



Nurse led change to influence HIV and AIDS workplace policy

CE MULLER

12665169

Thesis submitted for the degree

Philosophae Doctor (Nursing Science)

at the

Potchefstroom Campus of the North-West University

Promotor: Prof Dr HC Kloppe

November 2010

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DECLARATION

I, Catherina Elizabeth Muller, student number 12665169, declare that:

- **Nurse led change to influence HIV and AIDS workplace policy** is my own work and that all the sources that I used are indicated or acknowledged in the reference list.
- This study has been approved by the ethics committee of the Institutional Office of the North-West University (Potchefstroom Campus), Directorate Research, Policy and Planning of North-West Province, as well as public health institutions involved in the study.
- This study complies with the research ethical standards of the North-West University (Potchefstroom Campus).

CE MULLER

November 2010

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ABSTRACT

Globally, nurses' contribution to informed health policy decisions is limited, as there are many barriers to Nurse led change to successfully influence the HIV and AIDS policy process. In South Africa nurses at all levels of health care are not involved or consulted during the formulation of the HIV and AIDS workplace policy. This has led to concern about the absence of nurses at the policy table. This study forms part of a larger international study programme entitled: "*Strengthening Nurses' Capacity in HIV and AIDS Policy Development in Sub-Saharan Africa and the Caribbean*". This programme of international research aims to empower nurses to become involved in the policy process (formulation, implementation and evaluation) in order to strengthen health systems in the areas of HIV and AIDS care.

Nurses' absence at the policy table prompted the researcher to explore and describe barriers to Nurse led change to influence HIV and AIDS workplace policy. Phase 1 of the research consisted of a literature review to identify barriers to Nurse led change to influence the HIV and AIDS workplace policy. Management's opinion about the human resource management capacity and problems experienced working in an HIV and AIDS environment was obtained through a quantitative and qualitative empirical method of data collection and analysis. Frontline nurses' perspective was obtained through qualitative interviewing to identify problems experienced with policy in an HIV and AIDS workplace environment. A mixed-method triangulation research design was used to achieve the objectives of phase 1 of the study, and strategies applied included exploratory, descriptive and contextual designs.

The analysis of the data contributed to the identification and classification of problems experienced by nurses to influence HIV and AIDS workplace policy at macro, meso and microlevel, resulting in the formulation of fifty-nine (59) concluding problem statements. These concluding statements formed the basis for the strategy development for Nurse led change to influence HIV and AIDS workplace policy, which was the only objective of the second phase of the research.

The strategy for Nurse led change to influence HIV and AIDS workplace policy was developed by using a strategic process to determine the vision, mission, values, principles, assumptions, strategic objectives and functional tactics based on the concluding problem statements. Finally, the research was evaluated, limitations were identified and recommendations were formulated for practice, education, research and policy.

Key words: Nurse led change, policy process, HIV and AIDS, strategy formulation

OPSOMMING

Verpleegkundiges ervaar internasionaal struikelblokke om gesondheidsbeleid te beïnvloed. Hierdie struikelblokke ontmoedig verpleegkundiges om leiding te neem en insiggewende veranderinge te ontwikkel en te implementeer om sodoende die MIV- en VIGS-werksomgewingsbeleid te beïnvloed. In Suid-Afrika is verpleegkundiges op makro- (nasionale), meso- (provinsiale) en mikro- (distrik of instelling) vlak nie by die formulering van MIV- en VIGS-werksomgewingbeleid betrokke nie. Die ontwikkeling van 'n strategie om die afwesigheid van verpleegkundiges, veral by MIV- en VIGS-werksomgewingbeleidsformulering aan te spreek, was die oorkoepelende navorsingsdoelwit vir hierdie studie. Hierdie navorsing vorm deel van 'n groter internasionale navorsingsprojek wat onderneem word om verpleegkundiges in die Karibiese eilande en Afrika suid van die Sahara te bemagtig om betrokke te raak by die MIV- en VIGS-beleidsproses. Verpleegkundiges wat aktief betrokke raak by beleidsformulering, implementering en evaluering kan gesondheidstelsels in lande verbeter en versterk, aangesien dienslewering in hierdie lande hoofsaaklik deur verpleegkundiges gedryf word.

In die eerste fase van die studie is 'n literatuurstudie onderneem om struikelblokke te identifiseer wat verhoed dat verpleegleiers veranderings inisieer om betrokkenheid van verpleegkundiges by die beleidsproses te vestig. Kwantitatiewe navorsing is onderneem om mensehulpbronbestuurvermoëns in 'n MIV- en VIGS-omgewing te evalueer. Kwalitatiewe navorsing is onderneem om die perspektief van bestuur te verkry rakende probleme wat ervaar word met beleid in 'n MIV- en VIGS-werksomgewing. 'n Empiriese kwalitatiewe studie is ook onderneem om die opinie van eerstevlak-verpleegkundiges te verkry rakende probleme met beleid in 'n HIV- en VIGS-werksomgewing. 'n Trianguleringsnavorsingsontwerp het die studie begrond, met verdere klem op die aanwending van verkennende, beskrywende en kontekstuele strategieë.

Met die analisering van die literatuurstudie, kwantitatiewe en kwalitatiewe data kon nege en vyftig (59) probleemstellings geformuleer word waarom verpleegkundiges nie betrokke is by die beleidsproses op makro- (nasionale), meso- (provinsiale) en mikro- (distrik of openbare instelling) vlak nie. Hierdie gevolgtrekkings is gebruik as basis vir strategie-ontwikkeling sodat verpleegleiers veranderinge kan inisieer om betrokkenheid by die beleidsproses op

makro-, meso- en mikrovlak te vestig. Die ontwikkeling van 'n strategie was die enigste doelwit van die tweede fase van die studie.

'n Strategiese proses is gebruik om die strategie te ontwikkel en die stappe wat gevolg is, sluit in die bepaling van 'n visie, missie, waardes, beginsels, aannames, strategiese doelwitte en funksionele taktiese optredes gebaseer op probleme wat geïdentifiseer is. Ten slotte is die studie geëvalueer, beperkinge geïdentifiseer en aanbevelings geformuleer vir kliniese praktyk, verpleegopleiding, navorsing en beleid.

Sleutelwoorde: verpleegleiers, veranderingsbestuur, beleidsproses MIV en VIGS, strategie ontwikkeling.

ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
ART:	Anti-retroviral treatment
CNA:	Canadian Nurses Association
DENOSA:	Democratic Nursing Association of South Africa
DoH:	Department of Health
EAP:	Employee assistance program
EQUINET:	Regional Network for Equity in Health in East and Southern Africa
FUNDISA:	Forum of University Deans of South Africa
HAST:	HIV and AIDS and TB unit
HIV:	Human immune deficiency virus
HRM:	Human resource management
HRSC:	Health Science and Research Council
ICN:	International Council of Nurses
IDLE™:	Inductive and deductive logic evidence
N:	Population
n:	Sample Population
NGOs:	Non-governmental organizations
NWU:	North-West University
PEP:	Post exposure prophylaxis

PHC:	Primary Health Care
PI:	Problem identification
PMTCT:	Prevention from mother-to-child-transmission program
QAC:	Quality Assurance Committee
SANAC:	South Africa National Aids Committee
SANC:	South African Nursing Council
STIs:	Sexually transmitted infections
TB:	Tuberculosis
TC:	Teasdale-Corti
UNAIDS:	United the World against AIDS
VCT:	Voluntary counseling and testing
WHO:	World Health Organization

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CHAPTER 1

OVERVIEW OF STUDY

1.1 INTRODUCTION

The aim of the research study was to develop a strategy for Nurse led change to influence HIV and AIDS workplace policy. This chapter offers an overview of the study. An introduction and background to the study is given, followed by a discussion of the impact of HIV and AIDS on the nursing workforce. The overall aim of the study prompted the researcher to explore and describe the current policy landscape in South Africa and to identify the constraints that hinder nurses from becoming involved in the policy formulation process, as the researcher's point of departure is that nurses are absent at the policy table. The background information assisted the researcher in identifying the problem statement and the umbrella aim, and to set objectives for the study. The researchers' assumptions are outlined in the following paragraphs and the research design and methods are briefly discussed. Steps taken by the researcher to ensure rigour throughout the research study are outlined. Lastly the ethical considerations that guided the study are discussed in detail and the chapter ends with the layout of the thesis.

1.2 BACKGROUND TO THE STUDY

HIV and AIDS are a devastating global pandemic that weakens those health-care systems that are loaded with a high prevalence of HIV infection. Sub-Saharan Africa is most affected by the HIV and AIDS pandemic, as two-thirds of all AIDS cases worldwide are found in this area. This mean values that an estimated 22.4 million people live with HIV and AIDS in sub-Saharan countries. During the year 2007 an estimated 1.5 million people living in Africa died from AIDS and the epidemic has left behind some 11.6 million orphaned children (United the World against AIDS, 2009:21). A multitude of socio-economic factors are believed to have contributed to the aggressive spreading of HIV, including migratory labour, the status of women, poverty, high rates of other sexually transmitted infections (STIs) and ineffective leadership in health systems (UNAIDS, 2009:21-22). South Africa has a national HIV infection rate of 11.2% (Statistic South Africa, 2008).

This study forms part of a larger international study programme entitled: “*Strengthening Nurses’ Capacity in HIV and AIDS Policy Development in Sub-Saharan Africa and the Caribbean*”, referred to in this study as the Teasdale-Corti (TC) programme. This programme of international research aims to place nurses in leadership roles in order to empower them to become involved in policy formulation so that health-care systems can be improved in terms of HIV and AIDS (Edwards, *et al.*, 2007:30). The intention is to strengthen health systems in the areas of HIV prevention and AIDS care by supporting HIV and AIDS leadership activities for professional nurses. This is achieved by assisting them to engage in participatory action research in order to become involved in the HIV and AIDS policy formulation process and by empowering nurses to use research information to improve the quality of HIV and AIDS nursing care (Edwards, *et al.*, 2007:31-32). This study focused on the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.

In order to understand why Nurse led change is necessary to influence HIV and AIDS workplace policy, the impact of HIV and AIDS on the nursing workforce, the current South African policy landscapes and the constraints that hinder nurses from becoming involved in policy formulation have been included as discussion points for this chapter.

1.3 IMPACT OF HIV AND AIDS ON THE NURSING WORKFORCE

The nursing workforce in public health institutions in South Africa bears the brunt of the HIV and AIDS pandemic, as nurses are the first line of contact with the patient. A vast majority of affected patients are treated at public hospitals and community health centres due to the high costs involved in treating patients living with HIV or AIDS. There are inherent job stresses in caring for sick people and the increasing number of HIV and AIDS patients leads to an increase in the workload for professional nurses. Caring for AIDS patients is time consuming due to increased physical and psychological challenges, such as longer recuperation times and a lack of support from the families of patients. Nurses also have to cope with more human suffering and increased mortality under patients (Hall, 2003:6-7; Minnaar, 2005:31).

HIV and AIDS are largely managed at a primary level and cases are referred to hospitals only in the case of complications. A study conducted in Jordan indicates that nurses see working in the primary healthcare (PHC) field as inferior to working in a hospital. PHC clinics consequently have difficulty in recruiting and retaining professional nurses, as they perceive their value to be less in the PHC field. The study further indicated that professional nurses initiated therapeutic interventions only when directed by doctors, regardless of their level of

education. Nurses were not supported to enhance their knowledge and skills and they were not involved when policies concerning their practice were formulated. They received these policies as directives from higher levels of authority, which also indicates a top-down approach of policy making (Nawafleh, *et al.*, 2004:213). The top-down approach is also followed in South Africa with regard to the formulation of HIV and AIDS policies, but the situation of nurses working in anti-retroviral treatment (ART) centres in South Africa differs from that in the Jordan study. Nurses who work in South African ART centres specialize in the diagnosis and treatment of HIV and AIDS patients, receive continuous training on HIV and AIDS care (Harrison, 2010:4) and as a result experience an increased workload.

The fact that many in the nursing workforce, or some of their close relatives, are also infected with the virus requires managers to plan well to maintain adequate numbers of staff and to develop staff skills to meet the challenge of HIV and AIDS, while delivering other essential services as well (Bowler, 2007:72). The work environment is further complicated when the type of facility the nurse works in, the skills levels necessary to render an effective service and the scarcity of particular skills required are taken into consideration.

The first line of health care in South Africa is primary health care (PHC) centres or clinics, with most of the nurses practising in these settings being specialized nurses, as they have an additional qualification in clinical nursing science, health assessment, treatment and care. This course prepares nurses to work mainly independently from a doctor, as there is currently a shortage of doctors and nurses in South Africa (Dennil, *et al.*, 1999:35). According to the declaration of Alma Alta, the World Health Organization (WHO) strived towards health for all by the year 2000. PHC was a major strategy assisting the WHO in achieving this objective.

PHC is an approach to provide an essential, accessible, affordable and one-stop health-care service (Watson, 2008:119). Part of the PHC strategy is public participation in policy formulation and intersectoral collaboration, yet the slow reactions of South African politicians to deal with the HIV and AIDS pandemic promptly eroded the ideal PHC model. Some PHC programmes were implemented comprehensively, allowing for community participation and one-stop services. Some programmes, such as the HIV and AIDS programme, were implemented vertically and resulted in not all nurses receiving proper training on how to manage and care for an HIV or AIDS patient effectively (Dennill, *et al.*, 1999:16-17; Heunis, & Schneider 2006:287-269; Zellnick & O'Donnell 2005:177).

PHC specialist nurses can assess a patient, diagnose, prescribe treatment up to schedule 4 and follow up as necessary. They also have sound knowledge of when to refer a patient to a medical

practitioner or a referral hospital (SANC regulation no. 48). The fact that not all PHC nurses are trained in HIV and AIDS makes the management of these patients difficult. When they present at PHC facilities with side effects of drugs or AIDS-related illnesses the untrained PHC nurse needs to refer these patients back to an anti-retroviral centre, which are currently run only in large institutions or as a specialized clinic (see detailed discussions in chapter 2, paragraph 2.3).

Severe nursing shortages and low health-care profession retention rates are entwined with the impact of HIV and AIDS on workload, health-worker illness and mortality, workplace safety and delivery of basic HIV and AIDS health services. The overall shortage of professional nurses is staggering. Nurse shortages in sub-Saharan Africa are estimated at more than 600 000 (Buchan & Calman, 2004:21-25; Zellnick, 2005:69-70). The labour market for nurses is characterized by bountiful overseas opportunities and heavy recruiting amongst our country's most skilled professional nurses. The emigration of nurses to greener pastures leaves an increasing number of nursing positions open and this shortfall is exacerbated by the HIV and AIDS pandemic (Zellnick, 2005:200).

All of the abovementioned factors influence the impact of HIV and AIDS on the nurse workforce.

1.4 THE CURRENT POLICY LANDSCAPE OF SOUTH AFRICA

In South Africa the ultimate aim of HIV and AIDS policies is to fight the HIV and AIDS pandemic. Policies regarding HIV and AIDS are formulated at provincial and national levels of government, where the responsibility for dealing with ongoing HIV and AIDS-related matters is entrusted to the Inter-Ministerial Committee on HIV and AIDS, comprising eight ministries, known as the *South Africa National Aids Committee (SANAC)*. SANAC provides strategic and political guidance, support and monitoring of HIV and AIDS programmes. This organization developed the *National Strategic Plan for HIV and AIDS 2007–2011*, which outlines the key guiding principles that were accepted by the South African cabinet (SANAC, 2007:103) and functions at three levels:

- The highest level of this council is linked directly to parliament and meets twice a year, chaired by the Deputy President of South Africa.
- The second level, reporting directly to SANAC, is the sector-level coordination committee, responsible for implementing the HIV and AIDS strategic plans and programmes at national, provincial and district level, as well as for monitoring these programmes.

- The third level, the programme-level organization, is led by the social cluster of government to coordinate organizational functions and includes various departments. This group further coordinates all of the HIV and AIDS intervention activities launched by non-governmental organizations (NGOs). The shareholders included at the organizational level of SANAC include the HIV and AIDS initiatives of the Department of Health, the Department of Education, as well as the Department of Social Development and Security (SANAC, 2007:103). These in effect are the departments that are nationally involved in the formulation of HIV and AIDS policies. Figure 1.1 indicates The *National Strategic Structure Model*, which deals with HIV and AIDS in South Africa and was developed by SANAC. Figure 1.1 depicts a schematic diagram of the national strategic structure model.

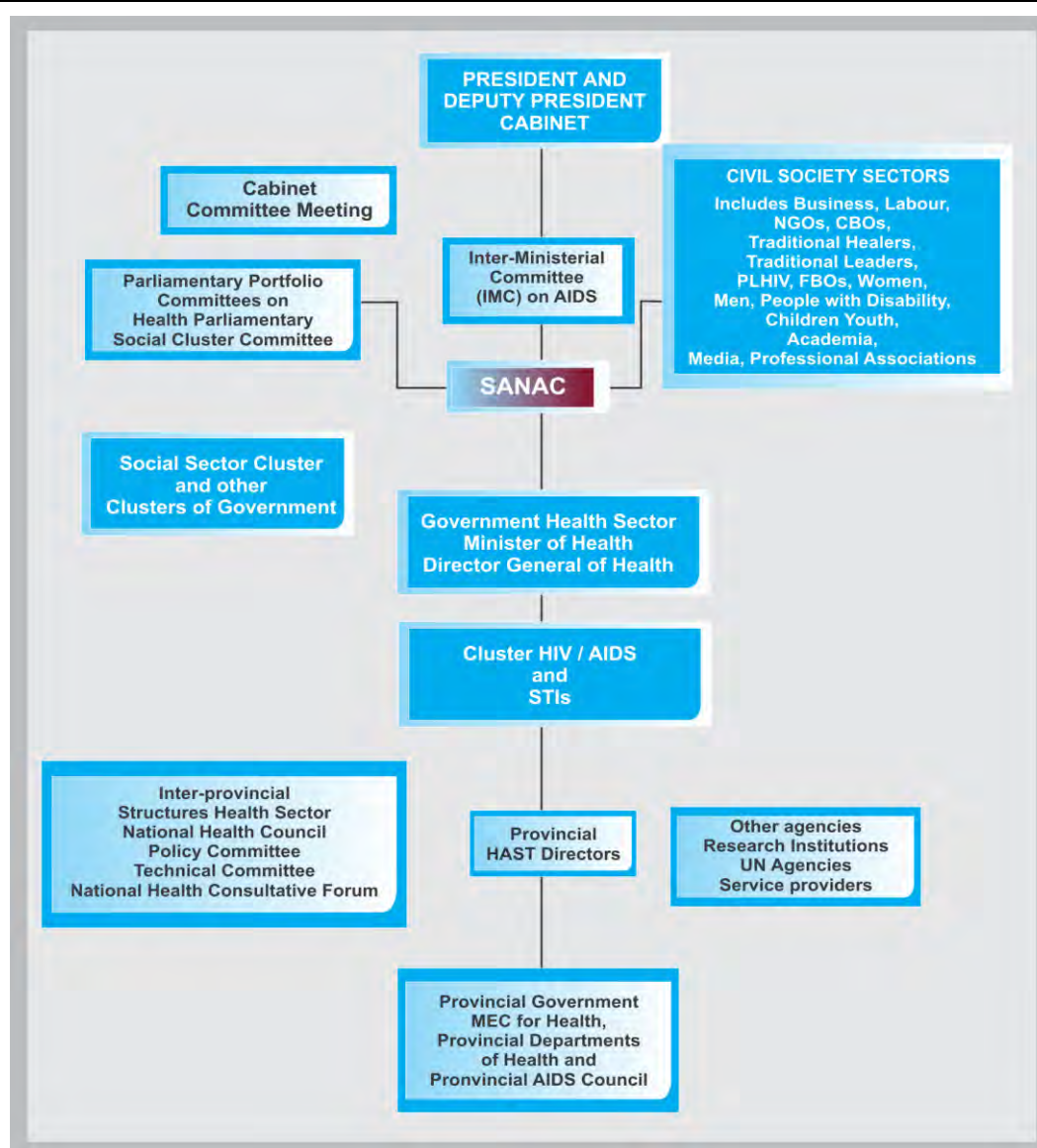


FIGURE 1.1: National HIV and AIDS strategic structure model (SANAC, 2007:103)

The *National Strategic Plan for HIV and AIDS 2007-2011* is based on a set of key guiding principles that includes supportive leadership, effective communication, effective partnership (including involvement of people living with HIV or AIDS), promotion of social change as well as cohesion and funding for sustainable programmes. The primary aims of the *National Strategic Plan for HIV and AIDS 2007-2011* are:

- to reduce the rate of new HIV infections by 50%, and
- to minimize the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of infected people by 2011 (SANAC 2007:53).

There are different approaches that can be used to formulate an HIV and AIDS policy: the top-down, bottom-up or the in-between approach. In South Africa the top-down approach is used.

- According to the top-down approach, the HIV and AIDS policy is formed at the national level of government and the policy implementation is very analytical. With top-down policy implementation, government evaluates the implementation of policy according to specific objectives as set out during the formulation of the policy. Government determines if the set objectives are met in the stipulated time frame (Cloete & Wissink, 2000:168). Paragraph 1.4.1 discusses this concept in detail.
- The bottom-up approach is largely a reaction to the top-down policy model. Policy is formulated at many forums, and even at a frontline level it is often hidden from public view (Cloete & Wissink, 2000:169). Nurses have an important role in formulating policy within their institutions. At frontline level nurses can start to enter the policy process through dialogue and by debating with frontline managers regarding the HIV and AIDS workplace policy.

These discussions should stimulate frontline managers' critical thinking and urge them to address the HIV and AIDS workplace policy gaps that were identified by frontline nurses. Frontline managers can use their contacts with the district health managers to discuss the practical issues around the HIV /AIDS workplace policy. If a discussion related to the HIV /AIDS workplace policy has merit, the district manager will take the matter to the provincial manager and the HIV /AIDS, Sexually Transmitted Infection coordinator. These channels form an explicit route that can be followed when frontline nurses identify gaps within the HIV and AIDS workplace policy that need to be addressed at provincial level.

The abovementioned steps indicate that the frontline professional nurses can identify policy gaps during the implementation of the HIV and AIDS workplace policy and can suggest remedial steps, which can evolve into a contribution towards a bottom-up policy approach. Lobbying with managers to address programme deficiencies can thus lead to policy change if utilized by frontline nurses (Olivier, *et al.*, 2003:661). If the formulation of the HIV and AIDS workplace policy can be expanded by bottom-up policy approaches, it will eventually balance the top-down policy formulation approach. The performance of districts regarding the formulation and implementation of HIV and AIDS workplace policies will have a ripple effect, and thus improve the image of the whole district and of the frontline nurse (Mechanic & Reinhard, 2002:8).

- The in-between approach appears the best, as top-down policy formulation is balanced with a bottom-up policy approach (Cloete & Wissink, 2000:169).

Nurses experience the top-down bureaucratic authority as negative because they are absent from the policy table and are merely seen as policy implementers. Involvement of nurses at all three levels of policy formulation can be of value to ensure the sustainability of the HIV and AIDS workplace policy (Gilson, *et al.*, 2006:13; Zellnick, & O'Donnell, 2005:168).

A study that included lower and middle-income countries (LMIC) was done to determine the role of policy in equity of health-care services (EQUINET) in East and Southern Africa. Some of the findings of the equity research provided insight into frontline nurses' experience of policies. In Zambia nurses reacted and said they never tried to give feedback or advice to higher authorities from frontline level and received policies with a top-down approach as an order. All that they could do as frontline nurses was to ensure compliance and to implement the policies. They further said that if you did not comply, you were perceived as a difficult person and a misfit in the health institution (Gilson, *et al.*, 2006:8). The researchers in the EQUINET research project argued that there was a lack of trust between management and frontline nurses that could threaten the effective formulation and implementation of a policy.

In South Africa nurses experience a continual change in HIV and AIDS policies and they are tired of new policies. Frontline nurses complained about the lack of consultation prior to the implementation of a new policy with the assumption that they should implement it. One nurse stated during the EQUINET study: *"No consultation beforehand, training afterwards. It had to be implemented first and then you go for training. Not the other way around. No feedback on how it is impacting on you. You will do it. That's it. No backchat"* (Gilson, *et al.*, 2006:13).

1.4.1 Top-down HIV and AIDS policy formulation

The top-down HIV and AIDS policy implementation is discussed in order to provide clarity about the current processes. In addition to the national-level HIV and AIDS workplace policy, provincial guidelines were developed on the basis of the national policy. The provincial Department of Health uses the HIV and AIDS workplace policy and develops guidelines as basis for discussion in workshops and for training the nurses who represent a particular health district. After this step the written HIV and AIDS workplace policy and guidelines are distributed amongst human resource managers, chief executive officers and nursing service managers in every health district. Each health district in every province is responsible for making sure that there is an HIV and AIDS workplace policy in each public health-care institution (Schutte, 2004:171). At each district health office there is an HIV and AIDS coordinator employed to oversee policy implementation regarding the HIV and AIDS workplace policy, voluntary counselling, prevention of mother-to-child-transmission policy, integrated anti-retroviral services and other services for HIV-infected individuals.

In addition to these guidelines, the Labour Relations Act (66/1995) and the Employment Equity Act (55/1998) identify key aspects to guide public institutions on how to develop an HIV and AIDS workplace policy to ensure awareness, safety and management of HIV-infected individuals in the workplace (Van Dyk, 2005:348).

Despite all these initiatives in place it is the experience of the researcher that the national HIV and AIDS policy and provincial guidelines are just another document to be filed, as they are not implemented according to national expectations. It is essential to develop an institutional HIV and AIDS workplace policy to suit the specific needs of the specific institution. An effective institutional HIV and AIDS workplace policy is necessary to address the impact of the HIV and AIDS epidemic on an institution's workforce, i.e. rising employee attrition, increasing absenteeism, declining morale and low productivity. It is important that health-care managers minimize the effect of HIV and AIDS on their institutions' workforce and need to prepare efficiently for the growing demand for HIV and AIDS-related health-care services (Page, 2005:98; Zellnick, & O'Donnell, 2005:168).

1.5 CONSTRAINTS THAT HINDER NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

Constraints observed in the nursing workforce include factors such as a lack of research training, mentoring and funding, limited experience with research knowledge transfer and few

opportunities for dialogue with policymakers. These factors hinder nurses from becoming involved in policy formulation (Edwards *et al.*, 2007:34). Regardless of these constraints, nurses need to engage in HIV and AIDS workplace policy formulation for several reasons:

- Nurses constitute the frontline workforce and have prolonged engagement with patients and families. They are caregivers who provide extensive physical care while simultaneously rendering emotional care to patients suffering from HIV and AIDS. The demanding nature of the nursing of HIV and AIDS patients leads to occupational stress, fatigue and burnout (Smit, 2005:23).
- Nurses work across different sectors of the health system and can identify obvious health-service gaps regarding effective and efficient HIV and AIDS care. They can challenge policy issues with their knowledge of these identified gaps and when such gaps are supported by research processes, such findings can be utilized to develop evidence-based policy formulation approaches that are highly relevant to nursing practice, quality and the cost-effectiveness of health care (Edwards, *et al.*, 2007:34).
- The fact that nurses have frontline experience, bearing the brunt of the HIV and AIDS pandemic, mean values they can easily identify HIV and AIDS workplace policy gaps and should be enabled to become actively involved in policy formulation. Nurses have an obvious contribution to make to bridge the frontline experience gap by incorporating evidence into policies and practice (Edwards, *et al.*, 2007:31; Phaladzi, 2003:30), yet studies indicate that nurses' technical knowledge and experience do not influence policy decisions. Nurse led change to influence HIV and AIDS workplace policy is essential in order to improve the workplace environment, which will in turn enhance feelings of security in the HIV and AIDS workplace and improve service delivery to HIV and AIDS patients.

1.6 PROBLEM STATEMENT

In South Africa the top-down policy approach is used to ensure that HIV and AIDS workplace policies are formulated. Nurses at all levels of health care are not involved or consulted during the formulation of the HIV and AIDS workplace policy. Nurses are merely the implementers of HIV and AIDS workplace policy due to this top-down approach and cannot use their frontline experience to develop bottom-up policy approaches to balance the top-down HIV and AIDS workplace policy. The formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy might be essential to get nurses involved in policy formulation and to bridge the barriers identified in literature that prevent nurses from becoming involved in policy formulation. Barriers were identified at macro, meso and micro

level, and components within these levels are nurses and the policy process (see chapter 3 for more details).

On the basis of the rationale and background the following research questions are posed:

- How can a strategy for Nurse led change to influence HIV and AIDS workplace policy be formulated?
- What are the barriers to Nurse led change to influence HIV and AIDS workplace policy?
- What is management's opinion about human resource capacity in an HIV and AIDS workplace environment?
- What are the problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective?
- What are the problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective?

1.7 AIM AND OBJECTIVES OF THE STUDY

The aim of this study is to formulate a strategy for Nurse led change to influence HIV and AIDS workplace policy, phase two, objective 1. The following objectives in phase one will assist in achieving this purpose:

- **Objective 1:** To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.
- **Objective 2:** To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.
- **Objective 3:** To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.
- **Objective 4:** To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.

1.8 RESEARCHER'S ASSUMPTIONS

The following meta-theoretical, theoretical and methodological assumptions define the framework within which the researcher conducted this study.

1.8.1 Meta-theoretical assumptions

Mouton and Marais (1994:192) defined meta-theoretical assumptions as non-epistemic statements that are not intended to be tested. Meta-theoretical assumptions are based on the researcher's view of the world and environment. Botes (1995:9) also refers to the researcher's beliefs about the human being (in this study the nurse), community, the discipline (in this study nursing) as well as the purpose of the discipline (to promote optimal health for HIV and AIDS patients by influencing HIV and AIDS workplace policy and to ensure a safe practice environment with minimal occupational exposure for nurses). Klopper (2008:67) states that the argumentative nature of science requires that these assumptions need to be stated explicitly.

The researcher believes God is the creator of the universe and He wants the best for His children. The universe was created perfectly; man corrupted it through sin. The only way that God could provide us human beings with an eternal life was through the death of His Son on the cross and His resurrection after three days. Jesus returned to His Father and God gave us the Holy Spirit to guide us through our life on earth. It is our responsibility to have an in-depth relationship with God to cope with the demands of our daily lives. In this study the researcher dealt with HIV and AIDS in the workplace. Nurses are viewed from a Christian point of view and are responsible for caring for the HIV and AIDS patient as God cares for them. It does not matter that HIV and AIDS was caused by sin: during our life God shows us grace and anyone can ask, and receive, forgiveness for their sin at any stage during their life. The core concepts embedded in the meta-theoretical assumptions are human beings, health, nursing science, nursing and environment, and are discussed in the following paragraphs.

1.8.1.1 *Human beings*

Human beings are unique. God created human beings with their own unique talents to use to contribute to the world in which we live. The view of the researcher is that life is a gift from God and all achievements in life are obtained through the grace of God. If human beings remember that they live for the purpose of God and do not misuse their talents for their own benefit, there is eternal life after death. Human beings should always keep in mind what they leave behind as a Christian when they leave this world for eternal life. By participating in the policy process, nurses can utilize their God-granted talents, as each human being has different talents and life experiences that enable them to react differently to challenges experienced in life. In life there cannot be a single person who is always correct and we

need the guidance of God even in Nurse led change to influence HIV and AIDS workplace policy.

Human beings in this study refers to nurses becoming active as change agents to influence HIV and AIDS workplace policy in order to improve their work environment for their own benefit and to provide better care to patients. Nursing is a service that strives to optimize the health of individuals, families and communities by promoting, maintaining and restoring health.

1.8.1.2 *Health*

The researcher agrees with the World Health Organization's definition of health (WHO, 1948). Health is a status of complete physical, mental and social well-being and not merely the absence of disease. Zweigenthal, *et al.* (2009:25) offer a fresh perspective on the WHO's definition of health. The authors state that the definition was expanded to include aspects such as intellectual, environmental and spiritual health and added to the Ottawa charter in 1986. Intellectual health is not just book knowledge, but the ability of human beings to be creative and to make informed decisions, including environmental and spiritual decisions. Health changes as the internal (body, mind and spirit) and external (physical, social and spiritual) environments of human beings change and vary on a continuum between optimal and minimal health. Health is therefore more a mean values to an end, allowing human beings to lead an individually, socially and economically productive life.

In this study, health applies to a healthy HIV and AIDS workplace environment so that the nurse workforce is able to meet the changing needs of the HIV and AIDS pandemic and to contribute to the improvement of the quality of life of HIV-infected as well as AIDS patients.

1.8.1.3 *Nursing science*

The researcher describes nursing science as the organized body of knowledge of nursing enquired in a scientific manner. Nursing science encompasses nursing, the caring for patients and nursing practice, which refers to the art of caring for patients. Within nursing science there are theories and frameworks that guide the practice of nursing in a professional and unique manner.

1.8.1.4 *Nursing*

The researcher subscribes to the International Council of Nurses" (ICN, 1987) definition of nursing, which states that: "Nursing encompasses autonomous and collaborative care of

individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and care of the ill, disabled and dying people. Advocacy, promotion of a safe environment, research participation in shaping policy and education are also key nursing roles.”

In this study, nursing is seen as the activities that nurses undertake to ensure the holistic health of the nurses themselves in the workplace. If the nurses themselves are not healthy, they are unable to render effective and efficient health services to their patients. For the purpose of this study the term „nurse“ will be used, as this study was conducted among nurses who are registered with the South African Nursing Council (SANC). The reason for using the term nurse and not „registered nurse“ or „professional nurse“ is solely that nurses internationally are seen as professional nurses who are licensed or registered with a regulatory body. The term nurse also assisted with the searching of international libraries during the literature review and this supported the researcher’s decision to use the term throughout the study. The SANC refers to the professional nurse as “a person who is registered as a nurse or midwife in terms of the Act” (SANC, 1984: Scope of Practice, R.2598).

1.8.1.5 *Environment*

The environment consists of societal structures in which human beings co-exist as physical, psychological, social and spiritual beings while interacting with other human beings in the community. The environment in this study comprised every element in the workplace surroundings of nurses that influenced or impacted on their lives. Nurses working with HIV and AIDS patients are constantly experiencing occupational exposure to the HI virus, which influences their physical, psychological, social and spiritual functioning in their practice area. Nurses’ practical environment within the health context, specifically referred to as caring for HIV and AIDS patients, is characterized by constant change and requires adapting constantly to new identified knowledge. In this changing environment nurses should strive to enhance and develop their knowledge and skills so that they can be accepted as positive change agents at the policy table, whilst being able to contribute to the improvement of quality health services for HIV and AIDS patients.

1.8.2 Theoretical assumptions

Theoretical assumptions are a reflection of the researcher’s view of valid knowledge, which can be based on theories, conceptual frameworks or models. The theoretical assumptions are epistemic in nature and are subject to testing with the intention of clarifying the research

problem (Klopper, 2008:67). The researcher needed to make a thorough study of existing theories and models in order to be able to state the theoretical assumptions of the research study (Botes, 1995:5). The theoretical assumptions of this study include the central theoretical statement, theoretical models used, as well as definitions.

1.8.2.1 *Central theoretical statement*

The study explored and described the barriers to nurses acting as change agents at macro, meso and micro-level with regard to their influence on HIV and AIDS workplace policy. It also studied the description of managers' and frontline nurses' opinion about problems experienced with policy when working in an HIV and AIDS workplace environment. A strategy was formulated on the basis of the results of the literature review and empirical research for Nurse led change to influence HIV and AIDS workplace policy.

1.8.2.2 *Theoretical models*

Tarlov (1999:285) developed a conceptual framework for the public policy formulation process. There are many models that describe the policy process, but for this study the researcher used the eight-step conceptual framework of Tarlov (1999:286) that was adapted and specifically recommended by the Canadian Nurses Association (CNA, 2008). This framework was used by the CNA to develop a model to assist nurses to influence health policy. Nurses can only use the policy formulation model if they are prepared to act as change agents. The conceptual framework for change leadership developed by Skelton-Green, Simpson and Scott (2007) served with the CNA policy model as a foundation for Nurse led change in this study. A discussion of the two models follows in the paragraphs below.

- **Policy cycle**

The CNA policy model explains the processes involved in formulating policies. The CNA uses this policy cycle to assist nurses in moving issues into the public policy arena and to help them to take their agenda forward into action. The CNA policy cycle has two distinct phases and each phase is anchored by a specific step in the cycle.

The first phase is the process of getting to the policy agenda and is anchored by beliefs and values. If the community and its representative structures do not value and believe in the issues that are put forward in the policy arena, the issues will not become a priority. This phase consists of four steps:

- Values and cultural beliefs.
 - Emergence of problems or issues.
 - Knowledge and development of research.
 - Public awareness.

The second phase is anchored by political engagement and involves the process of moving the issues or problems into action. It does not matter how relevant an issue is, policy issues can be widely known and acknowledged by the relevant stakeholders, without political engagement no actions will result in policy change. This phase also consists of four steps:

- Political engagement.
- Interest group activation.
- Public policy deliberation and adoption.
- Regulation experience and revision.

In this study these steps were applied to professional nursing practices related to HIV and AIDS workplace policies (CNA, 2008:1-12). Figure 1.2 depicts the Canadian policy cycle in schematic form.



FIGURE 1.2: THE POLICY CYCLE THEORY (CNA, 2008:1-12)

- **Leading change framework**

The leading change framework for change leadership was also used as a theoretical model in this study. Nurse led change often fails because nurse leaders have a brilliant vision, but fail to provide team members with the necessary direction or support to ensure that change actually happens. The leading change framework model incorporates three important elements that are essential in order to introduce and manage change successfully. These elements include being strategic, engaging the correct stakeholders and the management of the project (Skelton-Green, *et al.*, 2007: 3-4). For the purpose of this study these two models were used as theoretical departure points.

1.8.2.3 Strategy formulation

A strategy is a future-orientated plan to outperform other organizations or to interact with the competitive environment, to achieve the organization's purpose or objectives and to ensure customer satisfaction (Pearce & Robinson, 2004:4; Thompson & Strickland, 2001:10-11). In this study, the aim is to formulate a strategy for Nurse led change to influence HIV and AIDS workplace policy.

1.8.2.4 Definitions

The following concepts are central in this study and are defined as follows:

- **Policy**

In the simplest terms a policy mean values that there is an issue or a problem and a document is drafted in order to address that problem. Government can use a full range of possible responses to address an issue or problem when developing a policy, such as utilizing legal prohibitions, regulations, taxation, a specific system or direct government action such as the provision of services. Policies are designed to implement and control decisions made by government (Pearce & Robinson, 2000:380; Hague & Harrop, 2007: 377; Heywood, 2002:406). Policies should be developed in such a way that they allow for the judgment of frontline-level staff so that the policy can be implemented effectively. It is essential for policies to be created that also empower the implementers of the policy (Pearce & Robinson, 2000:380).

- **HIV and AIDS workplace policy**

An HIV and AIDS workplace policy is a document that aims to achieve the following goals (North-West Province: Workplace policy on HIV/AIDS, No date:3):

- To raise awareness of HIV and AIDS among all employees.
- To ensure a better understanding of HIV and AIDS in the workplace through information, training and communication.
- To seek to minimise the socio-economic and developmental impact of HIV and AIDS on the nursing workforce.
- To prohibit discrimination against nurses living with HIV and AIDS in the workplace on the basis of their HIV status.
- To provide a comprehensive programme to improve health and safety at work.

- **Leadership**

In order to achieve the aim of the study, nurses need to be leaders who act as change agents to influence HIV and AIDS workplace policy. It is therefore essential to describe the concept leadership as well. Leading is a dynamic process where the leader communicates to people their potential and their worth in such a clear manner that these people start to see the potential in themselves. Leadership entails guidance that is purposeful, planned and

focused, with the intention of influencing team members positively in order to achieve the desired results. Leadership dynamics include concurrent interaction between the leader, the situation and the team members (Klopper & Bester, 2010:189).

- **Nurse led change**

Leading change has become a core competency of the nursing profession. To succeed in change, nurse leaders should be able to incorporate three major elements in their plan (Skelton-Green, *et al.*, 2007:3):

- Firstly, they should be strategic in determining exactly the problems or challenges they need to address: will the change contribute towards a better service delivery to patients as end result, and is the timing for embarking on this change correct?
- Secondly, nurse leaders need to engage stakeholders who are interested and can contribute significantly with their skills, experience, strengths and political involvement towards the proposed change. The stakeholders should consist of team members bringing different skills and experiences to ensure success in change, e.g. if nurses need to influence the HIV and AIDS workplace policy, they need the buy-in of politicians.
- Lastly, nurse leaders should be able to manage the change project. They should be able to translate the vision, mission and objectives clearly, with key activities, accountabilities, and timelines. Excellent communication skills with all key stakeholders are essential to succeed in change as a nurse leader.

1.8.3 Methodological assumptions

Methodology is the science of determining the procedures for scientific investigation (Babbie, 2010:4). The methodological assumptions give direction to the methods within the study and are the logical application of scientific methods to the investigation of phenomena (Mouton & Marais, 1996:16). Methodological assumptions have their origin in science-philosophy and direct the research design as the researcher decides what the most suitable design is to address the research question (Klopper, 2008:67).

The researcher's premise is the pragmatic claim that knowledge arises out of actions, situations and consequences. Pragmatism is concerned with applications, in other words what works or what the solution for a problem is. Instead of focusing on methods, the

research is problem solution focused (Creswell, 1993:11). According to Creswell (1993:11-12), pragmatism provides a basis for the following knowledge claims:

- Pragmatism does not support any one system of philosophy or reality. It is therefore specifically applicable in a mixed-method approach due to the fact that the focus is solution-generative. This study employs strategies of inquiry that simultaneously focus on quantitative and qualitative data collection in order to understand the research problem better.
- According to pragmatism, the researcher is free to choose whichever method, techniques and procedures that best fit the purpose of the study.
- Pragmatists do not see the world as an absolute entity and researchers can use many approaches to collect and analyse data rather than to use only one approach, e.g. a qualitative approach.
- Trust is what works at the time; it does not indicate a strict dualism between mind and reality, nor does it state that reality is completely independent of the mind. The use of mixed methods for data collection and analysis embraces trust in the sense that the research provides the best understanding of a problem. Within the context of the research study the researcher supported the participant's construction of reality through interaction, which made it possible to obtain perspectives from them about policy problems they experience while working in an HIV and AIDS environment. The analysis of the data contributed to the identification and classification of these problems. Concluding statements could be made to assist in developing a strategy for Nurse led change to influence HIV and AIDS workplace policy.
- Pragmatists are clear on the „what“ and the „how“ of their research because it is based on intended consequences, indicating exactly where they would like to go with the research and why they use different methods for the collection and analysis of data. Researchers have a clear rationale for using specific applicable methods.
- Pragmatists agree that research occurs in different contexts and mixed-method studies may include a postmodern turn, a theoretical lens that reflects social justice and political claims.

The inquiry presented in this study was effectively studied through a pragmatic approach as the researcher identified a lack of nurses' involvement in HIV and AIDS policy formulation. The research questions guide the method of knowledge development and coupled with the

assistance of qualitative/quantitative data collection/analysis and supported by the literature review, a triangulation of concluding statements contributed towards the formulation of a strategy. This provided the research study with a problem-orientated solution. The pragmatic approach provided the researcher with the opportunity to conduct the research to formulate a strategy for Nurse led change to influence HIV/AIDS workplace policy in order to improve nursing practice in an HIV and AIDS workplace environment.

1.9 RESEARCH DESIGN

The design of a study is a logical strategy to gather evidence regarding the problem and is therefore the blueprint for the study. This study makes use of a **triangulated mixed-method** design in order to meet the aim and achieve the objectives of the study. Triangulation mixed methods can be described as the use of multiple methods to study a single problem (Denzin & Lincoln, 1994:215; Creswell, 2003:211). During this study the collection and analysis of quantitative and qualitative data took place simultaneously (Maree, *et al.*, 2007:266). The researcher chose this design because the mixing of qualitative and quantitative methods leads to triangulation in action.

The research strategies used within the design were exploratory, descriptive and contextual (Creswell, 1994:145; Klopper, 2008:67; Mouton, 1996:102, 103 &133). This will provide a clear and deeper understanding of the opinions of nurses and management about their roles and responsibilities in terms of the formulation of the HIV and AIDS workplace policy.

- **Exploratory research** explores the dimensions of the phenomenon. In this study a literature review was undertaken to explore barriers to Nurse led change to influence HIV and AIDS workplace policy, while the opinions of management and nurses regarding the problems experienced with policy when working in an HIV and AIDS environment were also explored.
- The design was **descriptive** in nature in order to provide a clear picture of what the current situation is regarding HIV and AIDS policies in public health-care institutions in the North-West Province. Literature, the opinion of management about human resource capacity in the HIV and AIDS environment, as well as the problems identified while working with HIV and AIDS from both a managerial and frontline nurse point of view were described. Descriptive statistics provide a summary of the principle characteristics that have been collected (Babbie, 2010:467).
- This research was **contextual** in nature as it focused on public health-care institutions at provincial and district level in the North-West Province, and therefore

no universal claims are made. A detailed discussion about the context follows in chapter 2, paragraph 2.2.1.5.

1.10 RESEARCH METHODS

Klopper (2008:69) refers to the research method as the steps of population, sample, data collection and data analysis. In this study phase 1 consisted of steps 1 to 4; the empirical research, which served as a basis for problem identification and phase 2, included step 5, the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy. Table 1.1 provides an overview of the research phases, while table 1.2 provides an overview of the summarized research methods (detailed discussion will follow in chapter 2).

TABLE 1.1: OVERVIEW OF RESEARCH PHASES

PHASE 1: Empirical research					
Objective 1:	Data collection:	Population and sample:	Data analysis:	Reliability and validity:	
To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.	Literature review. Retrieval using multiple electronic data-bases and hard copy search.	Purposive sampling of all relevant national and international sources. Sample size: n=58	Critical appraisal of documents regarding strength of evidence and relevance in context (Burns & Grove, 2009:104).	Content validity.	Detailed discussion in chapter 3.
Objective 2:	Data collection:	Population and sample:	Data analysis:	Reliability and validity:	
To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.	The Human Resource Management Assessment Questionnaire for HIV and AIDS environments.	- Population: Managers working in four of the participating institutions of the TC research programme (N=57). - Purposive sample (n=44).	Descriptive statistics analysis using Excel and SPSS software version 16. - Chronbach alpha coefficient. - Confirmatory factor analysis.	- Internal reliability scale should consistently reflect the construct it is measuring. The same scores are obtained for similar items. Chronbach alpha is used to determine reliability when using SPSS software version 16 (Babbie, 2010:173). - Construct validity is determined by using confirmatory factor analysis (Field, 2005).	Detailed discussion in chapter 4.

PHASE 1: Empirical research

Objective 3:	Data collection:	Population and sample:	Data analysis:	Reliability and validity:	
To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.	Semi-structured interviews with managers regarding their opinion of the factors and process of HIV and AIDS workplace policy from a managerial perspective.	Managers employed in TC participating institutions. - Population (N=48). - Purposive sample (n=12).	- Analysis involves concurrent conduct of interviews and analysis of data (TC Handbook, 2007:70). - First step will be careful reading of each transcription to identify concepts and links. (TC Handbook, 2007:70). - The technique of content analysis (Creswell, 2003:192). Data will be categorized into themes. An inductive approach to data analysis will involve iteratively identifying these themes. - The relationship between themes via systematic comparisons using negative cases and extreme cases (TC Handbook, 2007:70). - Data management with the help of Nvivo version 8.	- Instrument validated by Edwards, <i>et al.</i> (2007:35). - Trustworthiness.	Detailed discussion in chapter 4.

Objective 4:	Data collection:	Population and sample:	Data analysis:	Reliability and validity:	
To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse"s perspective.	Semi-structured interviews with nurses about their roles and responsibilities with reference to the HIV and AIDS workplace policy.	Frontline nurses employed in TC participating institutions. - Population (N=87). - Purposive sampling of frontline nurses (n=9).	- Analysis involves concurrent conduct of interviews and analysis of data (TC Handbook, 2007:70). - Careful reading of each transcription to identify codes and links. (TC Handbook, 2007:70). - The technique of content analysis (Creswell, 2003:192). Data will be categorized into themes. An inductive approach to data analysis will involve iteratively identifying these themes. - The relationship between themes via systematic comparisons using negative cases and extreme cases (TC Handbook, 2007:70). - Data management with the help of Nvivo version 8.	- Instrument validated by Edwards, <i>et al.</i> (2007:35). - Trustworthiness.	Detailed discussion in chapter 5.

PHASE 2: Strategy formulation					
Umbrella aim of this study:	Data collection:	Population and sample:	Data analysis:	Reliability and validity:	
To formulate a strategy for Nurse led change to influence HIV and AIDS workplace policy.	Integrating and synthesizing results from objectives 1, 2, 3 and 4.	All conclusions and statements from objectives 1-4.	Deductive and inductive reasoning (Chinn & Kramer, 2008:296-299).	- Content validity. - Deductive and inductive reasoning.	Detailed discussion as set out in chapter 6.

1.11 RIGOUR IN STUDY

Rigour in research refers to the establishment of confidence in the truth or credibility of the findings of the study. To ensure rigour throughout the research study the whole research process needs to be evaluated against a set of criteria to prove the validity of the study. This study used both quantitative and qualitative data collection and analysis methods according to the mixed-method triangulation design. Both quantitative and qualitative approaches needed to deal with different threats to validity and each approach has its own specific techniques to ensure validity. According to Klopper and Knobloch (2010:318), quantitative and qualitative approaches are guided by four basic epistemological standards to ensure rigour, namely:

- The truth value of the research findings, in other words can the research findings be trusted?
- Applicability of the research findings, which refers to the degree to which the research findings can be generalized to similar populations.
- Consistency of research findings, in other words: if the research is repeated in the same context with the same participants, will the same results be obtained?
- Neutrality of research findings refers to ways in which the research is conducted to eliminate bias and to ensure that findings are the actual view of the participants.

These four basic epistemological standards are underpinned by four basic rules for scientific practice, namely (Klopper & Knobloch, 2010:318):

- Using specific and acceptable problem-solving methods.
- Justifying of research findings.
- Enhancing scientific soundness of research by utilizing existing, accepted knowledge frameworks.
- Convincing the research community of the truth of the findings.

These standards and rules guide the researcher to generate sound scientific knowledge and ensured rigour throughout the study. Both quantitative and qualitative studies have their own techniques to ensure the validity of the findings. In quantitative research the principles of validity and reliability are used, while in the case of qualitative data-collection methods applicable strategies include credibility, applicability, neutrality, and consistency. Table 1.2 provides a summary of the criteria, techniques applied and application in this research to ensure rigour. However, the researcher addressed specific issues of rigour as relating to each objective throughout the thesis.

