what works and why, and what a programme intends to do (W.K. Kellogg Foundation, 2002: 1 – 5).

The theory of change supporting a programme is described in the logic model. A theory of change is an explanation of the causal links that connect the programme activities to the expected outcomes. It consists of elements and connections, as well as context for planning and managing activities in the programme where evaluation is important (Frechtling, 2007: 1- 2; Julian, 2005: 162; W.K. Kellogg Foundation, 2002: 27).

Accordingly, a logic model assists skilful construction and planning of a programme, because the success of programme planning relies on the following:

- the goals and objectives of a programme,

- which factors influence these goals and objectives,

- what the programme is all about,

- how the different components interact with each other, and

- how the programme will be managed (W.K. Kellogg Foundation, 2002: 6).

The conclusion is therefore made that a programme represents a theory and the evaluation is its test (W.K. Kellogg Foundation, 2002: 9 and 27), because the theory of change has an influence on the design and plan for a programme.

5.2.3.2 The theory of change logic model

The W.K. Kellogg Foundation (2002: 27) indicated that the theory of change explains the reasons for initiating a programme. Hereto determined by the researcher that a HIV/AIDS infected and/or affected nurse practitioner could experience positive health and wellbeing if the daily challenges, such as health and wellness issues, domestic problems and occupational demands are solved and dealt with.

The researcher continued that it is attainable with the implementation of a well-designed sustainable and effective operational workplace wellness programme. Factors that have an affect on such a programme could be furthermore emphasised for example factors related to the nurse practitioner and the workplace respectively. The researcher was henceforth enable to determine, as well as anticipate which strategies, example the performing of an impact study and resources such as managerial leadership will be required to warrant a successful programme.

The data that concedes that effective management of HIV/AIDS in the workplace is attainable through the establishment of a workplace wellness programme is demonstrated by the theory of change found within the logic model presented by the researcher.

The ingredients of the theory of change logic model are, according to the W.K. Kellogg Foundation (2002: 9 and 27), the following:

1) it contains components that specifies which problem will be addressed in the

    programme,

2) it describes the reason behind the selection of strategies,

3) it connects strategies to activities,

4) it may identify alternative assumptions a person holds that may influence the

    efficiency of the programme.

The theory of change logic model therefore illustrates how and why the researcher

believes that a workplace wellness programme will achieve its proposed goals and

objectives, because the focus is on the problem and the reasons for proposing the

given solutions (W.K. Kellogg Foundation, 2002: 28).

Subsequently the researcher focussed on the Theory of Change Logic Model template (W.K. Kellogg Foundation, 2002: 27, 31 and 57), as illustrated in Figure 5.2, to assist in understanding the framework.
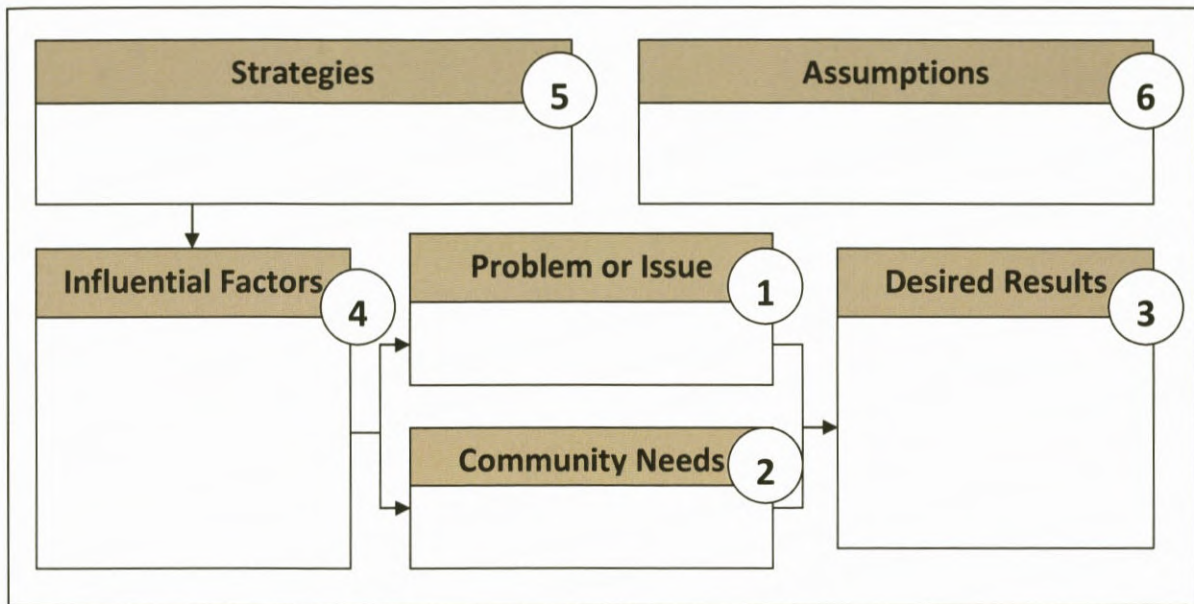
Figure 5.2   Theory of Change Logic Model Template (W.K. Kellogg Foundation, 2002: 57)

The theoretical components were arranged in six steps and linked together to explain the value and assumptions of the workplace wellness programme. The components, which are depicted in the six steps, consist of the problem (1), the community's needs (2), the desired results (3) , the influential factors (4), strategies (5) and assumptions (6) (Figure 5.2).

The researcher conducted a preliminary composition of the framework (Figures 5.3 –

5.8) where after a framework for a workplace wellness programme is presented and

illustrated (Figure 5.9, Page 243).

5.2.3.3   Preliminary composition of the framework for a workplace wellness programme

The preliminary composition of the framework is arranged in the six steps as

suggested in the Theory of Change Logic Model (W.K. Kellogg Foundation, 2002:

31), here forth referring to the six components as well.

The researcher furthermore attempted to compliment the explanation to each step by

highlighting the applicable coloured boxes from the components that should be

addressed as illustrated in Figure 5.1(a) (Page 217) to avoid any confusion to the

reader. Example: The problem or issue indicated in Figure 5.3 will be a light red

colour, coinciding with Figure 5.9 (Page 243), whereas the blue coloured box

indicating the community needs (Figure 5.4, Page 227), will coincide with both

Figures 5.1(a) (Page 217) and 5.1(b) (Page 228), as well as with Figure 5.9.

5.2.3.3.1 Step1: The problem or issue

The problem or issue describes the problem the workplace wellness programme is attempting to solve or will address and is illustrated in Figure 5.3.
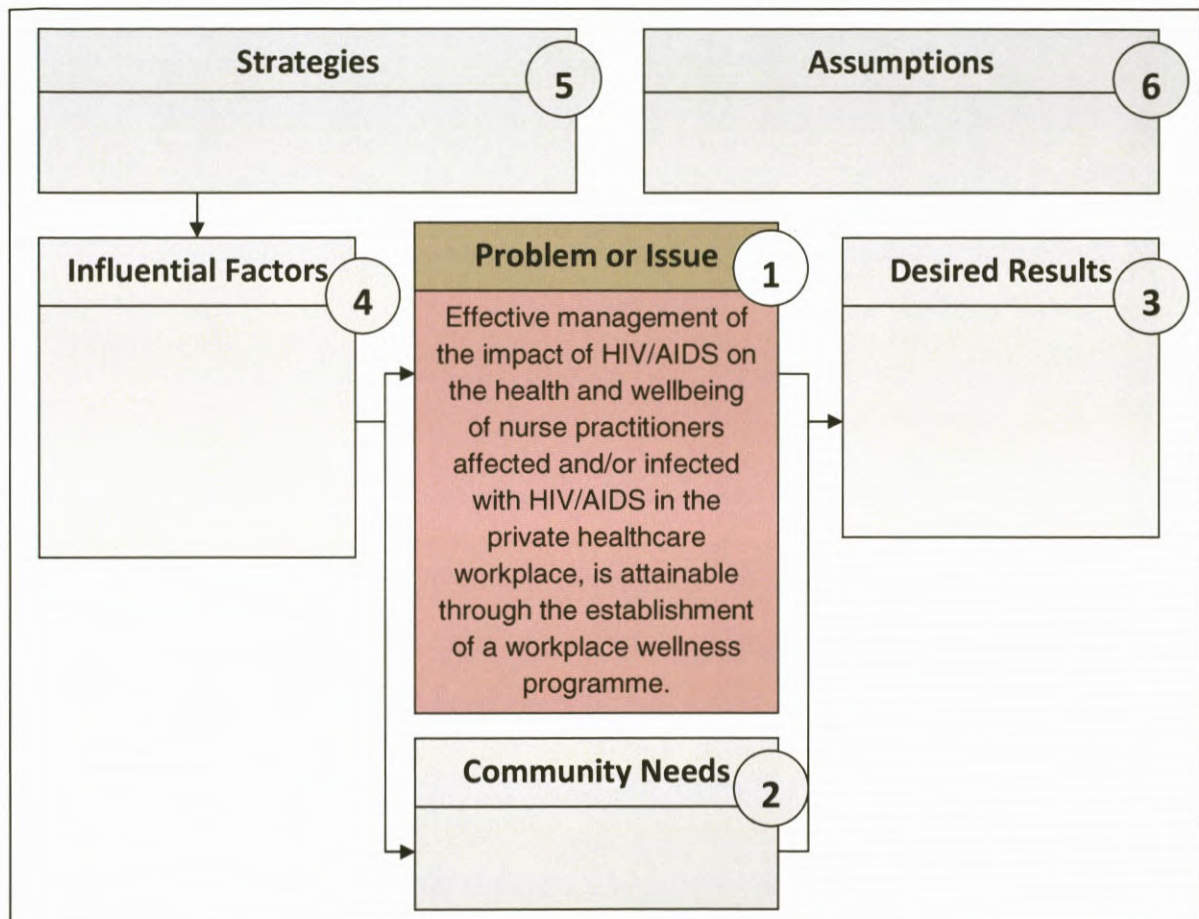
Figure 5.3   Preliminary framework describing the problem

The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (The Code) (The South African Labour Relations Act No. 66 of 1995, the South African Employment Equity Act No. 55 of 1998 and the Occupational Health and Safety Act

of 1993) and others such as the ILO, consider HIV/AIDS as a workplace issue (Geneva. International Labour Office, 2002: 6). The Code recommends the establishment of a workplace wellness programme to guide employers and employees, in this regard the nurse practitioners, with the intent to manage HIV/AIDS and prevent unfair discrimination within the workplace.

Coinciding, a literature review conducted by the researcher (Chapter 2) concluded that HIV/AIDS infected and/or affected nurse practitioners have a desire to stay healthy and well (Cavanagh, 1991: 16 & 17) within an environment where they experience the comfort and security of being in control of their daily living (Orem, 1980: 145). The researcher furthermore indicated that nurse practitioners are especially affected by the HIV-prevalence rate of 19.6% estimated for adult South African women within the 15 – 49 years age group (Statistics South Africa, 2008: Statistical release P0302) because approximately 92.51% registered nurse practitioners in South Africa, students and healthcare givers excluded, comprise of female adults (South African Nursing Council, 2008: online).

According to Van Dyk (2008: 470), the employer therefore has a legal obligation to develop and coordinate employee wellness to promote a supportive environment where the quality of life is improved and morbidity and mortality amongst HIV/AIDS infected and/or affected nurse practitioners are reduced. The researcher furthermore explained in the literature review that Janse van Rensburg (2008: 3, 4 & 61) and Versteeg (2004: 12 & 34) support the quality or worth and consequence that a workplace wellness programme should have on the workplace and its nursing

population through applying well-considered managerial processes and legislative input.

Consequently, the researcher yielded and interpreted information from a sample of the target population through quantitative descriptive research analysis (Chapter 4) which effectively indicated that the majority nurse practitioners:

(1)   propose to stay healthy and well,

(2)   regard the current management of HIV/AIDS in their workplace to be reconsidered, and

(3)   which health and wellness promotional interventions and services should be implemented to support a sustainable and effective workplace wellness programme.

The literature findings and research data procured finally identified the objectives and components necessary for a disposition of a workplace wellness programme. The disposition should focus on the following:

- creating an awareness of health and occupational topics that pose a hazard in the workplace and have an effect on nurse practitioners' wellbeing such as HIV/AIDS,

- health education, information and behaviour modification strategies to promote lifestyle changes and optimal health and wellbeing, as well as

- creating a supportive work environment that encourages nurse practitioners to obtain and maintain positive health and wellness (O'Donnell, 2002: xxii – xxiv, 211, 460, 545 and 571; Van Dyk, 2008: 469).

5.2.3.3.2 Step 2: Community needs

The community's needs (Figure 5.4), which depict specific needs of nurse practitioners (Figure 5.1(b), Page 228, blue boxes), prompted the researcher to design a programme to address the problem.

Figure 5.4 Preliminary framework describing the community needs

Nurse

HIV/AIDS

External factors

Internal factors

Workplace

Manage-rial

External factors

Internal factors

Concepts influencing a WWP

WWP are based on four concepts

Workplace wellness programme

Health	Wellness
Health promotion	Wellness program

Components & Integrated strategy for a sustainable HIV/AIDS WWP

Impact study & Leadership

HIV/AIDS programmes

Monitoring & Evaluation strategies

1) Statistical data; Absenteeism rates; Staff turnover; Employee perception; Risk factors at work.

2) HIV/AIDS Strategy & statement with goals & objectives; HIV/AIDS workplace policy, protocols & guidelines.

3) HIV/AIDS task team; Involvement of: Management, HR, service suppliers & clinical medical staff; Manpower; Equipment; Stock; Finances;

4) Venue or office; Special events e.g. World AIDS Day;

5) Top level management; Mid level management; Nurse practitioners.

1) An impact study

2) Policies and procedures

3) All resources

4) Visibility and accessibility of programme

5) Participation in decision-making

1) Educational and prevention programmes

2) Promotion of prevention and self-care

3) Care and treatment programmes

4) Wellness and support initiatives

Statistical reports; Service user feed-back; condom use rates; surveys; VCCT users; Peer educators.

1) HIV/AIDS training program; Sex education; Information on HIV/AIDS origin, prevention & treatment; STD & TB prevention; Nutrition; Exercise; Peer & counsellor education.

4) Protection against safety risks in w/place; WWP; Employer & colleague support; Family orientated activities & involvement; Employment options & remuneration package; Working hours; Psychology service; Occ.Health Nurse skilled in HIV/AIDS.

3) Information on personal hygiene and development; Physical, psychological & spiritual care for self and others; Stress management; Communication skills training; ART.

2) VCCT; Free condoms; Open discussions with disclosure; Interactive counselling; Awareness letters, posters & flyers; Group discussions.

Figure 5.1(b)   Community needs to be addressed in a workplace wellness programme for nurse practitioners (Illustration)

The researcher established from the literature review that a nurse practitioner is able to promote and protect her health if human and material resources are made available to her (Van Dyk, 2008: 423). Nutbeam (1998: 351) explained that access to education and information are important venues empowering the nurse practitioner to achieve her full health potential. Coinciding with the definition of the WHO in the Ottawa Charter for Health Promotion, health promotion is the process of enabling a person to increase control over, and improve their health (WHO/Europe, 1986: online).

Health promotion therefore represents the intercourse amongst health education, health enhancement and health behaviour with the prevention of disease and illness and the promotion of a higher level of health and wellbeing throughout life on a daily basis (Hartweg, 1990: 36; Kulbok, Baldwin, Cox and Duffy, 1997: 13 & 17). The nurse practitioner is hence prompted to undertake actions where personal habits and environmental issues such as experienced in the workplace are investigated and altered.

Nutbeam (1998: 351) continued to explain that health promotion is a process not only directed to develop skills and abilities of an individual, but it is actions directed to change social, environmental and economic conditions that have an impact on the physical, psychological, social and spiritual health of the nurse practitioner. The nurse practitioner has the ability to improve and sustain a positive health status if she could gain control over those determinants that influence her daily living.

The nurse practitioners in this study agreed with the literature review that the following component content of a workplace wellness programme could effectively address the needs of nurse practitioners (the community) confronted with HIV/AIDS (Figure 5.4):

- **educational and prevention programmes** addressing specific HIV-related information, sex education, STD and TB prevention, nutrition, exercise, as well as peer and counsellor education;

- **promotion of prevention and self-care**, focussing on VCCT, condom distribution, open and/or closed discussions, group discussions, counselling, as well as the distribution of awareness letters, posters and flyers;

- **care and treatment programmes** addressing health, wellness and self-care information such as stress management, promoting effective communication skills, ART, STD and TB screening, treatment and management; and

- **wellness and support initiatives** as supplied by a workplace wellness programme, employer support, occupational health support professionals and psychological assistance (IFC, 2002: online; Thomas, Colvin, Rosen and Zuccarini, 2005: online; Van Zyl, 2009: online; ILO, 2002: online).

5.2.3.3.3 Step 3: Desired results

The desired results refer to the identification of outcomes the researcher aspired to achieve in the short-, medium- and long-term (Figure 5.5).
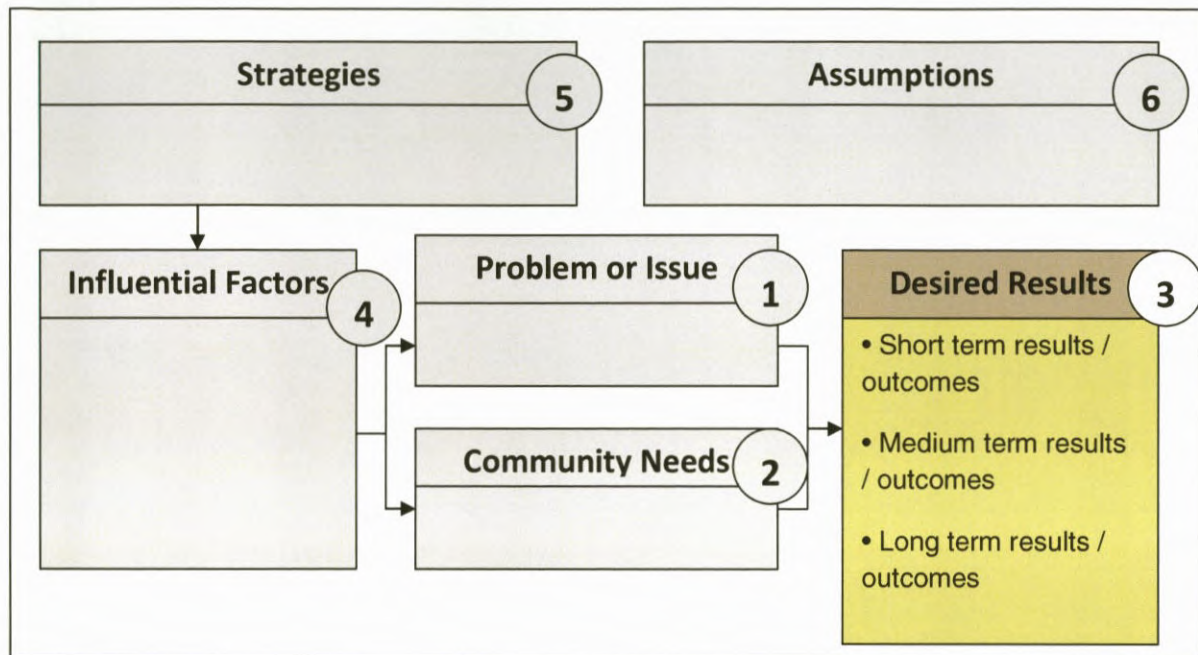
Figure 5.5   Preliminary framework describing the desired results

Frechtling (2007: 22) and Wholey *et al.* (2004: 9) explained that the desired results, also referred to as outcomes, represent the change or benefits that are intended to occur, indicating that the programme goals and objectives have been attained. The theory of change would be accurate if the desired outcomes were reached, such as change in attitudes, behaviours or that knowledge increased. McDavid and Hawthorn (2006: 48) furthermore stated that these desired results or outcomes are statements that the intentions of a programme to solve problems and bring about change, such

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as in the workplace, could be achieved if the programme is successfully implemented.

The desired results have a time dimension namely short-term, medium-term and long-term outcome(s) (Frechtling, 2007: 23; Wholey et al., 2004: 9 & 52). Short-term outcomes are changes or benefits most closely associated with the programme results, such as compliance of the HIV/AIDS workplace strategy, goals and legislation that was reached. Implementing a sustainable and effective workplace wellness programme is an example of a medium-term outcome explaining the changes that resulted from the short-term outcomes. Long-term outcomes are finally changes or benefits that stemmed from the medium-term outcomes, therefore the maintaining of a sustainable and effective workplace wellness programme. Figure 5.9 (Page 243) illustrates the desired results the researcher poses to reach.

5.2.3.3.4 Step 4: Influential factors

Influential factors represent a list of factors (Figure 5.6; Figure 5.1(c), Page 234, olive green oval shapes) the researcher believes would influence change in the target population, being the nurse practitioners.
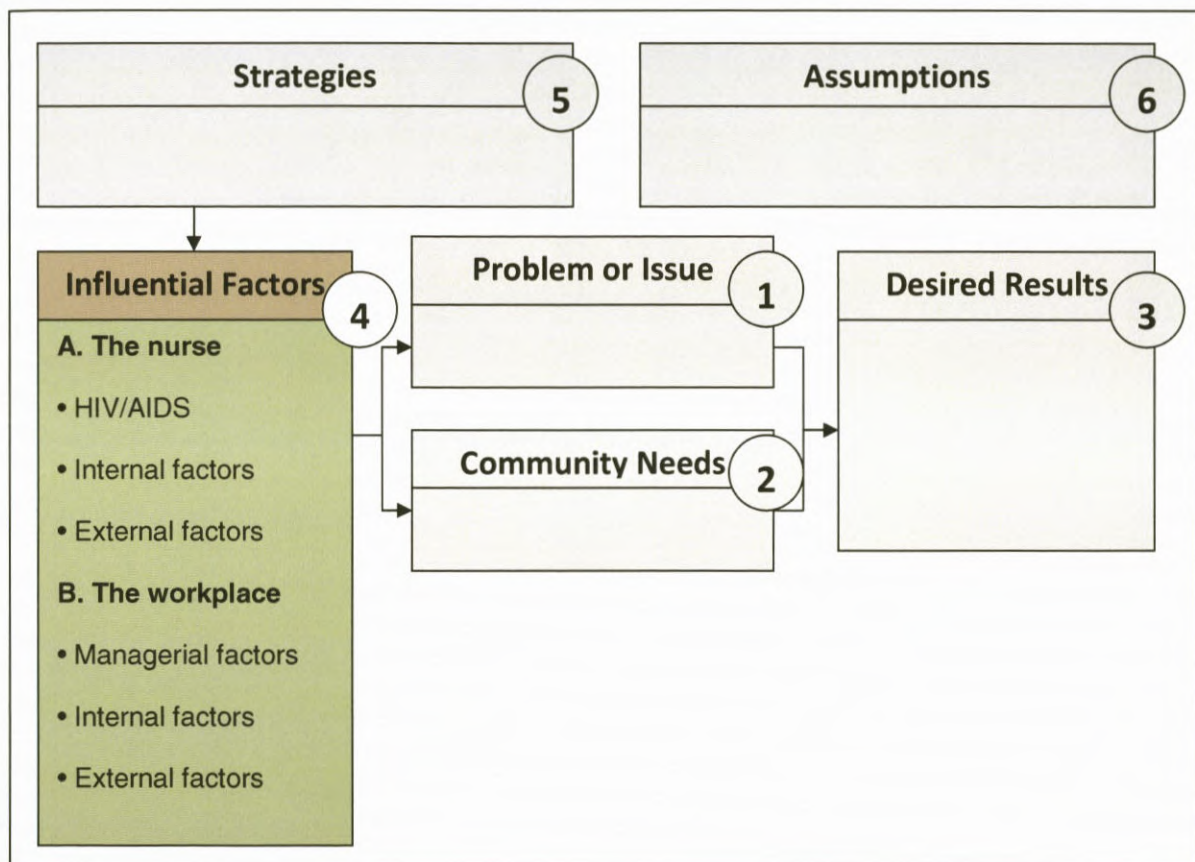
Figure 5.6   Preliminary framework describing the influential factors