TABLE 1.2: RIGOUR CRITERIA, TECHNIQUES AND APPLICATION IN RESEARCH STUDY

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
Reliability	According to Burns and Grove (2005:374), reliability mean values that if the instrument (in objective 2 of this study the HRM questionnaire) is repeated on the same participants at different periods, the results of the questionnaire will be the same. Reliability tells you how reproducible your measures are on a retest: the more reliable a measure, the fewer the participants and a smaller visible change in a measure. This further indicates that there might be some errors when collecting data, therefore reliability is utilized with the aim of achieving greater truth (De Vos & Fouche, 2000:97; Klopper & Knobloch 2010:322).		Use of an international standardized validation human resource management (HRM) questionnaire. See chapter 2, paragraph 2.5.2 and chapter 4, paragraph 4.3.1 for further details. The qualitative research (interviews and observations) in this study was sensitive to the time and place it was performed. Reliability (in qualitative research dependability) was proven through peer review, member checking and triangulation, as discussed in paragraphs below.
Validity	Validity is an important aspect with reference to the HRM questionnaire (quantitative instrument) and the policy process in-depth interview schedule used in this study (qualitative instrument). Validity of the questionnaire refers to two aspects, namely whether the questionnaire measures the concept in question and whether the concept is measured accurately (Klopper & Knobloch 2010:320).	Content validity	Content validity refers to the representativeness and adequacy of the items included in the HRM questionnaire and the in-depth policy process interview schedule. The researcher used a validated international HRM questionnaire that had been used since 2003 in numerous studies. See chapter 4, paragraph 4.2.2.2. Validity in qualitative research refers to credibility and a discussion follows in the paragraphs below. The in-depth policy process interview schedule was developed by Professor N Edwards (2007) for the international Teasdale-Corti research programme.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
	Internal threats to validity include using inadequate procedures with the application of quantitative or qualitative instruments. The following statement serves as an example of internal threats to validity. The researcher collecting data can become more experienced and make better observations or become tired and make less exact observations, which will influence optimal data collection (Klopper & Knobloch 2010:320).	Control threats	With data collection, using the HRM questionnaire the researcher needed to prepare for possible questions managers could be asked and to clarify questions in such a way that the answer did not influence the outcome of the constructs and items measured. With the qualitative policy process in-depth interview schedule the researcher used open-ended questions and probes to encourage elaboration in order to obtain more rich data (credibility strategies – discussion follows).
	Selection bias can be another internal threat to validity (Klopper & Knobloch 2010:320).	Explicit selection criteria for each research objective	The researcher stuck to the recruitment and selection criteria as set out in the TC programme. See chapter 2 discussions on selection criteria under each objective.
	External validity is concerned with the extent to which the findings can be generalised and threats may arise when the findings are generalised to groups in a totally different health context.	Generalised findings	It was stated that the aim of this study was not to generalise findings to other populations. Applicability of data includes transferability as strategy. The application of this strategy ensures saturation of data, thick description and concluding statements that can assist other researchers to evaluate contextual similarity – discussion follows.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
	Reactive effects can also be a threat to external validity. Reactive effects imply that participants know that they are being observed by the researcher and they may act unnaturally. They may try to please the researcher by providing the answer that they believe to be the desired outcome, or may deliberately choose to do the opposite, which could influence the believability of data (Klopper & Knobloch 2010:320).	Objectivity and confirmability	With reference to quantitative data, objectivity assists the researcher in collecting and analysing data objectively by remaining separate and handling data with a focus of enquiry (Klopper & Knobloch 2010:323). With regard to qualitative data analysis the techniques of audit trail and triangulation were applied to ensure confirmability, discussion follows (Klopper & Knobloch 2010:323).
	Construct validity refers to determining the degree to which an instrument successfully measures a theoretical construct. Construct validity refers to what the instrument is measuring and how and why certain results are found the way they are.	Concept clarification	Construct validity threats may occur when the researcher uses inadequate definitions and measures of variables. For this reason concepts were clearly defined by mean values of empirical data collection with the assistance of an independent reviewer, content expert as well a statistical consultant in this study.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
Credibility	Credibility refers to conducting data collection in such a way that believability of the findings is enhanced from the perspective of the participant, researcher or reader of the research (Klopper & Knobloch 2010:319; Denzin & Lincoln, 2003:69; Miles & Huberman, 1994:278-279).	Prolonged engagement	The researcher succeeded in establishing an inter-professional collaboration network in the North-West Province to ensure prolonged engagement and work towards a sustainable implementation of the formulated strategy after the research. The researcher immersed into the data through data collection and concurrent analysis until saturation was reached. An independent senior co-analyst analysed the qualitative data with the researcher and consensus discussion, comments and amendments clarified differences. An agreement on data saturation was also reached. (Poggenpoel, 2000:345-346).
		Persistent observation	Persistent observation mean values consistently pursuing interpretation in different ways (Klopper & Knobloch, 2010:319). The researcher was familiarised of the policy process status in institutions by going through internal and external policy manuals before implementing the HRM questionnaire with managers.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
			Individual interviews were conducted on different dates and with different time schedules. Field notes enhanced persistent observation in this study.
		Triangulation	Triangulation: multiple methods should be used in a study of a phenomenon to portray the findings accurately (Klopper & Knobloch, 2010:319) The researcher used triangulation methods for data collection and analysis, including quantitative (HRM questionnaire), qualitative data (policy process), in-depth interview schedule and embedded findings in literature during this study. Quantitative data were analysed under the supervision of a statistician and qualitative transcription codes were reviewed by an experienced senior researcher in the department (Morse, <i>et al.</i>, 1995:143; Klopper, 2008:69).
		Peer debriefing	Peer debriefing refers to review and exploration of either the method or the phenomena being studied (or both) by objective peers who are experts to enhance critical inquisitive thinking by the researcher (Klopper & Knobloch, 2010:319).

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
			Meetings with study leaders, doctoral seminars and doctoral committee meetings were employed. During this process bias was explored. Methods and ethical matters were questioned. Peer review contributed to the development of the researcher in methodological design used in the study as well as to ethical issues being addressed by the researcher.
Applicability	Applicability refers to the degree to which findings can be applied to different contexts and groups with the use of qualitative methods (Klopper 2008:69; Miles & Huberman, 1994:279).	Data saturation	Data saturation: The number of participants in a qualitative study is determined by rich information needed to gain insight into the phenomena being studied. Saturation of data occurs when additional interviews provide no information to identify themes and subthemes (Burns & Grove, 2005:358). Data saturation was reached with interviews held with both managers and frontline nurses.
		Thick description	Thick description of the research context, data collection and analysis embedded in literature in order to provide another researcher with sufficient information to evaluate contextual similarity (Polit & Hungler, 1997:308)

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
			The intent of the study was not to generalize findings, but to provide thick description of data that can assist other researchers to identify contextual similarities and assist them to determine areas needing further research.
Neutrality	Neutrality can be defined as research free from bias during the whole research process and refers to the degree to which the findings are a true reflection of the participant's view. The techniques used to determine neutrality in quantitative research is objectivity and in qualitative research confirmability (Klopper & Knobloch, 2010:232).	Audit trial	An audit trial implies a systematic collection of material and documents that allow an independent auditor to come to a conclusion about the data, implying that the methods and procedures followed in the study are described explicitly and in detail. A data audit can be conducted after the study to examine the data collection process and procedures of analysis, and to judge potential bias. Concluding statements were made. Personal assumptions, biases and values were stated explicitly (see paragraph 1.8, assumptions of the researcher). The raw data was retained and will be stored according to the TC programme requisites. Analysed data of the study can be used for secondary research with ethical approval of relevant stakeholders.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
		Triangulation	The combination of quantitative, qualitative data collection and analysis embedded in a literature review assures triangulation in the data collection, analysis, concluding statements that served as evidence for the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
Consistency	Consistency considers that if the interviews are repeated on the same participants in a similar context, the result will address the same objective. All sources used in the study are identifiable as described in the study. To ensure consistency the strategy of dependability was used. Dependability can be indirectly assured by applying the measures of credibility. Direct dependability of research findings was assured in three ways by mean values of a stepwise replication of methodology, inquiry audit and triangulation. In this study the researcher explained the methodological research process followed in detail (see chapter 2). Direct dependability can also be assured by doing an inquiry audit on the entire study (Klopper & Knobloch, 2010:232).	Stepwise replication of methodology, inquiry audit and triangulation	Clandinin and Connelly (1994:438) suggest that the researcher pay attention to the following points: • The researcher is sure that findings are grounded in the data, sampling was done according to the TC programme algorithm, and data analysis was done with the help of a statistical expert. • The researcher is sure that analytic strategies were applied correctly. • The researcher is of the opinion that the coding structure is appropriate. • The researcher is sure that inquiry decisions can be justified. • Determine the degree of researcher bias. The researcher's assumptions were stated – see paragraph 1.8.

CRITERION	DESCRIPTION	TECHNIQUES	APPLICATION IN THIS STUDY
			- Assured strategies for increasing credibility (in this study coded transcriptions were reviewed by a senior researcher, the researcher personally collected data in two of the three districts and therefore spent adequate time in the field). - The third way to ensure direct dependability is by triangulation. This study had a mixed-method triangulation design was described fully in the paragraphs above.

1.12 ETHICAL CONSIDERATIONS

Due to the fact that this study formed part of the International Teasdale-Corti research programme, the ethical approval process that was followed for the research project and the ethical principles adhered to in this study are discussed in this section.

1.12.1 Ethical approval process

The prerequisite of the international research programme entitled “*Strengthening Nurses Capacity in HIV-policy Development in Sub-Saharan Africa and the Caribbean*” was to have ethics approval from different Canadian universities and all the study countries before data collection could begin. Research could only begin officially in a study country after all the ethics approvals from Canada and the study country (in this study, South Africa) had been received. Ethics approvals were received from 14 ethics boards for this programme, and South Africa was one of four study countries (see addendums B and C for South Africa’s ethics approval). Table 1.3 outlines the ethics boards that approved the international research study and table 1.5 the ethical principles adhered to.

TABLE 1.3: RESEARCH ETHICS BOARDS THAT APPROVED THE INTERNATIONAL RESEARCH PROGRAMME WITHIN WHICH THIS STUDY FALLS (TEASDALE-CORTI HANDBOOK, 2007:44)

COUNTRY	ETHICS BOARD
1. CANADA	1. University of Ottawa. 2. Dalhousie University. 3. University of Lighbridge. 4. University of Alberta. 5. University of Toronto.
2. KENYA	6. Kenya Medical Research Ethics Committee.

COUNTRY	ETHICS BOARD
3. JAMAICA	7. Ministry of Health. 8. University Hospital of the West Indies, University of the West Indies. 9. Kingston Public Hospital.
4. UGANDA	10. Uganda National Council of Science and Technology. 11. Makerere University. 12. Mulago Hospital.
5. SOUTH AFRICA	13. North-West University. 14. North-West Provincial Health Department.

1.12.2 Ethical principles

As part of the international Teasdale-Corti research programme this study was required to conform to the international ethical principles of self-determination, privacy, autonomy and confidentiality, justice and inclusiveness, right of beneficence, competence, informed consent, voluntary consent and documentation of informed consent. Table 1.5 outlines the ethical principles adhered to and their application in this study.

TABLE 1.4: ETHICAL PRINCIPLES ADHERED TO IN THIS STUDY

ETHICAL ASPECT/PRINCIPLE	APPLICATION IN THIS STUDY
Self-determination	According to Burns and Grove (2005:181), self-determination mean values that the participant has the right to decide whether they want to participate in the study voluntarily, or to terminate participation when they so choose without any consequences. The biggest challenge of this study was to create awareness of the programme of research so that every eligible participant could have the right to decide whether they wanted to partake in the study. The researcher, in collaboration with other team members, assured that nurses in all participating institutions were aware of the research study. The researcher adhered to this principle by giving the participants the choice of participating in the study or not. Due to the fact that the international research programme requires a time period of five years, the participant has the right to withdraw at any time during the study. The consent form also gives the participant the right to indicate if they gave permission for the researcher to use data already collected in the study or if they would like to withdraw all participating data at the time of the decision to withdraw (see example of consent form – Addendum I).
Privacy	Right of privacy mean values that the participant has the right to decide who may share in the information the participant gives (Brink, <i>et al.</i>, 2006:33). The right to privacy was adhered to as there were no names on the questionnaire, and all identifying information was removed before transcripts were analysed or shared with partner countries. All interviews with participants were held in a private room. Standards of privacy protected the access, control and dissemination of personal information and adherence to them helped to protect mental or psychological integrity. These standards are also consonant with values underlying autonomy and confidentiality (Teasdale-Corti handbook, 2007:46; Welman, Kruger & Mitchell, 2005:201).

ETHICAL ASPECT/PRINCIPLE	APPLICATION IN THIS STUDY
Autonomy and confidentiality	The right to autonomy and confidentiality (breach of confidentiality, maintaining confidentiality). Autonomy mean values that a person who falls into a vulnerable group is not exploited in the study. In this study this included a nurse who was aware of their HIV-status and who felt uncomfortable with sharing information. However, no-one participated in the study without giving voluntary consent. Confidentiality mean values that information obtained from participants in the study will not be shared with others without the participant's consent. The researcher ensured that all participant information was handled confidentially with no names written on questionnaires and identifying information removed from transcripts (Burns & Grove, 2005:182-188).
Justice and inclusiveness	Justice includes fairness and equity (Teasdale-Corti handbook, 2007:46). Fair treatment (fair selection and treatment of participants) mean values that the participant has to be treated fairly, irrespective of race, social values or sexual preference. The researcher selected participants on the basis of the set criteria of the international programme of research (Brink, <i>et al.</i> , 2006:33). The researcher adhered to this principle by ensuring that participants knew that they could withdraw at any stage if they so wished without any form of discrimination towards them. Furthermore the researcher made sure that any person who met the required criteria and was interested in participating in the study had a fair chance of selection.
Right of beneficence	The right of beneficence mean values that the participant is protected from discomfort and harm (no anticipated effects, unusual levels of temporary discomfort or risk of permanent damage). Harm could be physiological, emotional, social or economic in nature. The researcher guarded against non-compliance with the right of beneficence. While conducting the study the participants were not exposed to any form of harm (Burns & Grove, 2005:190-191).

ETHICAL ASPECT/PRINCIPLE	APPLICATION IN THIS STUDY
Competence	Burns and Grove (2005:196) describe competence as a person having the ability to make autonomous decisions when participating in a study. The study participants were nurses who were registered with the South African Nursing Council and thus had the competence to make autonomous decisions. The researcher has worked for many years in primary health care clinics and has received international training for the Teasdale-Corti research programme. This study formed part of this international research programme. The experience of the researcher contributed to effective decision-making to direct the research process and to allow participants autonomous decision-making in the study.
Informed consent	According to Burns and Grove (2005:193), informed consent (introduction to research activities, description of risks and discomforts, description of benefits, disclosure of alternatives, assurance of anonymity and confidentiality, compensation for participation in research, offer to answer questions, non-coercive disclaimer, option to withdraw, consent to incomplete disclosure) mean values that the participants should be informed about the research and give voluntary consent to ensure the research is conducted ethically. Informed consent mean values that there is an agreement between the researcher and the participants stipulating that they received essential information regarding the study conducted (Brink, <i>et al.</i> , 2006:33). Informed consent mean values that the participant has freedom of choice in making the decision whether to participate or not. The researcher ensured informed consent by providing a voluntary consent form to be signed by the participants before collecting data (see Addendum I).
Voluntary consent	Voluntary consent is the decision of the participant to take part in the study without coercion, persuasion or pressure applied by the researcher (Burns & Grove, 2005:196). The researcher ensured that each participant signed a voluntary consent form before continuing with the research (Addendum I).

ETHICAL ASPECT/PRINCIPLE	APPLICATION IN THIS STUDY
Documentation of informed consent	See Addendum I.

1.13 LAYOUT OF THESIS

The thesis consists of the following chapters:

- Chapter 1:** Overview of the study.
- Chapter 2:** Research design and method.
- Chapter 3:** Literature review
- Chapter 4:** Results of management
- Chapter 5:** Results of frontline nurses.
- Chapter 6:** Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
- Chapter 7:** Evaluation of the study, limitations and recommendations for education, research, practice and policy.

1.14 SUMMARY

This chapter provided an introduction to and discussion on the background, problem statement, research questions, research objectives and the researcher's assumptions. The research design, method and ethical considerations were outlined, and lastly a brief outline of the rest of the chapters was provided. Chapter 2 focuses on the research design and method utilized in this study.

CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

In the previous chapter, an overview of the research study was provided. The intention of this chapter is to explain in detail the research design and method used in both phases 1 and 2 of this study. Descriptions are prepared according to the objectives of the study and special attention is given to the research design, the research method, a plan for data analysis and measures to ensure rigour. Phase 1 of the study deals with the literature review and empirical research, while phase 2 is the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy. The method of strategy formulation is also discussed.

The following objectives are stipulated for **phase 1 of the study**:

- **Objective 1:** To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.
- **Objective 2:** To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.
- **Objective 3:** To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.
- **Objective 4:** To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.

Phase 2 has only one objective: Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.

2.2 RESEARCH DESIGN

The research design is an overall plan of how the research is going to be conducted and it starts with a problem. The development of a research design is a logical outflow of the research problem and thus directs the choice of a design. A research design is a set of guidelines and instructions that need to be followed in order to address the research problem

and can be illustrated as a framework that was developed from the set objectives and the overall aim of the study. The design states clearly the procedures to be followed and the conditions under which data collection and analysis will be carried out (Klopper, 2008:67-68; Burns & Grove; 2009:236; Babbie, 2010:91). The purpose of a design is to achieve greater control and improve the validity, reliability and trustworthiness of the study in examining the research problem (Burns & Grove, 2005:231). Before the researcher could decide on a research design it was necessary to determine the knowledge claims that contributed towards the study, which strategies of enquiry to follow to enlighten procedures and which methods of data collection/analysis would be required (Creswell, 2003:5). These three important questions are discussed in the following paragraphs.

- What knowledge claims are being made by the researcher?

The researcher decided on pragmatism as knowledge claim. This was discussed in chapter 1, paragraph 1.8.3. This knowledge claim made it possible to focus on the research problem solution and also took into consideration the consequences of different actions while formulating a strategy for Nurse led change to influence HIV and AIDS workplace policy. The researcher furthermore needed to consider experiences in the real world.

- What strategies of inquiry will enlighten the procedures followed?

The aim of this study was to formulate a strategy for Nurse led change to influence HIV and AIDS workplace policy.

- Which method of data collection and analysis would be best suited to achieve the umbrella aim?

With the above taken into consideration a triangulation mixed-method design was selected for this study and is discussed in detail below.

2.2.1 Triangulation mixed-method design

The mixed-method approach is based on knowledge claims that are embedded in pragmatism and that include a consequence-oriented and problem-centred focus. Furthermore, a mixed-method approach employs strategies of inquiry that involve collecting data either simultaneously or sequentially in order to understand the research problem the best and also involves both quantitative and qualitative techniques (Creswell, 2003:19-20). A mixed-method design recognizes that all methods of data collection and analysis have weaknesses and strengths. By combining multiple methods of data collection and analysis,

the weakness inherent in the one method is offset by the strengths of the other, and this ensures a triangulation in data collection and analysis. In this design, the researcher conducted a literature review and collected both quantitative and qualitative data from different populations, and then with analysis integrated the interpretation of the findings (Creswell, 2005:217). Data was obtained as a concurrent procedure, i.e. data was obtained from participants at the same time, but with the integration of the results during analysis one can either note the convergence of the findings as a way to strengthen the knowledge claims of the study, or explain any lack of convergence that may result (Creswell, 2005:217, Tesch, 1990:80).

- Advantages of a mixed-method concurrent triangulation design (Creswell, 2003:217):
 - The study culminates in well-validated and substantiated findings.
 - Researchers are familiar with this type of study.
 - Concurrent data collection contributes towards a shorter data collection period compared to that of a sequential approach.
- Disadvantages of a mixed-method concurrent triangulation design (Creswell, 2003:217):
 - The design requires great effort and expertise to study a phenomenon adequately using multiple separate methods.
 - It can be difficult to integrate and compare data analysis findings obtained through two different methods.
 - The researcher may be uncertain about how to deal effectively with discrepancies that arise with data analysis.

Figure 2.1 shows a framework demonstrating the mixed-method triangulation design, while the concepts of quantitative, qualitative, exploratory, descriptive and contextual designs are discussed individually in subparagraphs 2.2.1.1 onwards.

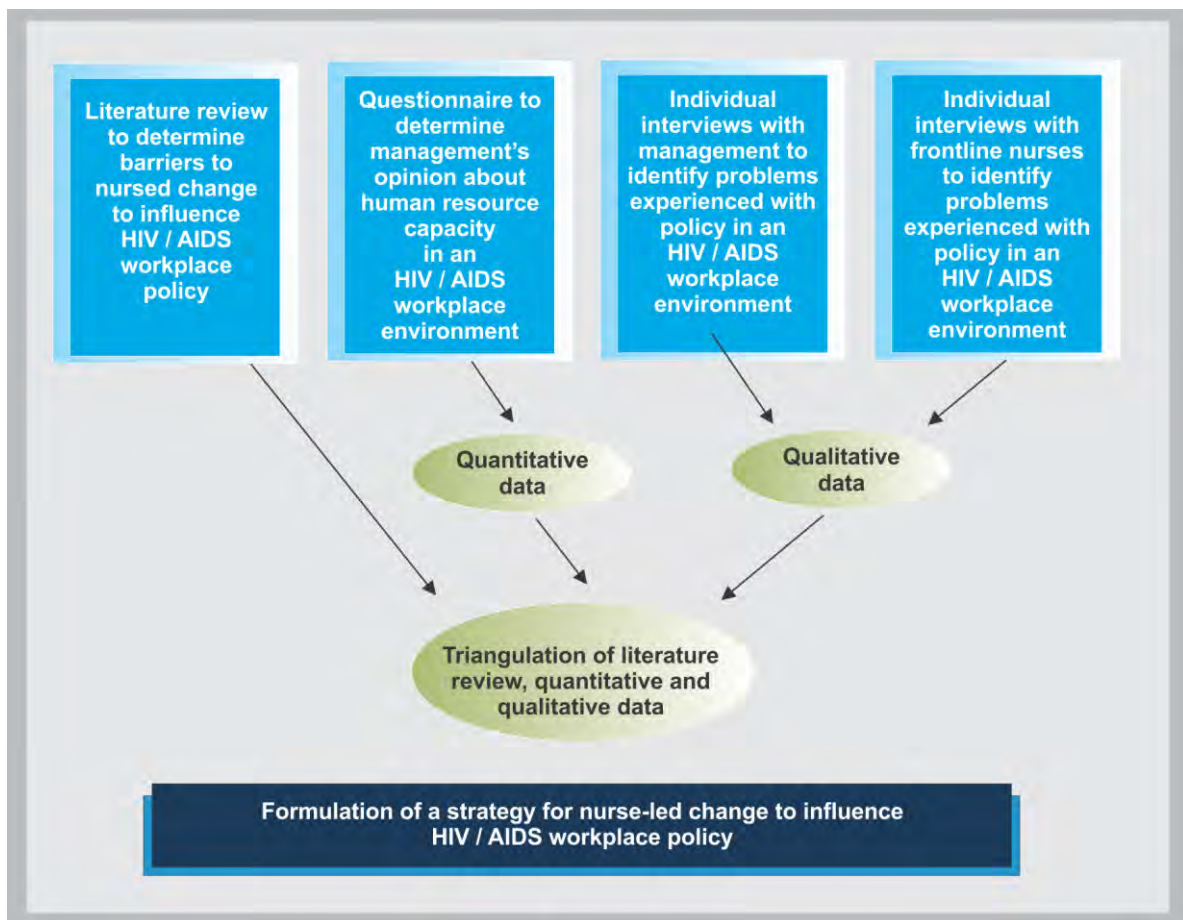


FIGURE 2.1: TRIANGULATION MIXED-METHOD DESIGN

2.2.1.1 Quantitative design

With a quantitative design the general structure of research can be three different types of research design, namely experimental research, quasi-experimental research or non-experimental research design (Welman, *et al.*, 2005:78). Quantitative research is a formal, objective and systematic process using numerical data from a selected subgroup of a population to describe variables, examine relationships between them and thus obtain information about the population being studied (Maree, *et al.*, 2008:45; Burns & Grove, 2007:7). Objectivity, generalization and numbers are therefore features associated with quantitative research. After data has been collected, it is coded into a numerical form for statistical interpretation (Terre Blanche, *et al.*, 2006:563). This study used a non-experimental quantitative design, as numerical data was obtained about human resource capacity in the HIV and AIDS workplace environment.

2.2.1.2 Qualitative design

A qualitative design uses an inquiry process of understanding where the researcher develops a complex, holistic picture in order to derive meaning of phenomena in the social world. It is a non-numerical exploration of a phenomenon (Denzin & Lincoln, 1994:1-2; Welman, *et al.*, 2005:188; Babbie, 2010:394; Creswell, 2007:36). Qualitative research seeks to preserve the integrity of the narrative data collected with semi-structured in-depth individual or focus group interviews (Terre Blanche, *et al.*, 2006:561). Qualitative research is always contextual, as the data is only valid in a specific context and cannot be generalized, Klopfer (2008:68) and Streubert and Carpenter (1999:15) emphasized six significant characteristics associated with qualitative design:

- A belief in multiple realities.
- A commitment to identify the best approach to understand the phenomenon being studied, e.g. individual interviews or focus group discussions.
- A commitment from the researcher to take note of the participants' viewpoint.
- To conduct research in such a way that disruptions are limited during the study of a phenomenon.
- Acknowledged participation of the researcher in the research.
- The conveyance of an understanding of the phenomenon being studied by reporting in a literary style that is rich with participants' comments.

This study uses a qualitative design, as it strives with individual interviews to get rich insight in order to describe problems experienced with policy when working in an HIV and AIDS workplace environment from both managerial and frontline nurses' perspectives.

2.2.1.3 Exploratory design

Exploratory research explores the dimensions of the phenomenon (Welman, *et al.*, 2005:23) and is used when investigating relatively unknown areas of research. The researcher uses open, flexible and inductive strategies to explore new insights into a phenomenon (Terre Blanche, *et al.*, 2006:44). According to Selitiz, *et al.*, (1976:92-101), exploratory research can only be conducted by three methods, namely a literature review, a survey among people who have experience about the phenomena being studied, and analysis of "insight stimulation". In this study literature, the opinion of managers about human resource capacity

and the opinions of management and nurses regarding problems experienced with policy when working in an HIV and AIDS workplace environment were explored.

2.2.1.4 *Descriptive design*

A descriptive design is used to provide an accurate portrayal of the qualities or characteristics of a studied population. Descriptive statistics provides a summary of the principle characteristics that have been collected (Burns & Grove, 2005:232; Brink, *et al.*, 2006:10). The design of this study is descriptive in nature in order to provide a clear picture of the current situation regarding HIV and AIDS workplace policies in public health-care institutions in the North-West Province. Literature, the opinion of managers about human resource capacity and the opinions of management and nurses regarding problems experienced with policy in an HIV and AIDS workplace environment are described.

2.2.1.5 *Contextual design*

Qualitative research is context-bound and cannot be generalized in another context. A contextual design refers to the critical understanding of the reality of the participants' experiences in their specific context. In addition, no universal claims can be made (Holloway, 2005:275). According to French (2005:172), the context in this instance can be defined as the institutional environment of health care, including physical, social, political and economical influences. This research is contextual in nature as it focuses on public health-care institutions in the North West-Province (specifically the Bojanala, Central and Southern districts) and therefore no universal claims are made. The specific context will provide a clear and deeper understanding of the opinions of management and frontline nurses about the problems experienced working in an HIV and AIDS workplace environment and how Nurse led change can influence HIV and AIDS workplace policy. To understand the context of the study an overall description of the context parameters is provided.

2.3 DESCRIPTION OF THE NORTH-WEST PROVINCE

The North-West Province is in the central north of South Africa. The province encompasses 116 320 square kilometres, constituting 9.5% of the total land area of South Africa. To create perspective: it is slightly smaller than the state of Pennsylvania in the United States of America. Only 34.9% of the population lives in urban areas and the majority, 65.1%, lives in rural areas. There is an increased migration to the cities, mainly due to a declining agricultural sector and growth in urban employment. The declining precious metal prices

leading to retrenchments in the mining industry exacerbate the situation (North-West Province: Geographical information, 2009). The following discussion deals firstly with the province as a whole, followed by the districts and institutions selected to participate in the research.

- **Economy**

The mining industry, e.g. platinum, diamond, fluorspar exploitation and gold mining, is the dominant economic activity. The mining industry contributes 33% to the North-West Province's economy and 18% of the total formal employment. Other main sectorial contributions are government services, trade and catering, manufacturing, finance and agriculture. Maize, tobacco, sunflower and cotton are the major farming products (North-West Province: Geographical information, 2009).

- **Population**

Table 2.1 provides statistics on the total population of the North-West Province, while table 2.2 indicates the age distribution of the population in the participating districts of the study. These statistics serve to prove the tendency of migration from rural to urban areas when the age group 5-19 years is compared to the age group 20-49 years, especially in the Bojanala and Southern districts, as these specifically have large mining industries.

**TABLE 2.1: POPULATION STATISTICS OF THE NORTH-WEST PROVINCE
(STATISTIC SOUTH AFRICA 2007 CENSUS)**

NORTH-WEST PROVINCE		
TOTAL MALE POPULATION	TOTAL FEMALE POPULATION	TOTAL POPULATION
1 699 200	1 751 200	3 450 400

TABLE 2.2: AGE DISTRIBUTION OF POPULATIONS IN THE PARTICIPATING SUBDISTRICTS (HEALTH SYSTEMS TRUST ORGANIZATION, 2008)

AGE RANGE	CENTRAL DISTRICT (Ditsobotla subdistrict)	BOJANALA DISTRICT (Rustenburg subdistrict)	SOUTHERN DISTRICT (Potchefstroom subdistrict)
0-4 YEARS	18 557	28 698	16 916
5-19 YEARS	51 673	75 979	53 889
20-49 YEARS	53 444	208 120	100 958
50-65+ YEARS	16 912	45 182	25 739
TOTAL POPULATION PER DISTRICT	140 586	357 979	197 502

- Health-care facilities in the North-West Province

Only 6% of the health facilities are private, but include 25% of all hospitals and 2% of the clinics. The North-West Province has the following public health facilities: two provincial hospitals (situated in the Southern and Bojanala districts), one psychiatric hospital, 29 district hospitals, 20 community health centres, 275 clinics and 70 mobile units. Local district authorities manage all fixed clinics and mobile units. Of the clinics, only 58% have grid electricity, 57% have telephones and 30% have no adequate water supply. There is no security fencing at 50% of the clinics and health centres (Health Systems Trust, 2008).

To understand the mean value of terms used in the description of the different health-care service institutions, a definition is provided of what is mean value if the researcher refers to an institutional facility or institutional capability (Health Systems Trust, 2008).

Provincial or secondary level hospitals

General and specialist hospital services, intensive care units ICU's, Casualty, Outpatients and Theatre Services are available – 24 hours a day, seven days a week. At some of these hospitals specialists are not available on a full-time basis, but only on certain days at certain hours, depending on the area, e.g. physicians, gynaecologists, urologists, oncologists, etc.

- **District or first level hospitals**

Hospitals offering inpatient care to patients on a continuous (full-time) basis by general practitioners (GP) – 24 hours a day, seven days a week. The hospital usually has an emergency department where a patient is stabilized before referral, an outpatient department, a theatre for minor surgical procedures (e.g. caesarean section, tooth extraction), general and maternity wards. Most district hospitals also have an anti-retroviral treatment (ART) clinic. This level serves as the referral hospital for clinics and community health centres, where the GP then decides whether referral to a provincial or secondary hospital is necessary (Health Systems Trust, 2008).

- **Community health-care centres**

This is a health-centre facility with more than four consulting rooms (see definition below) that provides primary health care (PHC) and maternity services on a 24 hour basis, seven days per week and may have inpatient beds, but is distinguished from a hospital by not having a theatre. All members of a multi-disciplinary team visit the health-care centre once a week. A doctor service is available daily in the urban areas, with the number of hours that the doctor is present depending on the location of the centre. In remote rural areas a doctor visits the community health-care centres once a week (Health Systems Trust, 2008).

- **Clinic**

Clinic facilities provide at least an ambulatory, preventative and curative health service and have less than four consulting rooms. The service should be available for at least eight hours a day, five days per week, while some clinics function 12 hours daily and are open on weekends, depending on the location area (Health Systems Trust, 2008).

- **Consulting rooms**

Consulting rooms have surfaces used exclusively for examining a patient (e.g. an examination couch) and for writing (e.g. a desk). A consulting room is usually a private room where the nurse or doctor obtains a history, and assesses, examines and manages the patient according to the diagnosis (Health Systems Trust, 2008).

- **Mobile clinic**

A mobile clinic is a vehicle that, when parked, functions as a location from which health services are rendered. The service need not be rendered exclusively from the vehicle, but

the vehicle must function as an integral part of the location and may have structural modifications in order to serve as a mobile clinic. These vehicles are specially equipped to deliver all PHC services in rural areas, for instance an examination couch, a space for recording diagnostic notes and all the necessary equipment, e.g. an otoscope, scale, fetoscope and baumanometer. The support staff are usually located outside the mobile clinic, where they receive patients and obtain the necessary information. Patients who do not have a consulting record are provided with one and then wait their turn to be consulted (Health Systems Trust, 2008).

- **PHC services provided by health care centres, clinics and mobile units in the North-West Province**

According to Zweigenthal, *et al.* (2009:8), PHC services include three main components that are the principles that guide the care that is rendered. A comprehensive package of health-care services and the different levels of health care must be clearly described so that the PHC provider knows the correct referral channels. Figure 2.2 illustrates the three components encompassing comprehensive PHC service delivery as implemented in the North-West Province (Health Systems Trust, 2008).

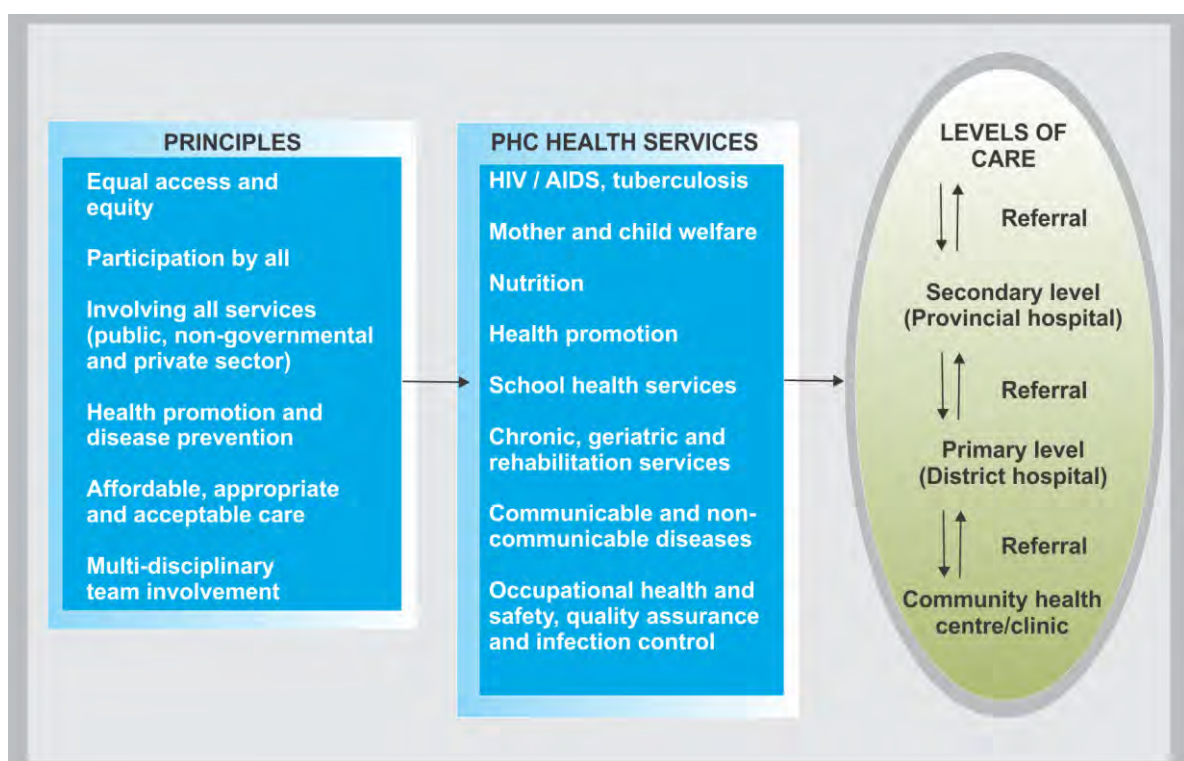


FIGURE 2.2: COMPONENTS OF COMPREHENSIVE PHC SERVICES (ADAPTED FROM ZWEIGENTHAL, ET AL., 2009:8)

- **The role of nurses in PHC services**

As indicated in figure 2.2, PHC is a comprehensive service and according to Harrison (2010:27), South African health services are primarily nurse driven. The scope of practice for nurses is determined by the South African Nursing Council (SANC), regulation 2598 (SANC, 1984: Scope of Practice, R.2598). According to Mokoena and Jooste (2009:41), the Nursing Act No. 33 of 2005 also makes provision for conditional authorization relating to certain advanced-practice nurses. The SANC allows nurses who are qualified and registered for clinical nursing science, health assessment, treatment and care, if employed in the public service or in designated approved services at a PHC level, to:

- Obtain a full history from a patient.
- Perform a physical examination on the patient.
- Diagnose the physical defect, illness or deficiency.
- Prescribe appropriate treatment up to schedule 4 medication (if the PHC nurse is qualified with an Advanced Psychiatric Diploma they may prescribe up to schedule 5).

PHC advanced-practice nurses are pivotal in providing care, as the majority of the North-West Province population, indicated in paragraph 2.3 as 65.1%, live in rural areas. These nurses practise independently and have the assistance of a general practitioner and other multi-disciplinary team members on a daily/weekly basis, depending on their location (e.g. GP daily in urban setting but weekly in rural area, physiotherapist once a week). In certain instances, visits by the GP or other health-team members only materialize twice a month as a result of their having to attend urgent meetings or other matters arising. Advance-practice nurses in the PHC services utilize the referral criteria as indicated in figure 2.2 for patients who require more advanced treatment (Health Systems Trust, 2008).

The total number of nurses practising in public-health institutions in the North-West Province is 3 140 (Health Systems Trust, 2008). Table 2.3 indicates the number of nurses registered with the SANC, but these nurses are not all employed in the nursing field or in the public health sector.

TABLE 2.3: NURSE STATISTICS OF THE NORTH-WEST PROVINCE (SOUTH AFRICAN NURSING COUNCIL, 2010).

NORTH-WEST PROVINCE		
TOTAL NUMBER OF MALE NURSES	TOTAL NUMBER OF FEMALE NURSES	TOTAL NUMBER OF NURSES
771	6 580	7 351

As was previously mentioned, the term registered nurse is not used in the study to facilitate searches through international libraries and therefore the researcher refers to nurses throughout, although the study was conducted among nurses who are registered with the South African Nursing Council.

2.3.1 Selected districts

The North-West Province has four districts, of which three were purposely selected, taking into consideration accessibility and the inclusion of urban, suburban, rural and remote rural areas. Due to the fact that each district consists of 4-5 subdistricts, as the North-West Province encompasses a large geographical area, it was also necessary to locate a subdistrict. The reason for this was the representation of the district, and the same criteria that were applied to the selection of the districts were applied to the selection of participating subdistricts. Figure 2.3 indicates the selected districts.

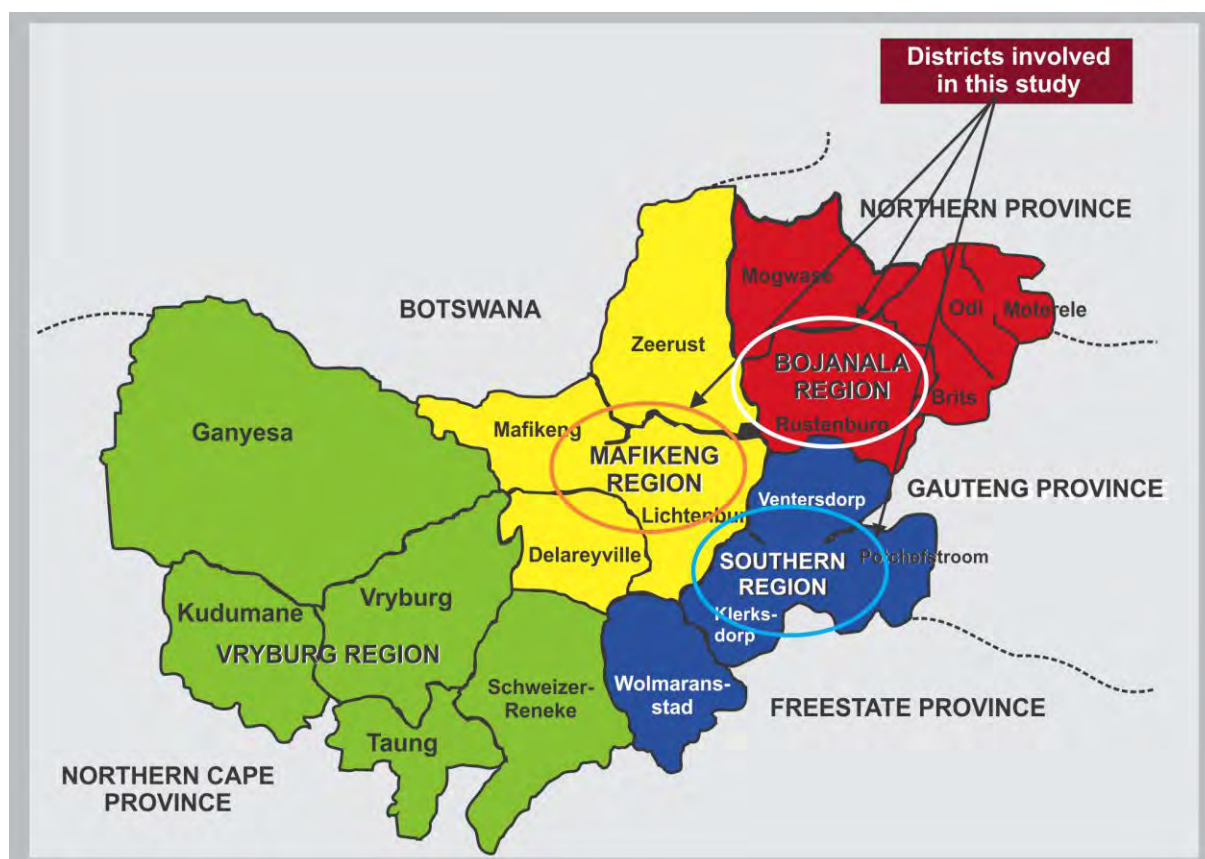


FIGURE 2.3: STUDY DISTRICTS OF THE NORTH-WEST PROVINCE (*MAFIKENG REGION NAME CHANGED TO CENTRAL DISTRICT)

2.3.1.1 Participating institutions

The international programme of which this study forms part, guides the researcher in the choice of districts and institutions used in this study. The research programme “*Strengthening nurses capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean*”, commonly known as the Teasdale-Corti (TC) research programme, has a strong element of capacitating nurses. The discussion below explains the selection criteria for the inclusion of public health institutions in the participating three districts, and table 2.4 provides a description of the selected public hospitals and community health centres in the participating districts.

- **Selection criteria**

The following selection criteria were kept in mind in the selection of participating institutions:

- Hospitals and institutions were randomly selected according to the requirements of the TC research programme. The level of care was determined according to the World Health Organization (WHO) classification of health institutions. Personal visits by the researcher to every participating institution were made to share information about the research programme, with more than one visit necessary as all the staff was not on duty at the same time. These informative visits took place before the recruitment of potential participants (Teasdale-Corti handbook, 2007:66). Permission to do research in each institution was obtained from the chief executive officer or manager (see Addenda E, F, G and H). Table 2.4 gives an overview of the randomly selected districts (Health Systems Trust, 2008).

TABLE 2.4: DESCRIPTION OF THE SELECTED PUBLIC HOSPITALS, COMMUNITY HEALTH CENTRES (CHC) AND CLINICS

INSTITUTION	LEVEL OF CARE	CATEGORY	DESCRIPTION
SOUTHERN DISTRICT (SD)			
Hospital: Potchefstroom	5	Provincial hospital	A provincial hospital in South Africa with added outpatient clinics where specialist services are available, e.g. gynaecologist, neurologist, orthopaedic surgeon, surgeons, etc. Hospital has 11 wards.
CHC clinic: Top City	3	PHC clinic	A primary health-care clinic rendering all PHC services, except deliveries. Clinic is open five days a week 07:00 – 19:00. This clinic is closed over weekends. No in- patient capability, only consulting rooms with couches and an emergency trolley to stabilize emergencies before referral.
CHC centre: Boiki Thlape	3	PHC centre, open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.
CHC clinic: Steve Tshwete	3	PHC clinic	A primary health-care clinic rendering all PHC services, except deliveries. Clinic is open five

INSTITUTION	LEVEL OF CARE	CATEGORY	DESCRIPTION
			days a week, from 07:00 – 19:00. This clinic is closed during weekends. No in-patient capability, only consulting rooms with couches and an emergency trolley to stabilize emergencies before referral.
CHC clinic: Promosa	3	PHC clinic	A primary health-care clinic rendering all PHC services except deliveries. Clinic is open five days a week, from 07:00 – 19:00. This clinic is closed during weekends. No in-patient capability, only consulting rooms with couches and an emergency trolley to stabilize emergencies before referral.
Bojanala District (BD)			
Hospital: Rustenburg	5	Provincial hospital	A provincial hospital in South Africa with added outpatient clinics where specialist services are available, e.g. gynaecologist, neurologist, orthopaedic surgeon, surgeons, etc. This hospital has various outpatient clinics. The hospital has 13 wards for patient admission and serves as a referral hospital for all other district hospitals in Bojanala District.
CHC centre: Tlhabane	3	PHC centre, open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.
CHC centre: Hartebeesfontein	3	PHC centre, Open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.
CHC centre: Phokeng	3	PHC centre, open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited

INSTITUTION	LEVEL OF CARE	CATEGORY	DESCRIPTION
			number of beds. Patients are normally discharged the same or the next day.
CHC centre: Boitekong	3	PHC centre, open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.
Central District (CD)			
Hospital: Thusong General de la Rey Complex	4	District hospital	Consisting of two hospitals located at different sites approximately 25 km apart, these hospitals have an outpatient and emergency department where patients are stabilized before referral to a provincial hospital. The one hospital has three wards and the other five for admission of patients. Serves a very large remote rural area.
CHC centre: Boikhutso	3	PHC centre, open 24 hours	Renders all PHC services. Inpatients are only maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.
CHC clinic: Blydeville	3	PHC clinic	A primary health clinic rendering all PHC services, except deliveries. Clinic is open five days a week from 07:00 – 19:00. This clinic is closed over weekends. No inpatient capability, only consulting rooms with couches and an emergency trolley to stabilize emergencies before referral.
CHC clinic: Lichtenburg	3	PHC clinic	A primary health clinic rendering all PHC services, except deliveries. Clinic is open five days a week from 07:00 – 19:00. This clinic is closed during weekends. No inpatient capability, only consulting rooms with couches and an emergency trolley to stabilize emergencies before referral.
CHC centre:	3	PHC centre,	Renders all PHC services. Inpatients are only

INSTITUTION	LEVEL OF CARE	CATEGORY	DESCRIPTION
Bodibe		open 24 hours	maternity cases and day clients who need an infusion for rehydration treatment. Limited number of beds. Patients are normally discharged the same or the next day.

The preceding paragraphs discussed the context of the study. An introduction was given regarding geographical and economic information, with the total population of North-West Province as well as the different age groups of subdistricts participating in the study and the nurse population indicated in table format. An overview was given on health services rendered in the North-West Province, where more emphasis is placed on PHC service delivery, as the largest part of the province comprises rural areas.

2.3 RESEARCH METHODS

Klopper (2008:69) refers to the research method as the steps of population and sample, data collection, data analysis and ensuring rigour. The research methods are discussed per phase and objective of the study.

2.4.1 Phase 1 – Empirical research, objective 1:

To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy

A literature review was carried out as a method of exploring objective 1. A literature review in this study assisted the researcher to identify barriers to Nurse led change to influence HIV and AIDS workplace policy (Welman, *et al.*, 2005:38; Maree, *et al.*, 2007:166). In recognition of the stated objective the researcher conducted a search of peer-reviewed studies and publications relating to nurses' involvement in leading change.

The literature for this objective consists of journals, books, theses, dissertations and the world-wide web. A broad set of keywords were combined in varying sequences for searching in the categories of „All“, „Title“, „Abstract“, „Author-Supplied Abstract“ or „Keywords“ (HIV, policy or policies and nurse*, nursing leadership, change agent and work environment, nurse or nurse* and occupational exposure, HIV / human resource capacity, HIV / human resource management, HIV / workplace policy or policies, policy or policies and policy

process, policy or policies and nurse* and formulation, policy or policies and nurse* and involvement, nurse* and political role). The subject librarian based at North-West University assisted the researcher with the search. The abstracts of all studies and publications were chosen on the basis of their relevance to the objective under investigation. A critical review of the literature also ensures that the current body of knowledge is not flooded with things that are already known. In the following sections, each category of study sources is discussed in more detail.

- **Journals**

The journal databases used in this study include the South African Journal Database System, SAePublications and the International Journal Database Systems, Science Direct and EBSCOHost. The EBSCOHost Research search engine that were used in this study included the following data bases: Academic Search Premier, CINAHL, Health Source: Nursing/Academic Edition and MEDLINE. These specific databases were selected because they were freely available and accessible at the North-West University and covered the field of this study. A multi-stage search was used to select relevant studies.

In the first stage of the search each database was examined individually and only peer-reviewed English articles published during the time frame January 2000 until April 2010 were taken into consideration. During the second stage of the search, studies that depicted duplicate reporting were identified and only the latest or most detailed copy was included in the review. The abstracts of each identified study were scrutinized to determine the relevance of the article for this study. Exclusion criteria that were used in this stage of the search included book reviews, commentaries, editorials and letters to the editor.

- **Books**

The South African Library Catalogue or SACat was used to search for books. A total of 30 books were identified and books with applicable information to this study were used.

- **Theses and dissertations**

The Nexus Database System was used to search for theses and dissertations in South Africa, while the ProQuest database was used to identify international theses and dissertations.

All the above mentioned sources were utilized to identify barriers to Nurse led change to influence HIV and AIDS workplace policy. After the discussion of literature, concluding

statements were made that assisted the researcher with the process of strategy formulation and n=29 conclusion statements were made from synthesizing literature sources.

2.4.2 Phase 1 – Empirical research, objective 2:

To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment

In order to achieve this objective a quantitative design exploration was conducted in the form of a human resource management (HRM) questionnaire.

2.4.2.1 Population

The study population represents the larger pool from which the sample is drawn. All eligible candidates who were the focus of the objective were included in the sample (Terre Blanche, *et al.*, 2006:133; Burns & Grove, 2010:344). The target population included all the candidates who met the sample criteria, and for this objective it was multi-disciplinary managers employed at four purposively selected participating health institutions in the Central, Bojanala and Southern Districts (Burns & Grove, 2010:344). The target population was 72 managers employed in two provincial and two district institutions identified from the 15 randomly selected institutions of the TC research programme.

2.4.2.2 Sampling method

A non-probability sampling technique was used, which refers to any technique used to select a sample of the type of people you need to gather your data and has the potential to obtain high-quality data if applied correctly (Rugg & Petre, 2007:67-69; Babbie, 2010:192). With the HRM questionnaire a purposive sampling method was used. According to Babbie (2010:193), purposive sampling is the selection of participants on the basis of the knowledge of a population. According to the recruitment algorithm of the TC programme, senior administrators (in this study subdistrict health office directors and deputy directors) nominate staff members who are knowledgeable about the institution's human resource policies. These staff members are then issued with a letter of invitation by the researcher to attend research presentation sessions (TC handbook, 2007:66), and in this case 57 candidates (N=57) were identified. Sample criteria (TC handbook, 2007:70) included:

- Multi-professional team members: nurse managers, physicians, allied health professionals as well as human resource managers.