The researcher furthermore determined from the literature review that factors believed influencing change in nurse practitioners could be explained as factors relating to the nurse practitioner and factors relating to the workplace.
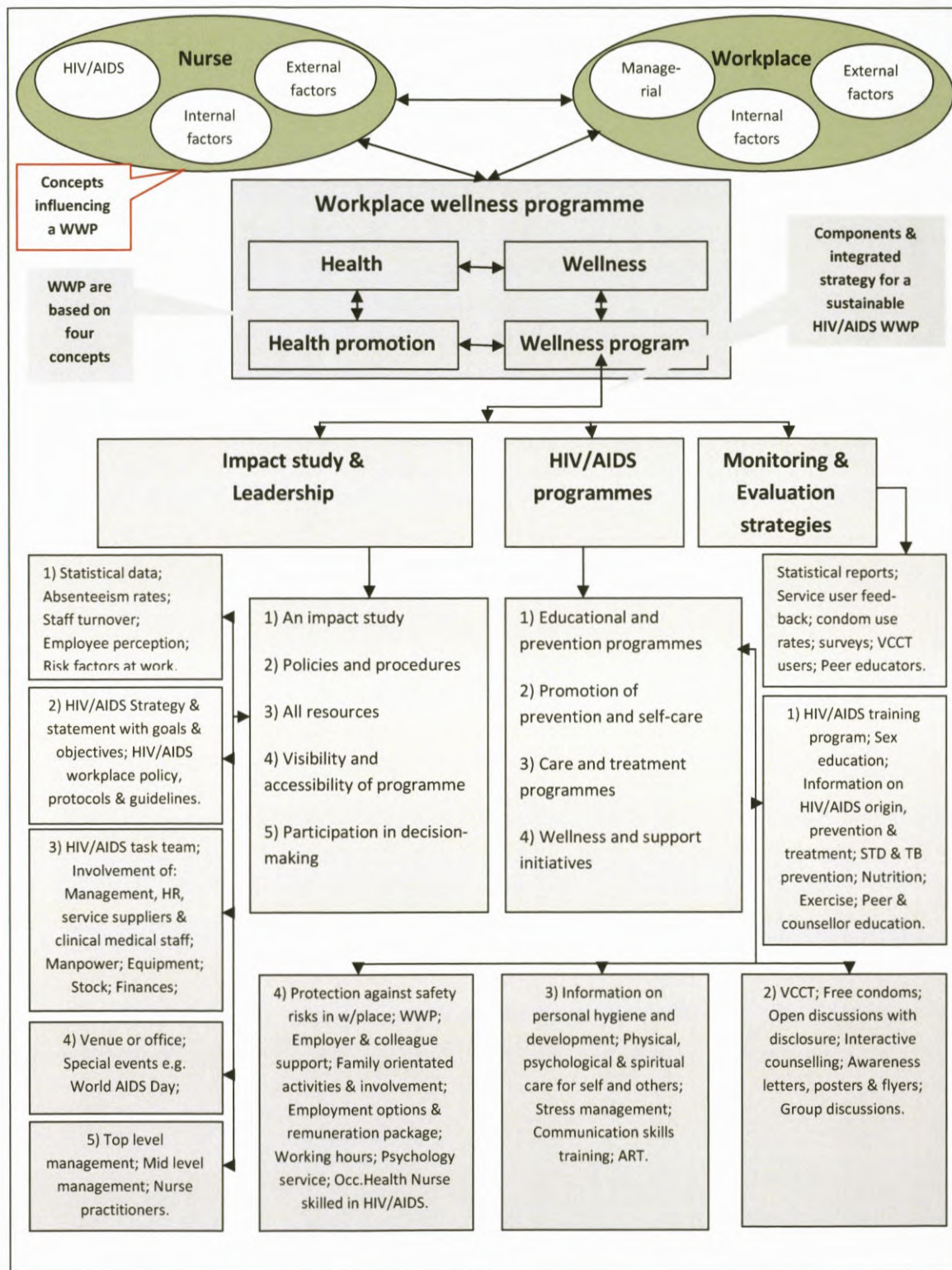
Figure 5.1(c) Influential factors to be considered in a workplace wellness programme for nurse practitioners (Illustration)

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Influential factors relating to the nurse practitioner (Figure 5.6) depict the following:

- **HIV/AIDS** related issues that affect nurse practitioners such as the HIV-prevalence rate for female adults 15 – 49 years of age in South Africa, because HIV/AIDS have become the leading cause of death amongst working adults in South Africa. Nurse practitioners are directly affected, because the nurse practitioners in South Africa consist predominantly out of the sexually and economically active members of society (Myslik, 2000: 14; Van Dyk, 2008: 34).

- **External factors** that comprise of social, economical and workplace issues that have a debilitating effect on the health and wellbeing of the nurse practitioner due to the increasing demands placed on their care-giving role (Holzemer, Uys, Makoae, Stewart, Phetlhu, Dlamini, Greeff, Kohi, Chirwa, Cuca and Naidoo, 2007: 549 - 550; Booysen and Mafereka, 2006: 2).

- **Internal factors** that challenge the ability of nurse practitioners to be in control of the quality of life and level of psychophysical wellbeing they aspire to. Oyeyemi, Oyeyemi and Bello (2006: 201 - 203) described in their study the apprehensiveness and hesitance of individuals to socialize with a HIV/AIDS infected or affected person due to the perceived stigma associated therewith. The degree of bio-psychosocial and spiritual wellbeing of a nurse practitioner enables her to redefine her life and find a sense of meaning and purpose as to enhance and maintain a positive approach to her daily existence (Bosworth, 2006: S3 - S4).

Influential factors relating to the workplace (Figure 5.6), which is an environment within which a nurse practitioner conducts her daily tasks (Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner, 2005: 20 – 21) consist of the following:

- **Managerial factors** providing educational and prevention strategies in a safe working environment that enable nurse practitioners to address barriers clouding their ability to apply efficient coping skills leading to a productive healthy life. The employer has to apply managerial activities endorsed by internal directives such as policies, protocols and strategic input for mechanisms to combat problems encountered by nurse practitioners in the workplace (Page, Louw and Pakkiri, 2006: 112).

- **External factors** that comprise of legislation and a company policy on HIV/AIDS that put an obligation upon the employer to ensure basic respect for human rights and the dignity of all people. This legislation and company policy governs an organization to position itself in dealing with the disease in the workplace and what guidelines are to be adopted to ensure consistent practices and decisions (Van Dyk, 2008: 454; Nel *et al.*, 2005: 296).

- **Internal factors** that suggest a workplace wellness programme as a valued venue whereby primary sexual behaviour change, open communication about HIV/AIDS and people infected and/or affected by the disease and organizational structures and interventions of support and contact and care could be managed (Low-Beer, 2005: 478; O'Donnell, 2002: 544).

5.2.3.3.5 Step 5: Strategies

Strategies refer to actions or activities (Figure 5.7; Figure 5.1(d), Page 238, orange & light purple boxes) that could bring about change to achieve the intended results or outcomes through means of a workplace wellness programme.

Strategies (5)
- Do impact study
- Establish appropriate policies and procedures
- Determine and instate all resources
- Determine visibility and accessibility of programme
- Determine participation in decision-making
- Identify, implement and execute HIV/AIDS programmes
- Develop monitoring and evaluation strategies

Assumptions (6)

Influential Factors (4)

Problem or Issue (1)

Community Needs (2)

Desired Results (3)

Figure 5.7   Preliminary framework describing the strategies
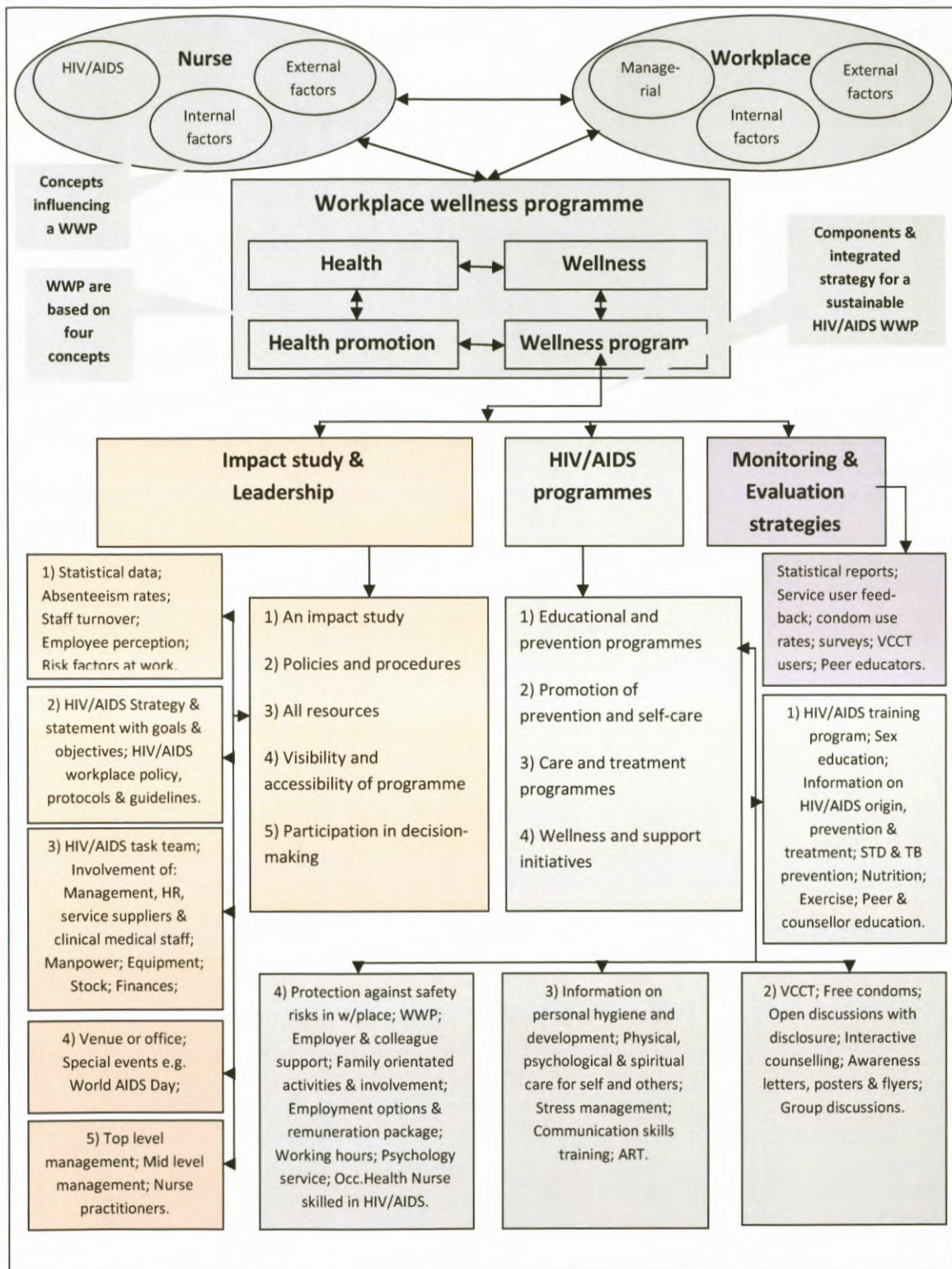
Figure 5.1(d) Strategies to be addressed in a workplace wellness programme for nurse practitioners (Illustration)

Frechtling (2007: 21 – 23) and Hamilton together with Bronte-Tinkew (2007:1) explained that if activities are systematically planned and implemented within a predetermined time frame, a programme should achieve the desired goals or outcomes. The researcher hence determined that the following well-planned strategies could contribute to an accepted workplace wellness programme for nurse practitioners (Figure 5.7):

- An **impact study** should be undertaken, strongly advised by the IFC (2002: online), to be knowledgeable on the fundamental facts about HIV/AIDS and the economical impact of HIV/AIDS in the organization;

- Determine the organizational response to HIV/AIDS, as well as the degree of compliance to **legal, ethical and policy issues**, as suggested by Van Dyk (2008: 461 & 466);

- Determine which **resources** should be acquired such as promotional material, manpower, equipment, stock, finances and communication structures. O'Donnell (2002: 211, 460, 571 & 545) and Van Dyk (2008: 469) furthermore emphasised the importance of determining visibility and accessibility by requiring an allocated office or venue, doing ongoing marketing and promotion on the benefits of a workplace wellness programme, as well as inviting employee involvement. Orem (1980: 210) expanded that appropriate expertise and resources should be selected to successfully address the nurse practitioner's self-care deficits such as providing a referral system with other healthcare providers to address her physical, social, or spiritual needs.