- Should be knowledgeable about their institution's human resource policies.

Note: The researcher could not prove that participants included in this study had sound knowledge of the institution's human resource policies as it could not be tested, but the researcher made the assumption that the district health director and deputy directors were conversant with the management team's capability in the selected health institutions.

2.4.2.3 Sample size

The total number of managers selected to participate in this objective was N=57. It was difficult to get participants to complete the questionnaires, as it took considerable time and managers have a very hectic schedule. In the end n=44 questionnaires were returned – a response rate of 80.7%, which is very good.

2.4.2.4 Data collection

Data collection is the process of gathering data from participants and there are various ways of doing this, e.g. through interviews, observation and questionnaires (Burns & Grove, 2005: 430). In this study data collection took place via the HRM international questionnaire.

A questionnaire is a self-report form designed to elicit information appropriate for analysis. It can have varying degrees of structure, namely structured (closed format) or unstructured (open format). In a structured questionnaire the participant needs to choose between preconceived answers, while with unstructured questionnaires participants need to answer a question by formulating their own replies (Babbie, 2010:255; Burns & Grove, 2010:406). In this study the questionnaire was developed as a structured format, but participants did have the opportunity of providing evidence for their answer and a substantiation, which they unfortunately did not make use of and left the spaces open. Brink, *et al.* (2006:147) mention some advantages and disadvantages of questionnaires, which were considered in this study.

Advantages of questionnaires:

- Participants could remain anonymous because the questionnaires were marked only with a barcode.
- Answers obtained from the participants could not be influenced by the researcher's views because the questionnaire consisted of a 4-point Likert scale to evaluate the human resource component of the institution intensively.

- Format was standard for all participants and was not dependent on the mood of the interviewer.

Disadvantages of questionnaires included:

- Completion of the HRM questionnaire took up to an hour and was time consuming.
- Some of the details on the questionnaires were not completed, for instance remarks were requested after each component and most participants left this space blank.
- Respondents could give an answer that would give the impression that their institution was „good“, although it was not actually the whole truth in practice.

The HRM questionnaire was developed and validated by Mary O'Neil, Sarah Johnson and Riita-Liisa Kolehmainen-Aitken for Management Sciences for Health (MSH). The original HRM questionnaire assists institutions in strengthening their human resource management, but this questionnaire was adapted for HIV and AIDS environments by MSH and UNAIDS. This was done to assist institutions in assessing and improving their management capacity in an HIV and AIDS environment. The core issues assessed by the HRM questionnaire included constructs such as HRM capacity (staffing, budget and planning), personnel policy and practice, performance management, training and HRM data. The HRM questionnaire includes a matrix of 26 components grouped under the abovementioned constructs. A Likert scale indicates four stages of development for each of the HRM components, while each HRM component has characteristics that describe the stage of development in the institution. The questionnaire also has blank spaces for participants to write a brief statement or to describe evidence that indicates why the participant chooses a specific Likert scale number. In assessing an institution's capacity with regard to the impact of HIV and AIDS there should be policies and practices in place in the institution (HRM Questionnaire, 2003:1-6), which include:

- A budget to support HIV and AIDS strategies.
- HRM staff training in HIV and AIDS issues.
- Benefit programmes adjusted to ensure low staff turnover.
- Non-discriminatory policies in recruitment, hiring and promotion.
- Workplace HIV and AIDS prevention programmes.
- Supervision responsive to HIV and AIDS issues.
- A training programme to manage staff.

Addendum K indicates the questionnaire used in this study.

2.4.2.5 *Pretesting of the instrument*

According to Burns and Grove (2005:42), a pilot study is defined as a minor study that is based on a proposed study to improve or refine the research method before the major study is conducted. The HRM questionnaire was pretested with two colleagues, neither of whom was working in one of the participating institutions. According to Burns and Grove, (2005:219), the elements of a good research design include suitability for the purpose of the study, feasibility and reducing threats to validity. In this research, the pilot study was conducted in an institutional environment in order to familiarise the researcher with the questionnaire in the practical situation and to identify which queries could arise or problems be experienced when the study was undertaken. The data obtained through the pilot study was not used in the analysis.

2.4.2.6 *Data collection process*

After voluntary informed consent forms had been signed by the participants, they were requested to complete the HRM questionnaire. Each item on the HRM questionnaire was marked by respondents on a 4-point Likert scale, which identified the stage at which the human resource component of the participating institution was. The respondent could choose from stage 1, which indicates that nothing about the specific human resource component is in place, up to stage 4, which indicates that all the elements are in place. There was also a blank space where the respondent could fill in comments, but responses here were limited.

2.4.2.7 *Data analysis*

Zechmeister and Posavac (2003:3) explain the term data as facts obtained when a scientific study has been conducted. The authors explained that when the researcher uses a quantitative research design, data is statistically analysed, interpreted and represented in figures (see chapter 4). Data analysis is conducted to reduce, organize and give mean value to the data (Burns & Grove, 2005:43). The aim of analysis is to understand various components of one's data through an inspection of the relationships between concepts, constructs or variables to see whether there are any patterns or trends that can be identified or isolated, or to derive categories from the data (Rugg, *et al.*, 2007:155). The following paragraphs provide an overview on the data analysis procedure followed.

The quantitative data was entered in Excel on the researcher's computer, with all data re-entered in a second Excel document. With the re-entering of data, errors were easily identified and could be corrected, as there were two sets of Excel data that could be compared. The two Excel 2007 data sets and the completed questionnaires were taken to the Statistical Consultation Services of North-West University, Potchefstroom Campus. The data was entered in the Statistical Package for the Social Sciences (SPSSTM, version 16:2009) Institute Inc. software package in order to interpret the data. A backup was made of each data set, marked complete and carefully stored in a safe place.

Data analysis included proof of reliability and validity of the HRM questionnaire and descriptive statistics, which incorporated statistical description of either the characteristics of the sample, or the relation among variables in the sample, including percentage distribution (Babbie, 2010:467). Descriptive statistics provided the opportunity to arrange the data in such a manner as to be able to understand and give meaning to it (Burns & Grove, 2005:461) and to use the mean value as a result. The term „mean value“ refers to the sum of the scores divided by the number of scores and the balance point; in other words, the average of the score (Zechmeister & Posavac, 2003:151; Babbie, 2010:429). In this study the mean value of each item under a construct is discussed individually and concluding statements were made from each item (see chapter 4). The reliability and validity of the HRM questionnaire within the South African context were confirmed by statistical analysis (see chapter 4, paragraphs 4.2.2.1 and 4.2.2.2).

2.4.3 Phase 1 – Empirical research, objective 3:

To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective

The researcher's pragmatic assumption allowed the opportunity of employing both quantitative and qualitative methods in obtaining data to answer research questions. The previous objective utilized quantitative data, but to achieve the rest of the objectives in this study the researcher used qualitative data collection techniques that focused on gathering rich data to identify problems experienced with policy when working in an HIV and AIDS workplace environment.

2.4.3.1 Population

Sampling for this objective was from among managers from a randomly selected sample of 15 public health institutions in the Central, Bojanala and Southern Districts. The target

population identified consisted of 182 candidates. Purposive sampling mean values that a particular case that exhibits features of interest to the research study can be purposefully chosen (De Vos, *et al.*, 2005:328). Managers working in the selected public health institutions in the participating districts were invited to participate in the study. A total number of 48 (N=48) indicated their willingness and availability to participate and a selection of 12 (n=12) participate in the in-depth interviews when data saturation occurred.

2.4.3.2 *Sampling method*

A random sampling technique was used, taking into consideration the inclusion criteria of the TC programme. Random sampling means that each participant had an equal chance of being selected to participate in the study (Babbie 2010:211). The following inclusion criteria were applicable (TC Handbook, 2007: 66):

- Participant should be employed at one of the institutions participating in the international research programme (Teasdale-Corti).
- Institutional permission was obtained from the relevant authorities.

2.4.3.3 *Sample size*

A total number of 48 (n=48) candidates were available for in-depth interviews on the problems experienced with policy when working in an HIV and AIDS workplace environment.

2.4.3.4 *Data collection*

The use of interviews as data collection technique in qualitative research is well described in literature. An in-depth interview provides the researcher with the opportunity to explore the phenomenon under investigation (Charmaz, 2006:25). Kvale (1996:xvii) defines interviews as conversations where the outcome is a co-production of the interviewer and the participant. The services of a co-researcher were utilized for the purpose of interviewing managers in the Southern District, in line with the concurrent nature of data collection in the triangulation mixed-method research design.

2.4.3.5 *Interviews*

The following bulleted paragraphs expound on the interview concepts, including individual interviewing, the role of researcher as interviewer, general guidelines for interviewing and the interviewing process itself.

- Individual interviews with management

Rugg, *et al.* (2007:137) state that “Interviewing is easy to do badly, and difficult to do well”. According to Babbie (2010:274), interviews are typically done during a face-to-face encounter, but can also be done telephonically. With this objective, data collection was done by conducting face-to-face interviews with managers.

- Role of the researcher as interviewer

Kvale (2006:144) states that an interview is the raw material for the later process of data analysis. It is therefore important for the quality of the original interview to contribute towards quality data analysis, verification and reporting of the interviews.

- The researcher’s aim was to obtain spontaneous, rich, specific and relevant
- Short interview questions and long responses by the interviewee are usually a good indication of a quality interview.
- The researcher needed to follow up and clarify the mean value of the relevant aspects of the answer to ensure more clarity. If an answer was too short, the researcher asked the manager to elaborate on a certain aspect that was not clear from the response.
- The researcher needed to verify the interpretations of the manager’s answer during the course of the interview.
- The interview had to sound like a self-contained story that did not require much extra description and explanation from the researcher (Kvale 1996:145).
- The researcher needed to assume that an interview question had the same mean value to all participants and every response had to mean value the same when given by different participants. This sounds like an impossible goal, but this assumption was emphasized during research training of the TC programme and survey questions were drafted to approximate the ideal as closely as possible (Babbie, 2010:275).
- The researcher tried to be absolutely neutral during the interview. With neutrality the researcher tried not to affect the managers’ perception of a question or answer, or lead them to give a certain answer. It was therefore of the utmost importance that the researcher did not communicate, by word or gesture, their own opinion. If the researcher had not been neutral and had influenced the manager in any way, the data obtained would have been biased and could have led to the wrong conclusions during data analysis

(Babbie, 2010:275; Maree, *et al.*, 2007:88). Being knowledgeable in both HIV and AIDS and policy, the researcher was sensitized to be neutral at all times.

- **General guidelines for interviewing**

Learning to become an interviewer takes place through interviewing. Reading books gives some guidelines, but practise makes perfect. It is therefore essential for the interviewer to be familiar with the general guidelines for interviewing and the role play before they embark on an interview. Kvale (2006:147) states that “practice remains the main road to mastering the craft of interviewing”, and on reflection the researcher found this phrase very appropriate.

The research participants and the research questionnaires will obviously have an influence on the way the interview will be conducted, but there are some general guidelines that apply to most interviewing situations:

- **Appearance and demean valueour**

The interviewers’ appearance should be on a level similar to that of the people they interview with respect to dress and grooming, e.g. if a richly dressed interviewer needs to obtain data from a poor resource community, the researcher will probably have difficulty getting good cooperation. This is an important point, as dress and grooming are typically regarded as signs of a person’s attitudes and orientations. When interviewing participants for this objective, it was necessary for the researcher’s dress and grooming to be at a professional level, as the participants were managers.

With regard to demean valueour it is important for interviewers to be pleasant. The research in this objective needed to pry into the participants’ institutional HIV and AIDS policy process and problems experienced with policy when working in an HIV and AIDS workplace environment. This form of questioning could be experienced negatively by participants, maybe as an attack on their ability as manager, resulting in defensive responses portraying their institution in a positive light, which is perhaps not evident in practice. It was therefore important for the researcher to be relaxed and friendly, but not too casual and familiar. Good interviewers have the ability to sense quickly the kind of person the respondent will feel most comfortable with, i.e. the kind of person the respondent would most enjoy talking to (Babbie, 2010:276; Welman, *et al.*, 2005:168).

- **Researcher should be familiar with the questionnaire**

If a researcher is not familiar with a questionnaire, the study suffers and the participant faces an unfair burden. The interview is likely to take more time, and with this objective managers

did not have time to waste, so thorough preparation was of the utmost importance. The researcher needed to know the umbrella aim of the instrument, the interview questions and applicable probes that could be used to elicit rich qualitative information (Babbie, 2010:276).

- **Following question wording exactly**

Interview questions were formulated in such a way that the participant's opinion was obtained. The danger in not following question wording exactly is that it may lead a respondent to answer with a simple yes or no, which immediately changes the question nature from open-ended to closed-ended. Changing the question wording can jeopardize the planned response that the questionnaire developers had in mind (Babbie, 2010:276).

- **Recording responses exactly**

Recording responses exactly is very important because the researcher does not know how the responses will be coded at that stage of the interview. The coding framework is only developed as data collection takes place and data is analysed (Babbie, 2010:277). For this study, digital voice recorders were used and a transcriber compiled an exact transcription from what was said during the interview. The second control over exact wording was the researcher, as every interview transcript was compared with the audio version and words filled in that the transcriber could not identify.

- **Probing for responses**

A probe is a technique the interviewer uses to elicit a more complete answer to a question. It is a non-directive phrase to encourage the participant to elaborate on an answer, e.g. "anything more"? Probes are more frequently required in eliciting responses to open-ended than closed-ended questions. It is important to keep in mind that probes should be neutral and not lead the participant in a specific direction. Babbie (2010:277) and Maree, *et al.* (2007: 88) distinguish between different probes: detail-orientated probes, which assist the researcher in understanding, the „who, where and what“ of the answer given by the participant, or clarification probes used by the researcher to check if their understanding of what has been said is correct.

- **Scheduling an interview**

Researchers need to make appointments for interviews and indicate to the participant the average time required for the interview. This gives the participants the opportunity to schedule their activities (Welman, *et al.*, 2005:168). Researcher punctuality is of the utmost importance to prevent the interviewee becoming irritated.

- **Use of digital voice recorders**

Digital voice recorders must be checked beforehand to ensure that they work properly, and consent must be obtained from the manager to use the voice recorder (Welman, *et al.*, 2005:168).

- **Communication skills**

During the interviews the interviewer used communication techniques that are effective in establishing trust and rapport with the respondent. According to Okun (2002:33, 81), such techniques include making eye contact, using an open posture, displaying a non-judgmental attitude and being respectful. Kvale (1996:128), mentions other important skills like attentive listening, showing interest and understanding. The aim of interviewing is to hear the information from the interviewee and it is therefore important to use minimal verbal responses, as non-verbal responses can encourage the participant to give more information. Non-verbal communication skills include appropriate and responsive facial expression, occasional eye contact (extensive eye contact can cause the interviewee to feel dominated) and economic use of head nodding as encouragement (Gilham, 2000:30).

2.4.3.6 Pilot study

Before the in-depth interviews were conducted, the interview background information and questionnaire were studied and pilot interviews were conducted with two managers working in institutions selected for the Teasdale-Corti research. This familiarized the researcher with the interview process and assisted in identifying additional probes that could be used to obtain rich data for the study. Practising interviewing skills was important for the researcher, as it helped to prepare specifically for potentially troublesome questions in the interview schedule. With the pilot study the risk for making ad hoc decisions was excluded (Babbie 2010:279; Royce, Singleton & Straits, 2002:63). The pilot study further assisted the researcher in determining the amount of time needed for an interview (Welman, *et al.*, 2005:168). The researcher was already skilled in using a voice recorder to obtain data. Data obtained through the pilot study was not included in the findings of the study as the participants were not part of the 12 candidates selected to be interviewed.

2.4.3.7 Data collection process

Eligible selected managers were contacted telephonically by the researcher to enquire about their interest in participating in the in-depth interview. At this stage the Teasdale-Corti research programme was recognized in each district and the researcher did not have

problems obtaining telephonic consent. However, it was quite difficult to schedule an interview with managers, as they have very hectic work schedules. The researchers had to reschedule interview dates due to unplanned emergency workload requirements of the managers. Before the interviews were conducted, the managers had to give voluntary written consent, after the consent form had been explained to them (Addendum I). The interviews were conducted in a private room and a voice recorder was used to digitally capture the interview. After the interview the participants were thanked for their contribution. Field notes were written up by the researcher as soon as possible after the interview, usually before leaving the institution.

The interview was downloaded onto the researcher's laptop, a backup was made and the interview downloaded onto the transcribers' computer. The transcriber was required to sign a confidentiality agreement before receiving transcripts to ensure the confidentiality of the participants and research. The transcriber transcribed the interview and returned it to the researcher, while track and tracing forms assisted the researcher in keeping track of which interview had been submitted on which date and when it was returned. After receipt the transcriptions were compared to the original audio version to ensure that the transcript was the exact wording that had been used during the interview and to complete any words that the transcriber had been unable to identify. After re-listening, sometimes three times per transcript, the transcript was ready for data analysis.

- **Interviewing process**

According to Burns and Grove (2010:403), there are various approaches to interviewing, ranging from totally unstructured interviews where the participant controls the content completely, to structured interviews where interview questions are determined beforehand and the participant responds to the specific question asked. Probes and elaborating questions can be used if permitted. An in-depth interview is a form of semi-structured interview where questions are phrased as open-ended to obtain as much rich information as possible.

The TC research in-depth interview schedule on workplace policies was used in this objective and the questions were developed by Professor Nancy Edwards (University of Ottawa, 2007) specifically for use by the TC research programme. The interview instrument consists of seven open-ended questions regarding HIV and AIDS workplace policies:

- Can you tell me what factors prompted your organization to develop policies about HIV in the workplace?

- Please describe the process for developing the HIV workplace policies in your organization.
- Who has been involved in the development of these policies?
- What disciplines have been represented?
- What roles do these individuals fulfil in your organization? (e.g. managers, caregivers, directors, etc.)
- Can you describe how the HIV policies in your organization fit with the policies that have been developed at national level?
- Can you please describe the policies that are still required in your organization relating to AIDS care?

Informed voluntary consent was signed prior to the interview being conducted and a demographic profile was obtained from the manager.

The interview was conducted and recorded.

After the interview of participants, field notes were written up. Streubert, *et al.*, (1999:26) define field notes as notations that are made after the interview about the researcher's reflections on the interview. These notes are very important, as they become part of the data analysis. It is advisable to do a voice recording of the field notes of what the researcher had heard, seen, thought and experienced directly after the interview. In this study a descriptive and reflective way of reporting field notes was developed and the researcher recorded field notes accordingly, becoming familiar with the format as the interviews progressed (Welman, *et al.*, 2005: 169; Polit & Beck, 2004:382; Morse & Field 1995:112-115; Creswell, 2007:135-137). Field notes are discussed in more detail as a separate entity in the following paragraphs.

2.4.3.8 Field notes

Field notes, also referred to as reflective notes, are the documentation of observations made during interviewing (Tjora, 2006:429; Wolfinger, 2002:86). Field notes are an important data source in qualitative research, as they consist of the researcher's recorded personal thoughts, such as speculation, feelings, problems, ideas, impressions, experiences and observations that are made during the collection and on reflection on data (Welman, *et al.*, 2005:168; Polit & Beck, 2004:382; Morse & Field 1995:112; Creswell, 2007:136-137). Groenewald (2004:15) and Babbie (2010:404) describe four different types of field notes:

- Observational notes include the „what happened“ notes and consist of observations that the researcher deemed important enough to record (punctuality of respondent, changes in body posture, facial expression, attitude, voice intonation, etc.). The senses of the body are used to make observational notes.
- Theoretical notes include notes that are used to derive understanding as the researcher thinks about or reflects on experiences during interviews.
- Methodological notes can be viewed as „reminders, instructions or critique“ regarding the research process.
- Analytical memos are the end-of-a-field-day summary or progress reviews.

Field notes are used because the human mind tends to forget quickly and they are therefore essential to ensure richness in data collection and analysis in qualitative research (Tjora, 2006:429). Field notes for this study included observations that struck the researcher as the most important, or outstanding data during the interviewing of managers regarding problems experienced with policy when working in an HIV and AIDS workplace environment, as well as how the policy process was dealt with in their institution. These particular observations were recorded as soon as possible after the interview. During the data collection and analysis process the researcher made field notes as needed and categorized them afterwards as observational, theoretical, methodological or analytical notes. These notes were included in the data analysis process and form part of the concluding statements made in chapters 4 and 5.

2.4.3.9 Data analysis

Qualitative data can be defined as the process of non-numerical analysis of transcriptions and field notes in order to find underlying meanings and patterns of relationships (Tesch 1990:79-80; Babbie, 2010:394; Nieuwenhuis, 2007:101). Qualitative data analysis is an active inquiry process in which conclusions do not emerge from the data if the researcher is not completely familiar with the data or without active intellectual work. The researcher should be able to recognize patterns and trends in the data in order to draw a conclusion (Morse & Field, 1995:125).

Qualitative data analysis is not a once-off occurrence, but a process that starts with and continues during data collection as the researcher and the independent senior qualitative research analyst overseeing the analysis reflect on the raw data as it becomes available or as interviews are transcribed. Conducting an analysis of qualitative data enabled the

researcher and the senior qualitative research analyst to focus and shape the study as it proceeded. The preliminary data analysis occurred as a very informal process: each analyst recorded ideas on dated memos as a record of insights regarding the reading and re-reading of transcripts, reading of field notes and listening again to the voice recordings in order to recall observations and experiences until both analysts became immersed in the data. Voice recordings contain more than just words; they contain feelings as well as cues of non-verbal communication (Burns & Grove, 2010:521).

Content analysis is a systematic process of looking at data from different angles with a view to identifying codes in the transcripts that will assist the researcher in understanding and interpreting raw data. Content analysis is an inductive and iterative process in which the researcher looks for similarities and differences in text that contribute to rich descriptions of, in this study, specific policy problems experienced while working in an HIV and AIDS workplace environment. Although the data analysis of each objective is discussed separately with the triangulation design, the researcher combined all forms of data and found convergence amongst the results (Creswell, 2003:222), as will become evident from the detail in chapters 4, 5 and 6.

- **Coding**

Content analysis as summarized by Creswell (2003:192) was used after data transcriptions had been completely reviewed and corrected. Each transcription was read as a whole to get a sense of emerging patterns. The researcher then started to code the transcribed data by reading again through each transcript and dividing it into meaningful analytical units. All meaningful segments were assigned a code. In this study the researcher used descriptive words to code transcripts.

The result of initial coding is the identification of numerous concepts relevant to the subject under study. After initial coding the researcher tried to summarize and organize the data, and this step resulted in refining and revising initial codes, categorizing and searching for relationships and patterns in the data.

The next step in the coding process was to combine related codes into themes, and each theme was assigned identifying words. A brief description of each theme was written down and outstanding quotes were marked with a coloured highlighter to illustrate the meaning of the theme. The whole process was iterative, as the researcher moved back and forth through the data and the researcher ended up refining themes into subthemes.

The coding process was finalized by re-reading transcripts and field notes to ensure that all essential insights that had emerged from the data through initial coding, themes and subthemes had been captured, keeping the research objective in mind (Babbie, 2010:400-404; Creswell, 2007:290; Burns & Grove, 2010:522; Tesch 1990: 79-80; Nieuwenhuis 2007:105-110). The initial codes, themes and subthemes, together with the analysed transcripts, were submitted to the independent senior research analyst for final review and comments and a few minor adjustments were made. Finally, the assistance of a computer software program for data management, Nvivo version 8, was introduced. It is discussed separately below.

- **Computer programme used for qualitative data analysis in this objective**

In this study, the Nvivo version 8 computer software program was used to ease the process of data sorting. The Teasdale-Corti programme supported the researcher with in-service training on the use of Nvivo version 8. This software program was used to merge all the data with the same codes into the same file, but it does not code the data. It is therefore important to regard computer software programs merely as data managers. Nvivo version 8 provides security by storing the database and files together in a single file, it has a merge function for team research and it enables the researcher to easily manipulate the categories of data (Morse & Field, 1995:125; Babbie, 2010:406; Creswell, 2007:167). Findings of the data analysis followed for managers are given in chapter 4, and the perspective of frontline nurses is outlined in chapter 5.

- **Rigour**

Rigour refers to the soundness of the research. This study used triangulation methods of data collection, including a literature review, and quantitative and qualitative data collection methods. With regard to quantitative studies reliability and validity are used to ensure rigour, while Klopper (2008:69) indicates that an alternative construct for validity and reliability in qualitative research can be trustworthiness. Rigour was ensured throughout this objective – see the discussions in chapter 1, paragraph 1.11.

2.4.3.10 *Embedded literature*

After consensus was reached on the themes, the literature was scrutinized to compare and contrast the findings. Creswell (2003:31) indicates that embedded literature is essential for the inductive process of qualitative research, as the literature does not guide or direct the study, but serves as evidence once the themes have been identified.

2.4.4 Phase 1 – Empirical research, objective 4:

To describe problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective

In this objective the viewpoint of frontline nurses regarding problems experienced with policy while working in an HIV and AIDS workplace environment was obtained using the same standardized in-depth interview questionnaire as was used with the managers in objective 3.

2.4.4.1 Population

The population parameters for this objective are similar to those as were discussed in paragraph 2.4.3.1, with the exception that the target population was frontline nurses. The target population identified consisted of 522 candidates of which 87 (N=87) indicated their willingness and availability to participate.

2.4.4.2 Sampling method

A random sampling technique was used and Babbie (2010:211) refers to this way of sampling as a systematic random sampling. Out of 87 (N=87) respondents a selection of nine candidates (n=9) was chosen, and every ninth candidate was contacted telephonically to schedule a time and date for interviewing. If there was a problem, the next candidate was contacted. For this objective, nine nurses were asked to participate in the in-depth interviews and therefore the population identified consisted of n=9 in-depth interviews.

2.4.4.3 Sample size

For the purpose of this objective, nine nurses (n=9) were selected to participate in in-depth individual interviews, three in-depth individual interviews from a participating institution in each district.

2.4.4.4 Pilot study

A pilot study was not necessary with this objective as the same instrument was used with frontline nurse participants as with managers.

2.4.4.5 *Data collection process*

The same process of interviewing and transcription as well as field notes as that detailed in paragraph 2.4.3.7 was followed with the frontline nurses for this objective.

2.4.4.6 *Data analysis*

The identical process of analysing the data to find mean valueings and patterns of relationship, coding, identifying themes and subthemes and the use of a computerized data manager as that described in paragraph 2.4.3.9 was followed with these participants" interviews.

2.4.4.7 *Rigour*

Rigour was ensured throughout this objective – see the discussions in chapter 1, paragraph 1.11.

2.4.4.8 *Embedded literature*

Embedded literature was used to support the empirical findings of frontline nurses" identification of problems experienced with policy when working in an HIV and AIDS workplace environment.

2.4.5 Phase 2 – Strategy formulation for Nurse led change to influence HIV and AIDS workplace policy

In this paragraph, the research method of the strategy formulation (phase 2) of the study is discussed with the aim and objectives of the study in mind and in relation to the research design.

- **Strategy formulation process**

Deductive and inductive logic was used in the formulation of the strategy. Deductive logic is a form of reasoning that moves from multiple realities to one or two specific conclusions. In deductive logic, the one or two relational statements provide the conclusion with complete support (Chinn & Kramer, 2008:296; Burns & Grove, 2005:733, Rossouw, 2003:39). Inductive logic departs from a specific premise to multiple realities and these multiple realities provide only partial support for the conclusion. According to inductive reasoning, there is not only one reality but many, and the researcher tried to reach the best possible understanding

of what was observed. These realities, underpinned by inductive reasoning, are seen as complete aspects of the whole study and cannot be understood in isolation from their context. The larger whole picture of realities serves as a general statement (Rossouw, 2006:40; Chinn & Kramer, 2008:299; Burns & Grove 2005:739).

In this study, deductive logic was applied to identify problems or formulate concluding statements about human resource capacity in an HIV and AIDS environment from a manager's perspective, and problems experienced with policy working in an HIV and AIDS environment, as well as concluding statements derived from the literature review. These problems identified (or concluding statements) were used as the basis or evidence for the strategy formulation for Nurse led change to influence HIV and AIDS workplace policy. Deductive logic reasoning was used to develop strategy objectives derived from the problems identified (or concluding statements) made throughout the empirical research, while inductive and deductive logic was applied to develop functional tactics to put into action and implement the strategy formulated for Nurse led change to influence HIV and AIDS workplace policy. Figure 2.4 depicts a graphic presentation of the method for strategy formulation.

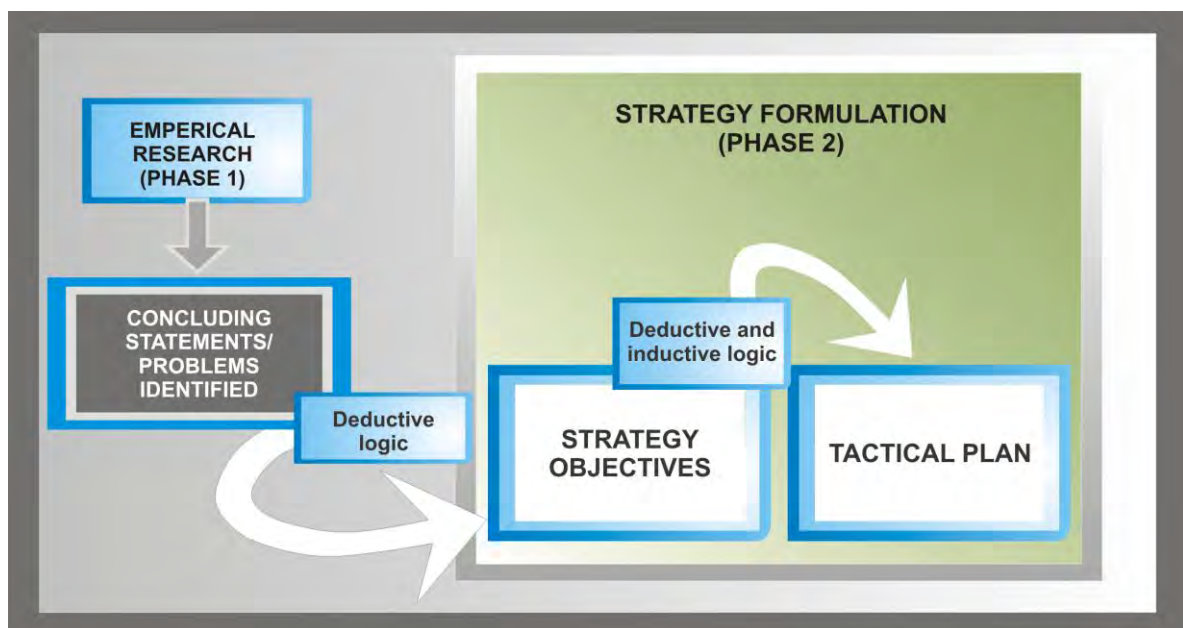


FIGURE 2.4: GRAPHICAL PRESENTATION OF STRATEGY FORMULATION PROCESS (ADAPTED FROM COETZEE, 2010:115)

2.5 RIGOUR

Rigour refers to the soundness of the research. This study used triangulation methods of data collection, including a literature review, and quantitative and qualitative data collection methods. With regard to quantitative studies, reliability and validity are used to ensure rigour, while Klopper (2008:69) indicates that an alternative construct for validity and reliability in qualitative research can be trustworthiness (see chapter 1, paragraph 1.11). With regard to the reliability and validity of the HRM questionnaire, see chapter 4, paragraph 4.2.2.1 and 4.2.2.2.

2.6 ETHICAL CONSIDERATIONS

The ethical considerations as required by the international study programme, including the approval process of participating countries and the principles adhered to, were described in detail in chapter 1, paragraph 1.8.

2.7 SUMMARY

In this chapter each step of the research process was explained, from the research design or blue print, to the smallest detail of how each step was implemented. The researcher focused on population, sampling method and sample size for each objective of the study. In order to meet the objectives of this study, a mixed-method triangulation, explorative, descriptive and contextual designs were utilized with the umbrella aim of developing a strategy for Nurse led change to influence HIV and AIDS workplace policies. Population sampling, sampling method and sample size were explained. The researcher further explained how the pilot study was conducted for objectives 2 and 3 to become familiar with the instruments, identify possible problems in the research field, to develop the researcher interview skills and to identify probes while doing qualitative interviewing. The data analysis process for each objective was described and attention was given to the importance of ensuring soundness during of the research process (rigour). By doing this, the whole process of research was thought through logically to ensure that the rights of the participants were protected and that nothing relevant was omitted.

CHAPTER 3

LITERATURE REVIEW

3.1 OVERVIEW

Chapter 3 deals with phase 1, objective 1, and the aim of this chapter is to perform a literature review in order to identify the barriers within the nursing profession regarding the different roles of the nurse and the influence they have on HIV and AIDS policy formulation. Table 3.1 depicts that empirical research: objective 1 is addressed within this chapter.

TABLE 3.1: PHASE 1 – EMPIRICAL RESEARCH: OBJECTIVE 1

PHASE 1: EMPIRICAL RESEARCH	PHASE 2: STRATEGY FORMULATION
Objective 1: To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.	Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
Objective 2: To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.	
Objective 3: To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.	
Objective 4: To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.	

3.2 INTRODUCTION

Leading change has become an essential core competency of health professionals today. Nurses especially need to lead change to influence health policies, as they are the frontline workforce in health care in South Africa. However, they are currently absent at the policy formulation table. The aim of this chapter is to explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy. Globally nurses are not optimally participating in the policy formulation process (Edwards, *et al.*, 2007:34), and this is also true for South Africa, where nurses are not at the policy table of the different levels of health services, e.g. national, provincial and district level. The question that therefore arises is: What are the barriers to Nurse led change to influence HIV and AIDS workplace policy?

A literature review was conducted in order to identify barriers that contribute to nurses' absence from the policy table. This chapter offers an introduction to the role of the literature review in this study. The policy process at macro-, meso- and micro levels of governance is discussed, followed by the South African scenario with reference to the HIV and AIDS workplace policy. The nursing profession and the image of nurses are discussed as a barrier for change to influence HIV and AIDS workplace policies at all levels of governance. Factors that were identified as barriers for practising nurses to influence the policy process are discussed in detail according to their different roles of practice. The policy process is discussed with reference to types of policy processes, the policy cycle and how the policy cycle can be used to influence the policy process. Lastly the role of nurses as „change agents“ to influence the political agenda with their leadership skills will be discussed.

3.3 LITERATURE REVIEW SOURCES

The literature review population and sampling were fully discussed in chapter 2, paragraph 2.4.1.1, and therefore the process of identifying data sources is not repeated in this chapter. Although much literature is available on policy formulation and implementation generally, very few data sources discuss the role of the nurse in the policy formulation process. Data sources emphasizing the role of the nurse in policy formulation and implementation were used, as they are particularly relevant to this study.

3.4 POLICY PROCESS AT MACRO-,MESO- AND MICRO LEVELS OF GOVERNANCE IN SOUTH AFRICA

The researcher's point of departure was the view that nurses have not been involved in the formulation of the HIV and AIDS workplace policy. In the following paragraphs the policy process at macro (national), meso (provincial) and micro (district and institutional) level are discussed.

3.4.1 Policy process at macro (national) level

The policy process starts at macro level, where the National DoH takes the lead, via Parliament, where the South African National HIV and AIDS council (SANAC) is a key stakeholder in the formulation of HIV and AIDS prevention and management strategies at national level. The function of SANAC was fully discussed in chapter 1, paragraph 1.4. SANAC serves as a guiding committee for Parliament to approve suggested changes in the management of the HIV and AIDS pandemic in South Africa by formulating strategic plans, taking into consideration trends advised by the World Health Organization (WHO). Suggested policies are an outflow of approved strategies developed at national level by the national DoH programme unit: HIV and AIDS and TB (HAST). The national HIV and AIDS and TB Programme Unit consists of five different programmes, but for the focus of this study the Directorate HIV and AIDS and Sexually Transmitted Infections (STIs), which is responsible for STI, HIV and AIDS prevention, treatment, care, support and research, is of importance.

The lack of involvement of nurses in the policy process at macro level emphasizes that nurses should become more involved, specifically in policy formulation. The researcher made this assumption on the grounds of the composition of the SANAC committee, where the national strategic plan was developed with only one nurse serving as the representative of all nurses in South Africa. The bulk of the committee members were medical doctors, social workers and politicians, who were each represented by more than one member (SANAC, 2007:3).

3.4.2 Policy process at meso (provincial) level

Policies were formulated and delegated to the provincial HAST directorate for dissemination and the training of provincial HAST managers. HAST managers are responsible for the same programmes as at national level, but the focus of this study is the HIV and AIDS and

STIs programme. The provincial programme director and staff for HIV and AIDS and STIs (mesolevel) refine the policies by developing guidelines covering all the HIV and AIDS policies, after which training is given to HIV and AIDS coordinators at provincial level on how these policies should be implemented in the different districts of a province (Department of health, HIV, AIDS and STI's directorate, 2010).

3.4.3 Policy process at micro (district and institutional) level

The HIV and AIDS coordinators of different district health offices (micro-level) receive training from the provincial HIV and AIDS and STIs coordinator on the guidelines developed and how they should be implemented. They are further provided with the national DoH policy and the provincial DoH guidelines and are then responsible for the training of all unit managers at district level on how to implement the national policies and provincial guidelines on HIV and AIDS. Programme monitoring and the evaluation of guidelines implemented is done via statistics provided by hospitals, ART clinics, CHC and clinics to evaluate the set objectives, as well as supervisory visits to these health service points (Department of health, HIV, AIDS and STI's directorate, 2010).

Nurses often see policy as „something“ that is not part of their scope of practice. When nurses were asked about policy during the in-depth interviews covered in chapter 5, their immediate thoughts were of policy and procedure manuals. Nurses often experience policymaking as some mysterious process that takes place at national and provincial level that is of little relevance to frontline nursing practice (Spenceley, *et al.*, 2006:180; Taft & Nanna, 2008:275). This perception leads to a disconnection between HIV and AIDS workplace policy formulation and the implementation thereof (Taft & Nanna, 2008:275), and it should be emphasized that policy is relevant to all nurses, whether they practice at national, provincial or district level (Spenceley, *et al.*, 2006:186; Algase, *et al.*, 2004:116). Frontline nurses specifically can argue that involvement in policy process is a tall order for them because they are already preoccupied with issues relating to the adequacy and accessibility of health services. However, these nurses bear witness to how effective HIV and AIDS workplace policy can assist them in improving health-care service delivery.

Further factors contributing towards the apathy of nurses in the policy process include heavy workloads, understaffing, powerlessness in institutional settings and lack of time (Boswell, *et al.*, 2005:5). This frontline experience of nurses at district level calls for the critical appraisal of nurses' roles, as they have the practical experience needed to improve HIV and AIDS workplace policy with their inputs (Reutter, *et al.*, 2002:298). HIV and AIDS workplace policy

can also impact on the quality of a nurse's professional life due to the time spent in the work environment and the implications of unproven or incorrectly prescribed practices. The nurse's role in the HIV and AIDS policy process should therefore be prominent in setting the tone, as they have frontline experience in working with HIV and AIDS and are more exposed to the virus than other professionals. However, this is currently not the case regarding the formulation of HIV and AIDS workplace policy (Ennen & Wachs, 2001:558).

Concluding statements: Policy process at macro- (national), meso- (provincial) and micro (district or health institution) levels of governance

- Frontline nurses are not knowledgeable about the function of SANAC within Parliament or the process of policy at macro (national), meso (provincial) and micro (district or institutional) level.
- The representation of nurses at national level involved in HIV and AIDS policy formulation is unsatisfactory.
- Nurses are viewed as the implementers of policies.
- Nurses think of policy as some mysterious national and provincial process and not as a function of nurses themselves.

3.5 SOUTH AFRICAN SCENARIO REGARDING HIV AND AIDS IN THE WORKPLACE ENVIRONMENT

The paragraph above elucidates the HIV and AIDS policy process at macro-, meso- and micro levels in South Africa. The current situation regarding HIV and AIDS in South Africa, the influence on the nurse workforce and the current role of the HIV and AIDS workplace policy is reflected in the bulleted paragraphs that follow:

- South Africa has a national HIV-infection rate of 11.2% (Statistic South Africa, 2008).
- The researcher could find no proof in one district of any HIV and AIDS workplace policy that was refined and formulated to suit the context of a district-level institution. During the process of data collection for this research project the researcher had the opportunity to look at the internal and external policy guidelines of participating institutions and only provincial HIV and AIDS policies were on file in the one district.

- Nurses were not aware that they could refine the institutional HIV and AIDS policy within the framework of the national and provincial policy to suit the HIV and AIDS needs of their specific institution (Dijkstra, *et al.*, 2007:636).
- The most critical health objective for the South African government is to reduce the rate of new HIV infections in South Africa. The HIV and AIDS pandemic contributes to the high levels of morbidity and mortality in South Africa. The failure to implement anti-retroviral treatment (ART) early enough has created a massive burden of HIV and AIDS orphans and this has severe socio-economic implications (Harrison, 2010:18; Zelnick, & O'Donnell, 2005:180). Harrison (2010:27) acknowledges that South Africa has a largely nurse-driven health system, but throughout the whole discussion document, where policies on how to prevent infection, and the scaling up of HIV and AIDS services, programmes and services which should be implemented to curtail new HIV infections are highlighted, the role of the nurse seems to be merely the implementer of policies and programmes (Harrison, 2010:19). A key strategy to improve the health system functioning is to lead from the front. Harrison (2010:3) states that it is important to give frontline nurses a clear vision of health-sector functioning until 2015, and to be seen to be working with them in its implementation.

The focus of government is currently on the roll out of ART services as a vertical programme and not as part of a comprehensive health-care programme. The roll out of ART services as a vertical programme had benefits, but because only a few doctors and frontline nurses are trained to specialize in ART, AIDS care in institutions other than an ART centre have HIV and AIDS workplace policy implications for the nurse workforce. The nurses experience increased numbers of AIDS patients who need intensified care and they are more exposed to the HIV virus. The fact that they are not specifically trained to treat an AIDS patient leaves them feeling insecure, anxious and vulnerable. There is support for both vertical and integrated health programmes, but being a professional frontline nurse mean values having to be multi-skilled. The questions can be raised: Can institutions in South Africa expect nurses to care for HIV and AIDS patients without effective training on how to care for them? and: What does the administering and side effects of ART entail? (Heunis & Schneider, 2006:268-274).

3.5.1 Nurses' perspective of the HIV AND AIDS workplace policy

According to a South African study done by Zellnick and O'Donnell (2005:164) they obtained nurses' perspective specifically on the HIV and AIDS workplace policy. They stated that HIV and AIDS have a triple effect on the nurse workforce:

- increased workload;
- increased exposure to HIV infection: and
- stressed morale.

One factor that leads to dissatisfaction about working conditions clearly stems from policies that do not address the specific needs of frontline nurses working with HIV and AIDS patients (Zellnick & O'Donnell, 2005:165). Coupled with this is the fact that frontline nurses face a risk of higher exposure to HIV and AIDS in their working environment.

South Africa's occupational health policy includes: safe needle disposal, reporting of blood-borne pathogen exposure, the availability of post-exposure prophylaxis (PEP) and compensation for workers who contract HIV / other blood-borne diseases at work. Zellnick and O'Donnell (2005:171) found that the occupational health policy is made at national level, „dictated“ through provincial DoH and implemented at frontline level. This emphasizes the researcher's real world experience that, although nurses' participation in policy formulation is limited to those in leadership positions, nurses play the major role in implementing these policies to achieve the set goals of the HIV and AIDS strategic plan.

- **Post-exposure prophylaxis (PEP) protocol**

The current protocol requires that the nurse „must“ be tested following an injury; those who refuse to be tested do not qualify for PEP treatment. Refusal of nurses to have themselves tested after occupational exposure negates any future claim with reference to the specific incident as the HIV status of the nurse was not known at the time of the incident. The chance exists that the nurse would test positive and then the steps to be followed include counselling for further management of HIV according to public protocol. Only nurses who gave consent for a rapid HIV test receive full PEP treatment.

Nurses are required to report exposure to their immediate manager within an hour and to complete the injury on duty form. The source patient's permission must be obtained to draw a blood specimen from them for a rapid HIV test and, if positive, to determine the patient's

current viral load. The source patient has the right to know the result of the test. If the source patient refuses to give permission, new developments indicate that blood is usually taken from these patients for other tests and this blood is stored in laboratories for one month. This blood can be used to determine the HIV status as well as the viral load if necessary, but only for the purpose of PEP and with the permission of the treating physician (Evian, 2003:323).

- **Nurses' view on completion of injury on duty forms with reference to occupational exposure to HIV and AIDS**

The paperwork required for PEP and the compensation commissioner is perceived as a mean values to blame nurses for carrying out their duties carelessly. The writing of these reports is therefore perceived as humiliating and, to aggravate matters, nurses receive little or no support from the nursing supervisor/manager or the medical officer in completing these reports. The policy language exacerbates the feelings because the nurse needs to have her status tested to qualify for PEP, whereas the patient has the right not to be tested and may not be forced (Zellnick & O'Donnell, 2005:173-175). The completed injury on duty forms, together with the final report and HIV results from both the nurse and patient, are sent to the human resource department, which in turn submits it to the compensation commissioner. Nurses who sero-convert from negative to positive after occupational exposure and who followed the abovementioned steps are assured of compensation and access to anti-retroviral treatment for the rest of their lives (Zellnick & O'Donnell, 2005:171).

- **Nurses' view on the HIV and AIDS workplace policy as a way for public institutions to protect themselves**

The analysis of data on nurses' perception of the HIV and AIDS workplace policy in South African public health institutions indicated that nurses felt that they were undervalued by the institution. They saw the HIV and AIDS workplace policy as the institutions' way of protecting themselves; some nurses viewed universal protection protocols and PEP primarily as a mean values for the public institution to protect itself against liability rather than protecting the nursing workforce (Zellnick & O'Donnell, 2005:175).

Concluding statements: South African scenario regarding HIV and AIDS in the workplace environment

- The roll out of ART services as a vertical programme causes feelings of insecurity among nurses. The fact that many nurses are not trained to treat AIDS patients leaves them feeling insecure, anxious and vulnerable.
- Nurses are not aware that they can refine the institutional HIV and AIDS policy within the framework of the national and provincial policy to suit the HIV and AIDS needs of their specific institution.
- A top-down approach is followed with regard to the formulation and implementation of the HIV and AIDS workplace policy.
- Nurses are dissatisfied with the formulation and implementation of the HIV and AIDS workplace policy. The paperwork required for PEP and the compensation commissioner is perceived as blaming nurses for carrying out their duties carelessly. The completion of reports is perceived as humiliating and nurses receive little or no support from the nursing manager in completing reports.

Figure 3.1 explains the different roles of nurses in the context of the study and their interaction with the policy process as well as the nurse interface with policy as visualised by the researcher at this stage of the research process. A discussion of each of the concepts in the figure follows afterwards. The figure graphically explains that nursing as a profession is influenced by the image of fulfilling several roles. Interface with the policy process should encourage them to take action and to act as change agents to plan change and to take the lead to influence HIV and AIDS workplace policy. The figure is followed by a discussion of the nursing profession and the image of nursing.

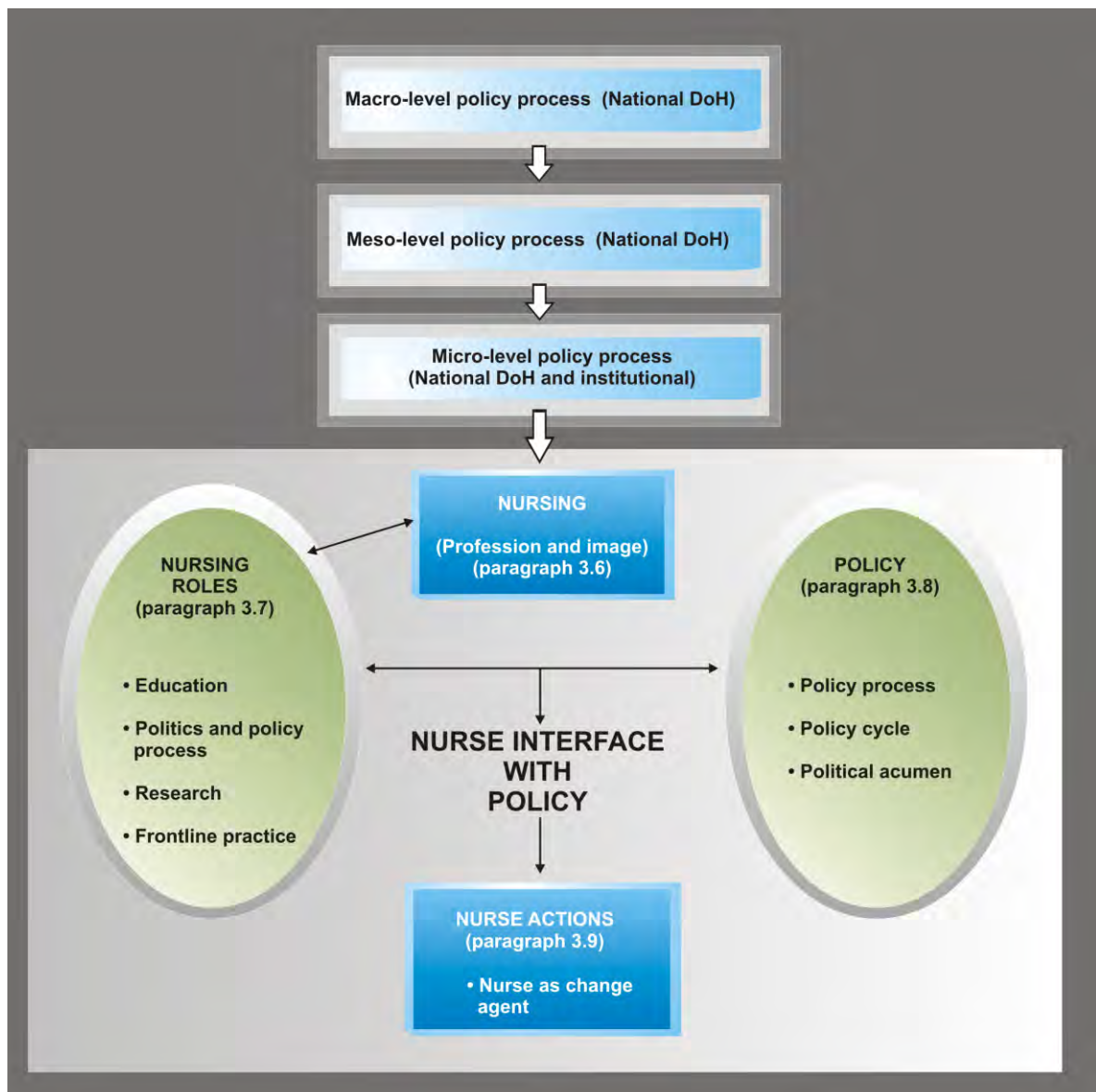


FIGURE 3.1: INTERACTION BETWEEN NURSING AND THE POLICY PROCESS

3.6 NURSING PROFESSION AND IMAGE OF NURSING

Nursing encompasses autonomous and collaborative health care for individuals of all ages, families, groups and communities. It includes health promotion, disease prevention, curative aspects as well as rehabilitation of patients in order to restore health or to obtain, as far as possible, an optimal functional health status. Nurses also have to care for the dying patient. Nursing further participates in advocacy, research participation to shape health policy formulation and in education (ICN, 1987). According to Van der Merwe (2010:8) and Jooste (2010:44), nursing met the criteria to be considered as a profession, some of which include control and regulation by a legal regulatory body, an internal disciplinary system, a unique

body of knowledge based on scientific principles, accountability and a high degree of autonomous practice, collegiality, collaboration, ethics and values. South Africa was the first country in the world that established a professional legal regulatory body and broke loose from the patronage of doctors and allied professional workers and gained control over the sphere of nursing practice, defending it under the law (Perkins, 2009:45).

The fact that nursing is a profession does not contribute to the image of nurses, because nurses are perceived as impeded if compared with other professions. Nurses are not perceived by politicians, other health professions and the public as powerful and autonomous – instead professional nurses appear to be submissive (Phaladze, 2003:27; Mechanic & Reinhard, 2002:7; Perkins, 1999:42-43). Brewah (2009:36), Spencely, *et al.* (2006:187) and Mechanic and Reinhard (2002:9) reported that nurses are powerless, subordinate and handled dismissively by physicians and it would seem that the physician's role is more valuable than the nurse's. Inter-professional conflict between physicians and nurses is well documented, and this concept of dismissive handling of nurses by physicians can emphasize nurses as an oppressed group (Hart, 2005:40; Coovadia, *et al.*, 2009:829).

Nurses often underestimate the importance of their role in health-care service delivery, and it seems that only a few can speak with confidence in public spheres. The fact that nurses are not assertive leads to the conclusion that nursing is a submissive profession, and if nurses perceive themselves as submissive they will not join the policy table. Nurses need to strengthen their image and prestige as professionals in order to set the tone in HIV and AIDS workplace policy (Ennen & Wachs, 2002:557; Hart, 2005:29; Phaladze, 2003:27).

Concluding statements: Nursing profession and image of nurses

- Nurses are not perceived as powerful and autonomous, but rather as powerless, subordinate and handled dismissively by physicians.
- Nurses underestimate the importance of their role; they need to strengthen their image and prestige as professionals in order to have confidence to join the policy table.

3.7 ROLES OF NURSES

South African nurses fulfil a variety of roles in their professional capacity, including those of clinician, educator, patient advocate, researcher, manager, change agent and leader. Clarification of the role of nurses and their status should be placed within the context of a shortage of nurses internationally. The global shortage of nurses emphasizes the need to improve the standards for nurse training, leadership and involvement in all aspects of management, education and research relating to the health-care system.

Even in a middle-income country such as South Africa the health system is struggling to retain sufficient numbers of skilled nurses in the public sector, and most specifically in rural areas. Poor monitoring and management of skill combinations exacerbate this problem (Daviaud & Chopra, 2008:49; Jooste, 2010:361; Clark, 2008:19-22). The ratio for qualified nurses in the North-West Province is 1 nurse for a population of 486 (SANC, 2008), and the Health Systems Trust (2008) reports that only 44% of these professional nurses work in public health institutions in the North-West Province that provide services to 80% of the population. The alarming shortage of nurses emphasizes the effective utilization of available resources to assist the practising nurses in fulfilling their different roles efficiently. Table 3.2 indicates the number of qualified nurses in the North-West Province in relation to those employed in public health institutions.

TABLE 3.2: TOTAL NUMBER OF NURSES QUALIFIED ACCORDING TO SANC REGISTER AND TOTAL NUMBER EMPLOYED IN PUBLIC HEALTH SECTOR IN NORTH-WEST PROVINCE

North-West Province: Total number of nurses according to SANC register	North-West Province: Total number nurses employed in public sector
7 047	3 140

(Health Systems Trust, 2008)

3.7.1 The role of nurses as educators

Nurse educators are responsible for training pre and postgraduate nurses. A registered nurse in South Africa has completed a comprehensive four-year programme to obtain either a national diploma at a nursing college or a nursing degree from a university (Bester & Klopper, 2008:108). The South African Nursing Council (SANC), the legal regulatory body for nurses, is an autonomous body that has been regulating the nursing profession for many

years. Self-regulation, according to Jooste (2010:44), describes the extent to which the profession controls itself. Nurses themselves are in the best position to determine standards of training and practice in order to ensure patient safety by clearly determining the scope of practice of nurses.

SANC regulations to ensure quality training currently do not prescribe a uniform training standard for all nurses, merely providing a basis as guideline, but nursing colleges are governed by the DoH and universities by the Department of Higher Education. A collaborative effort will be vital to ensure that nursing retains its status as an independent profession and that there is no compromise in service delivery, which could have a negative impact on patients' management outcomes. Quality monitoring by the SANC with regard to nurses' training by colleges is currently a debatable issue that threatens the supply of well-trained nurses to cope with health system demands within the South African context (Mellish, *et al.*, 2010:30-32).

Undergraduate professional education curricula that enable nurses to register with the South African Nursing Council do not include any compulsory policy process training (SANC, 1985:Regulation 425). Nursing education institutions that offer postgraduate training to nurses do not sufficiently equip them to play a role in the policy process, as this is not a stipulated requirement of the SANC. Curriculum formulating programmes for nurse training at nursing education institutions are based on set criteria (Jooste, 2010:46) prescribed by the SANC, but training regarding the policy process or nurses' involvement therein is not stipulated as one of them (SANC, 1985:Regulation 425).

According to Harrington, *et al.* (2005:99) and Ortner (2004:125) current nursing education undermines the ability of nurses to become involved in the policy process. Nurses are aware of policies and policy guidelines, but do not receive specific nurse policy training (Harrington, *et al.*, 2005:99). Nurses practise in a social, economic, cultural and political context, yet the overall focus of nursing curricula remains on the nurse-client relationship (Ballou, 2000:172). There have been calls to expand the nursing education and training curricula to include a greater emphasis on the policy process (Ellenberger, 2005:230; Harrington, *et al.*, 2005:100; Algase, *et al.*, 2004:116), but doctorate programmes in nursing science in South Africa focus the student only on the development of nursing as science (i.e. theories, methodology and philosophy), thus preparation for mentorship and internships to enhance policy involvement lags behind (Coetzee, 2010:83).

According to Mechanic and Reinhard (2002:9), to empower a nurse to become involved in the policy process a strong preparation in economics, finance, behaviour science,

epidemiology, decision sciences and health systems is essential. It is critical for educators to determine how the curricula offered can prepare nurses with the prerequisite awareness, political insights and strategic skills to become involved in the health policy process. Questions should include the following (Reutter, *et al.*, 2002:295):

- What value shifts and critical thinking skills do nurses need to recognize challenges in the political context?
- What is the role of specialist nurses (postbasic or postgraduate diploma with specialization in a specific field) in policy analyses and advocacy?
- What are the best mechanisms to prepare specialist nurses for their policy involvement role?
- What process is most essential and effective in influencing HIV and AIDS workplace policy at all levels of governance?

In Canada and the USA policy course modules were developed as a requirement for all students registered for an advanced practice course, especially for community and public health nurses (Spencely, *et al.*, 2008:182; Mechanic, *et al.*, 2002:9; Reuter, *et al.*, 2002:298).

Concluding statements: The role of nurses as educators

- The SANC provides minimum standards for standard training for all nurses and it provides a basis, but nursing colleges are governed by the DoH and universities by the Department of Higher Education, and a collaborative effort will be vital to ensure that nursing retains its status as an independent profession.
- Current nursing education does not facilitate the ability of nurses to become involved in the policy process, as the undergraduate curricula and some postgraduate courses do not include compulsory policy process training.
- Training in policy process is not required by the SANC.
- To become involved in the policy process a strong preparation in economics, finance, behaviour science, epidemiology, decision sciences and health systems is essential.

3.7.2 The role of nurses in politics

Politics is the science of government; the science of dealing with the form, organization and administration of a government. Politics is underpinned by ideologies; a set of ideas or beliefs that forms the basis for some form of political activities. Ideologies provide different ways of understanding political systems and governments, e.g. different solutions to economic and moral problems in a community or country. The values and principles underlying political ideologies are often seen as ranged along a linear spectrum of left to right, e.g. in South Africa the African National Congress is seen as left linear, compared to the Afrikaner Weerstandsbeweging, which appears to be far right. It is therefore important to recognize that political ideologies are preconceived traditions of thought that have evolved and developed under pressure of changing historical circumstances as a result of continuous argument and debate.

Nurses, in a predominantly female profession, are closely affected by the theory and practice of politics, as it not only determines their personal life but also their working conditions and the nature of the institution they are working in, for in South Africa 80% of citizens make use of public health institutions (Zelnick & O'Donnell 2005:167; Perkins, 1999:37 - 40). Many nurses often think "politics?", and due to the fact that they are nurses they do not visualize themselves as politicians. Nurses in the workplace should ask themselves: whom do I want to make decisions for me in this study about the HIV and AIDS workplace policy? and: who should decide about safety standards, professional, occupational and environmental health nursing practice standards?

According to Hart (2004:5), it is clear that nurses are less politically attuned and less politically involved in their personal life and in nursing issues than they have been in decades. Many nurses switch off when it comes to involvement in national and district or local politics, whatever their job, personal, social or economic situation. The loss of any sense of involvement in the direct politics of their own personal and working lives is costly for themselves because nurses always blame other health professions who make decisions on their behalf (Hart, 2005:29).

It is important for nurses to become aware that before a policy can be finalized it should go through a legislation process, which involves the following (Hart, 2005:156-157):

- The proposed legislation is discussed in Parliament and a white paper is issued for discussion by different political parties and for wider consultation.

- The appointment of committees follows to examine proposed legislation by obtaining the viewpoint of experts in the field, who thus contribute towards the policy process. The real power of nurses rests in their ability as an organized professional organization, e.g. the Democratic Nursing Association of South Africa (DENOSA), to provide input via critical constructive enquiry and active involvement.
- The same proposed legislation is debated in Parliament and voted upon, with the majority vote carrying it through.

Political involvement at national, provincial and district levels offers nurses in the workplace an opportunity to influence policy, seek improvements in their work environment and act as a voice for patients. The opportunity to become involved at all levels is via direct lobbying with elected politicians, state legislators and other important stakeholders. This could be seen as an „inside strategy“ in which nurses use their knowledge, expertise and experience to work directly with elected politicians to influence policy formulation (Ennen, 2001:562).

Concluding statements:	The role of nurses in politics and the political process
• • •	Nurses are not politically active in decisions made regarding their career and work environment. The absence of nurses at the policy table mean values that other disciplines make decisions on their behalf and are then blamed for the predicament, which impacts on nurses“ self-esteem. Nurses should utilize their organized professional association to provide input via critical constructive enquiry and active involvement in political decisions to influence the HIV and AIDS work environment of nurses. Nurses should be involved at macro-,meso- and micro levelsof the political process to influence the HIV and AIDS workplace policy by using their knowledge, expertise and experience to work directly with elected politicians.

3.7.3 The role of nurses in research

Research encompasses diligent, systematic inquiry or investigation to validate and refine existing knowledge and to generate new knowledge (Burns & Grove, 2010:719). Nursing research for the twenty-first century entails quality studies, synthesizing of research results into best research evidence available in order to be used for improving the quality of health care, reducing health-care cost, improving patient safety by decreasing medical errors, improving access to services and influencing the policy process (Jack, 2006:279; Wharam &

Daniels, 2007: 677). To ensure an effective research component in the nursing profession, the profession can implement the following steps (Burns & Grove, 2010:22):

- Create a research culture in the nursing profession.
- Provide quality educational (baccalaureate, master's degree, doctoral and postdoctoral) programmes to prepare a workforce of nurse scientists.
- Develop a sound research infrastructure within the profession as well as inter-professionally.
- Apply for and obtain sufficient funding for essential research.

The lack of research capacity amongst nursing personnel and the unavailability of opportunities to be involved in research projects is a major stumbling block for nurses to become involved in the policy process.

3.7.3.1 Research capacity

Research capacity is fundamental to ensuring evidence-based policies in practice (Edwards, *et al.*, 2008:1). Research evidence that is translated into HIV and AIDS workplace policy has the potential to improve health-care quality and service delivery. Calls to strengthen the generation and use of nurses' research is often a point of debate (Antrobus & Kitson, 1999:747; WHO, 2005:iii). Currently lower and middle-income countries (LMIC) face a nursing shortage, which could raise the point that research may be seen to be a luxury and that the focus should be on the provision of health-care services. It is important for politicians and nurse leaders to view research as an essential element that can improve the provision of effective and quality health-care services. In order to mitigate a balance between nursing research and clinical practice it is important for nursing research to be positioned within national and international health research strategies (Mechanic & Reinhard, 2002:10; Edwards, *et al.*, 2009:89).

Nurses' research knowledge can be used to shape health policy and health service delivery effectively, yet the research skills of nurses need further development. This is a major reason why professional nurses cannot become involved in the HIV and AIDS workplace policy process. Although research evidence is only one of many factors that influence policy, there is an increasing recognition that quality nursing research has great value for policy formulation (Campbell, *et al.*, 2009:21; Rasool, *et al.*, 2004:205).

3.7.3.2 *Involvement in research projects*

Nurses constitute approximately 80% of the health workforce in LMIC and the fact that leading research projects do not involve them mean values that research questions most pertinent to nurses' work in the front lines of the health-care system are likely to go unaddressed. This hampers the availability of evidence that is required for decision-making about health-care delivery systems to meet the needs of some of the world's most vulnerable populations (Edwards, *et al.*, 2008:1).

A recent literature review investigated trends in international organizations' allocation of research funds to nurses for Nurse led research and identified a tendency where higher-income countries exclude research funding for nurses from LMIC. This contributes to fewer research-empowered nurses and aggravates the lack of research capacity in these countries (Edwards, *et al.*, 2009:89). Fortunately, some higher-income countries develop research programmes in such a way that there is collaborative research with LMIC, with the emphasis on empowering nurse researchers and to increase the accessibility of graduate education opportunities. These initiatives assist in the fast-tracking of research preparation for nurses (Edwards, *et al.*, 2008:1; Cody & Mitchell, 2002:6; Mechanic & Reinhard, 2002:10).

Nurses should not conduct research in isolation, but top-level research scientists from diverse fields should be co-mentors on such research teams. This will ensure the advantages of strong mentorship and will create learning opportunities to do quality nursing research. Nurses should have innovative and effective knowledge translation strategies in place to disseminate research findings and to ensure that nursing research evidence is taken up in best practice guidelines that influence health policies effectively (Edwards, *et al.*, 2009:89; Jack, 2006:279).

A study in Nepal indicates that research driven by a policy agenda is far more successful than research undertaken in isolation. It is of the utmost importance that the ground for research be prepared and that the research principal investigator establish a strong link with the health department and politicians before research is undertaken. This link will make it more likely that research findings will be accepted and considerable effort should be made to ensure findings are disseminated between all stakeholders, including political leaders, e.g. discussion of findings in a language that politicians can understand (Ensor, *et al.*, 2009:251).

However, the development of and opportunity for scholarships and mentoring within large research programmes are limited in LMIC (Coetzee, 2010:83). The engagement of scholarship opportunities for students by using Boyer's model of scholarship includes:

scholarship of discovery, scholarship of integration, scholarship of application and scholarship of teaching and learning. This can be a solution to the absence of research development within LMIC. Each of the scholarships entails the following activities for students (Mellish *et al.*, 2010:388):

- Scholarship of discovery: Engage students in inquiry-based learning, undergraduate research and consultancy projects and enhanced co-research projects with staff.
- Scholarship of integration: Engage students in integration of material from different sources across disciplines; integrate life and clinical experience with academic studies.
- Scholarship of application: Engage with local, national and international service projects, volunteering and knowledge exchange projects,
- Scholarship of teaching and learning: Engage students in mentoring, peer support and assessment and collaborative group work.

Although these research scholarship opportunities exist, it is a challenge for nurse educators to involve students in the journey of development. Students tend to see research as another distraction from learning how to nurse a patient. It is therefore essential to foster research-mindedness during nurse training by including research as an integral part of each tuition session (Mellish, *et al.*, 2010:390).

Concluding statements: The role of nurses in research

- Research skills of nurses need further development.
- Development of and opportunity for scholarships and mentoring within large research programmes are limited in South Africa.
- Higher-income countries exclude research funding for nurses from LMIC.
- Nurses should not conduct research in isolation, but top-level research scientists from diverse fields should be co-mentors to ensure the advantages of strong mentorship and will create learning opportunities to improve quality of nursing research.

3.7.4 Role of nurses at frontline level

Nurses can be utilized on different frontline levels, e.g. in clinical nursing, as educators, researchers or managers. A study was conducted on the role of nurses in the HIV and AIDS policy process in Botswana and results indicated that although nurses are the backbone of the Botswana health-care delivery system, their participation in the HIV and AIDS policy process was minimal. The same situation is experienced in South Africa. Nurses who were involved in the policy process were in senior management positions at a national or provincial level and not involved in frontline health services (Zellnick & O'Donnell, 2005:168; Phaladze, 2003:27; Salmon & Rambo, 2002:140). Formulating policies at macro (national) level can lead to gaps that can be avoided by including frontline nurses in the formulation of an HIV and AIDS workplace policy (Ennen, *et al.*, 2001:564).

The top-down approach of policy formulation as was discussed in chapter 1, paragraph 1.4 also implies that a nurse working at a higher level, e.g. in government at macro (national) or meso (provincial) level, has more opportunity to influence the HIV and AIDS workplace policy. The lack of recognition and respect for frontline nurses' contribution to addressing the HIV and AIDS pandemic intensify its impact on the nursing workforce, which leads to low morale and absence from decision-making forums (Edwards, *et al.*, 2007:30). Health system policy strengthening should focus on strategies to improve communication and consultation with frontline level nurses during the process of policy formulation and the implementation thereof (Gilson, *et al.*, 1998:13).

Concluding statements: Role of nurses at frontline level

- Nurses' participation in the HIV and AIDS policy process is minimal and limited to those involved in senior management positions.
- The top-down approach of policy formulation implies that a nurse working at a higher level has more opportunity to be involved.
- Lack of recognition and respect for frontline nurses' contribution to addressing the HIV and AIDS pandemic lead to absence from decision-making forums.

3.8 POLICY PROCESS

The Ministry of Health's research and policy directorates are often blamed for leaving nurses out of the process of the formulation of HIV and AIDS workplace policies, but when asked to describe their core nursing functions, few nurses included involvement in the policy process as a component of their nursing practice (Ennen, *et al.*, 2001:557). Nurses are therefore unsure about the policy process and lack the communication skills to express their inputs to politicians. Health policy is an area where nurses in many countries, including South Africa, have not played an active role. However, they should develop their skills and confidence in order to influence and shape health policy effectively (ICN, 2005:4; WHO, 54th Health Assembly, 2002:1; Ennen, *et al.*, 2001:557; Shamian, *et al.*, 2010).

For nurses to influence and shape health policy they need to understand the policy process in its wider context at macro, meso and microlevel. Without understanding the process of policy, nurses will not be included in the process (ICN, 2005:5; Ennen, *et al.*, 2001:558). In the area of policy processes the nurses' aim should be to take the lead to influence those policies relating to their practice and that have an impact on the health of their patients. Nurses should be able to articulate and demonstrate their valuable and credible contributions in order for politicians to realize that they are integral role players in the policy process (ICN, 2005:8).

Nurses constantly work with the cost-quality constraints of health service delivery, which places them in an excellent position to contribute towards effective health policies. HIV and AIDS workplace policies can have a profound impact on the quality of a nurse's professional life, as most of a nurse's time is spent in the work environment. Nurses' involvement in the formulation of HIV and AIDS workplace policy will ensure that nurses' voices are heard and their contributions incorporated into the final decisions of the policy process (Ennen, *et al.*, 2001:561).

Nurses can influence health-related policies at all levels, but they need to be conversant with the political process and its use. The policy process involves the application of reason and evidence to problem-solving and exists as part of the daily practice of nurses, either via laws and regulations, national DoH policies and provincial DoH guidelines, institutional policies and union contracts, or as nursing unit procedures (Shamian, *et al.*, 2010).

As was discussed in paragraph 3.3, policies are formulated at macro (national), meso (provincial) and micro (institutional) level. Different approaches can be used to formulate and implement policies, as was discussed in chapter 1, paragraph 1.3: the top-down versus the

bottom-up approach and the in-between approach, which is a top-down approach balanced by a bottom-up approach making provision for a frontline policy feedback loop. This will possibly be the ideal approach to follow with regard to the policy process.

However, barriers around the policy process need to be addressed. In the following paragraphs an overview will be given of the policy process and the policy cycle and the barriers identified by literature will be discussed.

3.8.1 Stages in the policy process

Different models can be used to formulate, implement and evaluate a policy, and according to Clark (2008:145) the rational model can be used only for a policy process in the ideal rational world. In this model the policy formulation process consists of defining a problem, identifying a goal for its resolution, determining and prioritizing social values embedded in the goal for its resolution, weighing up alternative solutions, selecting the alternative that meets the identified goal the best, implementing, monitoring and evaluating the chosen alternative. As there is no rational world, the „garbage can“ model explains the policy process in a non-rational world, where four independent streams that influence the policy process flow into the can and policies arise from the mix of streams as influenced by other situational variables, e.g. media coverage. The four streams flowing into the „garbage can“ are problems, solutions, participants and opportunities for choice (Clark, 2008:145; Haque & Harrop 2007:381).

Shamian, *et al.* (2010) use the model of Kimball and O'Neil, which describes a continuum of kinds of actions needed to formulate, implement and evaluate a policy. The model consists of four stages, but does not necessarily follow the sequence of the way the stages are discussed.

- **Stage 1: Scramble**

This stage in the policy process is recognized as a flurry of short-term actions that are usually initiated unilaterally by health providers to address a policy issue. With reference to this study, one action to involve nurses to influence HIV and AIDS workplace policy can be to lead them in a critical debate about the gaps experienced in the HIV and AIDS workplace environment, then let them decide how they would like to address existing gaps at, say, micro (institutional) level. In the scramble stage little or no attention is paid to changing nursing education to bridge the gaps experienced or changing the nature of work procedures (Shamian, *et al.*, 2010; Heywood 2002:402).

- **Stage 2: Improve**

Once the reality and the seriousness of the policy gap are clear, the focus shifts to appropriate interventions, including different alternatives on how to bridge the policy gaps experienced or how to address a problem with the formulation of a new policy. With reference to the HIV and AIDS workplace policy, managers will realize that gaps exist during the implementation of the policy at frontline level within the institution and will possibly look, together with frontline nurses, at how to bridge the identified gaps. They may further communicate with managers of associated institutions to see if they experience the same problems with the implementation of the policy and how they deal with the gaps experienced or interventions they implement. At this stage there is still minimal structural change to the professional aspects of nursing (Shamian, *et al.*, 2010; Heywood 2002:409).

- **Stage 3: Re-invent**

At this stage it becomes clear that there is a need to re-think the methods of professional nurses working in an HIV and AIDS environment. After the management of an institution has identified the gaps experienced with the implementation of the HIV and AIDS workplace policy and alternatives have been elicited from frontline nurses on how to bridge these gaps, the manager takes the matter to the HIV and AIDS coordinator of the district or province for further attention by a higher level of authority. This example is what is known as a policy feedback loop, which allows frontline nurses to give an opinion on the top-down policy approach and whose feedback will balance the top-down approach of policy processes. This interaction can lead to improved morale among the frontline nurses of institutions, resulting in better clinical care practice and enhanced service delivery (Shamian, *et al.*, 2010; Heywood 2002:410).

- **Stage 4: Start over**

At the far end of the response continuum are interventions in which frontline nurses are viewed as professional partners practising optimally and respected by employers and patients. Start-over actions can include new systems or methods of service delivery that tend to cross traditional care boundaries and so expand knowledge as a mean values to start the policy process over again (Shamian, *et al.*, 2010).

3.8.2 Research indicators that nurses can utilize to influence the policy process successfully

Regardless of the theoretical stage at which the policy process is, the question can be raised as to how to move policymakers beyond the short-term scramble and improve strategies to focus on

the long-term re-invent and start-over strategies. Shamian, *et al.* (2010) specify a few indicators that nurses can utilize to assist them to influence the policy process successfully.

- **Availability of high-quality evidence or research**

Evidence of practice or research can lead to evidence-based informed decision-making across the health-care system, if not in practice then at least in theory. No political or nurse leader should venture into decision-making without being conversant with current evidence and leading practices. To ensure high quality of evidence, nurses should have a sound knowledge of themselves as well as detailed information about the context in which they are working to enable them to act as change agents to influence HIV and AIDS workplace policy.

- **Relevant information about themselves**

Nurses' knowledge of themselves can be improved by asking some pertinent questions: What are the demographics of the workforce today? How did the HIV and AIDS pandemic influence the workforce? Which decisions will improve nurse safety in an HIV and AIDS work environment? What do nurses need in order to perform their work more effectively?

- **Information about the context in which nursing is practised**

The context of the working environment can be easily determined by asking questions applicable to the workplace: What is the health status and care needs of the population? What are the most significant determinants of health? What changes are occurring in the national health system and how do they affect the nurse workforce specifically with regard to HIV and AIDS? What can be learnt from other countries that have dealt successfully with HIV and AIDS? What requirements do nurses suggest to ensure that they are safe practitioners when rendering a service to HIV and AIDS patients while reducing their own occupational exposure?

Answers to these questions are well researched and the query can be raised as to why it is that decision-makers and politicians are not acting on the relevant information.

- The timing of nurse concerns is not right.
- Nurse leaders need to know that policy windows open and close at their own pace, having more to do with elections than with the electorate. Other factors such as public opinion and financial issues also influence the policy window.
- Even if research evidence has been directly focused on problematic issues and competently acted upon, nurses still have to compete for attention with other priorities in the country.

- It is also important to realize that research information should be communicated to politicians in a language that they understand.
- Research findings can be limited for practical use if the researchers' bias for methodological purity overrules the research process or a manager coerces the outcome of research results.
- Nurses should strive from the outset to undertake research programmes in collaboration with policy analysts, managers and politicians in order for findings of that research to be taken up in decision-making.

- **Effective research-policy linkages**

Effective research-policy linkages ensure that the researcher focuses on areas high up on the policy agenda and provide research results that serve as a sound basis for decision-making and the allocation of resources. Shamian, *et al.* (2010) suggests the following tips to strengthen research-policy linkages:

- There should be an interface between research and policy formulation. Linkages between researchers and decision-makers are essential during the research process right up to the dissemination of results, policy formulation and implementation.
- Researchers should show sensitivity for deep-seated values, practices and traditions in the context of their research, as well as to prevailing decision-making climates and mechanisms.
- Researchers should show appreciation for stakeholders' contribution as the three main stakeholders in health research are decision-makers, the community and the researcher.
- Research should be generated towards solutions that are high on the political agenda. It is therefore essential for research programmes to distinguish between „our findings" and „their priorities".
- Researchers should publish summaries of scientific papers in an understandable language style in journals that policymakers are likely to read.
- The role of skilled mediators or research-knowledge brokers cannot be underestimated. Research brokers are specialists with effective communication skills, the ability to educate and to establish rapport with decision-makers and familiarity with research approaches and methods.

Researchers themselves must develop skills to be able to advocate and communicate excellently and to understand the arena in which decision-makers allocate resources. Nurses acting as research-knowledge brokers strengthen the links between research, decision-making and policy formulation.

3.8.3 Policy cycle

The policy cycle of Tarlov (1999:286) was adapted and used by the Canadian Nurses Association (CNA) in 2006 with the assistance and acknowledgement of previous policy work done by Shamian, Skelton-Green and Villeneuve. This model was used as the theoretical basis for this study, as it was specifically adapted to capacitate nurses in strategies and tactics to become involved in the policy process (CNA, 2008:1). The phases of the policy process according to the CNA policy cycle include steps as used by Millstead, (1999). The four major stages of the policy model consist of (Shamian, *et al.*, 2010; CNA, 2008:12):

- Agenda setting, which involves the identifying of a problem and the tactics used to bring it to the attention of government.
- Legislation and regulation are the formal responses of policy decision-makers to the problem.
- Programme implementation is the execution of programmes designed to enact legislation, e.g. strategies on how to deal with the programme.
- Programme evaluation is the appraisal of the programme's performance.

As was mentioned with previous policy process models, the policy process is not a sequential and logical series of steps, e.g. the definition of a problem that occurs during the agenda-setting phase may change during legislation. There could further be a change in the programme design during the implementation phase. The critical appraisal of an implemented programme (often considered to be the last phase of the process) may propel another problem that differs from the original problem onto the national agenda.

Tarlov's policy cycle consists of two distinct phases, each of which is anchored by a particular step in the cycle. The first phase of getting to the policy agenda is anchored by beliefs and values. It is therefore important for society and stakeholders to value and believe in the issues that are put forth in the policy arena, because if this is not the case, the issues will not have „oxygen“ to feed them and will not progress to the second phase.

The second phase of moving into action is anchored by political engagement. Political engagement is an absolutely core action to advance an emergent issue to policy and action, as

without political engagement, policy issues can be „out there“, acknowledged by various stakeholders but not resulting in policy change (Shamian, *et al.*, 2010; CNA, 2008:12). Figure 3.2 demonstrates the policy process as adapted from Tarlov and explains ways in which nurses can move identified problems onto the policy agenda and how to move that agenda forward. In the succeeding paragraphs the cycle steps will be elaborated on to indicate what each entails. Phase 1 of the policy process is anchored in values and beliefs, entails steps 1-4 and deals with how to move an issue onto the policy agenda. The second phase of the policy process is anchored in political engagement. This phase consists of steps 5-8 and deals with moving forward with an issue on the policy agenda.



FIGURE 3.2: THE POLICY CYCLE (CNA, 2008:12)

3.8.3.1 Phase 1, step 1: Values and cultural beliefs

Any policy issue must be firmly grounded in a supportable set of values and cultural beliefs (Shamian, *et al.*, 2010). Nurses are often engaged in professional relations with institutions, communities and societies, which have their own sets of values and policies. Nurses

themselves have personal values, which are often taken for granted, and as a result nurses can find themselves in frontline services where their professional values are incongruent with the policies and values of their clinical practice area. An example within the South African health-care context is the delay in the implementation of ART treatment for HIV sufferers due to lack of commitment from the side of politicians (see discussions under paragraph 3.5).

Nursing does value social justice that is consistent with the provision of services that should be accessible to all citizens, regardless of their ability to pay (Murphy, *et al.*, 2005: 21). In the case of an emergent issue with regard to the HIV and AIDS workplace policy examples of possible beliefs and values that can be valuable in moving the issue forward through the policy cycle are:

- The South African health system is primarily nurse driven.
- To offer access to and quality of health services, the work environment of nurses should be conducive to this, including the elimination of aspects that cause nurses to feel unsafe and anxious when working in an HIV and AIDS environment.
- The public needs and trusts nurses for effective and efficient health-care service delivery, including services to address the HIV and AIDS pandemic.

The identification, validation and articulation of basic values are very important to ensure that the emerging issue moving onto the policy agenda is value based and connected to other stakeholders that share those values (Shamian, *et al.*, 2010).

3.8.3.2 Phase 1, step 2: Problem or issue emerges

It is essential for the problem or issue that arises to land on fertile soil and to be nurtured. This highlights that it is not enough for a problem or issue to merely exist, but that it must have some urgency and be a problem that is visible to all relevant stakeholders, including decision-makers and politicians. It is also important for the problem to be moving forward at the right time when a policy window opens, keeping in mind that policy windows open infrequently and do not stay open for long periods. Nurses who wish to advance policy initiatives should be alert for policy opportunities, such as the opportunities to move an issue forward during the election of a new government (Hague & Harrop, 2007:379).

Workplace aspects are often experienced negatively by nurses, which then influences their productivity and performance as well as their personal health negatively. Most often nurses are reminded by managers and decision-makers that their role is to provide excellent nursing

care, and that is used to move the nurses' focus away from existing negative work conditions. Nurses need to mobilize their nursing organizations to assist them to identify and move current policy issues forward in the form of a meaningful unified nursing „voice“ (Shamian, *et al.*, 2010; Kurtzman, 2009:6).

3.8.3.3 Phase 1, step 3: Knowledge and development of research

The emerging problem or issue should be clearly identifiable and pressing, while nurses should ensure that solid evidence exists to support it (the availability of high-quality evidence or research and effective research-policy linkages were discussed in paragraph 3.6.2 above). Most of the time additional research is not necessary, but the research results package must be in a form that is understandable with an emotionally engaging message, e.g. true stories about nurses' experiences working in an HIV and AIDS environment. It is also important to focus on how research results are communicated to influential stakeholders to ensure successful use of research evidence to inform policy formulation. The use of many sources supporting the key message will add emphasis and credibility to the case (Shamian, *et al.*, 2010; Heywood 2002:405; Thompson, *et al.*, 2005:1298).

3.8.3.4 Phase 1, step 4: Public awareness

The final step in phase 1 of the policy cycle is the creation of awareness to as broad a base as possible and includes the problem or issue, strategies for addressing the problem or issue and the solution. Awareness should be created under as many potentially supportive audiences as possible, but the content and message should constantly be adapted and customized so that they can be understood by the target audience. In preparing to customize the message one needs to think like the target group thinks by identifying how they will benefit from the proposed problem solution. Messages about the HIV and AIDS working environment of nurses can be communicated to DENOSA, other organizations and unions nurses belong to, other care providers, different levels of the DoH (national, provincial and district), politicians (both the ruling and opposition parties) and the media (television, radio and print media). Raising of awareness is not a once-off action as it sometimes needs years of devotion and constantly updating information to keep the interest of supportive audiences (Shamian, *et al.*, 2010, Ballou 2000:182).

3.8.3.5 Phase 2, step 5: Political engagement

Before a problem or issue can be placed on a political agenda it must be „softened up“. The softening-up process refers to the fact that people have to get used to the problem or issue,

to facilitate support and so that acceptance of the proposed strategy and solution can be obtained. The process of political engagement should be designed to initiate a ripple effect that can grow into a wave of support for the proposed strategy. In planning for political engagement nurses should accomplish the following before embarking on the engagement process (Shamian, *et al.*, 2010):

- Know the country's government structure (committees, caucus and key members involved in Parliament, including the ruling party and opposition). Nurses should not underestimate the role of non-elected individuals who have informal power, remembering to identify them as they often have the political network connections and can contribute a lot to ensure political engagement.
- Target strategic individuals who have the interest and passion to promote the emerging problem or issue.
- Carefully consider person-person contacts with key stakeholders, plan and react strategically, making use of arising opportunities, and customize the message for each contact.
- Keep all target individuals updated regarding your activities and progress made, and communicate clearly what the ongoing nurses' support needs are.
- No change happens overnight and prepare for a long term of engaging.

3.8.3.6 Phase 2, step 6: Interest group activation

Once public awareness and political engagement are activated, it is of the utmost importance to deliberately exploit every opportunity to repeat the message to ensure continuing interest. This can be done by short key messages in the nurses' organization's monthly magazine, updating their information, messages about the problem scenario and progress via e-mail, and editorials and articles in other health publications. Nurses can further convey progress updates by word of mouth, e.g. by delivering keynote messages during conferences, formal and informal meetings, etc. (Shamian, *et al.*, 2010).

3.8.3.7 Phase 2, step 7: Public policy deliberation and adoption

When enough interest and support are ensured, the agenda needs to be deliberately moved to the policy tables, where it can be debated and policy formulated. Once an issue is on the political agenda, five criteria are needed to ensure attention and addressing by politicians (Shamian, *et al.*, 2010):

- Technical feasibility.
- The policy committee needs to view the problem or issue as value acceptable to the broader public.
- Dealing with the problem or issue should be at a tolerable cost.
- The problem or issue should be supported by general public agreement.
- The suggested strategies and solution should lead to reasonable change.

3.8.3.8 Phase 2, step 8: Regulation, experience and revision

During this stage of the policy cycle the proposed action becomes a formal policy, law or regulation. The addressed policy agenda problem or issue becomes a new cultural value or norm and is then routinely implemented, evaluated and revised if necessary. The whole policy process starts again when the next issue merges.

3.8.4 The drive behind political insight

Political insight is an essential component of most successful policies and entails a process of social influence that includes activities of persuasion, attitude change, compromising and decision-making. This is why the final prerequisite for influencing policy is political insight that was obtained throughout the process. It is important for nurses to realize that to control nursing practice and to move the nursing profession forwards as the major role player in the health-care arena, nursing and nurses need to become politically involved in influencing and formulating policy. Valuable tools and tactics to ensure problems or issues that are successfully driven through the policy process include (Shamian, *et al.*, 2010; Ennen, 2001:563):

- Maintaining ongoing positive relationships with knowledgeable and influential people.
- Being interested in current policy developments and understanding the driving forces behind policy trends.
- Being actively involved in and promoting activities of professional nursing organizations.
- Establishing an effective network framework involving every level of government.
- Sharing successful stories and previously successful strategies.

- Creating links between nursing research, political and policy-related strategies.
- Employing effective communication skills in order to communicate clearly and intelligently with policymakers.
- Capitalizing on nursing's positive aspects and image in the country.

Concluding statements: Policy process

- Policy formulators do not move beyond the short-term scramble and improve strategies.
- Policy formulators do not focus on long-term re-invent and start-over strategies.
- High-quality evidence or research is not utilized in the formulation of policies and a lack of knowledge to translate research results contributes to the situation.
- Effective research-policy linkages need to be established.
- Understanding of policy cycle is essential to improve policy decisions.
- Improvement of political acumen enhances nurses' political savvy.

3.9 NURSES AS CHANGE AGENTS

Nurses take steps to change things by becoming change agents, where necessary leading change when policies no longer support their values, principles or interests, to achieve the outcome they want and to serve the profession's need (CNA, 2008:15). Nurses as change agents see change as an opportunity rather than a threat and are instrumental in managing change and taking changes forward, which places them in an ideal position to give direction and momentum to influence the policy process.

To act as change agents nurses need strong leadership skills. Leading is the process of influencing people in such a way that they will enthusiastically contribute towards achieving specific objectives and encompasses effective leadership, motivation and communication. To lead a team effectively the leader should be thoroughly aware that each person is unique because of different needs, ambitions, expectations, perceptions, attitudes or background, and therefore people differ in their need for responsibility, knowledge or skills. The leader should have the leadership skills to deal with them in such a way that all members of the team can progress (Van Rensburg, 2008:54; Klopper & Bester, 2010:189). Professional

nurses are the largest group in the multi-disciplinary health team, but their leadership contribution in policy and strategic planning is still limited (Huber, 2006: 123). In this section the role of the nurse as change agent and an integrated conceptual framework for change leadership will be discussed.

For nurses to act as change agents, the following areas need to be addressed: the nature and the purpose of leadership, negotiating for change in the HIV and AIDS workplace policy context, in this study at macro, meso and microlevel, and making sense of collaboration. To be successful change agents nurse leaders should be able to develop nurses who really advocate change, and should be able to manage change (Ewens, 2002:70). To act as change agents, nurses need to have strong leadership skills and leadership should be a value-driven choice, which is essential to enter and succeed in influencing HIV and AIDS workplace policy (Klopper & Bester 2010:188).

Furthermore, nurse leaders need to cope with the management of HIV and AIDS changing pace, which is a big challenge as this constantly changing environment in the HIV and AIDS workplace area lowers the morale of staff (see chapter 1, section 1.4). Nurse leaders acting as change agents need to spend enough time and energy to plan the change initiative strategically, including the identification of key relevant stakeholders, and to manage the change initiative successfully. The integrated conceptual framework for change leadership was developed by Skelton-Green, *et al.*, 2007:3, and includes a strategic approach, an organizational or people-driven approach, and a project management approach. The framework integrated the three approaches to assist nurses in succeeding as change agents in this study to ensure Nurse led change to influence HIV and AIDS workplace policy.

3.9.1 Integrated conceptual framework for change leadership and barriers to Nurse led change

The Dorothy Wylie Nursing Leadership Institute was developed in 2001 (Skelton-Green, Simpson & Scott, 2007). The integrated approach to change leadership conceptual framework was developed as there was no practical approach or methodology that the institute felt assisted nurses to advance a change initiative in their practice settings. A comprehensive search of literature identified three important elements and they were utilized to formulate the integrated conceptual change framework.

The integrated conceptual framework to introduce and manage change successfully consists of three major elements, namely strategic, engaging relevant people and managing the

project. Figure 3.3 illustrates how nurses can utilize the conceptual framework to introduce and manage change with regard to the policy process. A discussion of this framework follows in the paragraphs after the figure and it is important to note that the integrated change leadership framework is not static, that the elements can overlap but for explanatory reasons and to ensure clarity the elements are discussed separately (Skelton-Green, Simpson & Scott, 2007).

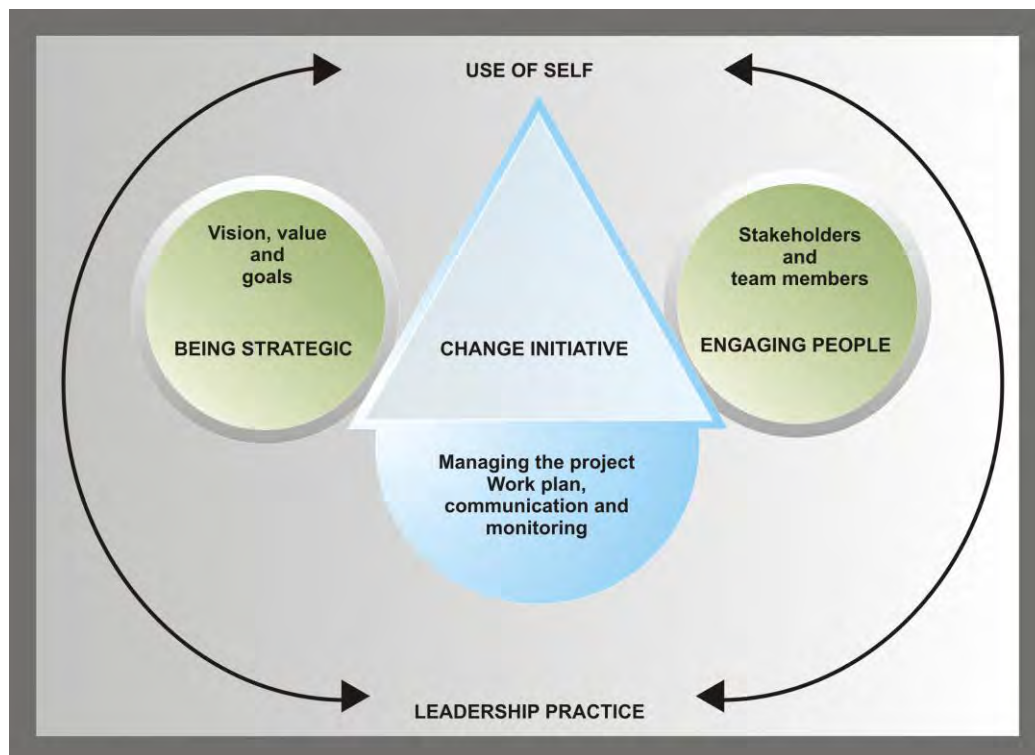


FIGURE 3.3: LEADING CHANGE FRAMEWORK (ADOPTED FROM SKELTON-GREEN, SIMPSON & SCOTT, 2007)

3.9.1.1 Planning strategically

The framework indicates that the first requirement for successful change leadership is to be strategic in the way in which nurse leaders deal with policy issues. It is important in the choice of a project and for ensuring that the timing is right. During the formulation of a strategy nurse leaders acting as change agents generate enthusiasm by formulating a compelling vision and values to guide the change. The vision, values and objectives should be clear, as should the reason why a change is necessary and what the desired outcomes would be. Planning strategically involves engagement in focused reflection. The following questions can be used to identify whether the planned initiative is strategic and has sufficient passion to carry it through:

- What are the challenges this change initiative needs to address?
- How will Nurse led change to influence HIV and AIDS workplace policy improve service delivery to HIV and AIDS patients?
- To what extent is Nurse led change to influence HIV and AIDS workplace policy congruent with the strategic aims of the inter-ministerial South African National AIDS Council (SANAC) objectives? Will the strategy contribute towards achieving the objectives of the national strategy?
- Is the timing good to embark on this strategy?

In this study the strategy aims to effect Nurse led change to influence HIV and AIDS workplace policy. Strategic planning also needs to bridge certain barriers, as is explained in the following paragraph.

Due to a constantly changing HIV and AIDS health environment, nurses as change agents should be able to set clear priorities, plan strategically, advocate in advance for changes and effectively participate in and influence health-care planning and the policy process (WHO, 2005:iii; Ennen, *et al.*, 2001:559; Mechanic & Reinhard, 2002:8; Skelton-Green, *et al.*, 2007).

3.9.1.2 Engaging stakeholders

The second requirement for nurses to lead change successfully is to engage stakeholders. Nurse leaders need to identify, network with and involve stakeholders who are enthusiastic about the project and have the acquired skills, knowledge and experience to contribute towards change. It is essential that after stakeholders have been identified, a project team be launched in a deliberate way emphasizing the skills and experience needed for the project. It is important to emphasize the strengths and skills of every team member, and how team members can contribute towards the project in order to succeed. Stakeholders should experience that they are valued and essential and be motivated to ensure that change happens (Skelton-Green, *et al.*, 2007: 8-13). In order to assist nurse leaders in identifying stakeholders they can reflect on the following questions:

- Who are the relevant key stakeholders who can assist the nurse as change agent to influence HIV and AIDS workplace policy?
- Is their sufficient support from these stakeholders?
- Are there any highly placed opponents? In this study the focus of government regarding the HIV and AIDS pandemic is to reduce the new rate of HIV infections

and to roll out the anti-retroviral treatment programme. The nurse leader as change agent with her key stakeholders should convince the government that an improved HIV and AIDS workplace environment for nurses can contribute towards the achievement of the SANAC aims.

Barriers to overcome in engaging stakeholders include:

Nurses as change agents should be skilled in the policy arena and should be able to institute networking locally, provincially, nationally and internationally in order to strengthen the health-care system. They should be able to look at policy problems from a political, economic, social, technological and international point of view in order to identify skilled and experienced stakeholders who could contribute positively towards the change project and who are enthusiastic about the project (Ferguson, *et al.*, 2003:181; Huber, 2006:123; Ennen & Wachs, 2001:557; Skelton-Green, *et al.*, 2007).

3.9.1.3 *Managing change initiative*

The last requirement to ensure change is to manage the change project. Nurse leaders should ensure that their vision is translated into concrete steps with key activities, accountabilities, timelines and communication.

- Will the nurse leader acting as change agent be able to manage the change initiative?
- Is there an adequate financial and human resource to ensure the success of the change initiative?

Barriers to overcome during the management of the change project include:

Many planned change projects fail because nurses as change agents fail to manage the project successfully. The change can only succeed if a project plan and an evaluation strategy are developed. The project plan is a map that determines the pacing and timing of change and those who will be responsible for set objectives. The change project should include key milestones, major activities and target dates as well as accountability measures. Nurses as change agents often launch projects and then leave them, and it is therefore important that they plan how they will support and measure the success of both the change process and the outcome of the change (Skelton-Green, *et al.*, 2007: 8-13).

Concluding statements: Integrated conceptual framework for change leadership and barriers to Nurse led change

- Nurses act as change agents when policies no longer support their desired outcome to render the service they should be providing.
- Nurses as change agents are instrumental in managing change and taking changes forward by giving direction and momentum to influence the policy process.
- To act as change agents, nurses need strong leadership skills. Nurses are the largest group in the multi-disciplinary health team, but their leadership contribution in policy and strategic planning is still limited.
- To be successful change agents, nurse leaders should be able to develop nurses who really advocate change and are able to manage change.
- Constant changes in the health environment have a negative impact on nurses who act as change agents.
- Change agents should be able to set clear priorities, plan strategically and advocate change in advance. Nurses are not skilled in these requirements.
- Nurses as change agents lack skills in the policy arena as well as in networking with relevant stakeholders locally, provincially, nationally and internationally.
- Nurses as change agents fail to manage projects successfully.

3.9 SUMMARY

This chapter discussed the different levels in South Africa where policy formulation, implementation and evaluation take place and the role of nurses at macro, meso and micro-level. From the literature it becomes evident that nurses are not at the policy table but are merely the implementers of policy. The role of the HIV and AIDS workplace policy was discussed with reference to the context of South African nurses, while nursing as a profession and their image were discussed as they have a direct influence on the different roles nurses fulfil in South Africa. Specific roles that nurses fulfil in South Africa as educators, in politics and the political process, as researchers and at community practice level, which could be frontline, district, provincial or national level, were discussed. The policy process was discussed by comparing two models that are beneficial for nurses to use, and especially the policy cycle of Tarlov as it was adapted for use by nurses specifically to become more involved in the policy formulation process. The interface between the different

roles of nurses and the policy process prompts nurses to become change agents to influence the political agenda. The role of nurses as change agents was discussed, with specific emphasis on the integrative approach to change leadership. The barriers relating to nurses as change agents in the context of the study were identified.

RESULTS OF MANAGEMENT

4.1 INTRODUCTION

In the previous chapter, barriers to Nurse led change to influence HIV and AIDS workplace policy were discussed. The aim of this chapter is firstly to determine management's opinion about human resource capacity in an HIV and AIDS workplace environment, and secondly to identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.

The opinion of management was obtained by mean values of an analysis of the human resource management rapid assessment questionnaire (HRM questionnaire) to address the first aspect, and refers to phase 1, objective 2 of this study. Qualitative data was also obtained from in-depth interviews with managers utilizing a standardized questionnaire that had been used in the international research programme: *"Strengthening nurses' capacity in the development of HIV and AIDS policy in Sub-Saharan Africa and the Caribbean"* and refers to phase 1, objective 3 of the study.

These qualitative results were analysed by reading, encoding data and using Nvivo version 8 as data manager. Table 4.1 explains the objectives that are dealt with in this chapter. Phase 1 deals with objective 2, indicating managers' opinion about human resource capacity in an HIV and AIDS environment (quantitative data analysis). Phase 1, objective 3 identifies problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective via in-depth individual interviews (a qualitative empirical research analysis).

**TABLE 4.1: PHASE 1 – EMPIRICAL RESEARCH, OBJECTIVES 2 AND 3:
MANAGEMENT’S OPINION ABOUT HUMAN RESOURCE CAPACITY
AND PROBLEMS EXPERIENCED WITH POLICY IN AN HIV AND AIDS
WORKPLACE ENVIRONMENT**

PHASE 1: SEARCH FOR EVIDENCE	PHASE 2: STRATEGY FORMULATION
Objective 1: To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.	Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
Objective 2: To determine management’s opinion about human resource capacity in an HIV and AIDS workplace environment.	
Objective 3: To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.	
Objective 4: To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse’s perspective.	

4.2 OBJECTIVE 2: TO DETERMINE MANAGEMENT’S OPINION ABOUT HUMAN RESOURCE CAPACITY IN AN HIV AND AIDS WORKPLACE ENVIRONMENT

The aim of this objective was to obtain the opinion of management as to the status of the human resource capacity in participating institutions in relation to the HIV and AIDS pandemic. This opinion was obtained by utilizing a quantitative HRM questionnaire as adapted for use by the Teasdale-Corti (TC) research programme.