- The nurse practitioners indicated in this study that although the head-office of a company took responsibility to direct HIV/AIDS strategies, a HIV/AIDS task team should be utilized as well. However, the nurse practitioners indicated

that they should be allowed to be involved as well. Page *et al.* (2006: 112) agreed that nurse practitioners should be encouraged to become involved in **decision-making processes** in the workplace and contribute input for mechanisms to combat problems encountered by HIV/AIDS when developing and executing a workplace wellness programme for nurse practitioners.

- Together the IFC (2002: online), ILO (2002: online) and Van Zyl (2009: online), with the nurse practitioners of this study, indicated that the following **component content of a workplace wellness programme addressing HIV/AIDS**, should comprise of the following:

    - educational and prevention programmes;

    - promotion of prevention and self-care;

    - care and treatment programmes; and

    - wellness and support initiatives.

- **Monitoring and evaluation strategies** should be developed to enable an organization to measure its progress against the stated goals and objectives to make informed decisions on the effectiveness of a workplace wellness programme and the HIV activities. Thomas *et al.* (2005: online), the IFC (2002: online), as well as Van Dyk (2008: 470) suggested several methods to conduct monitoring and evaluation strategies such as feed-back systems, condom use rates, number requests for VCCT service, including different kinds of surveys that could be undertaken.

5.2.3.3.6 Step 6: Assumptions

Assumptions are the convictions and belief why the change strategies should

achieve the objectives of a workplace wellness programme (Figure 5.8).
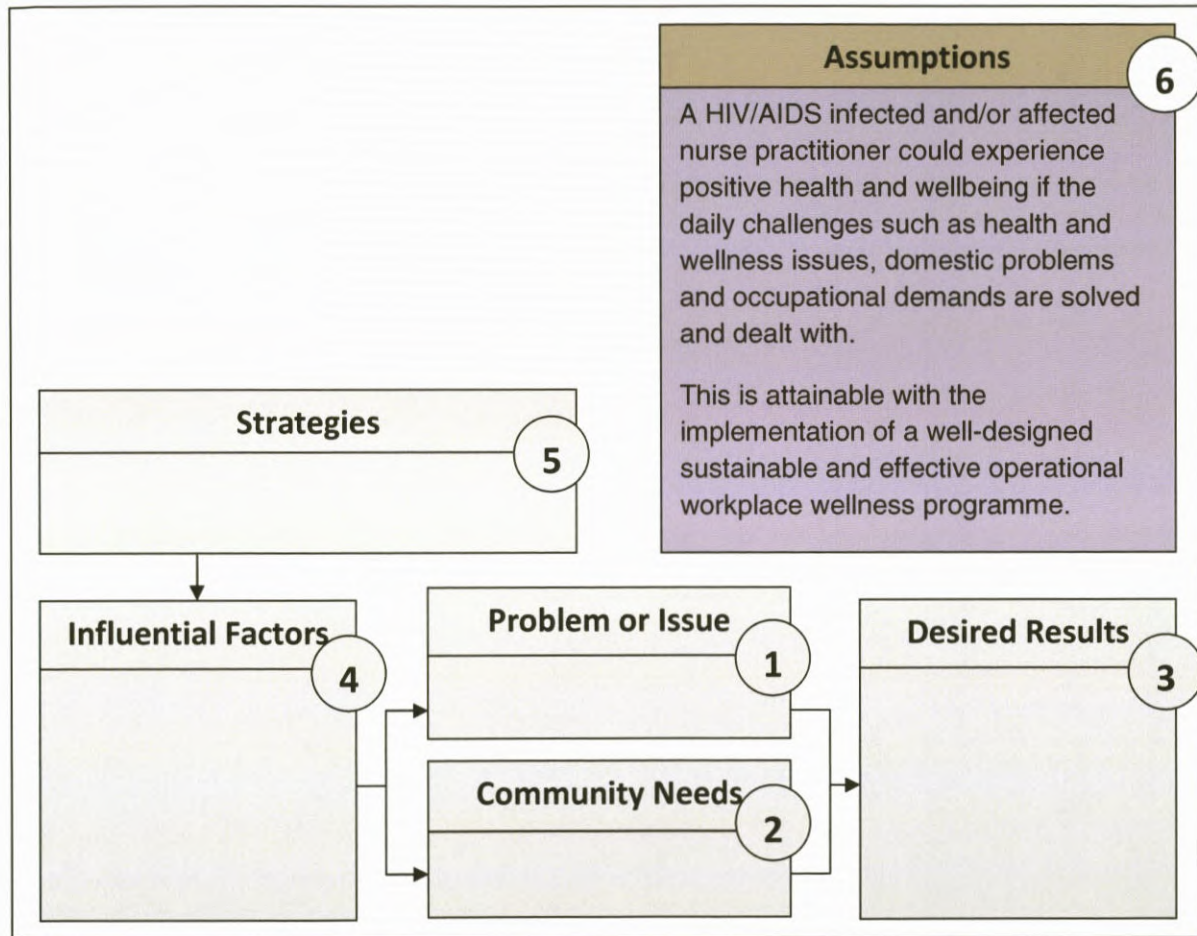
Figure 5.8 Preliminary framework describing the assumptions

The researcher finally arrived at an agreement with Hildebrandt (2002: 363 – 368)

and Smit (2005: 28) that positive wellbeing is embossed in the feeling of being in

control of your daily living, feeling good about yourself, being able to overcome energy tapping situations and avoid social biases and isolation. A nurse practitioner has a subjective perception of his/her physical, mental and social wellness, prosperity and context in which their life is being lived. A HIV/AIDS infected and/or affected nurse practitioner could arrive at a state of positive health and wellbeing if the daily situations like health issues, domestic problems and job related demands are creatively solved and dealt with through means of a workplace wellness programme.

5.2.3.4 Framework

A framework for a workplace wellness programme for HIV/AIDS affected and/or infected nurse practitioners is henceforth illustrated and visually presented (Figure 5.9, Page 243) by the researcher after having done the compilation of a preliminary framework.

Strategies ⑤

- Do impact study
- Establish & implement appropriate policies and procedures
- Determine and instate all resources
- Determine & instate visibility and accessibility of programme
- Determine & instate participation in decision-making
- Identify, implement and execute HIV/AIDS programmes
- Develop & instate monitoring & evaluation strategies

Assumptions ⑥

A HIV/AIDS infected and/or affected nurse practitioner could experience positive health and wellbeing if the daily challenges such as health and wellness issues, domestic problems and occupational demands are solved and dealt with.

This is attainable with the implementation of a well-designed sustainable and effective operational workplace wellness programme.

Influential Factors ④

A. The nurse
- HIV/AIDS
- Internal factors:
◊ Physical, psychosocial & spiritual factors
- External factors:
◊ Social, economical & workplace factors

B. The workplace
- Managerial factors
- Internal factors:
◊ Workplace policies, protocols & statements
◊ Informal & formal organizational structure
◊ Organizational culture
- External factors:
◊ National legislation
◊ International statements & policies

Problem or Issue ①

Effective management of the impact of HIV/AIDS on the health and wellbeing of nurse practitioners affected and/or infected with HIV/AIDS in the private healthcare workplace, is attainable through the establishment of a workplace wellness programme.

Community Needs ②

- **Educational and prevention programs:**
H/A program; Sex education; STD & TB prevention; Nutrition; Exercise; Peer & counsellor education
- **Promotion of prevention and self-care:**
VCCT; Free condoms; Open & group discussions; Counselling; Awareness letters, posters & flyers
- **Care and treatment programmes:**
Health and wellness info & self-care e.g. stress, communication skills, ART
- **Wellness and support initiatives:**
WWP; Employer support e.g. employment, safety, working hours, remuneration; Occ/H nurse; Psych aid

Desired Results ③

- **Short-term results:**
◊ Compliance of strategy, goals & legislation
◊ Decision-making process & tasks instated
◊ Health & wellbeing control gained
◊ Increased knowledge
◊ Nurse self-care acknowledged
◊ Absenteeism decrease & productivity increase
- **Medium-term results:**
◊ Implemented WWP
◊ Nurse's needs addressed
◊Health & wellness enhanced in workplace
- **Long-term results:**
◊ WWP maintained
◊ Nurse's maintain positive health & wellbeing
◊ Workplace maintain health & wellness enhancement

Figure 5.9 Framework for a workplace wellness programme

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5.3 Summary

The researcher presented a framework for a workplace wellness programme for nurse practitioners affected by and/or infected with HIV/AIDS, illustrating the theory of change underpinning the programme.

The component content of the workplace wellness programme was furthermore illustrated and summarized in consequence to a literature review and information yielded from nurse practitioners. Contextual influences on the workplace wellness programme were explained as well.

However, a recommendation is put forward in Chapter 6 (Page 248) for an appropriate evaluation strategy. The researcher agrees with the W.K. Kellogg Foundation (2002: 1) that evaluation strategies are of the utmost importance to evaluate to which extend a framework of a workplace wellness programme for nurse practitioners had succeeded to reach the expected outcomes.

A HIV/AIDS infected and/or affected nurse practitioner could experience positive health and wellbeing if the daily challenges such as health and wellness issues, domestic problems and occupational demands are solved and dealt with. This is attainable with the implementation of a well-designed sustainable and effective operational workplace wellness programme.

CHAPTER 6

Recommendations

6.1 Introduction

HIV/AIDS is a serious workplace health issue that involves the welfare of nurse practitioners, their health, social standing and employment responsibilities. Although they have a desire to stay healthy and well (Cavanagh, 1991: 16 & 17), they are daily confronted with the realities of HIV/AIDS considering the 19,6% HIV-prevalence rate estimated for South African female adults between 15 – 49 years of age (Statistics South Africa, 2008: Statistical release P0302).

The researcher concluded this study with the acknowledgement that nurse practitioners will experience positive healthy living and wellness if daily health and employment issues are effectively addressed. However, a requisite will remain for the co-responsibility and commitment of the employer to promote the health and wellbeing of people in the workplace (Hartwig, Pashman, Cherlin, Dale, Callaway, Czaplinski, Wood, Abebe, Dentry and Bradley, 2008: 1). The Code of Good Practice on Key Aspects of HIV/AIDS and Employment (the Code) was published on 1 December 2000 under the South African Labour Relations Act No. 66 of 1995 and the Employment Equity Act No. 55 of 1998 to guide employers and employees with the intent to ensure that people with HIV are not unfairly discriminated against in the workplace and how to manage HIV/AIDS within the workplace.