4.2.1 Human resource management (HRM) questionnaire

Human resource management (HRM) is a strategic and coherent approach to managing an institution's most valued asset, the staff working in an institution who contribute individually and collectively to reach the overall vision and mission of the institution (Armstrong, 2006:3). The HRM questionnaire was developed to assist institutions to determine their current human resource capacity and to strengthen human resource capacity. Within the HIV and AIDS care environment the assessment of institutional HRM capacity can assist managers to (HRM questionnaire, 2003:2-3):

- Formulate adequate human resource plans within the HIV and AIDS environment.
- Plan for changing numbers of staff on the basis of projections of employee turnover.
- Strengthen retention and recruitment of staff.
- Redefine job descriptions to reflect responsibilities for HIV-related services and to redistribute workloads after losing or gaining staff.
- Implement a workplace prevention programme to minimize the rate of infection amongst staff.
- Minimize the impact of HIV and AIDS on the health workforce by formulating policies in such a way that the institution will attract and retain staff while promoting non-discriminatory practices, responsive supervision, improved work climate and provision of training.
- Improve overall organizational morale and performance.

A human resource management rapid assessment questionnaire survey was carried out in one subdistrict of each of the Central (Ditsobotla), Bojanala (Rustenburg) and Southern (Potchefstroom) Districts of the North-West Province of South Africa. After having been briefed about the questionnaire and informed written consent having been obtained that they agree to voluntarily participate in the research programme, health-care managers from different public medical institutions (provincial hospitals, district hospitals, health-care centres and clinics) completed an internationally validated questionnaire. The HRM questionnaire was adapted as a human resource management rapid assessment tool for application in HIV and AIDS environments (see chapter 2, paragraph 2.4.2.4) and statements in the HRM questionnaire were related to human resource management components.

The responses to the questionnaire were categorized into four levels. In order to understand the Likert scale application, the existence of an HIV and AIDS workplace prevention programme is used as a basis:

- A response of 1 indicates no programme exists.
- A response of 2 indicates that a programme exists, but has not been implemented.
- A response of 3 indicates that a programme exists, is implemented on a regular basis, but not all staff participate in it.
- A response of 4 indicates that a programme exists, all the staff are aware of it, it has been implemented fully and is monitored for effectiveness.

This implies that a mean value response above 2.5 is good and above 3 is excellent. The HRM questionnaire was completed by 44 managers (explained in chapter 2, paragraph 2.4.2.3): 16 each from the Central and Bojanala Districts and 12 from the Southern District. The 44 completed questionnaires were given to the Statistical Consultation Department of the North-West University, Potchefstroom Campus, where the data was analysed by both the researcher and a statistician. With the data analysis, descriptive statistics were obtained that enabled the researcher to achieve objective 2 of this study, namely to determine management's opinion about human resource capacity in an HIV and AIDS workplace environment. Data analysis and the discussion of the results follows.

4.2.2 Data analysis and results discussion

The population consisted of 44 respondents and the data from the questionnaires was captured in Excel on the researcher's computer. All data was re-captured in a second Excel workbook. With the re-capturing of the data, mistakes were easily discovered and could be corrected, as there were two sets of data that could be compared. The two Excel 2007 version data sets and the completed questionnaires were taken to the Statistical Consultation Department of the North-West University, Potchefstroom Campus. The data was captured in the Statistical Package for the Social Sciences (SPSS, version 16) Institute Inc. software package for interpretation. A backup was made of each data set.

Before any analysis on a questionnaire can be done it is important to determine the reliability and validity of a questionnaire, as this guides the statistician and the researcher on the best way to deal with data analysis. The reliability and validity of the HRM questionnaire are discussed below, followed by the descriptive statistics.

4.2.2.1 Reliability of HRM questionnaire within the context of the study

The reliability of a questionnaire refers to the consistency of scores obtained by the same persons when they use the same questionnaires on different occasions (Babbie, 2010:150). To determine the reliability of the HRM questionnaire, a Chronbach alpha coefficient was calculated. According to Field (2005:668), a Chronbach alpha of 0.6 is acceptable reliability. The number of items under a certain construct determines the Chronbach alpha: if the number of items is low, the Chronbach alpha co-efficient will be low, but this will not be due to the unreliability of the questionnaire.

The HRM questionnaire consists of five constructs, namely HRM capacity, personnel policy practice, performance management, training and HRM data. Under each construct are certain elements relating to the construct. The researcher accepted a Chronbach alpha score of 0.6 as reliable due to the fact that an international standardized validated instrument was used in the research. The population of this study was managers who have different personal experiences of each construct item, which they rated on a scale of 1-4. Table 4.2 indicates the reliability coefficients of the HRM questionnaire constructs for the study population.

TABLE 4.2: RELIABILITY COEFFICIENTS OF HRM QUESTIONNAIRE FOR THE STUDY POPULATION

CONSTRUCT	NUMBER OF PARTICIPANTS (n)	CHRONBACH ALPHA COEFFICIENT
HRM capacity	44	0.62
Personnel policy and practice	38	0.81
Performance management	42	0.82
Training	41	0.75
HRM data*	43	0.34

*HRM data is not reliable according to Field (2005:668).

From table 4.2 the conclusion can be drawn that the constructs of the HRM questionnaire for this study population were reliable, except for the construct HRM data, due to a Chronbach alpha score of 0.34. This construct test was not reliable due to the fact that only two items

were measured under the HRM data construct, namely the employee tracking system and personnel files.

4.2.2.2 Validity of HRM questionnaire within the context of the study

Validity refers to the degree to which the measuring instrument measures what it is supposed to measure (Burns & Grove, 2005:775; Brink, *et al.*, 2006:159). Tests of construct validity offer a weight of evidence that the HRM questionnaire used in this study measures the quantity that was expected (Babbie, 2010:153). To determine the construct validity of this study, a confirmatory factor analysis was done (see table 4.2) because the researcher used an international standardized HRM questionnaire, with defined constructs and items under each construct that assess HRM capacity in an institution.

Confirmatory factor analysis is a statistical procedure that is used to test how well the measured variables represent the number of constructs, in other words the reliability coefficient of each of the pre-specified relationships of items under each construct of the HRM questionnaire were confirmed. This instrument was used in the international Teasdale-Corti research programme and the HRM questionnaire is reliable for the study population. Table 4.3 details the validity of the HRM questionnaire for the study population.

TABLE 4.3: CONSTRUCT VALIDITY OF THE OF HRM QUESTIONNAIRE FOR THE STUDY POPULATION

CONSTRUCT	NUMBER OF FACTORS RETAINED	PERCENTAGE VARIANCE EXPLAINED	KMO	COMMUNALITIES	
				Lowest	Highest
HRM capacity	1	57.79	0.58	0.40	0.72
Personnel policy and practice	4	70.45	0.70	0.45	0.85
Performance management	1	58.10	0.74	0.36	0.71
Training	1	58.51	0.65	0.44	0.66

The confirmatory factor analysis confirms the validity of the HRM questionnaire for this study population. With the percentage of variance the factor that is retained with the confirmatory factor analysis indicates the percentage of the construct the factor measures. Usually the

number of factors retained should be 1, as all the items measured fall under one construct. In this study for capacity one factor was retained under the construct and explained 52% of the construct results. The HRM capacity construct consisted of three items, which mean values the other two items under the construct measured 48% of the construct. The HRM construct personnel policy and practices retained four factors, which mean values that four factors stood out and could be classified under another construct, as they were closely related to each other. The variance measured by the four factors was 72%.

The fact that an internationally standardized questionnaire was used allows a slight difference between the retained factors and the factors under this construct, and this therefore did not influence the construct validity results. Communalities refer to the proportion of common variance present in a variable, and the result should be between 0 and 1. If the result is more than 1 it mean values that the construct is variable with items of another construct, which was not the case in this study. For this study the communalities measure well.

The Kaiser-Meyer-Olkin (KMO) measure tests whether the partial correlations among variables for the measurement should be greater than 0.5 to proceed with factor analysis, in other words to declare the instrument as valid within the context of the South African scenario. In this study the KMO tested above 50%, that is greater than 0.5 for all four constructs, and this was proof of sample adequacy for the study. The closer the KMO measure is to 1, the better the partial correlations are among variables (DeCoster 1998:5).

4.2.3 Descriptive statistics

Descriptive statistics in this study provided information about standard deviations, minimum and maximum values and frequency tables. The questionnaire consisted of five constructs and a total number of 26 items (three under human resource management capacity, 12 under personnel policy and practice, five under performance management, four under training and two under HRM data). The managers who completed the questionnaire were from 15 institutions in three different districts at provincial/district hospitals and community health centres or clinics. Table 4.4 provides a summary of the constructs, the mean value and the standard deviation applicable to this study.

TABLE 4.4: SUMMARY OF CONSTRUCTS, TOTAL NUMBER OF MANAGERS, THE MEAN VALUE AND STANDARD DEVIATION

HRM CONSTRUCT	TOTAL NUMBER OF MANAGERS PARTICIPATING IN STUDY	MEAN VALUE	STANDARD DEVIATION
HRM capacity	44	2.63	0.75
Personnel policy And practice	44	2.84	0.59
Performance management	44	3.07	0.71
Training	44	2.79	1.05
HRM data	44	3.0	0.97

The mean value refers to the average obtained by computing the sum of the items falling under each construct and dividing it by the number of items under the same construct (Babbie, 2010:429). From a human resource management questionnaire perspective it seems that managers are generally satisfied with performance management (3.07) and training (2.79), while the HRM data mean value was not taken into consideration as there is no reliability for the construct. The managers could give a rating of between 1 and 4, but the researcher did not want to depart from the point that a mean value response above 2.5 is good and above 3 is excellent for the human resource management assessment questionnaire. The interpretation of mean value score interpretation will depend on the phrasing of words of each item under each construct.

The standard deviation gave an indication of how close the researcher's data was to the data's mean value. The spread or distribution of data is measured by the standard deviation: a higher standard deviation mean values that the data is more dispersed, while a lower standard deviation mean values that the data is more consistent (Babbie, 2010:432; Bruce, *et al.*, 2008:62). The data in this study population shows a low standard deviation score.

4.2.3.1 Descriptive analysis of HRM questionnaire according to constructs and items measured

A discussion of each construct will be given in table format according to the items that fall under each construct. The mean value of each item will be indicated and the interpretation of the mean value will be discussed. Finally, concluding statements will be made in order to indicate the link between the analysis of the HRM questionnaire and the researcher's study.

With the analysis of each HRM questionnaire construct, each item listed under a certain construct provides useful information that can be used to develop the specific construct so that it can reach an optimal score, which then indicates that the human resource management is functionally effective regarding that item. If the HRM construct is classified as 1 or 2, the indication is that HRM needs to look into the construct and specific items, while the wording of stages 3 and 4 will guide HRM in what to do in order to be functionally effective in respect of the relevant construct.

- **Construct: HRM capacity**

A core function of HRM staff is to make sure that enough human resources are available in the institution, taking into consideration that staff should be skilled and well motivated, capable of learning, adapt well to changes, be innovative and creative (Armstrong, 2006:7). The human resource capacity consists of three components, namely HRM staff, HRM budget and HRM planning. These are the underpinning values of every HRM system. It is essential to access these constructs, because if the mean value allocated to these constructs is lower than 2, it mean values that there is no qualified staff to deal with HRM responsibility, no HRM budget or HRM planning taking place. Table 4.5 indicates the findings and the interpretation of HRM capacity results of this study.

TABLE 4.5: FINDINGS AND INTERPRETATION OF HRM CAPACITY

CONSTRUCT: HRM CAPACITY	MEAN VALUE	INTERPRETATION
HRM staff	2.64	There is adequate HRM staff in the organization to maintain basic functions and also develop HRM policies, but HRM policies do not address HIV and AIDS issues.
HRM budget	2.16	There is a budget to support human resource activities, e.g. recruitment and training, but no additional funds for activities to support HIV and AIDS strategies are available, e.g. for a quality workplace prevention programme, drugs and benefits for staff.
Human resource planning	3.05	A formal human resource planning system exists and it is understood by all employees. The system is used to establish salary upon entry to the organization so that qualified staff who are willing to work full days can be attracted.

The average mean value of 2.64 for the construct HRM capacity shows that the participating public health institution's mean value is above 2.5. This indicates that the HRM capacity is good. If one looks at the mean value of the individual items it is clear that human resource planning seems to function well in all the participating institutions.

The HRM staff element, with a mean value score of 2.64, shows there is adequate HRM staff in the organization to maintain basic functions and also develop HRM policies. However, HRM policies do not address HIV and AIDS issues satisfactorily. The question can be asked: "How much staff is enough to cope with the HIV and AIDS pandemic demands that currently overburden health institutions?"

The World Health Organization (WHO) provides an indicator that can be used specifically with regard to policy options that can also be applied in rural areas. The WHO's work-load indicator of staff needs (WISN) was used in a study including CHC and clinic services in South Africa. The two focus areas taken into consideration for the study were the impact of HIV and AIDS on the health care workforce and the extensive vacancies in rural facilities. The study found that the total number of nurses available for service delivery in participating institutions was 94% of the target needed, but the distribution was incorrect in participating districts, as two districts were oversupplied with nurses while four districts had overall shortages (Daviaud & Chopra, 2008:46-51).

Staff shortages are therefore exacerbated by inequitable deployment. Due to a severe shortage of doctors with an overall availability of 7% in CHC and clinics, the outflow result was a policy issue resulting in innovative clinical guidelines and support approaches. These were developed to enable nurses to medically manage patients in PHC and clinics who would otherwise be seen by doctors (Daviaud & Chopra, 2008:46-51).

The low mean value score of 2.1 under the HRM budget element indicates that the HRM budget does not make provision for funds to support human resource strategies that address HIV and AIDS in the workplace as the cut off mean value was 2.5. for this study (HRM questionnaire, 2006:22).

Concluding statements: Construct – HRM capacity

- Enough HR staff exist in each institution to maintain basic functions and also develop a HRM policy, but it seems that current HRM policies do not address HIV and AIDS issues satisfactorily.
- The HRM budget supports human resource activities but does not make provision for additional funds to include activities to support HIV and AIDS strategies, e.g. to ensure a quality workplace prevention programme, drugs and benefits for staff.
- Human resource planning seems to be functioning well in all participating institutions.

- **Construct: Personnel policy and practices**

All the components included in personnel policy and practice provide an essential framework for defining the terms and conditions of work and need to be in place before effective performance management and supervision systems can be implemented.

- **Compensation and benefits system**

A compensation system refers to a reward system and usually to the methods by which remuneration is determined. The compensation system includes the monthly salary of employees as well as fringe benefits such as housing subsidy, medical insurance and a car allowance, as applicable to the post (Burke, *et al.*, 2008:64).

- **Staff retention**

Staff retention actions ensure that staff with the necessary training, capabilities and high performance stay within the institution. High staff turnover, i.e. staff are frequently resigning and new staff appointed, is costly to an institution as it increases costs to orientate and train new members. It is crucial that the reasons why, in this study, nurses leave institutions should be analysed, which can then assist in the development of a nurse retention strategy (Armstrong, 2010:126).

- **Recruitment, hiring, transfer and promotion**

Recruitment, hiring transfer and promotion are dealt with by effective human resource management and if applied correctly, this results result in a low staff turnover. Rapid

turnover is a definite result of poor selection or promotion procedures and it is important that the capabilities of employees fulfil the demands of the work they need to do (Armstrong, 2006:126).

- **Policy of non-discrimination on the basis of HIV and AIDS status**

The use of pre-employment testing for HIV and AIDS is not allowed in employment practices, except in the defence force of South Africa (Van Dyk, 2005:336). HIV and AIDS by themselves do not justify termination of employment, transfer or discrimination in employment, but despite these legal arrangements the stigma relating to HIV and AIDS is prevalent in the public and private institutional work environment. A study done by Kywakua (2009:373) discussed the real stigma issues that HIV-infected nurses face in an institution and the alternative strategies they employ to obtain anti-retroviral drugs, treatment and support.

- **Orientation programme**

An orientation programme is offered to new staff to introduce them to the health institution as well as the specific department in which they will work. It is basically a structured process involving welcoming them, introducing them to colleagues and providing the necessary information about the institution and relevant work policies to assist them to settle down and let them feel at ease. An introductory overview of the workflow process is provided and of how their specific role contributes to the functioning of the institution, and a mentor is allocated to them to assist them with problems experienced within the first months (Jooste, 2010:168).

- **HIV and AIDS workplace prevention programme**

An HIV and AIDS workplace prevention programme focuses on using appropriate protocols to limit the risk of infection as well as education about HIV and AIDS (see chapter 3, paragraph 3.4).

- **Employee manual, e.g. organizational chart, work hours, health insurance, sick leave, grievances, etc.**

An updated employee manual that includes policies that refer to HIV and AIDS should be available. It should also be available to all employees and be used as a guide for all questions about employment in the organization. This manual should be kept updated at all times and is the responsibility of all managers, specifically for the department they are accountable for.

- **Policy regarding treatment of people (employees and patients living with HIV and AIDS)**

Policies on how staff and patients living with HIV and AIDS are to be treated should be up to date and available to all employees and should be utilized systematically. The health institutions participating in this study have HIV and AIDS policy guidelines that include the following policies (DoH policies):

- Management of occupational exposure to HIV.
- Testing for HIV, rapid HIV testing.
- Prevention and treatment of opportunistic and HIV-related diseases in adults.
- National anti-retroviral treatment guidelines.
- Managing HIV in children.
- Ethical considerations of HIV and AIDS clinical and epidemiological research.
- National management guidelines for sexual assault care.
- HIV and AIDS and TB management guidelines.
- Discipline, grievance, and termination procedures.

Formal procedures for discipline, grievances and termination should exist in an institution and be adhered to. The procedures should include protection against discrimination on the basis of HIV status.

- **Relationship with unions**

The unions should work together with management to resolve issues and prevent problems, including those relating to HIV and AIDS.

- **Labour law compliance**

HRM policy and practice should be adjusted to comply with national labour law, including any HIV and AIDS regulations. Applicable policies regarding HIV and AIDS in this policy include the occupational health and safety policy for the national Department of Health and the employment assistance programme for infected employees (<http://www.doh.gov.za/docs/index/html>); (http://www.eliasmotsoaledi.gov.za/docs/policy/empl_ass.pdf). Table 4.6 elucidates the mean value score obtained after analysis of the questionnaire for the construct personnel, policy and practices, with the interpretation of results explained next to the findings.

TABLE 4.6: FINDINGS AND INTERPRETATION OF PERSONNEL POLICY AND PRACTICES

CONSTRUCT: PERSONNEL POLICY AND PRACTICES	MEAN VALUE	INTERPRETATION
Compensation system	3.26	A formal compensation system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff that are willing to work full days can be attracted. The fair use of a merit award system seems to need further attention.
Benefits programme	2.12	A standard benefits programme is in place, but is not assessed for its effectiveness in supporting the retention of HIV and AIDS infected staff, e.g. extended sick leave, funeral benefits and free drugs.
Staff retention	1.86	Data on staff retention rates is available, but no analysis has been done to determine the contributing factors that lead to staff turnover or reasons why staff resign.
Recruitment, hiring, transfer and promotion	2.68	Formal procedures for recruiting, hiring, transferring and promoting staff are used consistently. Adherence to these procedures should be regularly monitored and evaluated (HRM questionnaire, 2006:6).
Policy of non-discrimination on the basis of HIV and AIDS status	2.97	The policy of non-discrimination on the basis of HIV and AIDS status is not consistently applied.
Orientation programme	3.05	Orientation is routinely offered but does not emphasize the mission, goals and expected performance by the organization, especially as they relate to HIV and AIDS.
HIV and AIDS workplace prevention programme	3.10	An HIV and AIDS programme is in place and focuses on using appropriate protocols to limit the risk of infection as well as provide education about HIV and AIDS, but only some staff members have participated in the programme.

CONSTRUCT: PERSONNEL POLICY AND PRACTICES	MEAN VALUE	INTERPRETATION
Employee manual, e.g. organizational chart, work hours, health insurance, sick leave, grievances	2.83	A current employee manual exists and is up to date, but is not used for personnel decisions.
Policy regarding treatment of people (employees and patients living with HIV and AIDS)	2.60	There are policies on how staff and clients living with HIV and AIDS are to be treated, but they are not available to all employees and are not always used as a basis for personnel decisions.
Discipline, grievance, and termination procedures	3.36	Formal procedures for discipline, grievances, and termination exist and are employed. The procedures include protection against discrimination on the basis of HIV status, but these are not adhered to.
Relationship with unions	3.39	Management, HRM and the unions should work together to resolve issues and prevent problems, including those relating to HIV and AIDS.
Labour law compliance	2.90	A review of labour law is done regularly as a formal part of the HRM function, but policy is not always adjusted to ensure compliance, including with HIV and AIDS regulations.

The average mean value for the construct personnel policy and practices is 2.84. However, looking at the different items it seems that attention should be given to the benefits programme (mean value: 2.12) and policy regarding the treatment of employees (mean value: 2.60). For the purpose of this study policies on the treatment of patients are excluded and therefore will not be discussed. The mean value result of the benefits programme and policy regarding the treatment for employees can be an indication that managers are not sure what support needs to be given to an HIV-affected/infected employee and what to do to improve retention rates.

Staff retention has a very low rating (mean value: 1.86), and while managers indicate that statistics are available, no analysis has been done to determine the contributing factors that

lead to staff turnover or the reasons why they resign. Armstrong (2006:126-130) notes that statistical analysis to determine the reasons for staff staying or leaving is essential, as these reasons can be used to develop a retention strategy. Some of the reasons that contribute towards staff retention issues include pay, job design that does not prevent job dissatisfaction nor promote learning, lack of personal and career development opportunities, lack of group cohesion, dissatisfaction and conflict with managers and supervisors.

Concluding statements: Construct – Personnel policy and practices

- The compensation system is effectively implemented in participating institutions.
- The benefits programme does not make provision for dealing with HIV and AIDS-affected staff effectively, e.g. extended sick leave, funeral benefits and free drugs.
- Staff retention seems to lag behind the other items. Although data on staff retention rates is available, no analysis is done to determine contributing factors, e.g. to what extent are declining rates due to HIV and AIDS, to what extent to natural attrition?
- Formal procedures for recruiting, hiring, transferring, and promoting staff are used consistently.
- The policy of non-discrimination on the basis of HIV and AIDS is consistently applied.
- An orientation programme is routinely offered to new or promoted employees. However, managers should emphasize the mission, goals and expected performance with specific reference to HIV and AIDS.
- An HIV and AIDS workplace programme is in place in all institutions and focuses on using appropriate protocols to limit the risk of infection and education about HIV and AIDS.
- A current employee manual exists and is up to date, but is not used for personnel decisions. There are policies on how staff and clients living with HIV and AIDS are to be treated.
- Formal procedures for discipline, grievances, and termination exist and include protection against discrimination on the basis of HIV status, but these are not consistently adhered to.
- Unions are included in HRM issues on a regular basis.
- A review of labour law is done regularly as a formal part of the HRM function.

- **Construct: Performance management**

Performance management is conducted to improve the results from an institution, teams and individuals by acting within the agreed framework of the vision, mission and objectives. Performance management is the integration of four components (Vieds, 2004:205; Armstrong, 2006:142), namely:

- Vertical integration, which involves the linking of institutional, team and individual objectives.
- Functional integration, which refers to the linking of functional strategies of different departments in the institution.
- HR integration, linking different aspects of HRM, e.g. training, development and rewarding of outstanding individuals.
- The integration of the individual needs of staff in the institution.

Performance management is therefore a strategy in the day-to-day management of employees in order to achieve the set aims. The elements that form part of the construct performance management that were measured with the HRM questionnaire included:

- **Job description**

A job description clarifies a staff member's role and accountability as well as the expectations of the manager in the institution. Tasks within the job description are grouped into main responsibility areas (Jooste, 2010:59).

- **Organizational strategies for HIV infection prevention, care and/or treatment of clients**

With regard to institutional strategies for HIV prevention three main areas can be addressed, which include:

- Staff education on how HIV is transmitted
- Testing opportunities for staff members: the behaviour of those who are negative must be reinforced by encouraging safe sex practices
- Cover for staff members for occupational exposure as outlined in the occupational exposure protocol

Staff can also be infected and strategies should be formulated to ensure confidentiality, evaluate their immune system and arrange treatment via the employment assistance programme officer. These procedures can be covered by medical assurance or obtained from centres that provide anti-retroviral treatment. The availability of an HIV and AIDS workplace policy that includes the involvement of unions and frontline staff from the start can protect the institutions against allegations of unfair discrimination (Biccard, 2004:323-325).

- **Staff supervision**

Supervision encompasses all levels of staff, regardless of seniority, and includes management at all levels of governance, because by supervising managers the efficacy and quality of their supervision can be determined. In a large health-care institution, e.g. a provincial hospital, it is impossible for the chief executive officer to personally supervise the quality of service that is rendered to patients. Supervision functions are therefore delegated to mid-level managers, who in turn delegate to frontline supervisors. It is important for supervisors to be appropriately qualified and experienced, and have received training to fulfil their respective roles (Jooste, Prinsloo & de Wet, 2010:169).

- **Training of supervisors with regard to HIV and AIDS**

Supervisors receive general training on the issues and policies relating to HIV and AIDS, but there is no sensitivity training on how to respond to employees, questions relating to HIV and AIDS.

- **Work planning and performance review**

Performance review focuses centrally on task standards and on work behaviours, not on personality, personal values or individual attributes.

Table 4.7 contains the findings and interpretations of the construct performance management.

TABLE 4.7: FINDINGS ON AND INTERPRETATION OF PERFORMANCE MANAGEMENT

CONSTRUCT: PERFORMANCE MANAGEMENT	MEAN VALUE	INTERPRETATION
Job descriptions	3.52	All staff members have job descriptions that are reviewed and adjusted regularly to take into account changes in responsibilities or to redistribute tasks.
Organizational strategies for HIV infection prevention, care and /or treatment of clients	3.07	There is an organizational strategy for HIV infection prevention, care and support of clients and the responsibilities of employees are well defined. However, the standards are not always followed.
Staff supervision	2.82	There are established lines of supervision and supervisors understand their roles and functions. Supervisors are trained in general supervisory skills as well as in HIV and AIDS policies and sensitivity to HIV-related staff issues.
Training of supervisors with regard to HIV and AIDS	2.64	Supervisors receive a general training on the issues and policies relating to HIV and AIDS, but there is no sensitivity training on how to respond to employees' questions relating to HIV and AIDS.
Work planning and performance review	3.27	A formal system for work planning and performance review is in place. Supervisors develop individual work plans and performance criteria for each supervisee and review past performance.

The average mean value of the construct performance management by institutions is 3.07, which indicates that HRM excelled in performance management. There is always room for improvement and some of the concluding statements indicate where performance management can be improved, especially in the HIV and AIDS environment.

Concluding statements: Construct - Performance management

- All staff have job descriptions that are reviewed and adjusted annually.
- There is an organizational strategy for HIV infection prevention and the responsibilities of employees are well defined.
- There are established lines of supervision and supervisors understand their roles and functions.
- Supervisors are trained in general supervisory skills and HIV and AIDS policies, but need training on how to be sensitive to HIV-related staff issues.
- A formal system for work planning and performance review is in place for individuals and supervisors develop individual work plans, performance criteria and review past performance.

- **Construct: Training**

Training encompasses a process of creating, acquiring, capturing, sharing and using knowledge, whether it is conducted within the institution itself or from a training institution outside. HRM aims to support the development of institution-specific knowledge and skills to capacitate staff in order to achieve the set objectives of the institution (Armstrong, 2006:7). Training is essential for an effective HRM system, but it is most effective when integrated with HRM planning, HRM policy and performance management. Training conducted in such a way ensures human resource capacity building. The construct training consists of four elements, and a brief definition of what each element entails is given in the paragraphs below, while table 4.8 depicts their mean value scores and interpretation of results .

- Staff training

Training can also be viewed as staff development and within an institution it refers to a well-planned comprehensive programme of ongoing training activities to ensure, within the scope of this study, professional development for managers and nurses. Training actions are carried out over a period to achieve specific institutional objectives and include numerous activities, e.g. orientation programmes, self-directed learning, symposia and official in-service training days on specific issues (Nkosi, *et al.*, 2010: 249).

- Staff training on HIV and AIDS protocols

Staff training on HIV and AIDS protocols seems to be insufficient in the South African scenario. HIV and AIDS are rolled out as a vertical programme leading to the training of only

a few doctors and nurses to specialize in the field of HIV and AIDS. These specialists are currently working in anti-retroviral (ART) clinics to speed up the ART programme roll out. A study conducted by Zellnick and O'Donnell (2005:177) revealed that nurses indicated they felt inadequate when relatives and members of the public asked them complex questions about HIV and AIDS treatment.

- Management and leadership programmes

The question can be asked: What do institutions do about managers' or leaders' development? Some institutions offer nothing: no individual reviews, plan for personal development, annual review of objectives achieved or nominations to attend courses, while other institutions provide a full range of opportunities. Development includes all activities that contribute to a lifelong learning process and therefore the aim of management development is to improve managerial effectiveness through a planned and deliberate learning process (Mumford & Gold, 2006:12-13).

- Links to external pre-service training

A loose relationship exists between institutions and pre-service training organizations, but is not utilized to formally update curricula to meet the growing need for management capacity within the health sector or provide a programme for continuous professional development.

TABLE 4.8: FINDINGS AND INTERPRETATION ON TRAINING

CONSTRUCT: TRAINING	MEAN VALUE	INTERPRETATION
Staff training	3.19	Training is a formal component of the organization and is linked to staff and organizational needs. However, it is not implemented in order to reduce staff's absence from their posts during training.
Staff training on HIV and AIDS protocols	2.65	Training relating to questions and strategies in dealing with HIV and AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their posts during training. However, not all employees receive the training. All employees should receive HIV and AIDS training.

CONSTRUCT: TRAINING	MEAN VALUE	INTERPRETATION
Management and leadership programmes	2.83	Management and leadership development opportunities are available on a regular basis, but they target senior-level staff. They are not directly linked to addressing the challenges facing the organization, such as focusing on HIV and AIDS and helping to implement the national HIV and AIDS strategy.
Links to external pre-service training	2.50	A loose relationship exists between the organization and pre-service training institutions. They do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector, nor to prepare people to work in HIV and AIDS prevention and or/treatment programmes.

The mean value score for the construct training is 2.79 and it seems that the mean values of items under this construct are above 2.50, which is good. With the rapidly changing HIV and AIDS environment it appears that links between external pre-service training institutions and the actual clinical practice of health workers should be much closer to ensure informed and skilled nurses to deal with HIV and AIDS in the workplace as well as to provide outstanding service to HIV and AIDS sufferers.

Concluding statements: Construct – Training

- Training is a formal component of institutions and is linked to staff and organizational needs.
- Training relating to questions and strategies in dealing with HIV and AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their post during training. However, not all employees receive the training.
- Management and leadership development opportunities are available on a regular basis.
- A loose relationship exists between the organization and pre-service training institutions, which do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector, nor to prepare people to work in HIV and AIDS prevention and or/treatment programmes.

- **Construct: HRM data**

The construct HRM data was not analysed, as the construct was deemed not reliable and valid within this study. The construct HRM data was statistically not reliable due to the fact that only two items were measured under this construct, namely employee tracking system and personnel files. Validity was not done because the construct measure is not reliable (Field, 2005:668). While TC research data collections are done, it appears that institutions do not keep statistics to generate reports on attrition, absenteeism and staff turnover, which could be utilized for effective human resource planning to minimize the effect of the HIV and AIDS pandemic on the workforce.

4.2.3.2 Discussion of HRM capacity in an HIV and AIDS environment according to management

From the data analysis it appears the HRM capacity of the four participating institutions of the North-West Province within an HIV and AIDS environment seems to be acceptable. There is room for improvement and each construct with a mean value score of less than 2.5 needs to be addressed, as it indicates problem areas within human resource capacity. The specific items that need to be addressed include HRM capacity, with a mean value score of 2.16, but only the item HRM budget indicates a concern.

This mean value score implies that there are no additional funds in the budget to implement a quality HIV and AIDS workplace prevention programme or to provide drugs and benefits for HIV AND AIDS-infected staff. To determine employment benefits for HIV-positive staff in institutions seems to be not an easy task. Firstly the age group that is mostly affected is between the ages of 19-35 years, which increases the official workload of the older nurses. Secondly AIDS deaths and disabilities lead to increased claims from pension funds, and can therefore dramatically increase the cost of risk benefits, while on the other hand untreated AIDS progresses quite quickly to death. This leaves the employer with two options:

- That the employer and retirement fund cap the risk portion or decrease the benefits in case of disability or death (which will have a negative effect on the family left behind), or
- Provide ART treatment to HIV-positive staff, thus resulting in reducing death or disability pay-out costs. Some South African insurance companies feel that providing HIV treatment is the better option for dealing with HIV-positive staff.

Although models exist to address the abovementioned benefit scenarios, very little has been done to address HIV-positive issues financially in the workplace, and it is still an area for further exploration (Biccard, 2004:317-318). The benefits programme construct personnel policy and practices revealed a mean value score of 2.12, indicating that currently there are no additional benefits for HIV and AIDS-infected staff, e.g. extended sick leave, funeral benefits and free ART drugs. This item can be linked directly to the HRM budget discussed in the abovementioned paragraph.

The lowest mean value score of 1.86 was attributed to the item staff retention. Participating institutions keep statistics on staff turnover available, but in none was an analysis conducted to determine contributing factors that lead to staff turnover rates. An analysis on staff turnover can identify the impact of HIV and AIDS on the nurse workforce or other workplace conditions that lead to resignations.

Links to pre-training institutions had a mean value score of 2.50, which indicates that there is a loose relationship between the institutions and pre-service training organizations. Due to the fact that some training institutions are indirectly governed by national DoH, the training issues discussed in chapter 3, paragraph 3.7.1 can be linked to this mean value score. This loose relationship between practice and pre-training institutions can result in a lack of a theory-to-practice link, as curricula can become outdated and training will not meet the requirements of practice. This will result in the delivery of poorly skilled qualified nurses and

a lack of continuous professional development to keep nurses updated on the relevant changes in their practice environment.

Of the 26 items that were measured to determine HRM capacity in participating institutions, only four items had a mean value score of than 2.50 or less. The conclusion can be drawn that HRM capacity is effective in an HIV and AIDS working environment.

4.3 OBJECTIVE 3: TO IDENTIFY PROBLEMS EXPERIENCED WITH POLICY IN AN HIV AND AIDS WORKPLACE ENVIRONMENT FROM A MANAGERIAL PERSPECTIVE

The overall purpose of this study is to develop a strategy for Nurse led change to influence HIV and AIDS workplace policy. According to Thompson, *et al.* (2010:9), a strategy can be defined as activities that are designed and carried out in order to fulfil certain designated purposes – in this study to get nurses to act as change agents to influence the policy process. The institutions should have a clear, articulated and well-understood mission statement and objectives to guide specific actions and to measure progress. To be able to achieve the overall purpose it was necessary to get the view of management regarding problems experienced with policy in an HIV and AIDS workplace environment. For the purpose of this objective a separate list of 12 senior managers was identified for individual interviews (see chapter 2, paragraphs 2.4.3.2, 2.4.3.3 and 2.4.4.4). The sample size proved sufficient when the data analysis indicated the saturation of coding, with no new codes emerging.

4.3.1 Data analysis

Qualitative data analysis is an ongoing and iterative process, meaning that data collection, processing, analysis and reporting are intertwined and not a number of consecutive steps to follow. In this qualitative study the researcher often needed to go back to transcripts and field notes to verify conclusions. In the initial phase of data analysis one needs to become familiar with the data by reading each transcript as soon as it is returned from the transcriber. The process of re-editing the transcript to be a verbatim representation of the voice recording familiarized the researcher with the content. The whole process of reading/re-reading notes and transcripts, recalling observations/experiences and re-listening to the voice recordings by the researcher ensures immersion in the data (Niewenhuis, 2008:99-100, Burns & Grove, 2009:521).

When analysing qualitative data one's goal is to summarize what has been seen and heard in terms of words, phrases, themes or patterns that would aid understanding and interpretation of data, as the aim is not to measure but to interpret and to make sense of the data. During the whole process of data analysis the researcher made sure that they kept in mind the questions that were asked during the interviews and what the objective for these questions was (Niewenhuis, 2008:100).

4.3.1.1 *Development of a coding framework*

Coding represents the first analytical phase in data analysis (Charmaz, 2006:42) and is the process of reading carefully through one's transcribed data line by line and dividing it into meaningful analytical units (Burns & Grove, 2009:522). The researcher continued with this process until all the transcripts had been segmented with an initial code. During the process of encoding the researcher kept a list of all the codes identified in the transcripts. The process followed with data analysis was discussed in chapter 2, paragraph 2.4.3.8. The in-depth interview consisted of five questions relating to problems experienced with policy working in an HIV and AIDS environment. The first question involved factors that prompted an institution to develop HIV and AIDS policies. From this question a total of three main themes and 11 subthemes were identified.

4.3.1.2 *Discussion of themes identified with data analysis*

The researcher compiled a list of initial codes and began to group the codes in categories. The researcher discussed the initial codes and categories with the senior co-researcher and from the grouping three main themes could be identified, namely the inevitable HIV and AIDS realities, organizational factors and human resource factors internally relating to nurses. The researcher decided on the theme of inevitable HIV and AIDS realities because the HIV and AIDS pandemic has an inevitable impact on the nurse workforce, it influences the organizational function, and some factors relate internally to nurses themselves.

The code appearing at the end of the excerpt, for example 1/3/5:56, refers to theme 1, interview number 3, followed by the page number of the interview and the line number from where the excerpt was drawn – in this case page number 5 and line number 56 respectively. Concluding notes were made at the end of each theme to assist the researcher in formulating a strategy for Nurse led change to influence HIV and AIDS workplace policy. Table 4.9 depicts the three themes together with the allocated codes.

TABLE 4.9: THEMES IDENTIFIED FROM INTERVIEWS WITH MANAGERS REGARDING POLICY PROBLEMS EXPERIENCED WORKING IN AN HIV AND AIDS ENVIRONMENT

THEMES	SUB-THEMES
1. Inevitable HIV and AIDS reality	1. HIV and AIDS magnified nurses' workload. - Increased number of HIV and AIDS patients. - Nurses bear the brunt of the HIV and AIDS pandemic. - Nurses are exposed daily to HIV and AIDS as they do not always know the HIV status of the patient.
	2. Confidential nature of the disease.
	3. Impact of HIV and AIDS on the workforce.
2. Organizational factors	1. Protection for employees.
	2. Stigma and discrimination issues in institutions.
	3. Lack of a wellness programme, full occupational health clinic or an employment assistance programme for nurses and other employees in institutions: - Voluntary counselling and testing (VCT). - Post-exposure prophylaxis (PEP). - Costs of anti-retroviral drugs. - Infected employee's partner or family should be involved. - Comprehensive approach in rendering wellness or occupational health services.
	4. Accreditation of institutions to manage HIV and AIDS in their communities.
	5. Public and private collaboration.
3. Human resource factors relating internally to nurses	1. Insufficient training for nurses.
	2. Nurses themselves are infected.
	3. Loss of skilled nurses due to denial.

- **Theme 1: Inevitable HIV and AIDS reality**

HIV and AIDS affect every part of life in South Africa, including the social and economic aspects of society. Economists are of the opinion that three factors slowed down economic growth, namely low levels of savings and investments, a poorly trained workforce, and HIV and AIDS. The first two factors were addressed in recent years, but the effect of the HIV and AIDS pandemic threatens to undermine actions taken to improve economic growth. A decline in economic growth due to HIV and AIDS can result in (Page, 2006:96):

- A decline in the size of the working age of the population.
- A decline in productivity due to ill health.
- Rising medical costs (Page, 2006:96).

In the following paragraphs the codes that emerged with data analysis under the theme: Inevitable HIV and AIDS reality are discussed:

- **Theme 1, subtheme 1: HIV and AIDS magnified nurses' workload**

In South Africa all health services form part of an umbrella organization, with nurses constituting the largest percentage of the workforce (Minnaar, 2005:32; Zelnick & O'Donnell, 2005:165), therefore it is nurses who bear the brunt of the HIV and AIDS pandemic, as more and more patients with AIDS-related diseases are diagnosed and admitted to health-care institutions daily. Currently public health institutions experience high HIV and AIDS patient numbers, and with the emphasis on the *Prevention of mother-to-child-transmission programme* (PMTCT), more previously undiagnosed children with HIV and AIDS are identified and need HIV and AIDS care. The health-care system is already markedly under-resourced as increasing numbers of patients require care for HIV and AIDS. In South Africa the HIV and AIDS pandemic relates to an HIV prevalence rate of 11%, with an estimated 5.7 million people living with HIV and AIDS, and the life expectancy decreased from 63 years in 1990 to 54 years in 2007 (Dohrn, *et al.*, 2009:1).

“...we do nursing a lot of HIV patients and we have noticed that even the staff is affected especially nowadays in the children’s ward HIV/AIDS it’s concentrated on children” (1/3/2/56-60)

“...we are all aware that how rampant HIV in the workplace is and my feeling personally is that the health department are not doing enough for the staff... “ (1/5/1/19-20)

“...the input and the impact of the, this pandemic in our area and then eh also ho, how involved are the health worker in this matter...” (1/6/1/20-21)

“.... We tend to do other activities like I’m doing the mobile services and I’m doing the HIV/AIDS programme and I have to deliver on these aspects. So it’s too much for me, I cannot. “ (1/7/4/169-171)

“...on a daily basis we are exposed...Uhm we see clients on a daily basis, we see clients and uhm you see sick clients” (1/12/1/16-17)

The abovementioned statistics and the increased number of HIV and AIDS patients emphasize the fact that nurses are exposed to HIV and AIDS every day. A study done by the Health Science and Research Council (HSRC) indicates that 46.2% of patients in medical and paediatric wards are HIV positive. Nurses are caregivers who provide extensive physical care while also rendering emotional care to patients suffering from HIV and AIDS, and the demanding nature of nursing HIV and AIDS patients leads to occupational stress, fatigue and burnout (Smit, 2005:23).

○ **Theme 1, subtheme 2: Confidential nature of the disease**

Multiple policies enshrine the confidentiality of a patient’s HIV status, even the South African Nursing Council (SANC), the regulatory body of all registered nurses, states that patients have the right to confidentiality. The right to confidentiality with regard to a patient’s HIV test results is further protected by the Department of Health’s National Policy on Testing for HIV. This policy states that the HIV status of a patient may only be disclosed with the individual’s fully informed consent. Health workers’ HIV status confidentiality is also specifically assured in the post-exposure prophylaxis (PEP) policy (Zelnick & O’Donnel, 2005:172).

The confidential nature of the disease is often problematic in the workplace environment, because if a nurse has, for instance, a needle-prick injury, their PEP management depends on the HIV status and often on the viral load of the source patient. The PEP management is complicated if the source patient refuses HIV testing or nurses do not want to be tested themselves. The nurses who refuse to be tested negate any future claim with respect to the injury (Zelnick & O'Donnel, 2005:171). As managers stated:

“...to develop an HIV and AIDS policy within the workplace for personnel to know how to handle situations in the workplace due to the secrecy of people not wanting to have their status known.” (1/2/1/25-28).

“...But eh what I know also that many of the employees in this hospital don't go there (occupational health and safety clinic). I don't know why, but they really don't go, they, they always, they feel like, I don't know, look as they don't trust the service too much.” (1/5/4/190-192)

- **Theme 1, subtheme 3: Impact of HIV and AIDS on the nurse workforce**

Managers noted that HIV and AIDS result in lower productivity in the workplace and that the productivity and work performance of nurses can be even further affected by the fact that at home they also need to take care of sick relatives and attend funerals. Nursing staff shortages are exacerbated by international recruitment programmes as well as poor working conditions resulting from the HIV and AIDS pandemic (Zelnick & O'Donnel, 2005:166).

The inevitable HIV and AIDS reality emphasizes the contribution of the HIV and AIDS pandemic to the increase in nurses' workload, problem areas regarding the confidential nature of the disease and the impact on the infected and affected nurse workforce.

Concluding statements: Theme 1 – Inevitable HIV and AIDS reality

- The health-care system is already markedly under-resourced due to an increasing number of patients.
- Nurses are caregivers who provide physical and emotional care to patients. The demanding nature of nursing HIV and AIDS patients leads to occupational stress, fatigue and burnout.
- The confidential nature of the disease is problematic in the workplace environment as PEP management depends on the HIV status and/or viral load of the source patient, who often refuses HIV testing, or the nurse does not want to be tested.
- Lower productivity and performance in the workplace are experienced.
- Nursing staff shortages are exacerbated by international recruitment programmes and poor working conditions.

• Theme 2: Organizational factors

Under this theme, five codes could be identified that are related and are discussed in the sections below:

○ Theme 2, subtheme 1: Protection for employees

When managers were asked to identify factors that prompted institutions to formulate an HIV and AIDS workplace policy the reaction of a chief executive officer and other managers to the question was:

“...we needed to have protection for the employee that is working with us...” (1/1/1/17).

“...the institution would be looking at issues like, eh, eh, uhm, PEP. That is for those people who are, are injected. Then this policy is in place and it is in OPD and its, will be place anywhere where workers...is informed about it.” (1/2/1/43-46)

“...With regard to the HIV policy in the workplace it is that I have to sensitize people about it and see that the protocols are been followed if there’s a needle prick injury, that the procedures got, that has to be followed, it’s done write...” (13/3/136-140)

According to the Position Statement of the International Council of Nurses (ICN), HIV is a growing health problem with complex and behavioural issues relating to protection, the prevention of transmission and care for nursing and midwifery personnel caring for people living with HIV and AIDS. The ICN statement elaborates on what national nursing and midwifery associations, employers and individuals should do to prevent and minimize the effect of occupational exposure (ICN Statement, 2008). A study done in a public hospital among nurses revealed that they know the universal precautions to take to prevent the risk of HIV transmission due to occupational exposure, but they were concerned about the low quality and frequent unavailability of gloves, aprons, masks and incontinence aids (Smit, 2005:25).

- **Theme 2, subtheme 2: Stigma issues**

Stigma around HIV and AIDS remains an important issue, with a persistent and contributory factor being the confidential nature of the disease. Managers elaborate on the staff infection rate and refer to the stigma as follows:

“Presently we don’t have statistics because they (nurses) don’t disclose to us. They would visit whoever and get their chronic medicine directly from pharmacists.” (2/1/3/113-114)

“...the stigma attached to HIV and AIDS makes the professional nurses afraid to test them. Now if you cannot test yourself then how are you going to test other people?” (2/2/3/158-160)

“...we deal with let me say stigma to avoid stigma and we emphasize very much that there should not, should not be discriminated...(silence)...” (2/3/2/103-104)

“...they are wandering, they don’t know where to go, because inside the hospital they don’t want anybody to know their status or that they are sick or whatever, and they need to go and get help elsewhere.” (2/6/3/132-134)

“Currently the practice is we are afraid to use our services. You go to private doctors whereby we can access the treatment.” (2/7/2/106-107)

Stigma and social factors are important barriers in addressing HIV and AIDS in the workplace (Schneider, 2006:25), and in a study done by Kywakuwa (2009:370-371), fear of stigma was high among HIV-positive nurses. All the nurses participating in the Kywakuwa study received their anti-retroviral treatment (ART) elsewhere and not the clinic where they worked or provided health care. To receive HIV and AIDS treatment in their workplace would require them to disclose their status to people they had never intended to know about this, which could lead to discrimination, as the workplace environment did not provide security for the nurses regarding destigmatization.

It seems that nurses fear judgment against their personality and sexuality because of a moral preconception that HIV and AIDS is mostly seen as sexually transmitted and tied to a „wanton“ character. Nurses participating in the Kywakuwa study also felt that they were under the scrutiny of the public, who expected them to manage their own health status properly to prevent illness. Another study confirmed the abovementioned perception of nurses that HIV and AIDS are primarily sexually transmitted, and they are seen as having cheated on their partner. They therefore do not perceive HIV and AIDS as having possibly been occupationally acquired (Zelnick & O'Donnel, 2005:173). In an intervention study measuring HIV stigma in five African countries at baseline, 80,3% of nurses reported experiencing HIV stigma events, and with a re-assessment a year later, stigma experienced by nurses had increased to 83,7% (Holzemer, *et al.*, 2009:76).

- **Theme 2, subtheme 3: Lack of a wellness programme, full occupational health clinic or employment assistance programme for nurses and other employees in institutions**

The lack of a wellness programme or a full occupation health clinic within the institution for nurses and other employees was a concern for at least two managers, who expressed themselves in the following excerpts:

“We are now in the process of developing staff clinics. The recent clinics running by the Health and Safety where all the chronic staff members are attending and get their treatment. But now I want to establish a fully fledged clinic that will be run by a doctor between specific hours. The use of the policy that is limited me is that somehow the cost of getting health services in the hospital is expensive...so there's some of the challenges.”
(3/5/2/49-55)

“We need to have a specific person running this programme with policies and guidelines in place that say this and that is happening in the employment assistance program. Currently it is not visible, it is not working hundred percent” (3/7/3/118-120)

It is the opinion of top level management that to develop a wellness programme in an institution it should be an umbrella programme that needs to have two components. The one component should be occupational, health and safety measures and the other should aim to render services to nurses and other employees to ensure a healthy workforce that will be able to deliver a high standard of health services.

The researcher addressed the first component, occupational health and safety, in the following paragraphs.

The National Department of Health (DoH) is legally obliged to create a healthy and safe work environment for all its employees. The South African National Occupational Health Policy was drafted according to the requirements as set out in the Occupational Health and Safety Act 85 of 1993 (OHS). This Act requires the DoH to provide and maintain a reasonable and practical work environment that is safe and without risk to the health of employees. The DoH strives to reduce risk by:

- Identifying hazards and possible risk causing incidents and accidents.
- Setting standards of practice, procedures and accountability.
- Measuring performance against standards.
- Correcting deficiencies and deviations as well as setting standards for procedures to be followed.
- Creating and maintaining a healthy and a safe work environment (DoH Occupational Health and Safety Policy, 2006:3).

For nurses and other health-care workers the OHS policy procedures include safe needle disposal, reporting of blood-borne pathogen exposure, PEP and compensation for nurses who contract HIV / other blood-borne diseases at work. In every health institution the PEP protocol and universal precautions against infection should be available and adhered to, and the North-West Department of Health furthermore developed an HIV and AIDS policy with guidelines to assist institutions in the prevention of occupational exposure to HIV and AIDS. According to Zelnick and O'Donnel (2005:174) and van Dyk (2005:353), these policies have

been in place since 2001, but the emerging codes that managers identified still included VCT and PEP. This could be because currently the implementation of the HIV and AIDS policy is challenging regarding VCT and PEP due to problems experienced with the implementation of the set provincial guideline.

To qualify for PEP treatment and possible future compensation after occupational exposure, informed consent must be obtained from the source patient to do an HIV test on them, which in itself is problematic as some refuse to give permission. The nurse would also be subjected to VCT for HIV to prove to the compensation commissioner that their status was negative at the time of the occupational exposure, and by refusing they negate any future claim with regard to HIV and AIDS as occupationally acquired. ART drugs also have side effects and often nurses do not complete the PEP course as prescribed. The stigma issue is also pertinent here and was fully discussed under stigma issues (Zelnick & O'Donnel, 2005:171-174; Smit, 2005:27). The second component, namely for employees to ensure a healthy workforce that will be able to deliver a high standard of health services, is addressed below.

The implementation of a wellness programme that includes occupational health-related issues, management of minor ailments and chronic conditions (e.g. diabetes, hypertension and HIV and AIDS) was an ideal, as was stated in excerpts from managers. However, the cost of such a service is a tremendous challenge. The ideal will be to render a comprehensive service throughout and not in specific time slots for specific problems, as this will enhance cooperation from nurses as their status will be secure. The following excerpts indicate the view of a manager regarding a comprehensive wellness programme:

“...health department are not doing enough for the staff...it doesn't talk about institutions like the hospital being force to ensure that there is staff wellness programmes which enable us to address these things. So we (as management) decide on our own and looking at the trend within the private sector to say what we feel that staff members been sick, we know others are positive, others are coming out to tell us really I'm suffering from this particular disease and it's a chronic disease.” (3/5/1/19-31)

Anti-retroviral drugs are expensive and to provide a comprehensive service to employees will remain, according to the researcher, a point for debate. One manager stated that the infected nurse's partner and/or family should be included in the rendering of comprehensive

clinic services. This point is valuable, but would further increase cost implications, as the family member could also be infected.

The wellness programme should further include an employment assistance programme. A study done among nurse managers to explore how they cope with HIV and AIDS-infected and affected nurses revealed that nurse managers go beyond their conventional management duties to assist these nurses. Aspects the managers deal with extensively are ongoing counselling to assist infected and affected nurses to cope with the demands of HIV and AIDS, and giving attention to ward or clinic placements depending on the nurse's current physical condition. If they have a high viral load and appear to be weak, for example, the nurse will work in a department where the risk of contracting AIDS-related infections is minimized and the job stress is not high. Nurses dying of AIDS need to be visited, as the manager is expected to support them and their families. The manager not only needs to attend the funeral but, especially in the case of African nurses, the family of the deceased nurse also expects management to get involved in organizing the funeral (Minnaar, 2005:32).

With reference to the abovementioned discussion it is important that professional, user-friendly and confidential services need to be established in the workplace for all institutional staff, and that this service should be rendered in such a manner that nurses can access it in an effortless way.

- **Theme 2, subtheme 4: Accreditation of institutions to manage HIV and AIDS in their communities**

Some managers pointed out that an HIV and AIDS policy is a prerequisite for the roll-out of the ART programme.

"...we had to prepare for accreditation..." (4/3/1/36)

"...so ART were introduced and that is how we got all these policies." (4/3/1/45)

The administrative processes required for institutions to be an ART centre and the poor coordination between local, provincial and national processes and access to resources were raised as an area of frustration. Many items in the accreditation process are based strictly on the initial guidelines of the ART roll-out plan, which by now has been widely adapted and simplified. If the roll out of ART is a priority, the process of accreditation should be

accelerated (Gaede, 2006:24), and the fact that public health institutions need to be accredited to render ART services prompts the formulation of HIV and AIDS workplace policies. However many institutions are as yet not accredited as ART centres and that contributes to the fact that ART is not available to many nurses, especially in rural areas.

○ **Theme 2, subtheme 5: Public and private collaboration**

The public and private collaboration factor emerges in all the interviews, specifically that non-governmental organizations (NGOs) seem to play a role in the training of staff to undergo VCT and empowering their counselling skills. Further private collaboration services may be possible in order to make VCT more acceptable to nurses, as public and private collaboration assures anonymity for the infected nurse or affected nurse.

Concluding statements: Theme 2 – Organizational factors

- Nurses know the universal precautions to prevent the risk of HIV transmission due to occupational exposure.
- Nurses are concerned about the low quality and frequent unavailability of gloves, aprons, masks and incontinence aids.
- Stigma and social factors are important barriers in addressing HIV and AIDS in the workplace.
- To receive HIV and AIDS treatment in their workplace would require nurses to disclose their status, and that could lead to stigma. The workplace environment does not provide security for the nurses regarding destigmatization.
- Nurses fear judgment against their personality and sexuality because of moral preconceptions that HIV and AIDS are mostly seen to have been sexually transmitted.
- The lack of a wellness programme or a full occupation health clinic within the institution for nurses and other employees is a concern.
- Occupational health and safety measures should be addressed in the workplace.
- To qualify for PEP treatment after occupational exposure, informed consent to do an HIV test must be obtained from the source patient, and this is often refused.
- The nurse must also undergo VCT to prove to the compensation commissioner that they were negative at the time of the occupational exposure. Refusing VCT negates any future claims with regard to HIV and AIDS as occupationally acquired.
- ART drugs also have side effects and often nurses do not complete the PEP drugs

as prescribed.

- Comprehensive health services to nurses and other staff can ensure a healthy workforce that will be able to deliver a high standard of health services.
- A wellness programme that includes occupational health-related issues, management of minor ailments and chronic conditions is required. It is important that this service should be rendered in such a manner that nurses can access it in an effortless way.
- The cost of a comprehensive wellness programme is a tremendous challenge.
- Rendering a comprehensive service throughout, not in specific time slots for specific conditions, will ensure patient confidentiality.
- Ongoing counselling is required to assist infected and affected nurses in coping with the demands of HIV and AIDS.
- Nurse managers give attention to placements, depending on the current physical condition of the nurse.
- Many institutions are as yet not accredited as ART centres, which contributes to the fact that ART is not available to many nurses in rural areas.
- More private collaboration services may be possible to make VCT more acceptable to nurses.

- **Theme 3: Human resource factors relating internally to nurses**

Certain codes emerged that relate internally to nurses and are addressed in the following discussions:

- **Theme 3, subtheme 1: Insufficient training for nurses**

The HIV and AIDS pandemic itself will increase the need for training of replacement staff and at the same time compromise the potential for mentoring and skills transfer. HIV and AIDS training in the nursing workplace should start with sufficient knowledge of HIV and AIDS issues among all levels of staff (Minnaar, 2005:32). Managers react towards training in the following excerpts:

“...we are following up on the risk areas which we have to discuss precautionary measures in terms of not having these repeats and we have gone through even the training of the trainer in terms of injection safety and that person is busy training even up to the cleaners in terms of injection safety...”(1/1/2/65-67)

“...sometimes we think like everybody who’s a health care worker is enough aware of what is going on about it having AIDS, in fact this is not true, because there is also a lot of people amongst us who doesn’t have enough knowledge...everybody must have at least a minimum knowledge ...”(1/6/1/40-44)

During interviews the researcher observed that a lot of HIV and AIDS training was given to nurses working in ART clinics, but those working in PHC centres and in hospital wards do not get this training and they feel they lag behind regarding updated information about HIV and AIDS treatment. This could also have a negative impact on nurses coming forward to receive medical care themselves if they are HIV positive and just hear of all the side effects of drugs. A lack of efficient HIV and AIDS training can also lead to poor patient care.

○ **Theme 3, subtheme 2: Nurses themselves are infected**

The fact that nurses are also infected increases the workload on the remaining staff, as there is an increased demand for HIV and AIDS services, which in turn lowers the morale of remaining nurses due to the loss and death of their colleagues. HIV and AIDS result in the loss of experienced and skilled nurses who are difficult to replace, and it is also expensive to train new nurses (Page, 2006:104-105; van Dyk 2005:348). AIDS causes prolonged illness, absenteeism, disability and death among the nurses, resulting in serious financial and emotional trauma as well as disruption in service delivery at health-care institutions (Zellnick & O’Donnel, 2005:166). Health services in rural and disadvantaged communities will be especially vulnerable due to a shortage of skilled nurses to render effective health services in addressing the needs of the community (Minnaar, 2005:32). The following excerpts stated management’s opinion:

“....we has noticed that even the staff is infected...” (2/3/2/57)

“...as management would realize uhm there absenteeism rate...” (2/9/1/8)

"We experience a lot of absenteeism. In the first place you wouldn't know...whether this person is HIV. It becomes after a very long time. In most cases they will be seen by private doctors who book them off and only at the advance stage now they come over to the facility."
(2/3/3/133-136)

○ **Theme 3, subtheme 3: Loss of skilled nurses due to denial**

This code emerges as a result of nurses being diagnosed and requesting treatment only when they are already in an advanced state of AIDS. Nurses need counselling, not only because they are suffering from HIV and AIDS, but to help them to cope with the changing demands of the high number of patients who do not recover from the illness and consequently die. It is important for nurses to realize that having HIV and AIDS does not mean value a death sentence, and that they can be productive for a long period if they recognize early in the disease that they need medical, social and psychological support (Minnaar, 2005:36). One manager inferred that they were losing many nurses due to their denial of their illness:

"...because we are losing nurses here because of denial, many of them, a lot of them."
(3/6/3/144).

Concluding statements: Subtheme 3 – Human resource factors relating internally to nurses

- Increased need for training of replacement staff and compromised potential for mentoring and skills transfer.
- Training in the workplace should start with sufficient knowledge of HIV and AIDS issues among all levels of staff so that all nurses should have updated information about HIV and AIDS.
- HIV and AIDS training given to nurses working in ART clinics but not to those working in PHC centres and hospital wards.
- The incapacity of the infected nurse increases the workload on the remaining nurses and the increasing demand for service delivery lowers the morale of remaining nurses due to the increase in workload, the loss and death of their colleagues.

- AIDS causes prolonged nurse illness, absenteeism, disability and death, resulting in serious financial/emotional trauma and disruption in service delivery and resulting in loss of skilled nurses due to denial.

The policy process followed in institutions when dealing with policies is discussed in the next section: the HIV and AIDS workplace policy that is used to obtain an opinion of what the process is after a policy has been received from meso (provincial) level. The role of the policy committee in the institutions and the steps followed to disseminate information about the policy are also discussed.

4.3.1.3 *Process of policy formulation according to management*

Questions 2–5 of the in-depth interview deal with the policy process within institutions. With the process of data analysis the researcher kept in mind the theoretical basis for the process of policy formulation, with reference to the policy cycle as discussed in chapter 1, paragraph 1.8.2, in which model there are two distinct phases. In the first phase nurses need to get to the policy agenda, and the second phase is moving issues and problems into action. Information was obtained from three districts regarding the policy process in their institution from a management perspective. The process as outlined by managers will be dealt with by indicating their contribution through excerpts. A discussion of the steps will follow and finally concluding notes will be derived from the findings.

“Uhm we first have to look at our...employees, we have to look...what type of our, eh, eh of our employees, you have to look at that. And the only thing is ...is look at the age as well of our employees. If they're old, nearly for pension or if they are still young.... Yeah, really before we can drop a policy we must look at our organization.” (1/7/1/40-44)

“...The policy will be formulate né and then it will, they, they just eh review the policy and it will have a date of additions like for instance they say they are going to review it after...maybe 2 years. And then after 2 years if there is some new things, developments, they're going to put those new developments on that policy and then it's going ...to be reviewed may be after 2 years again. (1/10/2/59-64)

The process will be first identifying the need, which is done through situational analysis. The second part will be to come up with some remedial actions, which will be forming a team that

will drive the process and the team be appointed and the team be given a mandate And then once the policy is drafted eh it will be circulated, people will make inputs and the inputs will be discussed in a common duty, which we usually use our quarterly meeting where I talk to all the staff. Then we'll say that everybody is aware now, and then there is the policy. While the policy is signed, it's circulated again, every manager sign for received of it and then I give a period to say by this time each manager should have make sure that all staff members in their units, also they know the policy. And then they signed that yes I've read the policy because in that meeting I just go over particularly the heading in brief, I don't go into details of the policy. Then what we do is they do clinical audits and we seen that the audits, this policy, the implementations is muddled out through the audits. So when there are those problems, then we try to address those problems". (2/5/2/89-105)

"...actually it was not developed from the hospital itself, it is a health department workplace policy, we are implementing that one." (3/1/1/37-38)

"Yes, we, yes, we implement the guidelines, it's not original from, from the institution, but the institution would be looking at issues like...PEP. That is for those people who are, are injected. Then this policy is in place and in out-patients department and its, will be placed anywhere where workers are, that everybody is informed about." (3/1/1/43-46).

"...myself as such (were not involved in HIV and AIDS workplace policy formulation) but in the province itself, the HIV and AIDS policy with regard to, uhm, in the workplace was developed and we've just...adapted the guidelines..." (3/2/1/38-43)

"The provincial office does order...photocopies are made and distribute to the (sections)..." (3/17/1/20-22)

"Monitoring. Our major role is monitoring if the policy is well implemented if there are any obstacles eh regarding the policy which needs to be revised you know, we would actually made such motivations." (3/4/3/153-155)

"Eh, mostly to start with the top management. Uhm after they have interrogated the policy, they would actually be send to the end users (clinic's and community health centres) for comment and after we have looked at this policy and you know uhm after we did the comments, we would actually refer the policy back for the, so it can be approved." (3/4/1/38-41)

"We develop our policies at the quality assurance, we have a Quality Assurance Committee (QAC) and that is where we sit to develop the different policies. The QAC is formed by all the people of the leadership and everybody is involved from the different wards and the different sections, there's one person from the different sections, so we come together to form a policy and that is where we develop our policies. We also use policies from provincial office and most cases that is where we develop from the provincial guidelines." (3/3/2/66-71)

As the managers stated in the previous excerpts the policy process in institutions entails the following steps.

TABLE 4.10: POLICY PROCESS IN INSTITUTIONS ACCORDING TO MANAGEMENT

STEP	ACTIONS ACCORDING TO MANAGEMENT
Step 1	Situation analysis about the situation with reference to the HIV and AIDS pandemic in the institutions.
Step 2	Dissemination of information that the institution had an affected workforce regarding HIV and AIDS , in order to enlighten staff as to what the institution will do to address HIV and AIDS in the workplace.
Step 3	Taking national DoH HIV and AIDS workplace policy and the provincial guidelines to develop an aligned institutional policy and how to deal with stigma issues.
Step 4	A draft HIV and AIDS workplace policy was formulated by a multi-disciplinary team, which was represented by the following members: • Manager of human resource department. • The occupational health and safety nurse manager. • Top management, including the chief executive officer, medical officer manager, nursing service managers, operational managers from nursing (this was a matron who had 3-4 wards allocated to their supervision), unit managers from each department in the hospital (wards, administrative, cleaning services, etc.). • Employees, which included cleaners, gardeners, support staff, allied health professionals, medical officers and workers from the administration department. • Unions, NGO representative, home-based care representative.

STEP	ACTIONS ACCORDING TO MANAGEMENT
Step 5	The draft HIV and AIDS policy was forwarded to all sections in the institution and feedback was awaited from staff. Then finally the HIV and AIDS institutional policy was developed, with the human resource department being a key stakeholder. Lastly all employees were made aware of the HIV and AIDS workplace policy.
Step 6	Policy feedback loop from frontline level, formulation of policy, monitoring the implementation of new policy and lastly readdressing of new problems identified during implementation.

It is clear from the management perspective that there is a policy formulation committee with a multi-disciplinary team involved, that a draft policy was compiled from the national HIV and AIDS policy and provincial HIV and AIDS guidelines, and was circulated through all sections before the final policy was formulated with extensive input from the human resource department.

- Top level managements view about nurses skills and experience to participate in the policy formulation process**

Top-level management was of opinion that nurses need a lot of capacitating to deal specifically with policy formulation. Managers even acknowledge that policy is not one of their functions as expressed by managers in the following excerpts:

“Definitely not. The serious problem of capacity in this hospital in particular is to the nursing professionals, where you literally have to take a manager at the level of Assistant manager step-by-step (through) the process of developing a policy. The processes are there but they don’t take chare full of the process and when you really want to find out exactly what’s happening, one, the conclusion that have come about is they are not capacitated. My understanding is that the previous administration it will seem that these things were not made their responsibility.” (2/5/3/119-123).

“I think we need to do a lot of work in terms of policy development and skills for the (nurse) managers” (2/5/2/140).

“Eh, to talk about policies eh, (laughing) eh really I’m not, I’m not really amongst the policies,

amending policies...” (2/6/1/35-36).

- **Management opinion about the role of the national Department of Health (NDoH) HIV and AIDS workplace policy and provincial guidelines while developing their own institutional policies**

Question 4 of the in-depth interview questionnaire asked managers if they thought that their institutional HIV and AIDS workplace policy fit within the NDoH and provincial guidelines. The following excerpts stated their perspective.

“We have to, the national policy says we must look at that, we must, the look at it and inform the people. First you must inform them...” (1/7/3/114-115)

“...We can't change the national policy because it's already adopted. But we can make ours from that one, so it works for us as a health institution. Everything that is in the policy, internal policy, should also be in the national policy.” (1/9/4/204-206)

“They (our policies) do fit with the national policy because provincial gets from the national policies and that is how it are dissipated down to us at the lower levels.” (3/3/2/78-79)

Concluding statements: Process of policy formulation according to management.

A process could be derived on reflection and analysis of interviews by the researcher and included the following steps:

- Situation analysis on the current situation regarding HIV and AIDS.
- Dissemination of information that the institution had an affected and infected workforce.
- Management took the national HIV and AIDS policy into consideration and compiled a draft workplace policy.
- The draft policy was forwarded to staff for feedback.
- After staff input the final HIV and AIDS policy was formulated with an extensive

input from the human resource department (policy feedback loop).

- Finally, awareness raising and sensitizing of all employees to the policy were undertaken.
- Clinical audits were done to ensure that implementation problems had been smoothed out.
- Any problems identified with the implementation of the policy were then re-addressed.
- A manager felt that nurses were certainly not empowered to deal with policy process but acknowledged that his institution needed to empower nurse managers.
- Another manager admitted that they were not good with policy issues and the intimation of the nurses was that not all unit managers were aware of the ongoing policy process, thus confirming the above empowerment acknowledgement.

4.5 DISCUSSION POLICY PROCESS FROM A MANAGEMENT PERSPECTIVE

The researcher perceived management as to be well informed about the steps of the policy process. In each of the participating institutions the managers confirmed that the institution had a policy committee with stakeholders from different sections within the institution, multi-disciplinary team presentation as well as involvement of unions. It was clear that at institutional level no other stakeholders such as politicians, non-governmental organizations or representatives from the local or provincial AIDS councils were involved. Institutional policies were developed within the scope of national HIV and AIDS workplace policy and provincial guidelines.

4.6 RIGOUR

Rigour refers to the strategies employed by the researcher to ensure validity, reliability and trustworthiness, as outlined in chapter 1, paragraph 1.11.

4.7 SUMMARY

In this chapter the opinion of management was obtained by using the HRM questionnaire to determine the current human resource capacity status in participating institutions. The perspective of management about problems experienced with policy in an HIV and AIDS workplace environment was also obtained. In the next chapter the researcher discusses interviews with frontline nurses to obtain their perspective of problems experienced with policy in an HIV and AIDS workplace environment.

RESULTS OF FRONTLINE NURSES

5.1 INTRODUCTION

In the previous chapter management's opinion about human resource capacity in institutions was described on the basis of data that had been obtained with the HRM questionnaire and analysed. A qualitative data analysis was done on management's opinion about policy problems in an HIV and AIDS workplace environment that had been obtained by in-depth interviews.

In this chapter the view of frontline nurses regarding policy problems experienced in an HIV and AIDS workplace environment was obtained by using the same in-depth interview schedule that had been used to obtain qualitative data from managers. The analysis of this data was done by reading, encoding data and using Nvivo, version 8 as data manager. Table 5.1 provides an overview of the aim of this chapter, phase 1, step 4, objective 4 to identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.

TABLE 5.1: PHASE 1, STEP 4, OBJECTIVE 4

PHASE 1: EMPIRICAL RESEARCH	PHASE 2: STRATEGY FORMULATION
Objective 1: To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.	Step 5: Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
Objective 2: To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.	
Objective 3: To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.	

PHASE 1: EMPIRICAL RESEARCH	PHASE 2: STRATEGY FORMULATION
Objective 4: To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.	

5.2 PHASE 1, OBJECTIVE 4: TO IDENTIFY PROBLEMS EXPERIENCED WITH POLICY IN AN HIV AND AIDS WORKPLACE ENVIRONMENT FROM A FRONTLINE NURSE'S PERSPECTIVE

The overall purpose of this study was to develop a strategy for Nurse led change to influence HIV and AIDS workplace policy. To be able to achieve this purpose it was necessary to obtain the view of management (chapter 4) and frontline nurses (this chapter) regarding policy problems in the HIV and AIDS workplace environment – objective 4 of the study. For the purpose of this objective nine (n=9) nurses (chapter 2, paragraphs 2.4.4.1, 2.4.4.2 and 2.4.4.3) were identified for individual interviews. The sample size proved sufficient when the data analysis indicated the saturation of data with no new codes emerging.

Qualitative data analysis, as was detailed in chapter 2, paragraph 2.4.3.8, was carried out in the same manner as with managers. The researcher experienced a difference between interviewing managers and frontline nurses, and although both categories seemed to possess knowledge about the policy process, it became evident during interviews that managers had a wider view of the influence of the pandemic on the nurse workforce, as well as of policy problems experienced in the HIV and AIDS workplace environment. This could be because they have been more exposed to personal development and experience than frontline nurses, and although frontline nurses identified the same themes as managers, fewer subthemes and one additional theme relating to patient care were identified, emphasizing that the nurses were directly involved in patient care. These factors are listed but not discussed fully as they were not the focus of this study.

- A coding framework was developed, as was explained in chapter 2, paragraph 2.4.3.8, with open coding and categorizing allowing for the emergence of themes and subthemes. The in-depth interview with nurses consisted of the same five

questions posed to managers. With the ask of question 1, which factors prompted your organization to develop policies about HIV in the workplace?, a total of three main themes and nine subthemes were identified. With questions 2-5 the researcher obtained information about the policy process in participating institutions from a frontline nurse's perspective. The interview instrument consisted of five open-ended questions regarding HIV and AIDS workplace policies.

- Can you tell me what factors prompted your organization to develop policies about HIV in the workplace?
- Please describe the process for developing the HIV workplace policies in your organization.
- Who has been involved in the development of these policies?
- What disciplines have been represented?
- What roles do these individuals fulfil in your organization? (e.g. managers, caregivers, directors, etc.)
- Can you describe how the HIV policies in your organization fit in with the policies that have been developed at national level?
- Can you please describe the policies relating to AIDS care that are still required in your organization?

5.2.2 Discussion of themes identified with data analysis

With data analysis the three themes identified corresponded positively with those identified in chapter 4, paragraph 4.3.1.2 during the manager's data analysis. Table 5.2 elucidates the three themes and nine subthemes identified with qualitative data analysis.

The researcher broadened each theme by eliciting the main excerpts stressing the subtheme. The code appearing at the end of the excerpt, for example 1/3/5:56, refers to subtheme 1, interview number 3, followed by the page number of the interview and the line number from where the excerpt was drawn – in this example page 5 and line number 56 respectively. Concluding notes were made at the end of each theme to assist the researcher in the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.

TABLE 5.2: THEMES IDENTIFIED WITH INTERVIEWS OF FRONTLINE NURSES REGARDING POLICY PROBLEMS EXPERIENCED WORKING IN AN HIV AND AIDS ENVIRONMENT

THEMES	SUB-THEMES
1. Inevitable HIV and AIDS reality.	1. HIV and AIDS magnified nurses' workload. Increased number of HIV and AIDS patients leads to increased daily occupational exposure to the HIV virus.
	2. Confidential nature of the disease.
	3. Impact of HIV and AIDS on the nurse workforce.
	4. Care of HIV and AIDS clients.
2. Organizational factors.	1. Protection for employees. The existence of an HIV and AIDS workplace policy reduces anxiety of working with HIV and AIDS patients as steps are in place to deal with occupational exposure.
	2. Stigma and discrimination issues in institutions.
	3. Lack of an employee assistance programme for nurses and other employees in institutions.
3. Human resource factors relating internally to nurses.	1. Insufficient training for nurses. Training currently is focused on those staff working in settings responsible for the roll out of anti-retroviral treatment to patients. Frontline nurses working in other settings, e.g. medical and paediatric wards, do not have sufficient training to manage HIV and AIDS patients effectively.
	2. Nurses themselves are infected.

5.2.2.1 Theme 1: Inevitable HIV and AIDS reality

Theme 1 deals with the inevitable HIV and AIDS reality under which the subtheme HIV and AIDS magnified nurses' workload was identified. The theme inevitable HIV and AIDS reality refers to the influence of the pandemic on the nurse workforce. The AIDS pandemic increased the workload of the nurses, as more patients are admitted with AIDS-related illnesses. In society there is still ignorance about HIV and AIDS, resulting in patients seeking medical attention during the advanced stage of illness. These patients need intensive nursing care, including bed baths, feeding, prevention of pressure ulcers and the increased exposure for nurses to the HI virus. At the same time nurses can be affected by family members who are infected or nurses themselves can be infected, resulting in sick leave and increasing the workload for remaining staff.

- **Theme 1, subtheme 1: HIV and AIDS magnified nurses' workload**

All participants mentioned that HIV and AIDS magnified the workload of the frontline nurse due to an increased number of HIV and AIDS patients, which in turn leads

"There are an increase number of HIV and AIDS patients admitted and that leads that we as nurses are more exposed to the virus. You know the community is still ignorant about the HIV and AIDS pandemic. When they are HIV positive they denial their status..." (1/2/1:18-23)

South African nurses are at the forefront of dealing with the HIV and AIDS pandemic, resulting in a dramatic impact on the nursing profession. Specifically, nurses themselves are part of the population at risk of contracting HIV. In addition, outside the professional work environment, nurses often have to take on caring roles for others in their families and communities who are suffering from AIDS. Nurses themselves are already carrying a considerable psychological and social burden relating to coping with personal sickness or family caring responsibilities. In addition, HIV has vastly increased the workload for nurses in contexts where health systems were already severely under-resourced. Numerous studies have shown that nurses are working in environments that lack basic equipment and resources to protect nurses from occupational exposure. Nurses feel extremely overworked, frustrated at being unable to provide basic nursing care, and are afraid of occupational exposure. Research indicates that high workloads and high levels of stress mean value that

nurses feel they have little time and few emotional resources left to provide intensive psychosocial care to their HIV and AIDS patients (Evans, *et al.*, 2009:725-726).

- **Theme 1, subtheme 2: Confidential nature of the disease**

The confidential nature of the HIV and AIDS pandemic emerged clearly during interviews. The fact that frontline nurses do not always know the status of the patient causes uncertainty amongst themselves, as one participant stated:

“...you know we are working in the environment which is not conducive to us. Most of them, our patients they are HIV, they are TB, so we are at risk of getting infected. So we are not covered in any way, we just pray every day when come to work. Please God help us so that we must not contract the diseases.” (2/6/1:25-29)

A multi-country case study was done where nurses and people living with HIV and AIDS completed the HIV and AIDS Stigma Instrument (HASI-P) and afterwards received intervention to assist them to address stigma-related issues. After a year of intervention activities, PLHA completed the HASI-P instrument again. People living with HIV AND AIDS reported less stigma and felt afterwards that their self-esteem had improved with the intervention actions (Uys, *et al.*, 2009: 1059).

- **Theme 1, subtheme 3: Impact of HIV and AIDS on the workforce**

Apart from having to cope with an increased workload, nurses found that taking care of terminally ill patients posed special challenges, such as being emotionally taxing, because caring for a dying HIV and AIDS patient needs more care and support. Nurses also have problems viewing themselves in their traditional role as healers because they know these advanced-stage HIV and AIDS patients will not recover (Hall, 2003:5). Kyakuwa (2009:367) identified barriers that prevent frontline nurses from caring for HIV and AIDS patients effectively. These barriers include stigmatization, discrimination, negative attitudes, inadequate knowledge, a lack of resources and fear of contracting the disease. The impact of the HIV and AIDS pandemic on the frontline nurses was evident from the following excerpt:

“...most of the patients particular around the villages here, they don’t know much what happened. They just come and go without anything... the staff that I work with, some of them; they don’t even have much time for these patients. They are neglecting to help them.” (1/7/1:15-23)

“Because they are not precautionary measurements that we are using. It’s only that we as the nurses working in a, eh especially the medical wards. I supposed to protect myself by wearing gloves and sometimes we’re running short of gloves, eh masks, running short of masks. There will be some eh, eh fluid, right drowned in the unit. When we change the patient we’ll be in touch with the, the fluid. Maybe at that present moment there are no gloves. So maybe perhaps they are not covered. Yeah you can get infected, yeah.” (1/6/2:25-39)

Studies done on the prevalence of needle-prick injuries among frontline nurses reveal that it is a common occurrence. These studies found that the main reasons for needle-prick injuries were lack of training on the prevention of needle-prick incidence, long working hours and factors relating to working habits, e.g. recapping of used needles, not using protective gloves and limited experience in the nursing profession. According to these studies, special attention should be paid to reducing heavy workloads by quality training for specific tasks for frontline nurses (Nsubuga & Jaakkola, 2005:779-780; Reid & Van Niekerk, 2009:816-819).

“There are more people coming here with the HIV status and that we think we are also in danger of contracting the disease...you can prick yourself by mistake or the blood can split, yes there are so many things...” (1/8/1/16-21)

“If, if you get a needle prick and then you, you refuse to be tested, you are only a risk for your life because will not sure whether you’ve got an, you contracted the virus from the patient or was it in your system already...” (1/4/2/33-34)

“The possibility of occupational exposure....if you get a needle-prick injury or blood spilled on your face, so that you know what to do...” (1/1/1/14-16)

- **Theme 1, subtheme 4: Care for HIV and AIDS clients**

Frontline nurses mentioned more subthemes relating to care, including the need to care for themselves as the caregivers for HIV and AIDS patients. Due to the fact that the focus of this study was the formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy, it is mentioned only because it is important to note that frontline nurses deal daily with HIV and AIDS issues.

- The identification of the number of South African citizens and employees who are infected with the HI virus.
- Health education to infected people about the disease and to give them necessary support they need.
- The implementation of guidelines to care for HIV and AIDS patients.
- The HIV counselling and testing policy protects nurses when they do counselling in order to do a rapid test, as patients cannot say they just test patients.

Concluding statements: Theme 1 – Inevitable HIV and AIDS reality

- HIV AND AIDS magnified the workload of the frontline nurse due to an increased number of HIV and AIDS patients, which leads to increased occupational exposure.
- The unknown HIV status of patients causes uncertainty amongst nurses and leads to negative attitudes, discrimination and stigmatization towards the patient.
- Taking care of terminally ill AIDS patients is emotionally and physically taxing because they need more care and support.
- Nurses have a problem viewing themselves in their traditional role as healers because they know these advanced-stage HIV and AIDS patients will not recover.
- The main reasons for needle-prick injuries are lack of training in the prevention of needle-prick incidence, long working hours and factors relating to working habits, e.g. recapping of used needles, not using protective gloves and limited experience in the nursing profession.

The following paragraphs identify organizational theme factors that emerged from the interviews.

5.2.2.2 Theme 2: Organizational factors

Theme 2 deals with organizational factors, which include matters such as the protection of frontline nurses, stigma, discrimination issues and lack of an employment assistance programme. The researcher decided on this theme due to the fact that the theme relating to the organization as a workplace and the subthemes identified could be a problem for workers on other levels as well and therefore do not affect nurses only.

- **Theme 2, subtheme 1: Protection of frontline nurses**

The protection of frontline nurses emerges strongly during interviews. One frontline nurse indicated that the mere fact that the institution had an HIV and AIDS workplace policy reduced their anxiety levels in working with HIV and AIDS patients. According to the participant, they knew that steps were in place to deal with occupational exposure:

“I think it’s because eh the ...epidemic makes us be afraid of eh taking care of the patients holistically, so if I know the HIV and AIDS workplace policy is present, I feel free to continue caring as much as I can....the problem might be let’s say I prick myself while I was giving a patient a certain medication through injection...the policy covers me, there are certain steps to follow...” (2/9/1:21-25)

The management of occupational exposure is outlined in a specific policy from the national DoH. This policy states the risk difference in occupational exposure, the role of ART in the prevention of HIV infection, which drugs should be prescribed for different risk exposures, the monitoring of side effects, recommendations for universal precautions and the monitoring of the frontline nurse who has been exposed (Department of Health, HIV and AIDS occupational exposure policy, 2000:11). The management of occupational exposure to HIV has some implications, namely that frontline nurses need to know their HIV status before they can start with post-exposure prophylactic (PEP) treatment, and if a nurse refuses testing to determine their status they relinquish the right to qualify for compensation for occupational injuries because they cannot prove that they were HIV negative at the time of the injury (Van Dyk, 2005:351; Department of Health, HIV and AIDS occupational exposure policy, 2000: 11).

- **Theme 2, subtheme 2: Stigma and discrimination issues in institutions**

Stigma associated with HIV and AIDS can be defined as a process of devaluation: the individual feels socially not equal to those who are not HIV positive. Stigma usually involves feelings of shame and affected people would therefore like to keep their status secret. Frontline nurses consequently withdraw from their colleagues due to previously triggered negative stereotypes and also fear discrimination against them due to their HIV positive status (Kyakuwa, 2009:368). One participant indicated stigma as follows:

“I work with someone with that problem. When you say okay let me take you to the occupational nurse to assist you, because that is a manager, so they will say no I’m not going to that person because he will know that I have problems and so because there is this thing of gossiping amongst nurses. So that thing is still in their mind. Nurses gossiping, they’re talking about other people.” (2/7/2:48-52)

There have been many misconceptions, myths, untruths and false information about HIV and AIDS in South Africa in the past causing HIV and AIDS patients and infected nurses to be unfairly blamed, discriminated against, rejected and alienated. Nurses have also been influenced by this negative information and many have allowed their own prejudices or moral values to influence the care of HIV and AIDS patients and their judgment of colleagues (Evans, 2003:313). The same multi-country interventions study that was done on PLHA included nurses as participants. The nurse participants who completed the HASI-N instrument were part of an intervention team. These nurses were requested after a year to complete the HASI-N instrument again. They reported no reduction in stigma or that they had personally experienced an increase in self-esteem and self-efficacy, but their HIV testing behaviour had changed positively (Uys, *et al.*, 2009: 1059). Throughout this study, stigma remains a persistent issue for nurses.

- **Theme 2, subtheme 3: Lack of an employee assistance programme for nurses and other employees in institutions**

In many institutions the employee assistance programme is not implemented correctly and therefore, like the managers, frontline nurses expressed their concern about this programme, as can be seen from the following excerpt:

“Because even, most of the infected they, they don’t know that there is a programme like this which can help problems experience like financially, alcohol abusing and HIV and AIDS treatment...” (2/7/2:45-47)

The employee assistance programme (EAP) makes provision for a manager to be appointed specifically to assist employees with a wide variety of problems such as psychological, social, financial, work performance and illness, but HIV and AIDS are not specified separately with any guidelines on how to deal with an infected nurse. The aim of the programme is to maintain the well-being and productivity of employees by providing confidential assistance, and participation in the EAP programme is voluntary. All documents relating to EAP are retained in the EAP manager’s office and do not become part of the employee’s personal file. The programme requires specific training for EAP managers (Department of Health, 2005:1-10). The EAP training sessions for managers should at least cover the following information:

- The administrative role with respect to the EAP programme, the confidentiality aspects and the procedure to be followed while assisting a frontline nurse for the purpose of this study, as well as how to effectively access the programme in the institution.
- The EAP manager should have sound knowledge about available sources that they can utilize or to which they can refer a frontline nurse in order to address the needs holistically.
- Proactive steps that can be followed to allow the early detection of problems that interfere with job performance, as the aim of the programme is to rehabilitate the frontline nurse before their job performance is influenced badly.
- How to deal constructively with frontline nurses experiencing performance problems due to illness, personal or behavioural problems.
- Knowledge of support approaches to assist the frontline nurse.

In the real world the EAP manager’s role is linked as a function of the occupational health and safety manager of an institution.

Concluding statements: Theme 2 – Organizational factors

- To qualify for post-exposure prophylactic (PEP) treatment, the nurse needs to give consent for testing their HIV status. If the nurse does not want to determine their status they relinquish the right to qualify for compensation for occupational injuries.
- Stigma remains persistent. Infected nurses have been unfairly blamed, discriminated against, rejected and alienated.
- Nurses have allowed their own prejudices or moral values to influence the care of HIV and AIDS patients and judge their colleagues.
- The employee assistance programme (EAP) should be implemented correctly.

The next theme merges with data analysis and refers to human resource factors relating internally to nurses. A discussion of the theme follows below.

5.2.2.3 Theme 3: Human resource factors relating internally to nurses

The researcher decided on this theme because codes can be classified under human resources, but it related specifically to nurses themselves.

Under the theme human resource factors, two subthemes emerge: insufficient training for nurses and the fact that nurses themselves are infected with HIV and AIDS. These subthemes are discussed below.

- **Theme 3, subtheme 1: Insufficient training for nurses**

Training currently focuses on the staff who works in settings responsible for the roll out of anti-retroviral treatment to patients, and other frontline nurses do not have sufficient training to manage HIV and AIDS patients effectively (Heunis & Schneider, 2006:268). The following excerpts indicate the need of all frontline nurses for training:

“Hmmm I have heard when the CD4 count is below 350 the patient should get the treatment. But what I have realized, not in this hospital. I once had a patient with a CD4 count of 61 and was not on ARV treatment and when I asked the doctor the doctor said the child’s liver function is not good, so they cannot start with ART...yes I would like him to start the patient on drugs.” (3/5/3/95-100)

“Just to care about ourselves, to look after ourselves when working the HIV patient. Have educated, have educate patients. And also the staff must also get in-service education. This... (in-service training) happens seldom, seldom in our institution.” (3/6/4/185-168)

In a discussion document compiled by the Henry J. Kaiser Foundations, the successes and failures of the health system in South Africa are pointed out. The document emphasizes that, fifteen years after democracy, the gains with the implementation of the district health system are eroded greatly by the increased burden of HIV and AIDS-related illnesses. This weakens health system management and leads to low staff morale. The author further suggests that the most critical objective for the South African government is to reduce the rate of new HIV infections in South Africa (Harrison, 2010:3).

In order to manage the HIV and AIDS pandemic, government started to roll out ART services as a vertical programme and not as part of a comprehensive health care programme. With the roll out of ART service, specific HIV and AIDS training was given to doctors and nurses who were responsible for rendering services to HIV and AIDS patients. Non-governmental organizations, e.g. the Clinton Foundation, objected to the training of all hospital and clinic doctors and nurses, as the idea was to have dedicated staff focusing on ART treatment, which also led to separate ART clinics within hospital premises and to PHC facilities. This focused training excludes other frontline nurses, as it is seen as specialized training.

With the *Alma Ata Declaration* a holistic and integrated approach to health care is emphasized. The roll out of vertical health programmes such as HIV and AIDS mean values that we now talk about the ART, sexually transmitted infection and the integrated management of childhood illnesses clinics. There is support for both vertical and integrated programmes, but being a professional nurse mean values being multi-skilled. The question can be raised: Can you be a nurse in South Africa without knowing how to care for AIDS patients? To enhance integrative services to HIV and AIDS patients, training in ART and AIDS services is essential for all frontline level nurses (Heunis & Schneider, 2006:268-274).

Counselling for HIV testing was previously done by trained counsellors. Nurses working in the wards and clinics just phoned the ART clinic on site and requested them to send a counsellor to counsel and test a patient in the ward or clinic. However, the DoH relaunched special training for all nurses at the beginning of 2010 to do counselling and testing themselves. During this training they also advised frontline nurses to know their status in order to capacitate them on how to deal with the patients' feelings. One frontline nurse reacted to this training as follows:

“I think it will be more proficient and if I know my status then I will be having more information because to give something that is in black and white written but not having the knowledge of how it is working I don’t think it will make another patient to be clear because there will be knowledge lacking somehow in you as a counsellor as the person who is rendering the service, but if you have tested knowing your personal status you will having more information and then it will be easy to give to others information fully.” (3/3/2:33-39)

- **Theme 3, subtheme 2: Nurses themselves are infected**

It becomes clear with interviewing frontline nurses that the nurse workforce should be motivated to know their status, as it is a reality that the nurse workforce themselves are also infected. The intensity of the AIDS pandemic in South Africa creates additional challenges for frontline nurses in that, apart from the fact that they can also be infected, they have to deal with an increasing number of people who suffer from HIV and AIDS (Hall, 2003:2). The psycho-social and emotional stress of nurses who are known to be HIV positive are even higher, as they still need to care for those suffering from chronic HIV-related illnesses, which makes providing care much more difficult. The following excerpts indicated nurses are infected as well:

“...but really for the infected HIV nurses and staff, we need a policy for staff dealing with compliance, because most of them they don’t comply with the treatment...” (3/7/5/37-39)

“...the newly diagnosed nursing staff, we need a policy for them, seeing they know the status, they not working in the medical wards...” (3/5/1/11-13)

A study done in Uganda indicated that strategies to reduce stigma and assist frontline nurses with psycho-social support and well-being are essential for frontline nurses working with HIV and AIDS patients. The study found that those infected nurses who received the necessary support managed HIV and AIDS patients better than those who were not infected, as they had understanding of the disease (Kyakuwa, 2009:367).

Concluding statements: Theme 3 – Human resource factors relating internally to nurses

- Training currently focuses on the staff who work in settings responsible for the roll out of anti-retroviral treatment (ART) to AIDS patients. Frontline nurses in other health-care services do not have sufficient training to manage HIV and AIDS patients effectively.
- The roll out of ART services is done as a vertical programme and not as part of a comprehensive health-care programme.
- Apart from the fact that nurses themselves are infected, they have to deal with an increasing number of people who suffer from HIV and AIDS.

5.2.4 Process of policy formulation from a frontline nurse's perspective

Interviews also made it possible to obtain information about the policy formulation process followed in an institution from a frontline nurse's perspective. With the process of data analysis the researcher kept in mind the theoretical basis for the process of policy formulation, with reference to the Canadian policy cycle as was discussed in chapter 1, paragraph 1.8.2.3. According to this model there are two phases:

- In the first phase, including steps 1–4, nurses need to get to the policy agenda.
- The second phase involves moving issues and problems into action and includes steps 5-8.

The following excerpts give an indication of the policy process in institutions:

"The policies came from management. Let me show you our policy files. (Participant stood up and fetched the internal policy file). We have internal policies which are drawn up in the institution and here at the back you see we signed after reading the policy stating that we know about the policies." (1/1/2:54-57)

"Our policies are mainly dealt with by our top management. They are the ones who are formulating the policies that we are going to imply in our workplace." (2/4/2:62-64)

"Uhm I cannot be be sure to say who and who are involved. The only thing that I know, I know that our management is responsible for formulating the policies of the hospitals. But I don't

know who is in and who is not in.” (2/4/2:69-71)

“We don’t have inputs as nurses regarding policy formulation. I am working two years here and never seen a draft policy to give input.” (1/1/2:81-82)

“Certainly I’m not eh knowledgeable of that, but what I think is the top management...” (3/9/3:95-96)

“If the policy come to the ward né, the unit manager made a point that all the staff, because we are working in shifts né, this policy are read to them and then also, then they also use to read for themselves, and then they sign, each and everyone who have read the policy before they starts shifts, it should have our signature to make sure that you read that policy.” (2/6/3:133-137)

“There is also a policy file where I can read if I am in doubt. Also in this box there are some guidelines here....developed by the department of health. Hmmm.” (2/5/2:74-80)

“Yes, I am aware of that (policy committee) because on daily basis we do read some policies and sign, even check the review date, the last review date of the policy.” (3/9/2:58-59)

“The information is here né, but in some cases you may fell that, but if they could have ask us this, it this could have been working better, it is going to be better if it was done like this but not like this but it’s already finalized. So it’s only for us to sign that you have received the policy and then you implement it.” (2/6/3:88-91)

Table 5.3 elucidates the opinion of frontline nurses about the steps followed in institutions with reference to the policy process. A discussion about the policy process from a frontline nurse perspective follows.

TABLE 5.3: POLICY PROCESS IN INSTITUTIONS FROM A FRONTLINE NURSE'S PERSPECTIVE

STEP	ACTIONS ACCORDING TO MANAGEMENT
Step 1	All frontline nurses are aware of a policy committee in their institution
Step 2	Policies are dealt with by top management
Step 3	Participants are not able to identify members or stakeholders who are involved in the policy process. Some frontline nurses could identify the occupational and safety and infection control managers
Step 4	Participants never saw a draft policy to give comment on, only finalized policies as stated in the following excerpt
Step 5	Dissemination and implementation of HIV and AIDS workplace policy is the responsibility of the unit manager
Step 6	No clarity on reviewing of policies

- **Discussion of findings regarding policy process in institutions**

It is clear from the analysing of data that all frontline nurses are aware of a policy committee in their institutions. Most of the frontline nurses could not identify who the members on the policy committee were, although some of the frontline nurses mentioned the occupational health and safety and the infection control managers. The steps that were outlined by the frontline nurses did not correspond with the fine detail about the policy process as described by management (see chapter 4, table 4.10). Therefore the conclusion drawn by frontline nurses that policy formulation is a top management function seems to be valid for this study.

A dissemination strategy is in place, as unit managers are responsible for frontline nurses being aware of the HIV and AIDS workplace policy. Frontline nurses are the implementers of policy, as they do not receive a draft policy to give comment on. However, some of them stated clearly that they could make a valuable contribution. The researcher could find no clarity about the reviewing process from a frontline perspective. Concluding statements could be made from the data analysis and follow in the next paragraph. No additional

literature is discussed, as a detailed discussion about the policy process was provided in chapter 1, paragraph 1.4, and chapter 3, paragraph 3.8.

Concluding statements: Process of policy formulation according to frontline nurses

- A policy process is visible in the institutions. Clarity on the functions of this policy committee could not be obtained.
- All members who serve on the policy committee are not known to frontline nurses.
- Frontline nurses are of the opinion that policy formulation is a top management function.
- Frontline nurses received a final HIV and AIDS workplace policy – no draft policy was circulated for input from their side according to them.
- Awareness raising and implementation are done via the unit managers.
- No clarity on reviewing of HIV and AIDS workplace policies.

5.3 RIGOUR

Traditionally rigour in qualitative research is encompassed by the concept, dealt with by the researcher in chapter 1, paragraph 1.11, and is known as trustworthiness.

5.4 SUMMARY

In this chapter the opinion of frontline nurses was obtained about problems experienced with policy in an HIV and AIDS environment from a frontline nurse's viewpoint. In the next chapter the researcher will endeavour to formulate a strategy of how to get nurses from national, provincial and frontline level involved in Nurse led change to influence HIV and AIDS workplace policy.

FORMULATION OF A STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

6.1 INTRODUCTION

The focus of this chapter is the development of a strategy for Nurse led change to influence HIV and AIDS workplace policy at macro (national), meso (provincial) and micro (district or institution) level of governance. A discussion elaborates on what a strategy is, the strategic process and the research findings, which serve as proof of why a strategy needs to be developed. Thereafter the strategy for Nurse led change to influence HIV and AIDS workplace policy at all levels of governance is discussed in terms of the vision, mission, values, principles, assumptions, strategy objectives and functional tactics. The chapter concludes with a discussion of the implementation of the strategy. Table 6.1 indicates that the chapter aim is phase 2, strategy formulation.

TABLE 6.1: PHASE 2, STRATEGY FORMULATION

Phase 1: Empirical research	Phase 2: Strategy formulation
Objective 1: To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.	Step 5: Formulation of a strategy for Nurse led change to influence HIV and AIDS workplace policy.
Objective 2: To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.	
Objective 3: To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.	

Phase 1: Empirical research		Phase 2: Strategy formulation
Objective 4: To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.		

6.2 DEFINITION OF A STRATEGY

Strategies and the process of strategy formulation usually refer to businesses and organizations. However, public health institutions and the different levels of governance in South Africa utilize the methodical steps and therefore the steps are adapted to fit within the context of this study.

A strategy is a planning process in a changing environment in order to formulate and implement actions that will lead to the achievement of the vision or direction of the plan. A strategy is concerned with the establishment of a clear direction for an organization and this direction should be well articulated in vision and mission statements. A strategy entails choices between alternatives, signals specific approaches and ways of functioning to achieve the vision of the plan. All strategies have one common feature: they are created and adapted in a variety of ways, either marginally or dramatically at times. A strategy consists of two phases:

- The formulation of a strategic plan. The formulation phase is aimed at determining the unique and compelling vision and mission of the plan, with recognition of opportunities and threats in the institutional environment.
- The implementation of the strategic plan. The implementation phase refers to putting the strategic plan into effect by means of suitable structures, leadership and a tactical plan. A tactical plan is derived from the strategic plan and determines the objectives that guide specific activities and are also used to evaluate the progress of the plan. The success of a strategic plan implementation depends on strategic and tactical control (Van Rensburg, 2008:60; Ortner, 2004:126; Thompson & Martin, 2005:8; Thompson & Strickland, 1998:1; Pierce & Robinson, 2000:14).

6.3 THE STRATEGIC PROCESS

The strategic process is the way organizations determine their purpose, objectives and desired levels of excellence in functioning. This process is methodical and dynamic, with decisions being made on how to achieve the vision and set objectives in an appropriate time schedule, frequently in a changing environment, by implementing proactive actions while accessing progress reports and results. The strategic process makes it possible to determine functional tactics in order to remain focused on the vision and mission of the strategy. The strategy is continuously adapted because strategies are created in a changing environment. Continuous evaluation of actions is necessary so that whatever changes need to be made, whenever required, can be executed in order to achieve the vision. The magnitude of these changes can be dramatic or more gradual (Van Rensburg, 2008:60-66; Thompson & Martin, 2005:8-12).

- **Key principles to ensure successful strategies**

A few important key principles, adapted to the context of the study, are highlighted to ensure the success of the strategy (Thompson & Martin, 2005:8-12; Turnbull 2002:368-401):

- A strategy should be appropriate for the context in which it is applied.
 - A strategy should be feasible with reference to the available resources, i.e. the skills, capabilities and finances should be in place to achieve the aim of the strategy.
 - A strategy should be desirable for all important stakeholders, internal as well as external. As this study aims to develop a strategy to mobilize Nurse led change to influence HIV and AIDS workplace policy it is important to keep the following aspects in mind:
- The internal stakeholders will be nurses, managers and other stakeholders working in institutions at a specific level of policy process (macro, meso and micro), for example union representatives, the human resource management department and other employees of allied professions.
 - External stakeholders are the Department of Health (DoH) (with reference in this study specifically the directorate for HIV and AIDS and STIs), the provincial DoH directorate for HIV and AIDS and STIs, district health management, with the emphasis on the role of the HIV and AIDS coordinator, politicians, unions, allied health professions and non-governmental organizations (NGOs), to mention but a

few. It is important to realize that strategies fail if they do not meet the expectations of their stakeholders.

- For Nurse led change to influence HIV and AIDS workplace policy successfully in the long term, it is essential that the strategy should encompass a culture of internal co-operation and health service delivery improvement, together with a willingness to learn and adapt to changes due to the dynamic nature of the strategy.
- A strategy needs to create added value for the organization's clients. In this study it should contribute towards better HIV and AIDS patient care because nurses would become more knowledgeable about Nurse led changes to influence the HIV and AIDS workplace policy. This will make them aware that they can give input, even with respect to other policies, to improve health-care service delivery at all levels or make recommendations regarding areas that need further research in order to influence policy formulation by mean values of research-based findings.
- Nurses need to become creative and innovative and start thinking differently to ensure that institutions are responsive to pressure for change. Strategies are a process for continuous change in order to improve performance and to attain the vision.
- Institutions should have the ability to manage strategic change. Changes could be continuous, gradual, incremental or more dramatic, such as a discontinuation.