The Code emphasizes the importance for the creation of a supportive environment in order that employees living with HIV/AIDS could continue their work under normal circumstances, especially female employees. Employers are encouraged to develop and implement HIV/AIDS health promotional programmes in the workplace, such as a workplace wellness programme.

The aim of this study was hence the development of a framework that represents a structured approach to the interaction and interdependence of components that influence the uptake of knowledge and evidence from research to guide the design of a workplace wellness programme for nurse practitioners affected and/or infected by HIV/AIDS.

The researcher applied research evidence acquired from a literature study and the feedback data received from a quantitative research methodology to offer a mode of reference to describe, integrate, and connect the theorized relationships amongst the components of the proposed framework (McCray, 2003: 392 and 393). The researcher furthermore utilized the logic model to demonstrate the theory of change underpinning this framework for the development of a workplace wellness programme.

However, the following recommendations are put forward to address the limitations found in this study:

1) recommendations relating to the nurse practitioner and the workplace, and

2) recommendations relating to the framework.

6.2 Recommendations relating to the nurse practitioner and the workplace

The majority of respondents in this study comprised of white female nurse practitioners. Approximately 79 (seventy-nine) percent of the total South African population constitutes of Africans (Statistics South Africa, 2008: Statistical release P0302) who embrace strong traditional and cultural beliefs. African persons tend to go into denial when confronted with their HIV status and tend to refuse advice and help from persons outside their framework of reference (Van Dyk, 2008: 414). The opinion of nurse practitioners from this racial grouping should be further investigated as to ascertain their willingness to seek advice and help from the employer by means of a workplace wellness programme.

Research has determined that HIV/AIDS counselling provokes resistance amongst Africans (Mawar, Sahay, Pandit and Mahajan, 2005: 472), because explicit and sensitive sexual and complicated cultural beliefs are addressed (Van Dyk, 2008: 413). Traditionally giving advice is more acceptable to counselling (Dieleman, Biemba, Mphuka, Sichinga-Sichali, Sissolak, Van Der Kwaak and Van Der Wilt, 2007: 144). Further research in this occurrence needs to be investigated, because it will have a profound outcome on the sustainability of counselling services rendered in a workplace wellness programme.

Research was limited to one private healthcare facility in one city in the province of The Free State, South Africa. The study findings are limited to one sample and could not be appropriately generalized to the complete nursing population represented in the private healthcare sector. It would therefore be of value if the study could be expanded to include all nurse practitioners practicing in the private healthcare sector of South Africa. Value could also be added to the research study with the inclusion of the public healthcare sector. Expanding the study to include the public service nurse practitioners is commendable.

6.3 Recommendations relating to the framework

Evaluation strategies should be developed to enable an organization to measure its progress against the stated goals and objectives of a company on HIV/AIDS issues, as well as make informed decisions on the effectiveness and appropriateness of a workplace wellness programme and the HIV activities (IFC, 2002: online; Thomas, Colvin, Rosen and Zuccarini, 2005: online; Van Dyk, 2008: 470).

The researcher presented a framework for a workplace wellness programme for nurse practitioners affected by and/or infected with HIV/AIDS, illustrating the theory of change underpinning the programme. However, evaluating a programme should not be viewed as a separate management activity but marrying evaluation and the framework will result in effective programming (W.K. Kellogg Foundation, 2002: 1).

Thus a recommendation for the development of a conjoining framework (henceforth referred to as an evaluation framework) to evaluate to which extend the framework of a workplace wellness programme had succeeded to reach the expected outcomes and which alterations should be made.

The logic model depicting the evaluation strategy of the evaluation framework of this study would be explained and visually presented by the researcher as follows:

- A brief description of the basic components of a logic model;
- An illustration explaining the logic model of a proposed evaluation framework (Figure 6.5, Page 257); and
- A complimentary logic model illustrating one topic in such a proposed evaluation framework (Figure 6.6, Page 258).

6.3.1 The basic components of a logic model

A logic model comprises of four basic features or components namely inputs, activities, outputs and outcomes (Frechtling, 2007: 21; McDavid and Hawthorn, 2006: 20), as illustrated in Figure 6.1.
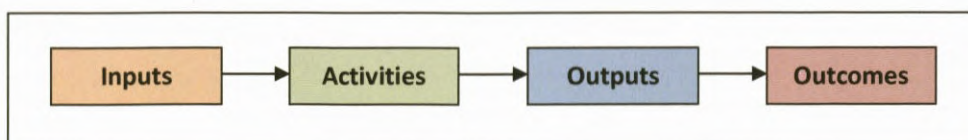
Figure 6.1 Basic logic model

6.3.1.1 Inputs

Inputs describe the commencement of a programme, being the resources at its disposal such as funding, equipment, facilities, managerial leadership, the research base, tangibles, service suppliers, manpower, monitoring and evaluation feedback, as well as information about the needs of the target population. Inputs furthermore represent and describe the mechanisms available to support the theory of change within a wellness programme (Frechtling, 2007: 24; Wholey *et al.*, 2004: 9; McDavid and Hawthorn, 2006: 47) for HIV/AIDS infected and/or affected nurse practitioners.

6.3.1.2 Activities

Activities explain the treatments or actions that are undertaken to arrive at the desired programme goals or outcomes. They are orderly planned and executed practical exercises that occurred within a specific time such as the appointment of a HIV/AIDS management task team. Activities may influence each other and have different grain sizes (Frechtling, 2007: 21 – 23; Hamilton and Bronte-Tinkew, 2007: 1; McDavid and Hawthorn, 2006: 47).

6.3.1.3 Outputs

Outputs indicate the immediate results of an action or activity. They are services, events and products that indicate that an activity has been implemented. Each activity should have one or more outputs (Frechtling, 2007: 22 – 24; Wholey *et al.*, 2004: 9; McDavid and Hawthorn, 2006: 52).

Outputs indicate the amount of work that is done whilst implementing a programme. Outputs are expressed numerically and focus on ways of counting participation in a programme. It furthermore points towards the progress of the theory of change within the framework (Frechtling, 2007: 22 – 24; McDavid and Hawthorn, 2006: 49). Example: A peer and counsellor HIV/AIDS training programme (activity) links to the number of persons trained (output).

6.3.1.4 Outcomes

Outcomes represent the change or benefits that occurred, indicating that the programme goals and objectives that resulted from the activities and outputs have been attained. The theory of change would be accurate if the desired outcomes were reached such as change in attitudes, behaviours or that knowledge increased (Frechtling, 2007: 22; Wholey *et al.*, 2004: 9). They are statements that the intentions of a programme (McDavid and Hawthorn, 2006: 48) to solve problems and bring about change, such as in the workplace, could be achieved if the programme is successfully implemented.

Outcomes generally have a time dimension, namely short-term, medium-term and long-term outcome(s) (Frechtling, 2007: 23; Wholey *et al.*, 2004: 9 and 52) as illustrated in Figure 6.2 (Page 252). Short-term outcomes are changes or benefits most closely associated with the programme outputs, such as compliance of the HIV/AIDS workplace strategy, goals and legislation that was reached.

Implementing a sustainable and effective workplace wellness programme is an example of a medium-term outcome explaining the changes that resulted from the short-term outcomes. Long-term outcomes are finally changes or benefits that stemmed from the medium-term outcomes, therefore the maintaining of a sustainable and effective workplace wellness programme as will be illustrated in Figure 6.5 (Page 257). It is furthermore important to indicate what changes are expected within which timeframe.
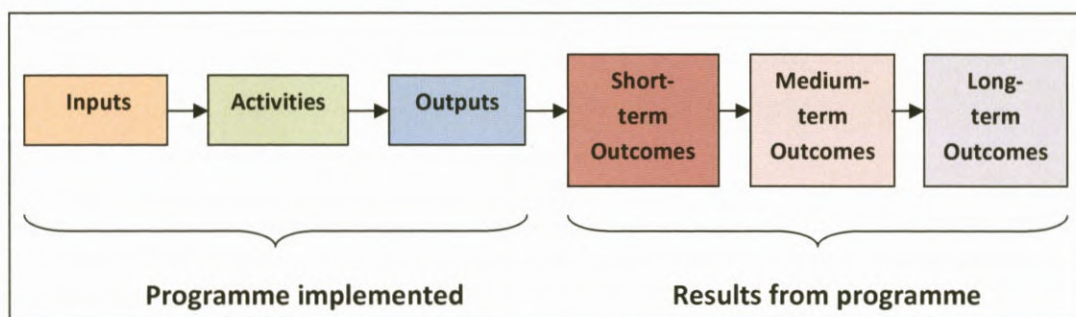
Figure 6.2   Basic logic model components with expanded outcomes time dimensions

6.3.2   Context

An additional component is included within the evaluation framework, namely context (Frechtling, 2007: 27) or also termed external contextual influences (Wholey *et al.*, 2004: 8) to a programme, as illustrated in Figure 6.3.
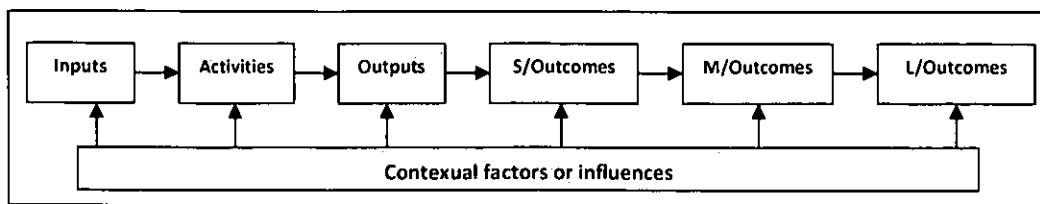
Figure 6.3   Basic logic model components with context

The context explains the environment in which the programme would function, as well as the factors and influences that have to be taken into consideration should a similar programme be initiated (Frechtling, 2007: 28; Wholey *et al.*, 2004: 23; McDavid and Hawthorn, 2006: 51). The context in the evaluation framework will therefore present:

- The internal and external factors that influence the wellbeing of a nurse practitioner confronted with HIV/AIDS in the workplace, and the

- Managerial, as well as internal and external workplace factors that have an influence on the disposition of the development of a workplace wellness programme.

The contextual factors could influence the design and delivery of the programme positively or negatively (Wholey *et al*, 2004: 10 and 18) because these factors are not under the control of the programme, as will be illustrated in Figure 6.5 (Page 257) and Figure 6.6 (Page 259).

6.3.3 Implementation objectives

Implementation objectives are included within the evaluation framework to focus the attention on each activity that is required to produce an output (McDavid and Hawthorn, 2006: 47) (Figure 6.4).
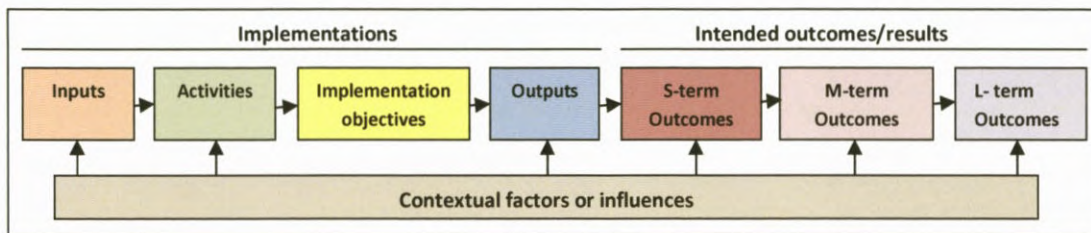
Figure 6.4   Basic logic model components with implementation objectives

Implementation objectives describe what are being done to operate the programme (McDavid and Hawthorn, 2006: 48) in order to achieve the intended outcomes. Words such as "to provide", "to do", "to give" are but few examples explaining typical ways of stating implementation objectives, as will be illustrated in Figure 6.5 (Page 257) and Figure 6.6 (Page 259).