In this study the strategic process was used to develop a vision and mission, to identify values, principles and assumptions, to formulate strategy objectives and functional tactics to increase the involvement of nurses in HIV and AIDS workplace policy formulation. The strategy was formulated by describing the relationships between the concepts found in the conclusions.

6.4 BASIS FOR STRATEGY FORMULATION

The literature review formed the evidence base for the development of this strategy. Concluding statements were made about barriers for Nurse led change to influence policy process. The empirical research comprised a list of concluding statements firstly with reference to management's opinion about human resource management capacity in an HIV

and AIDS environment, and secondly as the problems experienced with policy in an HIV and AIDS workplace environment from both a management and frontline nurse's perspective.

Concluding statements derived from each chapter of the study were converted into problems identified and were indicated per objective. In the case of a concluding statement identified by both managers and frontline nurses they were mentioned only under management's objective to avoid unnecessary repetition. Table 6.2 represents the concluding statements as well as the problems identified from these concluding statements.

TABLE 6.2: LIST OF PROBLEMS IDENTIFIED BY THE LITERATURE REVIEW AND EMPIRICAL RESEARCH

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
Literature review: barriers to Nurse led change to influence HIV and AIDS workplace policy.	- Frontline nurses are not knowledgeable about the function of SANAC within Parliament or the process of policy at macro (national), meso (provincial) and micro (district or institutional) level. - The representation of nurses involved in HIV and AIDS policy formulation at national level is unsatisfactory. - Nurses are viewed as the implementers of policies. - Nurses' perception of policy is some mysterious national and provincial process and not a function of nurses themselves.	- Nurses not knowledgeable about functions of SANAC. - Nurse representation at national level with reference to HIV and AIDS workplace policy formulation is unsatisfactory. - Nurses are viewed as the implementers of policies. - Nurses think policy formulation is not one of their functions.
	- The roll out of ART services as a vertical programme causes feelings of insecurity among nurses. The fact that many nurses are not trained to treat AIDS patients leaves them feeling insecure, anxious and vulnerable. - Nurses are not aware that they can refine the institutional HIV and AIDS policy within the framework of the national and provincial policy to suit the HIV and AIDS needs of their specific institution. - Top-down approach is followed with regard to the formulation and implementation of the HIV and AIDS workplace policy. - Nurses are dissatisfied with the formulation and implementation of the PEP policy.	- The roll out of ART services as a vertical programme causes feelings of insecurity, anxiety and vulnerability among nurses. - Nurses are unaware that they can refine the national HIV and AIDS policy to suit the HIV and AIDS needs of their specific institution. - Top-down policy approach excludes nurses from the policy table. - Nurses perceived policy prescribed paperwork required for post-exposure prophylaxis (PEP) as blaming them for executing their duties carelessly humiliating.
	- Nurses are not perceived as powerful and autonomous, but rather as powerless and subordinate and are handled dismissively by physicians. - Nurses underestimate the importance of their role; need to strengthen their image and prestige as professionals in order to have confidence to join the policy table.	- Nurses are perceived as powerless and subordinate and are handled dismissively by physicians. - Nurses underestimate the importance of their roles in the health system.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	- The SANC does provide minimum standards for training for all nurses and it provides a basis, but nursing colleges are governed by the DoH and universities by the Department of Higher Education. A collaborative effort will be vital to ensure that nursing retains its status as an independent profession. - Current nursing education does not facilitate the ability of nurses to become involved in the policy process, as the undergraduate curricula and some post graduate courses do not include compulsory policy process training. - Training in policy process is not required by the SANC. - For nurses to become involved in the policy process a strong preparation in economics, finance, behaviour science, epidemiology, decision sciences and health systems is essential.	
		11. Current nursing education curricula offered at universities and nursing colleges do not include training regarding the policy process.
	- Nurses are not politically involved in decisions made regarding their career and work environment. The absence of nurses at the policy table mean values that other disciplines make decisions on their behalf and are then blamed for the predicament that impacts on nurses' self-esteem. - Nurses should utilize their organized professional association to provide input via critical constructive enquiry and active involvement in political decisions to influence the HIV and AIDS work environment of nurses. - Nurses should be involved on macro-, meso- and micro levels of the political process to influence the HIV and AIDS workplace policy by using their knowledge, expertise and experience to work directly with elected politicians.	12. Nurses are not politically active in decisions made regarding their work environment.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	- Research skills of nurses need further development. - Development of and opportunity for scholarships and mentoring within large research programmes are limited in South Africa. - Higher-income countries exclude research funding for nurses from LMIC. - Nurses should not conduct research in isolation, but top-level research scientists from diverse fields should be co-mentors to ensure the advantages of strong mentorship. This will create learning opportunities to improve the quality of nursing research.	13. Nurses lack research skills. 14. Development of and opportunity for scholarships and mentoring within large research programmes are limited in South Africa. 15. Higher-income countries exclude research funding for nurses from LMIC. 16. Nurses conduct research studies in isolation, thus excluding top-level research scientists from diverse fields, resulting in low-quality nursing research.
	Role of nurse at frontline level - Nurses' participation in the HIV and AIDS policy process is minimal, those involved are in senior management positions. - Top-down approach of policy formulation implies that a nurse working at a higher level has more opportunity. - Lack of recognition and respect for frontline nurses' contribution towards addressing the HIV and AIDS pandemic lead to absence from decision-making forums.	17. Nurses' participation in the HIV and AIDS policy process is minimal. 18. Lack of recognition and respect for frontline nurses' contribution toward addressing the HIV and AIDS pandemic lead to absence from decision-making forums.
	Policy process - Policy formulators do not move beyond short-term scramble to improve strategies. - Policy formulators do not focus on long-term re-invent and start-over strategies. - High-quality evidence or research is not utilized in the formulation of policies and a lack of knowledge translation of research results contributes to the situation. - Effective research-policy linkages need to be established. - Understanding of policy cycle is essential to improve policy decisions. - Successful policy agenda setting does not secure changes in the frontline level practice. - Improvement of political acumen enhances nurses' political savvy.	19. Policy formulators do not move beyond short-term strategies and do not focus on long-term re-invent and start-over strategies. 20. Nurses do not utilize research knowledge or strong supportive evidence to drive items on the political agenda to influence health policy. 21. No effective research-policy linkages are established to move items to the policy agenda. 22. Nurses do not understand the policy cycle in order to utilize the process to improve policy decisions. 23. Nurses do not have political insight into how politicians visualize and address health problems. 24. Successful policy agenda setting does not secure changes in the frontline level practice.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	Nurse barriers to acting as change agents - Nurses act as change agents when policies no longer support their desired outcome to render the service they should be providing. - Nurses as change agents are instrumental in managing change and taking changes forward by giving direction and momentum to influence the policy process. - To act as change agents, nurses need strong leadership skills. Nurses are the largest group in the multi-disciplinary health team, but their leadership contribution in policy and strategic planning is still limited. - To be successful change agents, nurse leaders should be able to develop nurses who really advocate change and are able to manage change. - Constant changes in the health environment have a negative impact on nurses who act as change agents. - Change agents should be able to set clear priorities plan strategically and advocate in advance for changes. Nurses are not skilled in these requirements.	- Nursing leaders and policy formulators in the health-care system are not experts at creating and managing change. - Nurses lack skills in identifying key stakeholders who can provide support if they want to initiate changes. - Constant changes in the policy environment have a negative impact on nurses and discourage them from suggesting changes to influence HIV and AIDS workplace policy. - Nurses as change agents are not skilled in strategic planning and advocating in advance for changes. - Nurses as change agents lack skills in the policy arena as well as to network with relevant stakeholders. - Nurses as change agents fail to manage projects successfully.
	- Nurses as change agents lack skills in the policy arena and in networking with relevant stakeholders locally, provincially, nationally and internationally. - Nurses as change agents fail to manage projects successfully. - Nursing leaders and policy formulators in the health-care system are not experts at managing change. - Nurses lack skills in identifying key stakeholders who can provide support if they want to initiate changes. - Change agents should be able to set clear priorities plan strategically and advocate in advance for changes. Nurses are not skilled in these requirements. - Nurses as change agents fail to manage projects successfully.	

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
Quantitative empirical research: management's perspective about human resource capacity in an HIV and AIDS work environment.	Construct: Human resource management (HRM) capacity - Adequate HR staff exists in each institution to maintain basic functions and also develop an HRM policy. - The HRM budget supports human resource activities but does not make provision for additional funds to include activities to support HIV and AIDS strategies, e.g. to ensure a quality workplace prevention programme, drugs and benefits for staff. - Human resource planning seems to be functioning well in all participating institutions.	31. The HRM budget is insufficient for addressing HIV and AIDS workplace issues.
	Construct: Personnel policy and practices - The compensation system is effectively implemented in participating institutions. - The benefits programme does not make provision for dealing with HIV and AIDS-affected staff effectively, e.g. extended sick leave, funeral benefits and free drugs. - Staff retention seems to lag behind the other items. Although data on staff retention rates is available, no analysis is done to determine contributing factors, e.g. how much are declining rates due to HIV and AIDS, how much is due to natural attrition? - Formal procedures for recruiting, hiring, transferring, and promoting staff are used consistently. - The policy of non-discrimination on the basis of HIV and AIDS is consistently applied. - An orientation programme is routinely offered to new or promoted employees. However, managers should emphasize the mission, goals and expected performance with specific reference to HIV and AIDS. - An HIV and AIDS workplace programme is in place in all institutions and focuses on using appropriate protocols to limit the risk of infection and education about HIV and AIDS. - A current employee manual exists and is up to date. There are policies on how staff and clients living with HIV and AIDS are to be treated. - Formal procedures for discipline, grievances and termination exist and include protection against discrimination on the basis of HIV status. - Unions are included in HRM issues on a regular basis.	32. The benefits programme does not make specific provision for HIV and AIDS-infected staff. 33. Lack of staff turnover data analysis results in no clarity about contributing factors.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	A review of labour law is done regularly as a formal part of the HRM function.	
	Construct: Performance management - All staff have job descriptions that are reviewed and adjusted annually. - There is an organizational strategy for HIV infection prevention and the responsibilities of employees are well-defined. - There are established lines of supervision and supervisors understand their roles and functions. - Supervisors are trained in general supervisory skills and HIV and AIDS policies, but need training on how to be sensitive to HIV-related staff issues. A formal system for work planning and performance review is in place for individuals, and supervisors develop individual work plans and performance criteria and review past performance.	34. Supervisors do not receive sensitivity training on how to respond to employees' questions relating to HIV and AIDS.
	Construct: Training - Training is a formal component of institutions and is linked to staff and organizational needs. - Training relating to questions and strategies in dealing with HIV and AIDS is provided as an official priority of the institution. - Management and leadership development opportunities are available on a regular basis. - A loose relationship exists between the institution and pre-service training institutions, who do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector, nor to prepare people to work in HIV and AIDS prevention and or/treatment programmes.	35. Pre-service training institutions do not formally update their curricula to include new HIV and AIDS information that is implemented in practice via new policy requirements.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
Qualitative empirical research: policy problems experienced in an HIV and AIDS workplace environment from a managerial perspective.	Management: Inevitable HIV and AIDS reality - The health-care system is already markedly under-resourced due to an increasing number of patients. - Nurses are caregivers who provide physical and emotional care to patients. The demanding nature of nursing HIV and AIDS patients leads to occupational stress, fatigue and burnout. - Nurses are dissatisfied with the post-exposure prophylaxis (PEP) policy. - Lower productivity and performance in the workplace are experienced. - Nursing staff shortages are exacerbated by international recruitment programmes and poor working conditions.	36. The confidential nature of the disease is problematic in the workplace environment, especially with regard to PEP management. 37. Lower productivity and performance in the workplace are experienced due to increased workload, low staff morale and loss and death of their colleagues. 38. Nursing staff shortages are exacerbated by international recruitment programmes and poor working conditions.
	Concluding statements: Theme 2 – Organizational factors - Nurses know the universal precautions to prevent the risk of HIV transmission due to occupational exposure. - Nurses are concerned about the low quality and frequent unavailability of gloves, aprons, masks and incontinence aids. - Stigma and social factors are important barriers in addressing HIV and AIDS in the workplace. - To receive HIV and AIDS treatment in their workplace would require nurses to disclose their status, which could lead to stigma. The workplace environment does not provide security for the nurses regarding de-stigmatization. - Nurses fear judgment against their personality and sexuality because of the moral preconception that HIV and AIDS are mostly seen as sexually transmitted. - The nurse must also undergo VCT to prove to the compensation commissioner that they were negative at the time of the occupational exposure. Refusing VCT negates any future claims with regard to HIV and AIDS as occupationally acquired. - ART drugs also have side effects and often nurses do not complete the PEP drugs as prescribed. - More private collaboration services may be possible to make VCT more acceptable to nurses.	39. Low quality and frequent unavailability of gloves, aprons, masks and incontinence aids cause difficulties in the implementation of universal precautions. 40. Stigma is a persistent barrier to addressing HIV and AIDS in the workplace. Nurses do not want to disclose their HIV status due to fear of discrimination. 41. Nurses fear judgment against their personality and sexuality. 42. No wellness programme or a full occupation health clinic within the institution for staff. 43. Provision of PEP treatment after occupational exposure not possible without the informed consent for HIV testing from the source patient, which is often refused. 44. Nurse must prove HIV-negative status at time of occupational exposure to qualify for compensation in case of sero-conversion. 45. Management does not offer ongoing counselling to assist infected and affected nurses to cope with the demands of HIV and AIDS.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	▪ The cost of a comprehensive wellness programme is a tremendous challenge. ▪ Comprehensive health services to nurses and other staff can ensure a healthy workforce that will be able to deliver a high standard of health services. ▪ A wellness programme that includes occupational health-related issues, management of minor ailments and chronic conditions is required. It is important that this service should be rendered in such a manner that nurses can access it in an effortless way ▪ Rendering a comprehensive service throughout, not specific with time slots for specific conditions, will ensure nurses' confidentiality. ▪ Ongoing counselling to assist infected and affected nurses to cope with the demands of HIV and AIDS. ▪ Nurse managers give attention to placements, depending on the current physical condition of the nurse. Many institutions are as yet not accredited as ART centres, which contributes to the fact that ART is not available to many nurses in rural areas.	46. ART drugs are not available to many rural nurses as institutions are not yet accredited ART centres. 47. Training of replacement staff is unsatisfactory as the loss of experience cannot easily be replaced. 48. Training programmes in the workplace do not equip nurses with sufficient knowledge about HIV and AIDS issues. 49. Nurses practising in settings other than ART centres are afraid to work with HIV and AIDS patients and to answer questions about the subject, as they lack the correct information (only nurses in ART centres receive specialized HIV and AIDS training). 50. The incapacity of the infected nurse increases the workload on the remaining nurses. 51. Disruption in service delivery and financial/emotional trauma in the workplace are caused by AIDS, leading to prolonged illness, absenteeism, disability and death. 52. Skilled nurses lost due to their denial of their condition.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	Concluding statements: Theme 3 – Human resource factors relating internally to nurses - Increased need for training of replacement staff and compromised potential for mentoring and skills transfer. - Training in the workplace should start with sufficient knowledge of HIV and AIDS issues among all levels of staff so that all nurses should have updated information about HIV and AIDS. - HIV and AIDS training given to nurses working in ART clinics but not to those working in PHC centers and hospital wards. - The incapacity of the infected nurse increases the workload on the remaining nurses and the increasing demand for service delivery lowers the morale of remaining nurses due to an increase in workload, the loss and death of their colleagues. - AIDS causes prolonged nurse illness, absenteeism, disability and death, resulting in serious financial/emotional trauma and disruption in service delivery and resulting in loss of skilled nurses due to denial. Concluding statements: Process of policy formulation according to management A process could be derived on reflection and analysis of interviews by the researcher and included the following steps: - Situation analysis on the current situation regarding HIV and AIDS. - Dissemination of information that the institution had an affected and infected workforce. - Management took the national HIV and AIDS policy into consideration and compiled a draft workplace policy. - The draft policy is forwarded to staff for feedback. - After staff input the final HIV and AIDS policy was formulated with an extensive input from the human resource department (policy feedback loop). - Finally, awareness raising and sensitizing of all employees to the policy. - Clinical audits are done to ensure that implementation problems are smoothed out.	53. Only top-level management deals with policy process and decisions. (Data analysis from nurses.) 54. Nurses are certainly not empowered to deal with policy process.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	- Any problems identified with the implementation of the policy are then re-addressed. - A manager felt that nurses are certainly not empowered to deal with policy process. - Managers admit that they are not good with policy issues and the intimation of the nurses was that not all unit managers are aware of the ongoing policy process.	

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
Policy problems experienced in an HIV and AIDS workplace environment from a frontline nurse's perspective.	1. Theme 1: Inevitable HIV and AIDS reality (nurses' conclusions) - HIV and AIDS magnify the workload of the frontline nurse due to an increased number of HIV and AIDS patients and lead to increased occupational exposure. - The unknown HIV status of patients causes uncertainty amongst nurses and leads to negative attitudes, discrimination and stigmatization towards the patient. - Taking care of terminally ill AIDS patients is emotionally and physically taxing because they need more care and support. - Nurses have a problem in viewing themselves in their traditional role as healers because they know these advanced-stage HIV and AIDS patients will not recover. - The main reasons for needle-prick injuries are lack of training on the prevention of needle-prick incidence, long working hours and factors relating to working habits, e.g. recapping of used needles, not using protective gloves and limited experience in the nursing profession.	55. Increased numbers of HIV and AIDS patients lead to increased occupational exposure. 56. Taking care of terminally ill AIDS patients is emotionally and physically taxing because they need more care and support. 57. Nurses also have problems in viewing themselves in their usual role as healers because they know these advanced-stage HIV and AIDS patients will not recover. 58. Lack of training, long working hours and limited experience in the nursing profession result in needle-prick injuries.
	Concluding statements: Theme 2 – Organizational factors - To qualify for post-exposure prophylactic (PEP) treatment the nurse needs to give consent for testing their HIV status. If the nurse does not want to determine their status they relinquish the right to qualify for compensation for occupational injuries. - Stigma remains persistent. Infected nurses have been unfairly blamed, discriminated against, rejected and alienated. - Nurses have allowed their own prejudices or moral values to influence the care of HIV and AIDS patients and judge their colleagues. - The employee assistance programme (EAP) should be implemented correctly.	59. The employee assistance programme (EAP) is not implemented, thus resulting in lack of support to HIV-infected staff.

RESEARCH COMPONENT	CONCLUDING STATEMENTS	PROBLEMS IDENTIFIED
	Concluding statements: Theme 3 – Human resource factors relating internally to nurses • Training currently focuses on the staff who work in settings responsible for the roll out of anti-retroviral treatment (ART) to AIDS patients. Frontline nurses in other health-care services do not have sufficient training to manage HIV and AIDS patients effectively. • The roll out of ART services is done as a vertical programme and not as part of a comprehensive health-care programme. • Apart from the fact that nurses themselves are infected, they have to deal with an increasing number of people who suffer from HIV and AIDS.	Problems identified were incorporated under management discussion: Human resource factors relating internally to nurses.
	Concluding statements: Process of policy formulation according to frontline nurses • A policy process is visible in the institutions. Clarity on the functions of this policy committee could not be obtained. • All members who serve on the policy committee are not known to frontline nurses. • Frontline nurses are of the opinion that policy formulation is a top-level management function. • Frontline nurses received a final HIV and AIDS workplace policy; no draft policy was circulated for input from their side according to them. • Awareness raising and implementation are done via the unit managers. • No clarity on reviewing of HIV and AIDS workplace policies. • Policy a top-level management function.	Problems identified have already been discussed under management policy process.

6.5 STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

The strategy for Nurse led change to influence HIV and AIDS workplace policy was formulated by using a process to develop a vision and mission, identify values, principles and assumptions, and each step is discussed in more detail in the following paragraphs.

6.5.1 Vision

Developing a vision is the first step in the strategic process and it provides a framework for strategic planning. The vision statement answers the question: What do we want to become? or Where do we want to go? and therefore focuses on what the long-term direction of the strategy is. The vision of this study denotes the direction or purpose to influence HIV and AIDS workplace policy through Nurse led change and serves as a „road map“ for the desired future (Thompson, *et al.*, 1998:5; Skelton-Green, *et al.*, 2007: 1-15).

The vision of this strategy is to influence HIV and AIDS workplace policy through Nurse led change.

6.5.2 Mission

The mission statement embodies the philosophy, values, identity, character and priorities of service delivery of an organization and also reflects the image the organization wants to reflect. The mission is the task, together with the purpose, that clearly indicates the action to be taken and the reason for this (Pierce & Robinson, 2007:63-68; Thompson, *et al.*, 1998:4).

The mission of the strategy is to empower nurses to become change agents to influence HIV and AIDS policy by utilizing levers such as high-quality evidence or research, establishment of effective research-policy linkages, effective management of change initiatives, using of policy cycles and political acumen to engage with management and the political arena in order to improve their workplace conditions and service delivery.

6.5.3 Values

Values are freely chosen, enduring beliefs or an attitude towards a person, object, idea or organization (Morton, 1996:165-166). In an organization values determine the way decisions

are made and embody what the organization stands for. However, it is important for these values to be widely accepted by all stakeholders (Thompson, *et al.*, 2005:257). Nurse led change to influence any policy must be firmly grounded in a supportable set of values and cultural beliefs (Shamian, *et al.*, 2010). In this study the following basic beliefs or values are supportive of Nurse led change.

The following beliefs and values underline the strategy development for this study:

- SANAC is committed to reducing the number of new HIV infections and to the reduction of the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV (SANAC 2007:10). The citizens believe that government will address the HIV and AIDS pandemic effectively and any Nurse led actions that can assist SANAC to reach this goal be a dominant value.
- Nurses are an essential part of the health-care delivery system (Harrison, 2010:27). Addressing the HIV and AIDS workplace policy issues will assist in improving HIV and AIDS services.
- Collaboration is a voluntary and willing association with and interaction between individuals and organizations with a common destiny that bring diverse skills and perspectives to a project and contribute towards the objectives agreed upon (Dictionary.com, 2010). The Nurse led change strategy needs to be underpinned by the value of strong collaboration between participating stakeholders as the nurse, acting as a change agent, should enable and utilize shared responsibility in the team for the planning, implementation and evaluation of change initiative, because every stakeholder brings different skills, experience and network connections to the team.
- Integrity is an unconditional and steady commitment to moral values and ethical principles as well as mean valueingful, mature and coherent unity between the person's existing moral values and actions. Integrity refers to the quality of a person that can be counted upon to give precedence and adherence to moral values and ethical principles, even when there is strong inducement to pursue self-interest or personal desires (Dictionary.com, 2010). Integrity in this study emphasizes that each team member is committed to contributing toward the successful implementation of strategy.
- Respect mean values to acknowledge and consider every team member's unique contributions (Dictionary.com, 2010). The key stakeholders should be influential in ensuring that Nurse led change to influence HIV and AIDS workplace policy is

successful and that each member's unique contribution will lead to success in the change process.

The abovementioned beliefs and values were adhered to in the formulation of the vision, mission, strategy objectives and the functional tactics of the strategy for Nurse led change to influence HIV and AIDS workplace policy.

6.5.4 Assumptions

The strategy for Nurse led change to influence HIV and AIDS workplace policy is affected by several assumptions. The explicit statement of these assumptions is important, as it provides a point of departure for the interpretation of the strategy and ensures mutual understanding between the researcher and the reader.

The strategy for Nurse led change to influence HIV and AIDS workplace policy is affected by the following assumptions:

- The strategy is developed for use within the public health context of the North- West Province of South Africa.
- The development of the strategy must be interpreted in terms of the pragmatic assumption, which is problem-solution generated.
- In this strategy the focus is on Nurse led change to influence HIV and AIDS workplace policy in order to improve the workplace environment and service delivery to HIV and AIDS patients. Nurses as change agents have strong leadership skills and are able to visualize and initiate changes by being strategic, engaging stakeholders and manage the change project effectively if existing policies do not address their desired outcome. With reference to this, study nurses acting as change agents are necessary to address problems experienced with policy in the HIV and AIDS workplace environment in order to provide better service delivery to HIV and AIDS patients.
- The theoretical point of departure was the policy cycle as adapted by the Canadian Nurses Association (CNA). An unpublished chapter, provided by and used with the permission of the authors Shamian, *et al.* (2010), assisted the researcher in obtaining greater clarity on the CNA policy cycle and the policy process, and this theoretical premise forms the basis for nurses to act as change agents. Nurses using the strategy will be able act as change agents if they have sound knowledge

of the eight-step policy cycle (see chapter 1, section 1.8.2 and chapter 3, paragraph 3.8.2). Nurses also need to know what it mean values to be a change agent and how to act as a change agent (see chapter 3, paragraph 3.9). Knowledge about the policy process is essential for acting as a change agent (see chapter 3, paragraph 3.8).

- The vision of the strategy gives rise to the mission, and both are driven by the values, principles and assumptions of the strategy, which is based on nurses acting as change agents to lead change and to influence HIV and AIDS workplace policy.

6.5.5 Strategy for Nurse led change to influence HIV AND AIDS workplace policy

The strategy was developed within the HIV and AIDS workplace policy context. In the paragraphs below the strategy is discussed according the set objectives for the strategy from the perspective of the researcher.

6.5.5.1 HIV and AIDS workplace policy process context

HIV and AIDS workplace policies are formulated at macro (national) level, disseminated to meso (provincial) level, which formulates guidelines and gives training to microlevel managers of district institutions on how to implement the HIV and AIDS workplace policy. Management at microlevel gives training to unit managers, who are responsible for ensuring that nurses are informed on how the policy should be implemented to achieve the set objectives.

The aim of the strategy is to balance the top-down approach, followed with a bottom-up approach. The bottom-up approach suffices when frontline nurses give feedback regarding problems experienced with the HIV and AIDS workplace policy, with proposed solutions, to their managers. The managers take their suggestions to the policy committee of the institution.

The management of institutions refines problems and solutions in a report and then discusses problems with the district health management (microlevel). From microlevel district management uses the policy feedback loop to discuss nurses' concerns with the management of the Directorate HIV and AIDS and STIs at meso (provincial) level. The management of the Directorate HIV and AIDS and STIs at meso (provincial) level use the policy feedback loop, refine their guidelines by incorporating changes if required on their

level and use the policy feedback loop to communicate the adaptations of provincial guidelines back to micro (district or institutions) level for further discussion and implementation.

If the policy problems with the HIV and AIDS workplace policy fall outside the jurisdiction of the meso (provincial) level, they will use the policy feedback loop to communicate policy problems experienced to macro (national) level management, in this study the Directorate HIV and AIDS and STIs. The national HIV and AIDS workplace policy can be adapted, changed or amended by incorporating suggestions from micro and mesolevel. If this is not possible, feedback should be given by again using the policy feedback loop via meso (provincial) to micro (district and institutions) level, indicating the reasons why proposed changes cannot be accommodated. This will ensure understanding and buy-in in the HIV and AIDS workplace policy and provincial guidelines at microlevel. This strategy will balance the top-down approach with a bottom-up approach and frontline nurses will be more cooperatively to implement changes in the HIV and AIDS workplace policy as their concerns was considerate.

6.5.5.2 Nurses act as change agents

It will not be easy to change the HIV and AIDS workplace policy context by using the policy feedback loops if nurses do not act as change agents and take the lead to initiate changes in the HIV and AIDS workplace policy by strategically planning the change initiative, identifying stakeholders according to the level where the initiative is facilitated, and managing the change. Nurses should therefore be change agents at micro, meso and macrolevel.

6.5.5.3 Nurses act as change agents using the policy cycle

Nurses acting as change agents should use the policy cycle to ensure nurses' concerns are getting on the policy agenda, especially at meso and macrolevel, and moving forward to be addressed.

6.5.5.4 Training

Training institutions should look at ways of incorporating changes in their curricula to include training about the policy cycle, leadership skills, acting as change agents, research skills and the successful establishment of research policy links. These training needs are essential to prepare nurses practising in different roles for perceiving the influencing of policy decisions relating to their practice as their responsibility.

6.5.5.5 Stakeholders

Different stakeholders needed to be identified according to the level at which nurses want to influence HIV and AIDS workplace policy decisions. At micro (district and institutional) level every institution that participated in this study did have a policy committee. Frontline nurses should utilize communication channels to address their concerns with regard to policy problems experienced when working in an HIV and AIDS environment by talking to their immediate manager or utilizing union representatives within the institutions to move the concern to management and the policy committee. Nurses need to identify relevant, skilled key stakeholders who are interested in the work environment of nurses to influence the HIV and AIDS workplace policy in order to improve service delivery to HIV and AIDS patients at the end.

Key stakeholders that nurses can identify include members of SANAC, DoH: Directorate HIV and AIDS and STIs, non-governmental organizations, organized nursing organizations and unions, policy committees at different levels of government, politicians, representatives of national, provincial or local AIDS councils. As was stated before, members identified will depend on the level at which nurses want to influence the HIV AND AIDS workplace policy.

6.5.5.6 Evaluation of strategy

The strategy objectives and the actions as set out in the tactical plan were used to evaluate the implementation of the strategy. The evaluation is a continuous process as policy changes do not happen overnight. A strategy is also a continuous process that does not include sequential steps, as strategies need to be adapted when changes in the practical environment appear.

A schematic representation of a strategy for Nurse led change follows in figure 6.1.

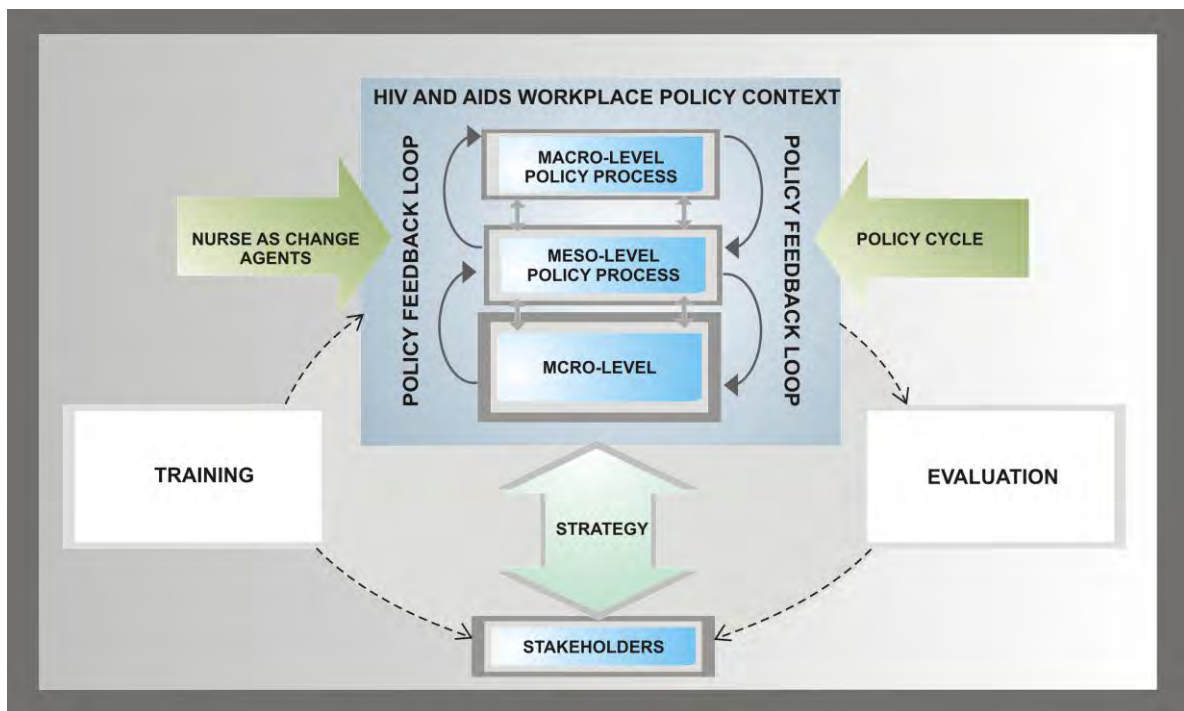


FIGURE 6.1: STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

6.5.6 Principles

Principles refer to an accepted or fundamental basis of conduct or management for application in action (Dictionary.com, 2010). In order to substantiate the principles of the strategy for Nurse led change to influence HIV and AIDS workplace policy, the researcher applied the principles of the SANAC National Strategic Plan 2007-2011 (SANAC, 2007:9), as outlined in table 6.3, to this study.

TABLE 6.3: APPLICATION OF SANAC PRINCIPLES TO THE STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

SANAC PRINCIPLES	APPLICATION
1. Leadership.	Nurses who act as change agents need to have strong leadership skills to develop strategic plans, engage important stakeholders and manage the change initiative. Nurse leaders should be able to develop a clear plan on how they are going to manage the change project, including the tactical plan and evaluation of the strategy (Skelton-Green, <i>et al.</i> , 2007:1).
2. Effective communication.	Communicating effectively and deliberately with key stakeholders is crucial for ensuring effective development and implementation of the change initiative. Nurse leaders need to inform stakeholders on many occasions about the key features and progress of the change initiative and how their specific skills contribution assists in its effective implementation. It is also important to communicate the key features and benefits to a group of constructively critical colleagues to re-invent additional changes if necessary (Skelton-Green, <i>et al.</i> , 2007:8-9).
3. Effective stakeholders.	Nurses as change agents need to identify influential and supportive stakeholders who have the potential and skills to promote and direct the adoption and implementation of the change initiative. These stakeholders are the change initiatives' best networkers, as they can do a great deal to ensure its success. Nurse leaders need to give them the necessary recognition and information in order to maintain their commitment and endorsement (Skelton-Green, <i>et al.</i> , 2007:8-10; Hague & Harrop, 2007:381). Depending on the level of policy influence (e.g. at national level), stakeholders in this study included key members of SANAC, members of the national and provincial DoH HIV and AIDS and STIs directorate, management, political leaders, South African Nursing Council (SANC) representatives, Democratic Nursing Association of South Africa (DENOSA) and unions. In the case of stakeholders at microlevel these were all the people dealing with the policy process at district or institutional level, called the internal stakeholders.

SANAC PRINCIPLES	APPLICATION
4. Promoting social change and cohesion.	Nurses as change agents should influence HIV and AIDS workplace policy at all levels in order to facilitate social change and behaviour within the workforce. Nurses should view their infected colleagues and HIV and AIDS patients as people who suffer from a chronic disease and not isolate or neglect them due to their infective status. The change initiatives can result in addressing HIV and AIDS stigma issues in the workplace (Holzemer, <i>et al.</i> , 2007:1002).
5. Sustainable programmes and funding.	The nurse as change agent should determine what will be the required in terms of resources, including human resources, supplies and capital during the preparation of a strategic plan. They should further investigate the potential funding sources, e.g. donations or grants, and identify the potential savings, e.g. if the change initiative reduces staff turnover by improving the workplace environment and improves effective HIV and AIDS patient care. The nurse leader should also build opportunities to capacitate staff members to gain experience in managing change, as this component can increase the success and adoption of the change initiative (Skelton-Green, <i>et al.</i> , 2007:11-13).

6.5.7 Strategy objectives

In the strategic process, strategy objectives are the long-term goals that are determined in line with the organization's vision and reflect the organization's direction. Long-term goals are the statements that are made to indicate the results that an organization seeks to achieve over a period of time (Thompson, *et al.*, 1998:5).

In this study the aim of the development of a strategy was Nurse led change to influence HIV and AIDS workplace policy. The strategy objectives were determined in line with the vision, mission, values, principles and assumptions of the strategy and based on the fifty nine (59) problems, as indicated in chapter 6, paragraph 6.3, identified from the comprehensive literature review and empirical research. The fifty-nine (59) problems identified were clustered together through deductive logic to develop five strategy objectives based on the CNA policy cycle, as depicted in chapter 3, paragraph 3.8.3, with the goal of ongoing involvement of nurses to influence health policy through active engagement within the policy arena, policy process and policy cycle, and the integrated approach to change leadership explained in chapter 3 paragraph 3.9.2. Table 6.4 defines the five strategy objectives for

Nurse led change to influence HIV and AIDS workplace policy, with the corresponding numbers of the problems identified in table 6.2 linked to them.

TABLE 6.4: STRATEGY OBJECTIVES FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

STRATEGY OBJECTIVE	PROBLEMS IDENTIFIED
To promote Nurse led change in the HIV and AIDS workplace policy process at macro, meso and microlevel.	1, 2, 3, 5, 6, 7,8,12, 17, 18, 19, 23, 24, 25, 26, 27, 29 & 53.
To address policy problems experienced working in an HIV and AIDS environment.	4, 30, 31, 32, 33, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 55, 56, 57, and 59
To initiate steps to improve the image of nursing so that they can have the confidence in using the policy cycle.	9 and 10.
To facilitate nurse training with reference to the policy process, utilization of the policy cycle, leadership skills and how to act as change agents to influence the formulation of health policies.	11, 22, 23, 28, 34, 35 and 54
To empower nurses" research skills to assist them in conducting high-quality research and to use research results to promote informed policy decisions.	13, 14, 15, 16, 20 and 21.

6.5.8 Functional tactics

The strategy objectives serve as the basis for more specific functional tactics or short-term goals, which are formulated at an operational level and can be monitored and evaluated (Pearce & Robinson, 2000:360). Functional tactics provide broad guidance on key activities that should be performed at different levels, but more detailed guidance is often necessary, which is then provided by policies (Ehlers & Lazenby, 2010: 343).

In this study, functional tactics were developed from the strategy objectives in table 6.4, which were in turn based on the fifty-nine (59) problems identified in table 6.2 from the comprehensive literature review and the empirical research. Table 6.5 depicts the functional tactics linked to the strategy objectives

TABLE 6.5: FUNCTIONAL TACTICS PER STRATEGY OBJECTIVE

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
1. To promote Nurse led change in the HIV and AIDS workplace policy process at macro, meso and microlevel.	1. Policy problems at macrolevel with reference to nurses • Cultivate and maintain relationships with relevant stakeholders who are influential, knowledgeable and interested in improving nurses' HIV and AIDS workplace environment to be conducive to service delivery, especially for frontline nurses. Collaboration with the nine provincial Directorate HIV and AIDS and STIs managers and HIV and AIDS coordinators can be used to keep abreast of the problems experienced in the frontline nurse HIV and AIDS workplace environment. Macrolevel nurses can motivate HIV and AIDS coordinators to obtain information from different districts of what the actual problem is that nurses experience with the HIV and AIDS workplace policy. The relevant stakeholders and decision-makers can be informed and kept updated on these problems. • Directorate HIV and AIDS and STIs nurse leaders should become knowledgeable about current developments on policy-relevant issues. What is the incidence of occupational exposure in South Africa? What are the leading causes – long working hours, increased HIV and AIDS morbidity and mortality, wrong clinical practices in place? How many of these occupational exposures sero-convert and what is the latest research available to prevent and manage occupational exposure? How satisfied are nurses with the steps the DoH put in place to prevent occupational exposure? • Use the opinions of organized nursing organizations in South Africa and the South African Nursing Council to explicitly state in policy briefs, memorandums and during salary negotiations with the DoH what they expect from macrolevel to address HIV and AIDS workplace policy problems. • Train nurses how to create linkages between nursing research, political and policy-related activities. The moment the policy window opens, problems with reference to HIV and AIDS workplace policy can be forwarded and these linkages can assist to establish support and evidence to move problems forward to the policy agenda. • Develop clear, well-informed, jargon-free communication when interacting with policymakers through policy briefs and research reports that are user friendly. These policy briefs and user friendly research reports should be published in magazines that are frequently read by politicians. Be an informed nurse leader. Policymakers need to understand the problem clearly, what possible solutions can be proposed and the consequences and cost implications of such solutions.

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	• The top-down approach of policy formulation excludes nurses from the policy table, and while those nurses involved in the national and provincial DoH are more informed, have a solid background on why a policy is formulated and how it should be implemented, this does not ensure understanding of problems experienced by frontline nurses. Create a policy feedback loop with frontline nurses who can explain the problems experienced with the HIV and AIDS workplace policy, and then share this information with district HIV and AIDS coordinators and national DoH: Directorate HIV and AIDS and STIs via the provincial DoH. Make sure communication channels are in place to communicate the reaction of the national Directorate HIV and AIDS and STIs to this policy feedback. This can result in exposure of frontline nurses to the policy process, they feel valuable to the service, and at the same time the top-down approach of policy formulation is balanced with a bottom-up approach, which is the ideal way to deal with the HIV and AIDS workplace policy. • Change-led nurses employed at macrolevel should make the effort so that they are not visualized by politicians and other stakeholders as managers who merely oversee the implementation of HIV and AIDS workplace policy and become part of policy formulation committees. • Leadership change initiative is necessary to drive the abovementioned initiatives. Nurse leaders in the Directorate HIV and AIDS and STIs can act as change agents to use policy gaps opening at national level. Nurse leaders can use levers to shape and influence health policy at macrolevel. • Ensure the availability of high-quality research evidence. Knowing exactly what the emerging problem is now, what the latest research revealed, how the problem is addressed internationally and in neighbouring countries. Can the suggestions be applied in the South African context? Being an updated change agent who will be able to supply relevant information the moment it is needed. • Establish effective research-policy linkages, lobbying with various stakeholders interested in the HIV and AIDS workplace environment. Keep key informant stakeholders up to date with short bits of information at strategic times e.g. elevator speech. Keep stakeholders up to date on where the change initiative is and what is needed to move it forward. Identify for key stakeholders what they can contribute to ensure that the change initiative is moving forward. • Enhance leadership skills by participating in course work offered by leadership institutions such as the Dorothy Wylie Nursing Leadership Institute, which prepares the nurse leader to initiate policy changes and manage these changes. • Have a good understanding of the working of the policy cycle by doing a policy course at a leading university, e.g. the online course offered by the Canadian Nurses Association. • Ensure understanding of the way politicians think about and deal with health problems. Leadership institutes and/or political study courses can assist the nurse leader to obtain political insight on how political leaders prioritize health problems.

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	Policy problems at macrolevel with reference to policymakers: - Policy formulators do not move beyond short-term strategies and do not focus on long-term „re-invent“ strategies. Long-term re-invent strategies refer to a strategic plan that is implemented. If set objectives appear not to be achieved in the set time, rethink ways of how to deal with the delay and re-plan to achieved set objectives. Many studies were done on the impact of HIV and AIDS on the nurse workforce but to date, as indicated by this study, most of the problems identified relate to the work environment of the nurse and still have not been addressed satisfactorily. Nurse politicians in the DoH need to be the change agents, questioning why these problems are constantly identified in studies and what can be done to ensure that they are addressed by the HIV and AIDS workplace policy while being strategic in moving the problem to the agenda in the SANAC committee for incorporation in their strategic plan. With nurses being the driving force of the health services, what do policymakers do to assist them to address the HIV and AIDS pandemic: Policy problems at meso and microlevel: Nurse led change initiatives: Nurses at meso and microlevels should be empowered to initiate changes so that problems identified are addressed at their level of practice, either by provincial guidelines formulated within the frame of the national DoH HIV and AIDS workplace policy, or at institutional level. - Frontline nurses should be trained to understand the policy process in the institution. Frontline nurses should be part of the policy committee as an individual or through their union representatives. Mobilize issues to be discussed and addressed or to be forwarded to a higher level for attention. Nurse led change has the ability to move agenda items forward by identifying and involving informed, skilled and experienced stakeholders to assist them to influence HIV and AIDS workplace policy, e.g. elected political stakeholders at governance level, a member of the provincial or local AIDS council, union members, managers with skills and networks to address or move forward with a policy feedback loop, as discussed in the next paragraph. - The role of the policy feedback loop via district level to provincial level and to national level was outlined in chapter 1, paragraph 1.4. Clear communication channels should be in place in order to assure frontline nurses that their contributions towards policy problems are welcome at meso and macrolevels, are dealt with or at least considered and they informed about the outcome.

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	Facilitation of Nurse led change Nurses should receive training about leading change and how to act as change agents, the integrated approach to change leadership, the policy process and the policy cycle. The Democratic Nursing Association of South Africa (DENOSA) has nine provincial offices and a head office situated in Pretoria and they can be approached to conduct leadership courses, e.g. a three-day workshop three times a year, which could expose many nurses to the policy process, policy cycle and how to lead as a change agent. Universities can also conduct short courses on the same topics. The chair of the Forum of University Deans of South Africa (FUNDISA) could also assist in identifying universities who offers policy courses.
2. To address policy problems experienced working in an HIV and AIDS environment.	2. Policy problems experienced working in an HIV and AIDS environment A total of twenty-eight (28) problems were identified with this study. These problems are divided in subcategories and tactics needed are discussed under each subcategory. Problems identified relating to HIV and AIDS workplace policy - Nurses not satisfied with the PEP policy need a Nurse led change initiative: National DoH and officials from the compensation commissioner should conduct training with the staff of the Directorate HIV and AIDS and STIs, including the provincial HIV and AIDS coordinator, about why the reports need to be completed, how management and the general practitioner should assist nurses who had an occupational exposure incident and what follow-up support can be given. Guidelines should be formulated, information disseminated and training workshops provided to district HIV and AIDS coordinators and institutional managers and nurse managers. These managers can reach frontline nurses via the policy committee of the institution. Actions to refine institutions' internal HIV and AIDS workplace policy, e.g. managers or supervisors should know how to deal with problems. Nurses with HIV and AIDS experience have a well-established network and resource system of referral agencies available to refer nurses in case they need the help of other multi-disciplinary team members. - Low quality and frequent unavailability of gloves, aprons, masks and incontinence aids cause difficulties in the implementation of universal precautions, see chapter 4, paragraph 4.3.1.2. Nurses should report these issues to their supervisors. The supervisor should contact the pharmacy head of the district and she should contact the supplier in case of a problem with the low quality of gloves etc. If necessary, steps can be taken to withdraw any further ordering of gloves. The frequent unavailability of universal protection material is due to poor stock control within the institutions. Orders from the pharmacy are done haphazardly and the institution, usually a rural clinic, runs out of stock. Every effort should be made to prevent this from happening. Every district does have an HIV and AIDS coordinator available and she needs to be

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	contacted in case of continuous of stock shortages. Every clinic does have a provincial guideline on how drugs should be ordered to ensure enough supplies. • The occupational clinic should include treatment for all common conditions, chronic diseases and anti-retroviral drugs. This is a costly project, but literature discussed in chapter 4, paragraph 4.2.3.1 suggested that these services should be available. Currently the trend in private companies in South Africa is to supply especially ART drugs to staff due to the impact on pension funds in case of death or disability, see chapter 4, paragraph 4.2.3.1 • Training to be conducted by the HIV and AIDS coordinator in each district, managers should know how to support and which referral sources in there district are available, for referral if necessary. • To prevent needle-prick injuries, training should be conducted on universal precautions by the district HIV and AIDS coordinator. The occupational and safety manager of the institution should oversee that the correct disposal containers are available, staff should replace it when the needles reach the mark that the supplier indicates as the replacement level. • Management and the policy committee should oversee the implementation of the employment assistant programme. A psychologist, social worker, doctor or the HIV and AIDS coordinator can sensitize supervisors and management on how to offer the necessary support to nurses who are infected themselves or are affected by caring for a family member at home. Nurse led change at macro-,meso- and micro levels are essential on how to deal with the infected nurse's workforce. Change initiatives should be facilitate in such a way that support is given to those nurses who are infected or affected as well as support to remaining healthy nurses so that they are not unnecessarily overburdened, e.g. at microlevel infected nurses can be allocated to wards where they have a smaller risk of becoming ill with opportunistic infections, resulting in lower absenteeism rates. Human resource department issues • The human resource department should analyse reasons for staff turnover, as this is essential for human resource planning in the institution. The total number of HIV-infected nurses is not known to management and an audit on sick leave notes will further assist human resource planning, as the institution can plan to recruit skilled trained staff well in advance. Change initiatives by nurse leaders to assist the human resource department to ensure a strategic plan are developed, which includes action to address the absence and loss of experienced and skilled nurses. Keep the institutional policy committee up to date about progress, as this can lead to an overburdened workforce, aggravated by unnecessary absenteeism, depression and low staff morale, resulting in unnecessary occupational exposure incidents.

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	• The human resource department should evaluate the performance of staff against set objectives and if required, remedial support can be given or staff underperformance can be dealt with. Managers and supervisors can assist with performance evaluation. Performance data can be used for human resource planning and motivational personal interviews should be held with nurses that underperform and is not infected in order to determine the reasons for their underperformance and what can be done to address raised issues. By obtaining nurses' opinion on why they do not perform as they should, action plans can be developed according to the need of the institution. • The human resource department should increase in-service training sessions conducted by senior experienced nurses in the workplace. Newly appointed nurses should be properly orientated and be allocated to a senior mentor who needs to assist them to fast track the skills required for the ward or clinic of placement. The human resource manager should do human resource planning in institutions, effectively using staff turnover reasons, absenteeism tendencies and sick leave audits to prevent situations where staff needs to just take over without opportunity for proper orientation in the institution. • Training programmes should be conducted by a nurse qualified and up to date with new trends with regard to HIV and AIDS in the workplace. This should equip nurses with sufficient knowledge about HIV and AIDS issues to avoid uncertainty and feelings of anxiousness working with HIV and AIDS patients and enable them to answer questions asked by family members. HIV and AIDS impact on the workplace • To address the impact of HIV and AIDS in the workplace, unit managers need to make sure that nurses and support staff are allocated equally to balance the workload between all available nurses. Collaboration between wards and clinics to re-allocate staff according to need should be a standard practice for managers. Appropriate ordering of drugs, nappies, linen and towels limits unnecessary time wasting. • Nurses also have problems viewing themselves in their usual role as healers and to assist with these feelings, role clarification can be conducted by an in-service training officer (social worker or psychologist) or unit manager and repeated every three months. A short course on death-bed counselling offered by universities with the involvement of multi-disciplinary members or experts in the field can also be attended. Stigma • To address stigma sufficiently, management, national DoH and SANAC need to take the lead and address stigma. HIV and AIDS should become a notifying disease with full detail of the patient. Tuberculosis also had a stigma until the national DoH intervened and made it a notifying disease, ensuring that citizens' knowledge was up to date and it was no longer a shame. Although tuberculosis is still a prevalent health problem, it is not any longer a problem for patients to admit and say that they have TB. Government needs to start making it

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
	compulsory for every person to be identified as an AIDS sufferer once their CD4 count drops below 350. When a patient dies, it should be revealed that the patient suffered from AIDS. The integration of HIV and AIDS as a chronic disease like hypertension, diabetes or epilepsy will enhance openness and people will start talking about the disease. Government should make every effort to ensure that the information that citizens and patients as well as health-care providers have is up to date so that this process of stigmatization in the community and workplace will be phased out. Nurses should view their infected colleagues and HIV and AIDS patients as people who suffer from a chronic disease and not isolate or neglect them due to their infected status. Clarification training by specialist nurses in the field should be conducted to assist nurses to reflect on their vision of HIV and AIDS within themselves, and how they perceive other infected nurses or patients.
3. To initiate steps to improve the image of nursing so that they can have the confidence in use of the policy cycle.	3. Improving image of nursing DENOSA should build capacity for the nurses to understand their valuable contributions towards health care. International nurses' day should be celebrated by institutions with management providing a motivational speech to express appreciation for their contribution. Outstanding clinical nurses in institutions should be nominated for awards by DENOSA and other relevant organizations, who often arrange for media coverage during the award ceremony. Belonging to different professional nursing organizations such as the national nurses education association, national nurse leader's forum, and internationally to the nurse honour society Sigma Theta Tau can build nurses' image, as they often arrange conferences, arrange media coverage, and provide opportunities for networking with nurses and multi-disciplinary team members often practising in difficult circumstances as well. A career in nursing and the various career paths available should be marketed so that the public can become aware that nursing is not only about bedside nursing, but with the contribution of research, better services can be rendered to HIV and AIDS patients. This is the responsibility of each nurse training institution as well as DENOSA who specifically represents the nurse workforce. Assertive behaviour should be developed throughout academic training programmes.