6.3.4   Connections

As previously defined, a logic model is represented by components and the connections among them (Frechtling, 2007: 31). The connections or links describe how the components or elements within a framework relate to each other and how the theory of change will occur. Linking or connecting components furthermore

depicts the programme objectives, what the outputs are and to decide which actions or activities in the logic model need to take place in order to convey outputs into outcomes that are linked to the programme objectives (McDavid and Hawthorn, 2006: 50).

Two types of connections are found in the evaluation framework, namely:

(1)   those connections depicted as a one-way arrow, indicating the direction whereto the changes are expected to occur after an activity has taken place or as a result of it, and

(2)   connections indicated as a simple line or bracket, thus explaining that the items belong together as part of the same component (Frechtling, 2007: 32).

The logic model was utilized to explain and evaluate the theory of change supporting the framework of a workplace wellness programme. This was done to effectively link the programme activities to the expected outcomes (Frechtling, 2007: 1 – 2; Julian, 2005: 162), thus achieving the desired objectives or goals of the programme.

The theory of change illustrated in the framework of this study (Figure 5.9, Page 243) underpins the co-existence of the components of the logic model applied in the evaluation framework. The inputs, activities, outputs and outcomes, context and implementation objectives are therefore considered integral components to the theory of change underlying the framework for a workplace wellness programme.

6.3.5 A logic model of a proposed evaluation framework (Illustration)

A logic model of a proposed evaluation framework is illustrated in Figure 6.5 (Page 257) by the researcher as a diagram with columns and rows of boxes containing text and causal connections (Wholey, Hatry and Newcomer, 2004: 20) to conform to the basic components of a logic model.

Conforming to this requirement, the framework depicts seven (7) columns or sections. Each column or section will represent a component derived from a logic model, as already illustrated in Figure 6.1 (Page 249). Each column will be colour-coded to prevent any confusion whilst reading the evaluation framework.

Each column will consist of a row of boxes containing text briefly indicating which subsection of a component will be addressed.

Each column with its subsections will be linked or connected to each other through means of one-way arrows or simple lines and brackets. The linkage of the columns will indicate the direction whereto the changes are expected to occur or which items belong together as part of a same component (Wholey *et al.*, 2004: 20; Frechtling, 2007: 31 - 32).
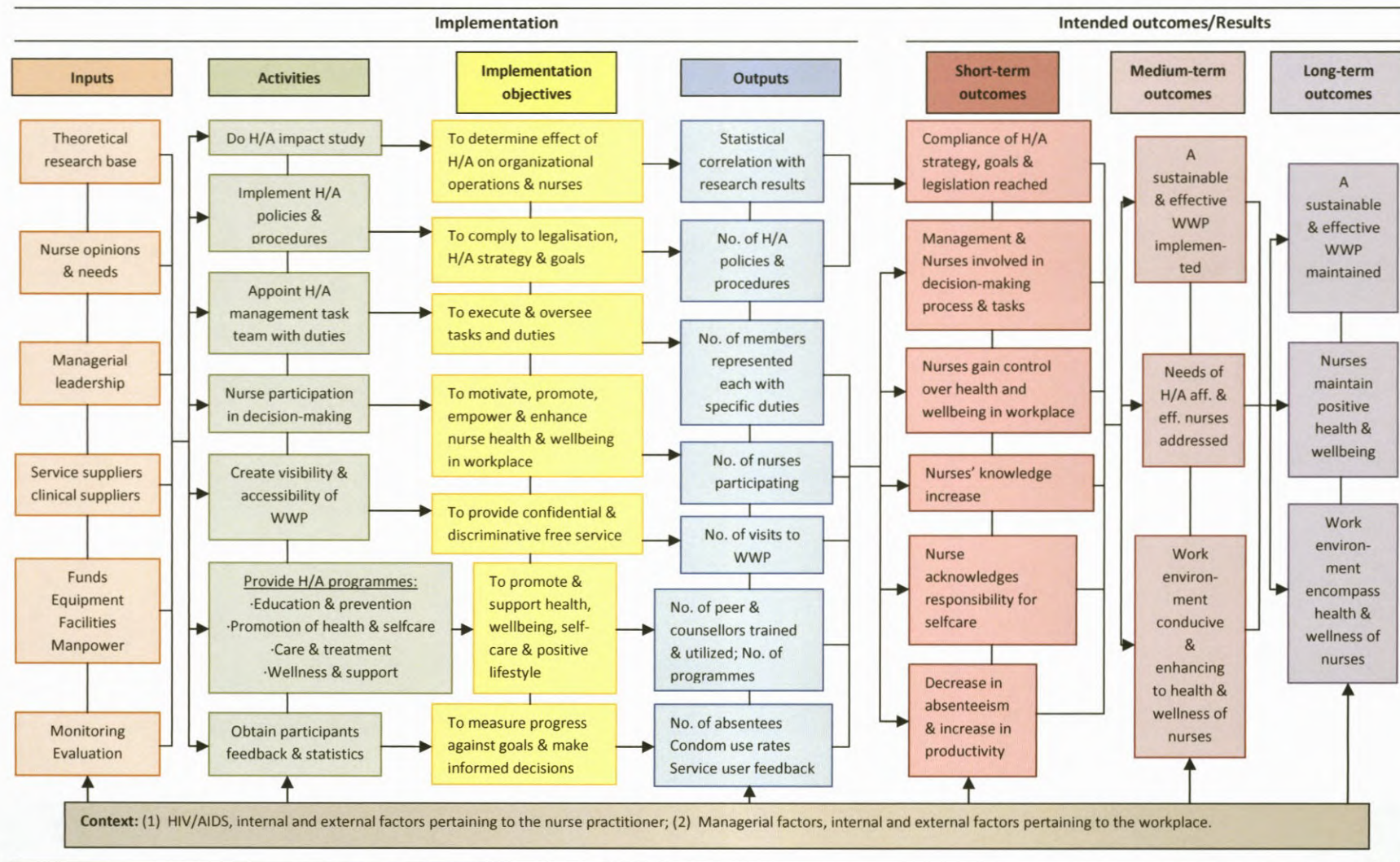
Figure 6.5 Logic model for an evaluation framework

6.3.6 A logic model depicting one topic in a proposed evaluation framework (Illustration)

The researcher attempted in Figure 6.6 (Page 259) to compliment Figure 6.5 through illustrating an example of an expected result of an action or activity that could be reached after implementing a different HIV/AIDS programme. The process of occurring change could be interrupted and evaluated during any stage of the framework. This monitoring and evaluation process could provide timely opportunity to alter a workplace wellness programme (W.K. Kellogg Foundation, 2002: 1). The evaluation of an expected outcome could hence be done during any stage of the flow of events.

Implementation

Intended outcomes/Results

| Inputs | Activities | Implementation objectives | Outputs | Short-term outcomes | Medium-term outcomes | Long-term outcomes |

2) VCCT; Free condoms; Open discussions with disclosure; Interactive counselling; Awareness letters, posters & flyers; Group discussions

4) Protection against safety risks in w/place; WWP; Employer & colleague support; Family orientated activities & involvement; Employment options & remuneration package; Working hours; Psychology service; Occ.Health Nurse skilled

1) HIV/AIDS training program; Sex education; Information on HIV/AIDS origin, prevention & treatment; STD & TB prevention; Nutrition; Exercise; Peer & counsellor education

3) Information on personal hygiene and development; Physical, psychological & spiritual care for self and others; Stress management; Communication skills training; ART

Provide H/A programmes:
(1) Education & prevention
(2)Promotion of health & self-care (3)Care & treatment
(4)Wellness & support

To promote & support health, wellbeing, self-care & positive lifestyle

No. of peer & counsellors trained &utilized; No. of programs presented; No. of visits to WWP

Nurses gain control over health and wellbeing in workplace

Nurses' knowledge increase

Nurse acknowledges responsibility for selfcare

Decrease in absenteeism & increase in productivity

A sustainable & effective WWP implemen-ted

Needs of H/A aff. & eff. nurses addressed

Work environ-ment conducive & enhancing to health & wellness of nurses

A sustainable & effective WWP maintained

Nurses maintain positive health & wellbeing

Work environ-ment encompass health & wellness of nurses

Context: (1) HIV/AIDS, internal and external factors pertaining to the nurse practitioner; (2) Managerial factors, internal and external factors pertaining to the workplace.

Figure 6.6 Logic model for an evaluation framework depicting HIV/AIDS programme content

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6.4 Summary

Recommendations directed at future research are encouraged concerning issues related to nurse practitioners and the workplace. A logic model for an evaluation framework is recommended, briefly explained and illustrated. Although all the recommendations are not imperative or always feasible to warrant the success of a workplace wellness programme, it could provide considerable value to the study.

"If you don't know where you're going, how are you gonna' know when you get there?" -Yogi Berra

(Quotation: W.K. Kellogg Foundation Logic Model Development Guide, 2002: III)

Framework for a Workplace Wellness Programme for HIV and AIDS affected and/or infected Nurse Practitioners

Summary/Abstract

Purpose: The purpose of this study was to propose a framework for the development of a workplace wellness programme for nurse practitioners who are infected with and/or affected by HIV/AIDS in the healthcare private sector.

Research objectives: The objective of the study was to identify and describe components, as well as propose a framework, necessary to develop a workplace wellness programme.

Background: Nurse practitioners are daily confronted with illness, disease and debilitating health, psychosocial and economical conditions, especially in South Africa, where the prevalence of HIV/AIDS is very high amongst the sexually and economically active adult women between 15 – 49 years of age.

Although the nurse practitioner perceive this state as being a negative notion to health, they accept it as a way of living and choose to adopt the positive concept of health, namely wellness, for themselves. The nurse practitioner thus experiences wellness if she is holistically sound and healthy, but acknowledges that her/his work environment and economical circumstances have a profound influence on their quality of life and sense of wellbeing. Furthermore emphasizing that nurse practitioners have the desire to stay healthy and well within an environment where they are daily confronted with HIV/AIDS.

To support and help nurse practitioners reach an optimal level of positive health and wellbeing, research was done to explain the interrelationship between health and

wellness and how health and wellness could be promoted in a workplace by instituting a workplace wellness programme.

Research design: A descriptive research method in quantitative research design was used to obtain and explore information about the components found in the workplace that have a direct impact on the physical, psychosocial, spiritual and economical wellbeing of nurse practitioners confronted with HIV/AIDS which could be addressed by means of a workplace wellness programme.

A structured questionnaire and the application of the Likert scale of measurement was presented to registered and enrolled nurse practitioners (n=232) after probable sampling based on randomisation, was done at the designated institution.

Findings: The nurse practitioners indicated that they were afraid of being infected with HIV/AIDS and that they wanted to stay HIV negative. They regarded the then current management of HIV/AIDS in their workplace to be reconsidered. They were of opinion that HIV/AIDS pose a serious threat in the workplace and considered a workplace wellness programme as a priority whereby HIV/AIDS issues could be effectively addressed. The enhancement of positive health and wellbeing could be attained through applicable workplace interventions, awareness initiatives, HIV/AIDS information, health and wellness promotional services and programmes, as well as effective counsellor and peer educational initiatives.

Conclusions: A framework utilizing a logic model to demonstrate the theory of change was presented that illustrated and explained the following:

- Components inherent to the nurse practitioner and the workplace that influence the development of a workplace wellness programme;

- A workplace wellness programme involves health, wellness, health promotion and a structured wellness programme;

- Components necessary for instituting an effective integrated HIV/AIDS workplace management strategy for the development of a workplace wellness programme for nurse practitioners affected and/or infected with HIV/AIDS.

Raamwerk vir 'n werksplek gesondheidsprogram vir MIV/VIGS geaffekteerde en/of geïnfekteerde verpleegkundiges.

Samevatting/Opsomming

Doel: Hierdie studie het ten doel gehad om 'n raamwerk voor te stel vir die ontwikkeling van 'n werksplek welstands gesondheidsprogram vir verpleegkundiges wat geaffekteerd is deur en/of geïnfekteerd is met MIV/VIGS in die privaat gesonheidsorg sektor.

Navorsings doelstellings: Die doelwit van die studie was die identifikasie en beskrywing van komponente, sowel as die voorstelling van 'n raamwerk, wat nodig sou wees vir die ontwikkeling van 'n werksplek gesondheidsprogram.

Agtergrond: Verpleegkundiges word daagliks gekonfronteer deur ongesteldheid, siekte en aftakelende gesondheids, psigososiale en ekonomiese toestande in die werksplek, veral in Suid Afrika, waar die voorkomsyfer van MIV/VIGS baie hoog onder die seksueel en ekonomies aktiewe volwasse vrouens binne die ouderdomsgroep van 15 – 49 jaar is.

Ofskoon 'n verpleegkundige hierdie toedrag van omstandighede waarneem as 'n negatiewe begrip omtrent gesondheid, voel hulle om dit as 'n leefwyse te aanvaar en die positiewe konsep van gesondheid, naamlik welvarende welsyn, aan te neem. 'n Verpleegkundige ervaar dus welvarende welsyn indien hy/sy holisties kragtig en gesond is, maar gee toe dat die werksomgewing en ekonomiese omstandighede 'n diepgaande invloed op hul lewenskwaliteit en welstandsbesef uitoefen.

Voorts word benadruk dat verpleegkundiges 'n begeerte het om gesond en wel te bly binne 'n omgewing waar hulle daagliks deur MIV/VIGS gekonfronteer word.

Om verpleegkundiges te ondersteun en te help om optimale positiewe gesondheid en welstand te bereik, is navorsing gedoen om die onderlinge verband tussen gesondheid en welvarende welsyn te verduidelik, asook die manier waarop gesondheid en welvarende welsyn d.m.v 'n gesondheidsprogram in die werksplek, bevorder kan word.

Navorsingsontwerp: 'n Beskrywende navorsings metode in kwantitatiewe navorsingsontwerp was gebruik om inligting te bekom en te ondersoek oor komponente in die werksplek wat 'n direkte impak op die fisiese, psigososiale, geestelike en ekonomiese welstand van verpleegkundiges het. Hierdie verpleegkundiges word daagliks gekonfronteer deur MIV/VIGS in die werksplek en sodanige komponente kan d.m.v. 'n werksplek welstands gesondheidsprogram aangespreek word.

'n Gestruktureerde data insamelingsinstrument, naamlik 'n vraelys, en die toepassing van die Likert metingskaal, was aan geregistreerde en ingeskrewe verpleegkundiges gegee (n=232) nadat waarskynlike gerieflikheidseleksie in die aangewese instelling gedoen is.

Bevindinge: Die verpleegkundiges het aangedui dat hulle bang was om met MIV besmet te word en dat hulle MIV negatief wou bly. Hulle het aangedui dat die huidige bestuur van MIV/VIGS in die werksplek in heroorweging geneem moes word. Hulle was van mening dat MIV/VIGS 'n ernstige bedreiging vir die werksplek inhou. Die verpleegkundiges het verder die implimentering van 'n werksplek gesondheidsprogram as 'n prioriteit beskou waardeur MIV/VIGS aangeleenthede effektief aangespreek kan word.

Die instandhouding en bevordering van positiewe gesondheid en welstand kan

bereik word d.m.v. toepaslike werksplek tussentredes, gewaarwordings initiatiewe,

MIV/VIGS inligting, gesondheids- en welstands- bevorderende dienste en

programme, asook effektiewe beradings en portuur opleidingsprogramme.

Gevolgtrekking: 'n Logika model wat die teorie van verandering aandui is deur 'n

raamwerk voorgestel wat die volgende illustreer en verklaar:

- komponente inherent aan die verpleegkundige en die werksplek wat 'n

  invloed het op die ontwikkeling van 'n werksplek welstands

  gesondheidsprogram,

- 'n werksplek welstands gesondheidsprogram wat gesondheid, welstand en

  welsyn, gesondheidsbevordering en 'n gestruktureerde gesondheidsprogram

  behels, en

- komponente wat noodsaaklik is vir die instelling van 'n effektiewe

  geïntegreerde MIV/VIGS bestuursstrategie vir die ontwikkeling van 'n

  welstands gesondheidsprogram vir verpleegkundiges wat deur MIV/VIGS in

  die werksplek geaffekteerd, of self geïnfekteerd, is.

Sleutelwoorde: Raamwerk – gesondheidsprogram – MIV/VIGS – gesondheid -

verpleegkundige – Orem se teorie – logika model – teorie van verandering -

welstand – gesondheidsbevordering – werksplek - kwantitatiewe

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19 March 2010

Helena Basson
University of the Free State
Bloemfontein

Dear Helena

Workplace wellness program for HIV/Aids refers.

The management of Life Rosepark Hospital considered your application to conduct research at Life Rosepark Hospital.

We approve of your proposed method of data collection and trust that apporopriate information will be gathered.

Yours faithfully

Elzeth Bezuidenhout
HOSPITAL MANAGER

HEALTH CARE

19 March 2010

Helena Basson
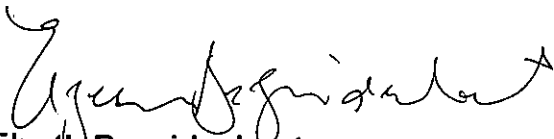University of the Free State
Bloemfontein
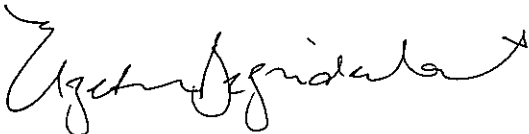
Dear Helena

Workplace wellness program for HIV/Aids refers.

The management of Life Pasteur Hospital considered your application to conduct research at Life Pasteur Hospital.

We approve of your proposed method of data collection and trust that apporopriate information will be gathered.

Yours faithfully

**Elzeth Bezuidenhout
HOSPITAL MANAGER**

<u>INFORMATION DOCUMENT</u>

Framework for a Workplace Wellness Programme for HIV and AIDS affected and/or infected Nurse Practitioners

Dear Nurse Practitioner

I, H.A. Basson, a Professional Nurse registered at the South African Nursing Council and M.Soc.Sc. student at the School of Nursing of the University of the Free State, am currently conducting research at Life Healthcare Rosepark Hospital. The aim of the research is to develop a workplace wellness programme for nursing staff who is infected and/or affected for HIV and AIDS in the private healthcare sector.

I need to obtain and explore information about the components needed to develop a sustainable and effective wellness programme. A literature research revealed that a wellness programme does not currently exist for nurse practitioners infected and/or affected by HIV and AIDS in South Africa. The information that will be gathered will thus provide basic knowledge and an explanation to the existing occurrence.

I hereby invite you to participate in this research study.

You will be asked to voluntary consent to complete a questionnaire without stating your name or location. You will not be coerced into completing the questionnaire. Your honest responses will remain anonymous and the information that you will provide will be treated as confidential at all times. The information will be made known by means of a research report and the research findings could be published in a journal to provide direction for future research. The language of preference in your institution will be adhered to, namely English as to avoid confusion of any question and/or statement.

The research will be conducted with the necessary integrity, honesty and confidentiality. You may however, terminate participation at any stage of the study, despite giving voluntary consent to complete the questionnaire.

You will not be offered any remuneration for taking part in the study because of your voluntary participation and that you will not have any financial expenses. I therefore appreciate your interest and participation in this very important study.

HIV and AIDS are a serious workplace health issue and the nurse practitioner and employer need a supportive tool to assist them with employee welfare, health and social dilemmas and organizational issues. Legislation requires equality in the workplace and financial and legal assistance to the employee. The affected and/or infected HIV and AIDS employee needs to remain in employment without the fear of job loss or discrimination.

Should you at any time have any enquiries about the research study, I could be contacted at the following number: 079 5166 270

You may contact the Secretariat of the Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 405-2812 if you have any questions about your rights as a research subject in this particular study.

H.A. Basson

Questionnaire to determine the components necessary for the development of a workplace wellness programme for nurse practitioners

- It is important that the following terms are clearly understood:

(a) A **nurse/nursing practitioner** is a person who practises nursing and who is registered or enrolled with the South African Nursing Council.

(b) An **infected nurse** is a person who became infected with the HI-virus after the virus has entered the person's bloodstream.

(c) An **affected nurse** is a person that became emotionally involved with an HIV/Aids infected person and is influenced by the physical, psychological, emotional and/or spiritual needs of the person(s) infected with the virus.

- By completing the questionnaire you are voluntary consenting to participate in the research study. It is important that you read the questions carefully and answer it honestly. It is also important that you do not skip any question. The information obtained through this questionnaire will be regarded as confidential and will only be made known by means of a research report and the publication of statistical information.

- The questionnaire consists of the following sections:
  - Section A: Biographical information;
  - Section B: The nurse and the need for a workplace wellness programme for HIV and/or AIDS affected and/or infected nurse practitioners;
  - Section C: Interventions;
  - Section D: Personal information.

- **Please ensure to complete all 10 (Ten) pages.**

- Clear and easy-to-follow instructions will guide you through the questionnaire.

Thank you for participating in this study!

Section A

1. Biographical information

Example:

Please answer the following questions by placing a check mark (√) in the appropriate box:

    1.2 What is your gender?

          Male.............. [√]

          Female.......... [ ]

Please answer the following questions by placing a check mark (√) in the appropriate box:

1.1 In which nursing category are you registered at the South African Nursing Council?

Registered Nurse/Professional Nurse............... [1]

Enrolled Nurse... [2]

Enrolled Nursing Auxiliary Nurse...................... [3]

1.2 What is your gender?

Male.............. [1]

Female.......... [2]

1.3 What is your age?

    In complete years (e.g. 24)...

1.4 To which race group do you belong?

Black.................................... [1]

Coloured.............................. [2]

Asian................................... [3]

White................................... [4]

Other................................... [5]   Specify...

1.5 What is your marital status?

Not married......................... [1]

Married............................... [2]

Divorced............................. [3]

Widow/Widower.............. [4]

Living together................... [5]

For office use boxes: [4], [5], [6][7], [8], [9]

1

1.6 **How many people stay in your house?**

One.. | 1 |

Two.. | 2 |

Three.. | 3 |

Four... | 4 |

More that 4 people..................... | 5 |

1.7 **How many children do you have?**

No child...................................... | 1 |

One child..................................... | 2 |

Two children............................... | 3 |

Three children............................ | 4 |

Four children.............................. | 5 |

More than 4 children.................. | 6 |

1.8 **Do you financially support anyone else besides your children and spouse/partner?**

Yes............................... | 1 |

No................................. | 2 |

1.9 **Do you have any kind of health insurance/medical aid insurance?**

Yes.................... | 1 |

No..................... | 2 |

| 10 |

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| 12 |

| 13 |

2

Section B

2. The nurse and the need for a workplace wellness programme for HIV and/or AIDS affected and/or infected nurse practitioners

Please answer the following questions by placing a check mark (√) in the appropriate box:

2.1	Please answer the following questions to describe your opinion on a workplace wellness programme		
		Yes	No
	1. Do you think HIV/AIDS presents as a serious threat to your profession as nurses in the workplace?	1	2
	2. Do you know of a workplace wellness programme currently operating in your workplace?	1	2

3. Do you think that it is **important** to have a workplace wellness programme for nurse practitioners affected by HIV/AIDS in the workplace?
Place a check mark (√) in the appropriate box below:

Not important	Slightly important	Important	Very important
1	2	3	4

4. Please explain/motivate your answer to question 2.1, no. 3

2.2	Have you had any health problems during the previous 3 (three) months? • If no, skip question 2.3 (the next question)	Yes 1	No 2	25
2.3	If yes, have you suffered from any of the following? 1. Workplace injuries such as needle pricks, etc.	1	2	26
	2. Lower activity levels	1	2	27
	3. Frequent headaches	1	2	28
	4. Fever	1	2	29
	5. Cold/flu	1	2	30
	6. Cough without symptoms of flu	1	2	31
	7. Diarrhoea	1	2	32
	8. Sleeping disorders such as nightmares, broken sleep pattern, etc.	1	2	33
	9. Felt very sad	1	2	34
	10. Fear	1	2	35
	11. Lack of motivation	1	2	36
	12. Feelings of despair	1	2	37
	13. Nausea	1	2	38
	14. Anxiety	1	2	39
	15. Stress	1	2	40
	16. Other: Please specify..	1	2	41

2.4	Have you taken days off work during the previous 3 (three) months due to any of the following? 1. Ill health	Yes 1	No 2	42
	2. Caring for an ill person	1	2	43
	3. Attending a funeral	1	2	44
	4. Caring for a dependant person e.g. a child	1	2	45

4

Section C

	3. Interventions	

Please answer the following questions by placing a <u>check mark (√) in all the blocks that is applicable</u>:

3.1	Which of the following interventions does your place of work have in place?	√ all applicable	
	1. A formal HIV/AIDS policy	1	46
	2. A HIV/AIDS prevention and awareness programme	1	47
	3. Voluntary Counselling and Testing facilities	1	48
	4. A HIV/AIDS task team	1	49
	5. A Peer education programme	1	50
	6. Management training on managing HIV/AIDS in the workplace	1	51
3.2	Who directs your workplace HIV/AIDS strategy and policy?		
	1. Head-office of Company	1	52
	2. Human Resources department	1	53
	3. HIV/AIDS task team	1	54
	4. Occupational health professional	1	55
	5. Unit manager/Matron of department	1	56
	4. Nobody	1	57
	5. Do not know	1	58
3.3	Which parties do you believe should be involved in the development of a HIV/AIDS strategy and/or policy?		
	1. Management of Company	1	59
	2. Human Resources Department	1	60
	3. Nurse practitioners	1	61
	4. Medical practitioners	1	62
	5. Administrative practitioners	1	63
	6. Unions	1	64
	7. Outsourced companies in hospital e.g. cleaners, caterers, physiotherapists, security, etc.	1	65

5

3.4	Please indicate if the following statements concerning HIV/AIDS issues are important to you as a nurse in the workplace	Not important	Slightly important	Important	Very important	
	1. I should be well informed about the Company's HIV/AIDS policy.	1	2	3	4	66
	2. I should be well informed about HIV/AIDS.	1	2	3	4	67
	3. HIV/AIDS should be a subject that is freely and frequently discussed amongst nurses.	1	2	3	4	68
	4. Nurses should be voluntary and confidentially counselled and tested for HIV/AIDS at the workplace.	1	2	3	4	69
	5. I should feel comfortable to disclose my status at the workplace if I was to be tested HIV positive.	1	2	3	4	70
	6. Condoms should be easily accessible in the workplace.	1	2	3	4	71
	7. Nurses on antiretroviral therapy need emotional support in the workplace from their employer.	1	2	3	4	72
	8. Nurses on antiretroviral therapy need emotional support in the workplace from their colleagues.	1	2	3	4	73

3.5	Do you think that the following interventions are important to keep you healthy and well in your place of work?	Not important	Slightly important	Important	Very important	
	1. Health education	1	2	3	4	74
	2. Adequate nutrition and rest	1	2	3	4	75
	3. Periodic medical examinations	1	2	3	4	76
	4. Attention to personal development	1	2	3	4	77
	5. Medical aid or health insurance	1	2	3	4	78
	6. Market related monthly salary	1	2	3	4	79
	7. Agreeable working conditions	1	2	3	4	1
	8. Sex education	1	2	3	4	2
	9. Attention to personal hygiene	1	2	3	4	3
	10. Protection against safety risks in the workplace	1	2	3	4	4
	11. A HIV/AIDS workplace wellness programme	1	2	3	4	5
	12. Family orientated activities	1	2	3	4	6

3.6	Do you think nurses will be interested in the following HIV/AIDS awareness initiatives?	Not at all interested	Not so interested	Fairly interested	Very interested
	1. Awareness newsletters	1	2	3	4
	2. Awareness posters	1	2	3	4
	3. Awareness flyers	1	2	3	4
	4. Educational classes	1	2	3	4
	5. Health screening such as Voluntary Counselling and HIV testing **with** feedback	1	2	3	4
	6. Health screening such as Voluntary Counselling and HIV testing **without** feedback	1	2	3	4
	7. Interactive counselling	1	2	3	4

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3.7	Please answer the following question by placing <u>a check mark (√) in all the blocks that is applicable:</u>	√ all applicable
	Do you think that the following information on HIV/AIDS should be addressed in a workplace wellness programme?	
	1. Prevention strategies	1
	2. Treatment options	1
	3. Symptoms and signs of infection	1
	4. Other sexually transmitted diseases	1
	5. Where HIV/AIDS come from	1
	6. Getting a HIV test	1
	7. How to stay healthy and well if one is HIV positive	1
	8. How to stay HIV negative	1
	9. How to tell a husband/wife/partner/friend if I am tested HIV positive	1
	10. Employment options	1
	11. How to prepare myself spiritually should I be affected by or infected with HIV/AIDS	1
	12. Financial planning	1
	13. How to care for my family/partner/husband/wife should I be affected or infected by HIV/AIDS	1
	14. How to prepare myself emotionally should I be affected by or infected with HIV/AIDS	1
	15. How to involve my family in supporting me should I be affected by or infected with HIV/AIDS	1

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3.8	Do you think nurses will be interested in the following life style initiatives?	Not at all interested	Not so interested	Fairly interested	Very interested	
	1. Managing stress	1	2	3	4	29
	2. Following a healthy diet	1	2	3	4	30
	3. How to take care of my health such as immunity levels, safe sex practices, etc.	1	2	3	4	31
	4. How to achieve my occupational goals	1	2	3	4	32
	5. How to satisfy my spiritual needs	1	2	3	4	33
	6. Managing my finances and economical outlook	1	2	3	4	34
	7. Managing my relationship with my partner/family/friends/colleagues	1	2	3	4	35
	8. How to stay employed	1	2	3	4	36
	9. An environment where management encourages you to participate in a healthy life style such as how to care for dependant family/friends with HIV/AIDS, develop coping skills, etc.	1	2	3	4	37
	10. Working hours to allow you to undertake regular exercise	1	2	3	4	38
	11. Managing symptoms of illness and when to ask for medical advice or treatment	1	2	3	4	39
	12. Support group(s)	1	2	3	4	40
	13. Face-to-face individual confidential counselling facilities where problems and/or concerns can be discussed	1	2	3	4	41
	14. Telephonic confidential counselling facilities where problems and/or concerns can be discussed	1	2	3	4	42
	15. Legal assistance	1	2	3	4	43
	16. Protection against life threatening diseases such as HIV/AIDS	1	2	3	4	44
	17. Group information sessions	1	2	3	4	45
	18. How to uphold my immunity levels	1	2	3	4	46
	19. How to practice safe sex	1	2	3	4	47
	20. Working hours to allow you to enjoy family outings	1	2	3	4	48
	21. Working hours to allow you to have enough rest periods	1	2	3	4	49

3.9	Please answer the following question by placing a <u>check mark (√) in all the blocks that is applicable:</u>	√ all applicable	
	Would you as a nurse like to see the following in your place of work? 1. Self-care education on issues such as nutrition, sexual health, exercises, sleep and rest	1	50
	2. Communication skills training	1	51
	3. Self-care education on HIV/AIDS	1	52
	4. Voluntary confidential counselling and HIV testing	1	53
	5. Peer and counsellor education to raise awareness on HIV/AIDS issues	1	54
	6. A HIV/AIDS task group	1	55
	7. A HIV/AIDS policy addressing issues such as discrimination, stigmatization, victimisation, sick leave and retrenchment	1	56
	8. Psychology service to address emotional health such as depression and stress or anxiety relating issues	1	57
	9. Protection against health hazards in the workplace such as the provision of personal protective equipment	1	58
	10. Distribution of free condoms	1	59
	11. Availability of Antiretroviral Therapy or medication for HIV positive nurses	1	60
	12. Prevention and treatment services for Sexually Transmitted Diseases	1	61
	13. Prevention and treatment services for Tuberculosis	1	62
	14. Health promotion programmes open to family members	1	63
	15. An occupational health nurse practitioner dealing with HIV/AIDS issues	1	64

Section D

4. Confidential information

This section consists of questions that may be sensitive to some nurses. It will however be appreciated if you could answer the questions **honestly**. This information will **only** be used for the completion of the study.

Please answer the following questions by placing a check mark (√) in the appropriate box:

4.1		Yes	No		
		1	2		65
	1. I am afraid of HIV/AIDS				
	2. I have been tested for HIV before	1	2		66
	3. I have a **family member** diagnosed with HIV/AIDS	1	2		67
	4. I know a friend who is **affected** by HIV/AIDS	1	2		68
	5. I know a colleague who is **infected** with HIV/AIDS	1	2		69
	6. I am HIV positive	1	2		70
	7. I have a **friend** diagnosed with HIV/AIDS	1	2		71
	8. I want to stay HIV negative	1	2		72

Thank you for your participation in this important exercise!

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Ms H Strauss

2010-04-14

MS H BASSON
P O BOX 31956
FICHARDT PARK
9317

REC Reference number: REC-230408-011

Dear Ms Basson

ETOVS NR 145/08
PROJECT TITLE: FRAMEWORK FOR A WORKPLACE WELLNESS PROGRAMME FOR HIV AND AIDS AFFECTED AND/OR INFECTED NURSE PRACTITIONERS.

- You are hereby informed that The Ethics Committee approved the questionnaire as an amendment to the study at the meeting held on 13 April 2010.

- Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA; Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Dept of Health: Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition 2006; the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.

- Any amendment, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

- The Committee must be informed of any serious adverse event and/or termination of the study.

- A progress report should be submitted within one year of approval of long term studies and a final report at completion of both short term and long term studies.

- Kindly refer to the ETOVS reference number in correspondence to the Ethics Committee secretariat.

Yours faithfully

....
CHAIR: ETHICS COMMITTEE

UNIVERSITEIT VAN DIE VRYSTAAT
UNIVERSITY OF THE FREE STATE
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Ms H Strauss

2008-09-10

MS H BASSON
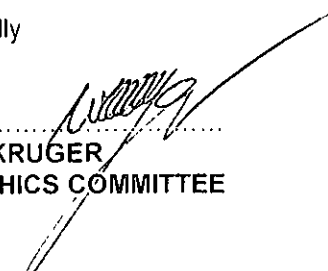P O BOX 31956
FICHARDT PARK
9317

Dear Ms Basson

ETOVS NR 145/08
PROJECT TITLE: FRAMEWORK FOR A WORKPLACE WELLNESS PROGRAMME
FOR HIV AND AIDS AFFECTED AND/OR INFECTED NURSE PRACTITIONERS.

- You are hereby informed that The Ethics Committee provisionally approved the above study at the meeting held on 9 September 2008 on condition that the questionnaire has to be submitted for final approval by the Committee.

- Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA;   Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Dept of Health: Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition 2006; the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.

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- Kindly refer to the ETOVS reference number in correspondence to the Ethics Committee secretariat.

Yours faithfully

PROF WH KRUGER
CHAIR: ETHICS COMMITTEE

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