STRATEGY OBJECTIVE	FUNCTIONAL TACTICS
4. To facilitate nurse training with reference to the policy process, utilization of the policy cycle, leadership skills and how to act as change agents to influence formulation of health policies.	4. Facilitating nurse training in the policy process, policy cycle, how to act as change agents Universities need to prepare nurses to become involved in a policy process. For nurses to influence health policy they should have a sound basis of political science, economics, financial management, behavioural science, epidemiology and knowledge of health systems. The nursing curriculum needs to be adapted to provide a basis for these requirements. Universities should provide opportunities for scholarship, postdoctoral opportunities in large research programmes empower nurses to become involved in health policy formulation. Policy courses offered need to empower nurses to gain political insights and strategic skills, as these make nurses competent to engage in dialogue and debate with politicians and key stakeholders to improve the HIV and AIDS workplace policy. Universities offering postgraduate courses need to develop policy course modules as a requirement for all specialised nurse students, preparing nurses to enter the political arena and take the lead in challenging health issues, in this study to influence HIV and AIDS workplace policy.
5. To capacitate nurses' research skills to assist them in conducting high-quality research and in using research results to promote informed policy decisions.	5. Capacitate nurses' research skills Universities should provide opportunities for mentorship and research internships in postgraduate studies, including a focus on influencing health policy. These will create opportunities for dialogue and debate with key stakeholders, including political leaders, creating assertiveness among nurses to influence HIV and AIDS workplace policy. Nurse leaders should be encouraged to develop research programmes with an empowering nurse component, including collaboration with political leaders and key stakeholders as part of the empowerment process to improve leadership skills to identify open policy windows and utilize them to influence health policy formulation. Nurse researchers should be networking and identifying collaborative international research programmes to ensure scholarships, mentoring and research skills and learning opportunities, with the emphasis on the policy process and leadership to influence health policy. Nurses need to become competent in writing research grant proposals covering a programme of research and not only one specific area. These international collaborative research programmes offer those opportunities to nurses. Nurse educators and nurse associations need to create a research culture in the nursing profession, developing enquiring minds about the workplace area and what they can contribute to improve working in an HIV and AIDS workplace environment.

6.6 IMPLEMENTATION OF THE STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS WORKPLACE POLICY

The vision of this strategy is to influence HIV and AIDS workplace policy through Nurse led change. The mission is to empower nurses to become **change agents** to influence HIV and AIDS policy by utilizing levers such as high-quality evidence or research, the establishment of effective research-policy linkages, effective management of change initiatives, using of policy cycles and political insight to engage with management and the political arena in order to improve workplace conditions and service delivery.

The vision and mission are underpinned by beliefs and values such as the commitment of the SANAC to reduce new infections and the impact of HIV and AIDS on individuals, families, communities and society by expanding access to appropriate treatment, care and support. South African citizens believe that the government has the ability to address the HIV and AIDS pandemic, and any Nurse led change that can assist SANAC to achieve its commitment will be value added for the country and its people. Nurses are an essential part of the health-care delivery system and addressing the HIV and AIDS workplace policy issues will assist in improving HIV and AIDS services. Values underpinning the strategy include collaboration, integrity and respect.

The strategy is based on key guiding principles including leadership, effective communication and the strategic involvement of key stakeholders with the knowledge, skills and experience to be able to make a special contribution to its success. The sustainability and funding of the strategy was a further guiding principle.

The strategy objectives were determined from concluding and problem statements obtained through a literature review to identify barriers for Nurse led change to influence HIV and AIDS workplace policy, and empirical research entailing quantitative and qualitative data collection and analysis. The objectives derived included:

- To promote Nurse led change in the HIV and AIDS workplace policy process at macro, meso and microlevel.
- To address policy problems experienced working in an HIV and AIDS environment.
- To initiate steps to improve the image of nursing so nurses they can have the confidence to join the policy table.

- To facilitate nurse training with reference to the policy process, utilization of the policy cycle, leadership skills and how to act as change agents to influence the formulation of health policies.
- To capacitate nurses' research skills to assist them in conducting high-quality research and to use research results to promote informed policy decisions.
- To monitor and evaluate the implementation of the strategy according to the set objectives and tactics, and adapt the strategy if shortcomings are identified with implementation.

6.7 CHAPTER SUMMARY

- In this chapter the researcher developed a strategy for Nurse led change to influence HIV and AIDS workplace policy. The strategic process was discussed with regard to the vision, mission, values, principles, assumptions, strategy objectives and functional tactics of the strategy. Problem statements were identified from a literature review and empirical research and served as a basis for the development of strategy objectives. Finally, the implementation of the strategy for Nurse led change to influence HIV and AIDS policy was also discussed.

EVALUATION OF STUDY, LIMITATIONS AND RECOMMENDATIONS FOR PRACTICE, EDUCATION, RESEARCH AND POLICY

7.1. INTRODUCTION

In this chapter the study is evaluated with reference to the achievement of its aim and objectives. The contributions made to nursing science are highlighted, the limitations are identified and recommendations are made for practice, education, research and policy.

The overall aim of the study was to develop a strategy for Nurse led change to influence HIV and AIDS workplace policy in South Africa. To attain this aim the following objectives were set:

- To explore and describe the barriers to Nurse led change to influence HIV and AIDS workplace policy.
- To determine management's opinion about human resource capacity in an HIV and AIDS workplace environment.
- To identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective.
- To identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective.
- To develop a strategy for Nurse led change to influence HIV and AIDS workplace policy in South Africa.

7.2 EVALUATION OF STUDY

The study is evaluated in terms of the achievement of set objectives and its unique contribution to the scientific body of knowledge of nursing science.

7.2.1 Evaluation of the achievement of objectives

The study was conducted in two phases. During the first phase a literature review was conducted to identify barriers to Nurse led change to influence HIV and AIDS workplace policy. Empirical research was undertaken by applying both quantitative and qualitative data collection and analysis methods, in order to firstly determine management's opinion about human resource capacity in an HIV and AIDS workplace environment, secondly to identify problems experienced with policy in an HIV and AIDS workplace environment from a managerial perspective, and thirdly to identify problems experienced with policy in an HIV and AIDS workplace environment from a frontline nurse's perspective. A total of fifty-nine (59) problems were identified during this phase of the study, which served as a basis for phase 2, where the identified problems were used to develop a strategy for Nurse led change to influence HIV and AIDS workplace policy. Figure 7.1 presents a graphical representation of the phases and objectives of the study, followed by a discussion of each phase of the study.

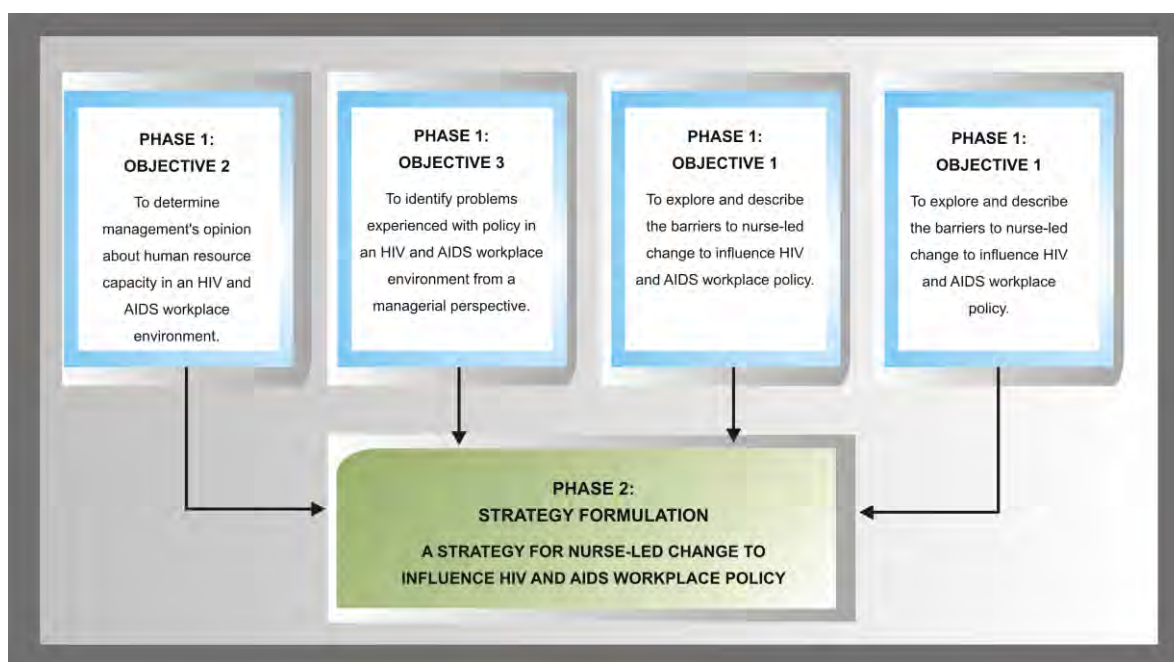


FIGURE 7.1: GRAPHICAL PRESENTATION OF THE PHASES AND OBJECTIVES OF THE STUDY TO DEVELOP A STRATEGY FOR NURSE LED CHANGE TO INFLUENCE HIV AND AIDS POLICY IN SOUTH AFRICA

7.2.1.1 Phase 1, Objectives 1-4

Phase 1, objectives 1-4 of the study entailed the collection and analysis of data pertinent to the study, obtained from a sample population applicable to the aim of the objective, by mean values of a review together with quantitative and qualitative empirical research methods.

- Objective 1 was attained through a literature review, which was extensively described in chapter 3, to identify barriers to Nurse led change to influence HIV and AIDS workplace policy. A total of thirty (30) barriers could be identified that prevent nurses from acting as change agents to influence HIV and AIDS workplace policy. These barriers were highlighted by the chapter 3 concluding statements under the various discussion headings.
- Objective 2 was achieved through the use of an internationally adapted quantitative empirical research tool for HIV and AIDS environments, the HRM rapid assessment questionnaire used by the Teasdale-Corti research programme, to obtain management's opinion about human resource capacity in an HIV and AIDS workplace environment. By using a structured (Likert-type) questionnaire, as was explained in chapter 4, paragraph 4.2.2, the status of human resource capacity in four participating institutions in the Central, Bojanala and Southern Districts of the North-West Province of South Africa was determined by utilizing the mean value scores allocated to each item under specific constructs, namely human resource capacity, personnel policy and practice, performance management and training. HRM data constructs were also measured but were found to be not reliable with statistical analysis and the analysis of findings was not used for interpretation. The human resource capacity in participating institutions was interpreted as good, with a total of four (4) problems, emphasized in chapter 4, paragraph 4.2.3.1, being identified for use in the development of the strategy.
- Objective 3 was accomplished through a qualitative in-depth interview schedule, based on a predetermined series of questions approved by the abovementioned research programme, to identify policy problems experienced in an HIV and AIDS workplace environment from a managerial perspective. The analysis of the data, as laid out in chapter 4, paragraph 4.3.1.2, revealed a total of twenty-two (22) problems that could be used in the strategy development.
- Objective 4 was achieved by the same method as objective 3 to identify policy problems experienced in an HIV and AIDS workplace environment from a frontline nurses perspective. In this instance, as was indicated in chapter 5, paragraph

5.2.1.2, data analysis acknowledged a total of six (6) problems. The researcher found overlapping of data analysis between the managers and the frontline nurses and incorporated these findings together with management results. More problems were thus identified with frontline nurses, but these were combined with management's results.

7.2.1.2 Phase 2, Formulation of strategy

The singular objective of phase 2 of the study was achieved through the formulation of a strategy for Nurse led change to influence HIV and AIDS policy, as was described in chapter 2, paragraph 2.4.5.1, by using a deductive and inductive logic reasoning method. The strategy was developed in chapter 6 by using a strategic process (paragraph 6.3: develop a vision, paragraph 6.5.2: mission, paragraph 6.5.3: values, paragraph 6.5.4: principles, paragraph 6.5.5: assumptions, paragraph 6.5.6: strategic objectives, paragraph 6.5.7: functional tactics, paragraph 6.5.8: pragmatic philosophical assumptions, chapter 2, paragraph 2.2: the policy cycle model adapted by the Canadian Nurses Association, chapter 1, paragraph 1.8.2.2 and chapter 3, paragraph 3.8.2: the leading change framework, chapter 1, paragraph 1.8.2.2 and chapter 3, paragraph 3.8.2).

Five (5) strategy objectives were formulated on the basis of the fifty-nine (59) problems identified, see chapter 6, table 6.2, from the literature review and the empirical research. The strategy objectives were based on the pragmatic assumptions which are **solution generative** for nurses who are absent from policy tables in South Africa, thereby creating the aim of the study: Nurse led change to influence HIV and AIDS workplace policy. The functional tactics were formulated from the strategic objectives and are an operational plan for implementation of the said objectives, including the application of the CNA policy cycle and the leading change framework, see chapter 1, paragraph 1.8.2.2 to assist nurses in acting as change agents.

7.2.2 Contributions made to nursing science

This is the first study of this nature to be conducted at provincial level to explore and describe barriers to Nurse led change to influence HIV and AIDS workplace policy. Studies had been conducted to determine the impact of HIV and AIDS on nurses' perception about the HIV and AIDS workplace policy, as was indicated by the literature control to support empirical findings in chapters 4 and 5. However, these studies, though making valuable recommendations, did not address the absence of nurses at policy tables in South Africa.

A strategy for Nurse led change to influence HIV and AIDS workplace policy is therefore a unique contribution in the South African context of public health services. Nurses need to know how to act as change agents, to apply the CNA policy cycle to get policy issues on the policy agenda and move it forwards to be addressed in policy formulation and so ensure a successful change initiative.

This study in itself is part of an international collaborative study, namely *“Strengthening nurses’ capacity in HIV policy development in Sub-Saharan Africa and the Caribbean”*, which is still in progress and can be used by other participating countries to evaluate the applicability to their context or determine which adaptations can be made to suit their context situation. The strategy is, however, applicable only within the South African context of public health service delivery. This study has therefore fulfilled the requirements of doctoral education, in that it has made a unique contribution to the scientific body of knowledge of nursing science, has mean valueingful impacts and potential for nurses at district, provincial or national level of governance.

The researcher defended the research proposal by conducting a presentation about the research programme to the research committee of the School of Nursing Science, North-West University: Potchefstroom Campus. Constructive input led the researcher to rephrase the research questions and to refine the research objectives. During the time devoted to this study, the researcher had the privilege of attending an international Sigma Theta Tau research conference in Florida and presenting five poster presentations. The constructive discussions about the study enriched the researcher’s perception and enhanced the completion of the study. The researcher prepared one article during the study, which was submitted for peer review.

7.3 LIMITATIONS OF STUDY

The researcher encountered specific limitations in respect of the study:

- The human resource management (HRM) questionnaire used in the study was an internationally validated questionnaire, but some managers had difficulty in allocating a score and an explanation of the constructs or items needed to be clarified in the case of uncertainty by the researcher.
- It was difficult to get participants to complete the questionnaires, as it took considerable time and managers have a very hectic schedule. The aim was to schedule a time and venue where managers could complete the questionnaire

together, but this did not happen and it degenerated into a once-off data collection session per participating institution. The researcher needed to visit participating institutions more than once, which proved to be time consuming, as some of the institutions were two and a half hours' drive away from the researchers' town of residence and resulted in increased costs.

- The HRM questionnaire was developed in a structured format with participants having the opportunity to provide evidence for their Likert score answer and a motivation thereof. Unfortunately they did not make use of this and left the designated spaces blank. These unused spaces could have contributed to more rich data being obtained by applying quantitative and qualitative data analysis, rather than using only the HRM questionnaire.
- Conducting individual interviews with managers was quite challenging and costly due to their hectic schedules and urgent matters arising. The researcher's experience when visiting an institution was that, although the time and date for the interview had been confirmed the day before, urgent Department of Health issues arose that had a higher priority for the manager and they were therefore not available or even at the institution for the interview. This resulted in rescheduling another time slot and another trip to the institution, which in turn raised research costs.

7.4 RECOMMENDATIONS FOR PRACTICE, EDUCATION, RESEARCH AND POLICY

Recommendations are provided to promote Nurse led change to influence HIV and AIDS workplace policy in practice, education, research and policy.

7.4.1 Recommendations for practice

The researcher makes the following recommendations for practice:

- Awareness-raising sessions for nurses to sensitize them to the fact that they can influence the HIV and AIDS workplace policy at every level of practice by sharing problems experienced and suggesting solutions in the application of the HIV and AIDS workplace policy with unions, supervisors, first line and top-level management.

- The Democratic Nursing Association of South Africa (DENOSA) can provide specific practical training workshops at each of their regional offices regarding the policy process, the need for nurses to act as change agents within the policy cycle and how they can apply the theoretical information in their daily work to influence HIV and AIDS policies.
- Brief editorials or articles to the editors of all union periodicals in South Africa about ways practising nurses can initiate change to influence HIV and AIDS workplace problems.
- Deliberate arrangement of contact sessions by identified prominent nurse leaders who are competent to act as change agents, to meet with practising nurses for brainstorming about HIV and AIDS policy problems experienced and how they can initiate change by taking the lead.
- The use of current Leadership Hub members, which is the capacitating lever for the international TC programme, to discuss policy issues with frontline nurses.

7.4.2 Recommendations for education

Proposed education recommendations are:

- To arrange with directors of nursing schools to hold a participative workshop to share research findings and facilitate discussions.
- The SANC to include policy process training by the introduction of a short course to empower nurses at all levels of practice and upgrade curriculum requirements in such a way that they incorporate the policy process, the policy cycle and the management of change initiatives.
- Nursing deans to investigate the possibility of the development of a leadership academy for nurses such as the Dorothy Wylie Leadership Institute in Canada.

7.4.3 Recommendations for research

The following recommendations are advanced in respect of research:

- The DoH Directorate: Policy, Planning and Research should formulate a research agenda for master's degree and PhD students about emerging problems in the DoH. They have a cluster for resource mobilization and governance and under this cluster

they could add applicable topics, e.g. managing and leading change to health policies, which they have problems with implementing. This will provide opportunities for nurse researchers to become involved in the policy arena.

- Conducting of research within a large research programme offering the opportunity to choose relevant topics, to be empowered and mentored by specialist researchers from diverse fields. This will produce strong evidence-supported findings which, when translated into a language that policy users can understand and disseminated in publications that politicians read, are more prone to be used in informed policy decisions.
- Development of research programmes with a nurse empowerment component will provides opportunity for mentorship and research internships.

7.4.4 Recommendations for policy

Regarding policy the following recommendations are put forward:

- Nurse researchers need to know that research is more likely to be translated into policy if researchers negotiate the language and frame of reference with policy analysts, managers and politicians before the research is undertaken.
- Effective research policy linkages need to be established to ensure that if a policy window is open, nurses can utilize the research policy link to move an issue onto the policy agenda.

7.5 SUMMARY

This study was conducted to explore and describe why nurses are seen only as the implementers of policies and are absent from the policy formulation table with reference to the HIV and AIDS workplace policy. The aim of the research was to develop a strategy for Nurse led change to influence HIV and AIDS policy. This chapter provided a reflective overview of the study by evaluating it in relation to the set objectives, determining its contribution to nursing science, identifying its limitations and providing recommendations for practice, education, research and policy.

SOLA GRATIA

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ADDENDUM A : ETHICAL APPROVAL FROM UNIVERSITY OF OTTAWA



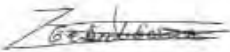
Université d'Ottawa University of Ottawa
Université d'Ottawa / University of Ottawa

HEALTH SCIENCES AND SCIENCE RESEARCH ETHICS BOARD

CERTIFICATE OF ETHICAL APPROVAL

This is to certify that the University of Ottawa Health Sciences and Science Research Ethics Board has examined the application for ethical approval of the research project entitled **Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean (H 01-07-12)** submitted by Pr. Nancy Edwards of the School of Nursing at the university of Ottawa, Pr. Eulalia Kahwa of the School of Nursing at the University of the West Indies (Jamaica).

The Board found that this research project met appropriate ethical standards as outlined in the Tri-Council Policy Statement and in the Procedures of the University of Ottawa Research Ethics Boards, and accordingly gave it a Category 1a (approval). This certification is retroactive to March 7, 2008 and valid until March 7, 2008.



Germain Zongo
Protocol Officer for Ethics in Research
For Dr. Daniel Lagarec, Chair of the
Health Sciences and Science REB

June 4, 2008
Date

Document communiqué en vertu de l'accès à l'information / Document released pursuant to the Access to Information Act
Document communiqué en vertu de l'accès à l'information / Document released pursuant to the Access to Information Act

ADDENDUM B : ETHICAL APPROVAL FROM NORTH-WEST PROVINCE: DEPARTMENT OF HEALTH



HEALTH
DEPARTMENT:
HEALTH
NORTH WEST PROVINCE

2nd Floor/2de Ruking
Dr Albert Luttrell Drive
Windang, 2716
Private Bag 20008
MABATHO, 2716

Directorate: Policy,
Planning & Research

Enoch Masekane
Tel: (018) 567 5747
Fax: (018) 567 3617
Email:
emasekane@nwde.gov.za

To : Professor H. Kloppe
North West University (Potchefstroom Campus)

Date : 29 Feb 2008

From : Mr K. Rabanye
Director: Policy, Planning & Research

Subject: Approval for research study: Strengthening nurses capacity in HIV Policy
Development in Sub Saharan Africa and the Caribbeans

Approval is granted to conduct the above study in the North West Province, kindly make relevant arrangements with Institutional management for suitable dates and times. Detail at the bottom of this letter has to be completed by you and returned to Policy, Planning and Research Directorate before your study commence. This serves as an agreement between yourself as principal researcher and the North West Department of Health.

With kind regards

Mr K. Rabanye
Director: Policy, Planning and Research
North West Dept of Health

I, the undersigned Hester C. Kloppe will furnish the final report
to NWDOH by:

Prof H. Kloppe

December 2011
Submission date of the final report

NWDOH/PP&R

1
Page 1

07/04/2008

ADDENDUM C :

ETHICAL APPROVAL FROM NORTH-WEST UNIVERSITY (POTCHEFSTROOM CAMPUS)



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X5001 Potchefstroom
South Africa 2520

Tel: (018) 299-2542
Faks: (018) 297-5306
Web: <http://www.nwu.ac.za>

Prof H Klopper

Ethics Committee
Tel: +27 18 299 2542
Fax: +27 18 297 5306
Email: Ethics@nwu.ac.za

5 February 2008

Dear Prof Klopper

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Programme of Research: Strengthening Nurses Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean	
Ethics number:	N W U - E C D G - 0 1 8 - 0 1 8 - 0 1 8
Approval date: 1 October 2007	Expiry date: 30 September 2012

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principal investigator) must report to the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project;
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as submitted in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after its expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented;
 - the required annual report and reporting of adverse events was not done timely and accurately;
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof M M J Louw
(Chair NWU Ethics Committee)

ADDENDUM D :

INSTITUTIONAL APPROVAL FROM CENTRAL DISTRICT, DITSOBOTLA SUB DISTRICT: COMMUNITY HEALTH CARE CENTERS AND CLINICS

1



NORTH WEST UNIVERSITY
YUNIBESITHI YA BOKONE BOPHIRIMA
NORDWEST-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

The Ditsobotla sub-district in the Central Region of North West Province agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean).

The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kaseje (Kenya) and Dr. Eulalia Kahwa (Jamaica) in collaboration with other investigators from Canada (Universities of Ottawa, Alberta, Toronto, Lethbridge, and Dalhousie; and the Canadian Nurses Association); South Africa (North-West University-Potchefstroom Campus), Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados).

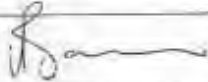
The specific objectives of this study are to:

1. To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs)
2. To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers, some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies;
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes;
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by individual interviews with three staff members. The researchers would like to repeat these activities at a later date in the study to assess changes.

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in an interview about the impact of the HIV and AIDS epidemic on the nursing workforce. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in a focus group about innovative national HIV and AIDS programs. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission to contact them about participating in a focus group about innovative bottom-up HIV and AIDS programs introduced by nurses at the local level. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Allowing staff to participate in research activities if they have been invited and choose to do so.

SIGNATURE OF DISTRICT MANAGER	
NAME OF DISTRICT MANAGER	A. le Roux
CONTACT DETAILS	DITSOBOTLA SUB-DISTRICT
TELEPHONE	018 6324059
FAX NR	018 6324930
E-MAIL ADDRESS	leroux@nwpq.gov.za
DATE OF CONCENT	27/08/08

Please note: Bakhutsa - Bodibe Clinics
Blydenville - Town Clinics

ADDENDUM E :

INSTITUTIONAL APPROVAL FROM CENTRAL DISTRICT, DITSOBOTLA SUB DISTRICT: THUSONG – GENERAL DE LA REY HOSPITAL COMPLEX

1



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

The General de la Rey – Thusong Complex in the Central Region of North West Province agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean). As a institution we give permission that our staff can be contacted and interviewed for the purpose of this research program.

The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kasoja (Kenya) and Dr. Eulalia Kahwa (Jamaica) in collaboration with other investigators from Canada (Universities of Ottawa, Alberta, Toronto, Lethbridge and Dalhousie; and the Canadian Nurses Association); South Africa (North-West University-Potchefstroom Campus), Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados).

The specific objectives of this study are to:

1. To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs)
2. To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers, some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies;
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes;
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by

individual interviews with three staff members. The researchers would like to repeat these activities at a later date in the study to assess changes.

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in an interview about the impact of the HIV and AIDS epidemic on the nursing workforce. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in a focus group about innovative national HIV and AIDS programs. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission to contact them about participating in a focus group about innovative bottom-up HIV and AIDS programs introduced by nurses at the local level. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Allowing staff to participate in research activities if they have been invited and choose to do so.

SIGNATURE OF CHIEF EXECUTIVE OFFICER/	<i>[Signature]</i> M. E. LOBELLO
NAME OF MANAGER PRINTED	MARIA ELEANOR LOBELLO
CONTACT DETAILS	078453 2180
TELEPHONE	018 632 3041
FAX NR	018 632 4270
E-MAIL ADDRESS	mlobello@nwpg.gov.za
DATE OF CONCENT	2008.03.27

OFFICIAL STAMP PLEASE

THUSONG - GENERAL
DE LA REY
COMPLEX PERMISSION



ADDENDUM F :

INSTITUTIONAL APPROVAL FROM BOJANALA DISTRICT, SUB-DISTRICT: RUSTENBURG: COMMUNITY HEALTH CARE CENTERS AND CLINICS



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Bojanala District, of North West Province agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean). As an institution we give permission that our staff can be contacted and interviewed for the purpose of this research program.

The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kaseje (Kenya) and Dr. Eulalia Kahwa (Jamaica) in collaboration with other investigators from Canada (Universities of Ottawa, Alberta, Toronto, Lethbridge, and Dalhousie; and the Canadian Nurses Association); South Africa (North-West University-Potchefstroom Campus), Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados).

The specific objectives of this study are to:

1. To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs)
2. To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers, some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies;
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes;
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by

individual interviews with three staff members. The researchers would like to repeat these activities at a later date in the study to assess changes.

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in an interview about the impact of the HIV and AIDS epidemic on the nursing workforce. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in a focus group about innovative national HIV and AIDS programs. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Distributing letters to specific individuals asking if they will give permission to contact them about participating in a focus group about innovative bottom-up HIV and AIDS programs introduced by nurses at the local level. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
- Allowing staff to participate in research activities if they have been invited and choose to do so.

SIGNATURE OF CHIEF EXECUTIVE OFFICER/AUTHORIZED (SUD DISTRICT OFFICE	<i>[Signature]</i>
NAME OF MANAGER PRINTED	<i>K. L. LUGOTHO</i>
CONTACT DETAILS	<i>014-5948300</i>
TELEPHONE	<i>083-64 22624</i>
FAX NR	<i>014-59473667</i>
E-MAIL ADDRESS	<i>mmajile@nwppg.gov.za</i>
DATE OF CONCENT	<i>2008/04/09</i>
COMMUNITY HEALTH CENTRE INVOLVED INSTUDY	Thlabane CHC, Hartebeesfontein clinic, Phokeng Health Centre, Boitakong Clinic

OFFICIAL STAMP PLEASE

NORTH WEST PROVINCE
Department of Health
DATE: *2008/04/09*
SIGNATURE: *[Signature]*
DISTRICT OFFICE
TEL: 014-597 1071 FAX: 014-597 107
PRIVATE BAG 30000
0200 FLEETWOOD

ADDENDUM G :

INSTITUTIONAL APPROVAL FROM BOJANALA DISTRICT, SUB-DISTRICT: RUSTENBURG: RUSTENBURG HOSPITAL



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Rustenburg Provincial Hospital of North West Province agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean). As an institution we give permission that our staff can be contacted and interviewed for the purpose of this research program.

The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kaspeje (Kenya) and Dr. Eulalia Kahwa (Jamaica) in collaboration with other investigators from Canada (Universities of Ottawa, Alberta, Toronto, Lethbridge, and Dalhousie, and the Canadian Nurses Association); South Africa (North-West University-Potchefstroom Campus), Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados).

The specific objectives of this study are to:

1. To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs)
2. To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.
- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers, some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes.
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by individual interviews with three staff members. The researchers would like to repeat

- these activities at a later date in the study to assess changes.
- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in an interview about the impact of the HIV and AIDS epidemic on the nursing workforce. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.
 - Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in a focus group about innovative national HIV and AIDS programs. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.
 - Distributing letters to specific individuals asking if they will give permission to contact them about participating in a focus group about innovative bottom-up HIV and AIDS programs introduced by nurses at the local level. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.
 - Allowing staff to participate in research activities if they have been invited and choose to do so.

SIGNATURE OF CHIEF EXECUTIVE OFFICER/AUTHORIZED	
NAME OF MANAGER PRINTED	Mr. Pabli Mokatane
CONTACT DETAILS	(014) 590 5401
TELEPHONE	(014) 590 5401
FAX NR	(014) 592 3789
E-MAIL ADDRESS	p.mokatane@nwb.gov.za
DATE OF CONCENT	27 March 2008

OFFICIAL STAMP PLEASE

ADDENDUM H :

INSTITUTIONAL APPROVAL FROM SOUTHERN DISTRICT, SUB-DISTRICT: POTCHEFSTROOM: POTCHEFSTROOM HOSPITAL



NORTH-WEST UNIVERSITY
TUNISSETI TA BOKONE-BOPHIRIMA
HOOROWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Potchefstroom Hospital in the Southern District of North West Province agrees to participate in the project "Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean). As an institution we give permission that our staff can be contacted and interviewed for the purpose of this research program.

The Principal Investigators are: Dr. Nancy Edwards (Canada), Dr. Dan Kaseje (Kenya) and Dr. Eulalia Kahwa (Jamaica) in collaboration with other investigators from Canada (Universities of Ottawa, Alberta, Toronto, Lethbridge, and Dalhousie; and the Canadian Nurses Association); South Africa (North-West University-Potchefstroom Campus); Kenya (Great Lakes University of Kisumu); Jamaica (University of the West Indies); Uganda (Mulago Hospital); and Barbados (Ministry of Health and Barbados Community College).

The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados).

The specific objectives of this study are to:

1. To examine the dynamic interplay of multi-level factors that influence nurses' engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs)
2. To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Our participation will consist of the following:

- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant.
- Assemble a list of names of eligible nurses according to eligibility criteria provided by the researchers, some of whom will receive letters asking if they will give permission to contact them about participating in interviews or focus groups about HIV and AIDS nursing care, stigma, and workplace policies.
- Distributing letters of information/consent and questionnaires about HIV and AIDS nursing practice to nurses involved with HIV and AIDS care. This questionnaire would be repeated at a later date in the study to assess changes;
- Participating in a Human Resource Management Assessment for HIV and AIDS Environments which would involve three staff members at our organization completing individual assessments and then a group assessment. This may be followed by

- individual interviews with three staff members. The researchers would like to repeat these activities at a later date in the study to assess changes.
- Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in an interview about the impact of the HIV and AIDS epidemic on the nursing workforce. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
 - Distributing letters to specific individuals asking if they will give permission for researchers to contact them about participating in a focus group about innovative national HIV and AIDS programs. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
 - Distributing letters to specific individuals asking if they will give permission to contact them about participating in a focus group about innovative bottom-up HIV and AIDS programs introduced by nurses at the local level. Those willing to be contacted are asked to send their affirmative response and contact information directly to the research assistant;
 - Allowing staff to participate in research activities if they have been invited and choose to do so.

SIGNATURE OF CHIEF EXECUTIVE OFFICER/AUTHORIZED (SUD DISTRICT OFFICE	
NAME OF MANAGER PRINTED	M. A. Mtambo
CONTACT DETAILS	079 813 7189
TELEPHONE	018-293 4401
FAX NR	018-293 1729
E-MAIL ADDRESS	Amtambo@wsp.gov.za
DATE OF CONCENT	2008-04-18

OFFICIAL STAMP PLEASE



ADDENDUM I : EXAMPLE OF INFORMATION AND CONSENT DOCUMENT



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

• INFORMATION SHEET AND CONSENT FORM

Individual Interviews (Work place policies) – Administrators, nurse managers, and nurses

Invitation to participate: I am being invited to participate in the above-mentioned research study.

Study Purpose: The purpose of this study is to describe and understand issues that affect the role of registered nurses and midwives and enrolled nurses in HIV prevention and AIDS care for individuals and families living with HIV and AIDS in five study countries (South Africa, Uganda, Kenya, Jamaica, and Barbados). This project is part of a larger research program to strengthen nurses' capacity in HIV policy development in Sub-Saharan Africa and the Caribbean. The specific objectives of this study are to:

1. Examine how multi-layered dimensions of AIDS stigma (institutional, personal, societal) influence nurses' provision of prevention, care and treatment to patients and families; Understand how work place policies and their genesis (including gaps between institutional policies and national HIV and AIDS strategy recommendations) affect nurses in providing care for individuals and families living with HIV as well as obtaining treatment for themselves;
2. Understand gaps between current nursing practice and organizational supports for front-line nurses and managers caring for individuals and families living with HIV and AIDS;
3. Examine the impact of leadership hubs in improving nursing practices and workplace policies for individuals and families living with HIV and AIDS.

Which objective is relevant to the research I am asked to participate in: My participation will contribute to Objective Two: Understanding how work place policies and their genesis (including gaps between institutional policies and national HIV and AIDS strategy recommendations) affect nurses in providing care for individuals and families living with HIV as well as obtaining treatment for themselves.

Participation: I am being asked to participate in an interview to discuss human resource management and policies for HIV and AIDS at my workplace. Topics will include existing policies, their development and genesis, and gaps in policies and implementation. The interview will take approximately 45-60 minutes. I may be asked to participate in a second interview on the same topic in several years as follow up to examine any changes in policies. Data will also be used in comparative case studies across the five study countries about the impact of leadership hubs on nurses' engagement in HIV and AIDS policy development and collaborative action. The data may be used for secondary analysis at a future date following consent by all relevant research ethics boards. Secondary analysis mean values that the data would be used to examine issues other than the one being considered by this research team in this present study: for example, to test additional hypotheses or to apply mixed methods to look at emerging relationships in the data. Only researchers working with a member of the team for the current study will be permitted to access the data. Anyone conducting a secondary data analysis will only have access to anonymized data, or will be unaware of the identities of the participants.

Risks: Minimum risk is expected from my participation in this study. My decision as to whether or not to participate in the study will not have any positive or negative repercussions for me. I understand that I am requested not to disclose my HIV status in the study and I will not be asked to disclose my HIV status. I understand that my participation in this study will entail that I discuss topics that may cause me emotional distress or concern about human resource management at my workplace. If I disclose HIV status or am emotionally distressed about my HIV status or that of a family member, a referral will be made to an appropriate individual or agency in the community. I have been assured that I can withdraw my comments and quotes, or refuse to be quoted. I have been advised to say only what I am comfortable saying, and I know that I may withdraw from the study at any time. I know that permission has been given by my institution for staff to participate in the study, but that my responses during this interview will not be shared with my employers. I know that at the end of the interview, I will be asked if there are any portions of what I have said that I do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer.

Benefits: My participation in this study will not have a direct benefit to me; however, it will give me an opportunity to identify the process of how policies were developed in my workplace. The information I share may help the investigators identify strategies for strengthening human resource management for HIV and AIDS, and nurses' involvement in decision making and policy development.

Confidentiality and anonymity: I have received assurance from the researcher that any information I share will remain strictly confidential. I understand that the contents will be used only for the purpose of the study and that my confidentiality will be protected. The content will only be discussed within the research team. Anonymity will be protected by not recording my name with my responses or identifying me in any way. A unique code number will be assigned to me to identify my taped interview and interview transcripts. My institution will also have a unique code and will not be named when presenting results. Aggregate results will be published so my identity will not be revealed in any reports or publications. Although my name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not I participated in this study.

Conservation of data: All information collected from me (audiotapes, interview transcripts, notes) will be kept in a locked filing system in the project office in North West University: Potchefstroom Campus in South Africa. All computers on which study data will be stored will be password-protected. The data will be accessible only to the study's investigators, research staff, audiotape transcriber, graduate and post-doctoral students working with the

project, and research interns. (Research interns are participants in an international research training program for nurses that will be held during the project.) Everyone who has access to the raw data will be asked to sign a confidentiality agreement. The study data will be stored for ten years following completion of the study or publication of related articles, after which time paper transcripts will be destroyed. Audiotapes will be destroyed five years after transcription.

Compensation: There will be no monetary compensation in this study.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I may withdraw from the study at any time and/or refuse to answer any questions.

This study has received ethics approval from the University of Ottawa Research Ethics Board and the ethics boards of all Canadian partner universities, and North-West University Research Ethics Board in South Africa. Ethical concerns may be directed to:

Research Program Manager: Francois Watson

North-West University: Potchefstroom Campus

(018) 299 1220 or Francois.Watson@nwu.ac.za or"

The Country Program Director: Professor Hester Klopper (Details below)

If ethical problem are not handled satisfactory you can also contact the Ethics Board in Canada.

Protocol Officer for Ethics in Research,

University of Ottawa, Tabaret Hall,

550 Cumberland Street, Room 159,

Ottawa, Ontario, Canada K1N 6N5

(613) 562-5841 or ethics@uottawa.ca

CONSENT

I, _____ (print name) have understood to my satisfaction the information regarding my participation in the research project "*Nursing Practice in HIV Prevention and AIDS Care in Sub-Saharan Africa and the Caribbean*" and agree to participate as a subject. In no way does this waive my legal rights nor release the investigators, or involved institutions from their legal and professional responsibilities.

- a) I agree to allow my interview to be audio-taped: ☐ Yes ☐ No

If I do not agree to allow my debriefing interviews to be audio-taped, I agree to allow the interviewer to take notes: _____ Yes _____ No

- b) I agree to be quoted but all personally identifying information shall be removed or altered and contents of the quote shall not reveal my identity. _____

I do not wish to be quoted at all. _____

- c) If I choose to withdraw, I agree that all data gathered from me may continue to be used in the study. _____

If I choose to withdraw, I request that all data gathered from me be destroyed. _____

- d) I agree that data may be used for pedagogical purposes such as in classes by professors, workshops, presentations and case studies. All personally identifying information will be removed or altered and data shall not reveal my identity.

_____ Yes _____ No

There are two copies of this consent form, one of which is mine to keep.

Participant's Signature: _____ Date: _____

List of Research Team Members:

Hester Klopper, RN, RM, RPN, MBA, PhD, North-West University, South Africa

(018) 299 1830 or Hester.Klopper@nwu.ac.za

Eulalia Kahwa, RN, PhD, University of the West Indies, Jamaica

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This study is funded by the Global Health Research Initiative, Canada.

ADDENDUM J : **HUMAN RESOURCE MANAGEMENT** **QUESTIONNAIRE D DEMOGRAPHIC INFORMATION** **OBTAINED FROM MANAGERS**

Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments

ID CODE	
Date of Completion	
Researcher	2
Country	4
District	1
Institution	
Tool number	3
Type of tool	4
HRM Tool number	

**PLEASE READ THE INSTRUCTION CAREFULLY BEFORE
ANSWERING**

Instructions:

For each of the HRM components in the matrix below, you will fill in the columns labeled "Current Stage" and "Evidence." In the blank box under "Current Stage," enter the number of the stage (1–4) with the statement that best applies to the current stage of your organization. If only part of the statement applies, enter the number for the previous stage. In the blank box under "Evidence," please record the reasons that led you to select this box and any additional key information related to this component.

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Biographical Background

What is your educational background (check all that apply)?

- ☐ diploma (specify specialty) _____
- ☐ baccalaureate degree (specify specialty) _____
- ☐ other specialty training (specify) _____
- ☐ medical degree (specify specialty) _____
- ☐ master's degree (specify specialty) _____
- ☐ doctoral degree (specify specialty) _____
- ☐ Other (please specify) _____

What is your present position in this facility:

How long have you worked in your present position? _____ months _____ years

How long have you worked in this organization? _____ months _____ years

Thank you for participating in this study. Your opinions and experiences are very valuable to us. When we finalize the research, we would like to be able to describe the institutions that participated in this study. This information will be aggregated and will never be released individually; no one will be able to identify you or your organization.

Facility description:

- Number of beds _____
- Number of in-patients in 2007: _____
- Number of out-patients in 2007: _____
- % of admitted patients with HIV/AIDS _____
- Total number of staff _____
- Number of staff who are registered nurses _____
- Number of staff who are enrolled nurses _____
- Number of staff who are physicians _____

Level of facility:

- National
- Provincial
- District/parish
- Health centre
- Other _____

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Capacity

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
HRM Staff	1	There are no staff specifically charged with responsibility for HRM functions.		
	2	There are adequate HRM staff in the organization trained in maintaining basic procedures and record-keeping functions, but they do not have a leadership role in developing human resource plans or policies and are not trained to deal with HRM issues related to HIV/AIDS.		
	3	There are adequate HRM staff in the organization who maintain basic functions and also develop HRM policy, but they do not address HIV/AIDS issues.		
	4	There is an adequate number of experienced HRM staff in the organization who maintain HRM functions, develop policy, and participate in long-range strategic planning on the organization's response to the impact of HIV/AIDS on human resources.		
HRM Budget	1	Outside of the personnel budget, there is no money allocated for addressing ongoing HRM activities (e.g., recruitment and training), including those needed to support HIV/AIDS strategies.		
	2	There is a budget to support ongoing HRM activities (e.g., recruitment and training), but no additional funds for activities to support HIV/AIDS strategies (e.g., a workplace prevention program, drugs, benefits).		
	3	Funds are allocated for ongoing HRM activities and also for HRM activities needed to support HIV/AIDS strategies, but the allocation is irregular and cannot be relied on for useful long-range planning.		
	4	Funds are allocated for ongoing HRM activities and also to sustain HRM activities needed to support HIV/AIDS strategies. These funds represent a permanent budget item, reviewed annually and adjusted as needed.		

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM	Stages of HRM and Their Characteristics		Evidence	Other Comments
	1	2		
Human Resource Planning	1	There is no capacity to develop human resource staffing plans for the organization		
	2	A formal system exists for determining the salary scale for each job category, but it is not routinely used.		
	3	A formal system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff who are willing to work full days can be attracted.		
	4	A formal system exists and is used to establish starting salary, and also is fairly used to establish merit awards and salary upgrades.		

Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Personnel Policy and Practice

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Compensation System	1	No formal system exists for determining the salary scale for each job category.				
	2	A formal system exists for determining the salary scale for each job category, but it is not routinely used.				
	3	A formal system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff who are willing to work full days can be attracted.				
	4	A formal system exists and is used to establish starting salary, and also is fairly used to establish merit awards and salary upgrades.				
Benefits Program	1	No benefits program is in place.				
	2	A standard benefits program is in place, but it is not assessed for its effectiveness in supporting the retention of HIV/AIDS infected staff (e.g., expanded sick leave, funeral benefits, and free drugs).				
	3	A standard benefits program is in place. It is assessed for its effectiveness in supporting the retention of HIV-infected staff. No action is taken based on the assessment data.				
	4	A standard benefits program is in place and adjusted as appropriate to support the retention of HIV-infected staff. Its effectiveness in helping to retain staff is monitored regularly.				

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Staff Retention	1	There are no data available on staff retention rates and the factors contributing to declining rates (e.g., how much are declining rates due to HIV/AIDS, and how much are due to out-migration, retirement, or other factors).				
	2	Data on staff retention rates are available, but no analysis has been done to determine the contributing factors.				
	3	Data on staff retention rates are available. An analysis has been done to determine the contributing factors, but no strategy has been developed to address these factors.				
	4	A strategy is in place to improve the staff retention rate. It is based on data and a realistic analysis of the available pool of qualified employees.				
Recruitment, Hiring, Transfer, and Promotion	1	No formal process exists for recruiting, hiring, transferring, and promoting staff.				
	2	There are formal procedures for recruiting, hiring, transferring, and promoting staff, but they are not followed consistently				
	3	Formal procedures for recruiting, hiring, transferring, and promoting staff are used consistently.				
	4	Formal procedures are consistently used for recruiting, hiring, transferring, and promoting staff. Adherence to these procedures is regularly monitored and evaluated.				
Policy of Nondiscrimination Based on HIV/AIDS Status	1	There is no policy of nondiscrimination on the basis of HIV/AIDS.				
	2	A policy exists for nondiscrimination on the basis of HIV/AIDS, but it is ignored.				
	3	The policy of nondiscrimination on the basis of HIV/AIDS is not consistently applied.				
	4	The policy of nondiscrimination on the basis of HIV/AIDS is followed.				

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Orientation Program	1	No formal orientation program exists for new employees.		
	2	An orientation program exists, but it is not implemented on a regular basis and lacks a component about the organization's HIV/AIDS policies.		
	3	Orientation is routinely offered but does not emphasize the mission, the goals, and the performance expected by the organization, especially as they relate to HIV/AIDS.		
	4	Orientation is offered to all new employees. It emphasizes the mission, goals, and performance expected, and makes people feel welcomed and valued, as well protected from stigma if they are affected or infected by HIV/AIDS.		
HIV/AIDS Workplace Prevention Program	1	No HIV/AIDS workplace prevention program is in place to develop awareness and protocols to prevent HIV/AIDS infection (e.g., proper handling of needles, peer education program, distribution of condoms).		
	2	An HIV/AIDS workplace program has been developed, but no resources are available to implement it.		
	3	An HIV/AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection as well as education about HIV/AIDS, but only some staff have participated in the program.		
	4	An HIV/AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection, and provides HIV/AIDS education. All staff participate, and it is monitored for effectiveness in increasing staff knowledge and use of protocols.		

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**Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean**

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
	1	2	3	4		
Employee Manual (e.g., organizational chart, work hours, health insurance, sick leave, grievances)	No overall employee manual exists.	An employee manual exists but is out of date.	A current employee manual exists and is up to date, but is not used for personnel decisions.	An updated employee manual exists and includes policies that refer to HIV/AIDS. It is available to all employees and is used as a guide for all questions about employment in the organization. It is update		
Policy Regarding Treatment of People (Employees and Clients) Living with HIV/AIDS	No policy is communicated about how people (staff and clients) living with HIV/AIDS are to be treated.	There is a policy regarding how to treat people (employees and clients) living with HIV/AIDS, but it does not include all the relevant information on HIV/AIDS.	There are policies on how staff and clients living with HIV/AIDS are to be treated, but they are not available to all employees and is not always used as a basis for personnel decisions.	The policies on how staff and clients living with HIV/AIDS are to be treated are up to date and available to all employees and are utilized systematically.		
Discipline, Grievance, and Termination Procedures	No formal procedures for discipline, grievances, or termination exist.	Formal procedures for discipline, grievances, and termination exist, but they are not practiced and do not include protection against discrimination on the basis of HIV status.	Formal procedures for discipline, grievances, and termination exist and are practiced. The procedures include protection against discrimination on the basis of HIV status, but these are not adhered to.	Formal procedures for discipline, grievances, and termination exist, including nondiscrimination on the basis of HIV status. These procedures are followed.		

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**Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean**

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Relationship with Unions (if appropriate)	1	There is no link between HRM, management, and the union(s).				
	2	Links exist between HRM, management, and the union(s), but roles are not clear.				
	3	Management involves HRM in union issues, but not on a regular basis.				
	4	Management, HRM, and the union(s) work together to resolve issues and prevent problems, including those related to HIV/AIDS.				
Labor Law Compliance (if appropriate)	1	No review of HRM policies occurs to ensure compliance with the letter and spirit of local and/or national labor law, including HIV/AIDS regulations, if they exist.				
	2	There is some effort to review labor law, but it is not done regularly.				
	3	A review of labor law is done regularly as a formal part of the HRM function, but policy is not always adjusted to ensure compliance, including compliance with HIV/AIDS regulations.				
	4	HRM policy and practice is adjusted to comply with local and/or national labor law, including any HIV/AIDS regulations.				

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Performance Management

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Job Descriptions (e.g., job title, qualifications, job responsibilities, supervisor)	1	No job descriptions are developed. Jobs are not reviewed in light of organizational strategies, or when tasks need to be redistributed				
	2	Some staff have job descriptions, but they are not always up-dated to include new responsibilities or to redistribute tasks, when needed.				
	3	All staff have job descriptions, but they are not adjusted or reviewed to take into account changes in responsibilities or redistribute tasks, when needed.				
	4	All staff have job descriptions which are reviewed and adjusted regularly to take into account changes in responsibilities or redistribute tasks, when necessary				
Organizational Strategies for HIV Infection Prevention, Care and/or Treatment of Clients	1	There is no organizational strategy for HIV infection prevention or for care and support of clients.				
	2	There is an organizational strategy for HIV infection prevention or for care and support of clients but the responsibilities of individual employees are not specified				
	3	There is an organizational strategy for HIV infection prevention or for care and support of clients and the responsibilities of employees are well-defined. The standards, however, are not always followed.				
	4	There is an organizational strategy for HIV infection prevention or for care and support of clients and the responsibilities of employees are well-defined. The standards are always followed.				

Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
	1	2	3	4		
Staff Supervision	There is no clear system of supervision. Lines of authority are unclear. Supervisors do not meet regularly with their staff, nor do they receive training on supervision skills.	There are established lines of supervision, but supervisors' roles and functions are not understood, and little supervision takes place.	Supervisors do not receive training of any kind.	There are established lines of supervision, and supervisors understand their roles and functions. Supervisors are trained in general supervisory skills.		
				Supervision is well institutionalized within the organization. Supervisors are trained in general supervisory skills as well as in HIV/AIDS policies and sensitivity to HIV-related staff issues.		
Training of Supervisors with Regard to HIV/ AIDS	Supervisors do not receive any training on questions related to HIV/AIDS issues related to staff	Some supervisors receive training on how to deal with employees in regard to HIV/AIDS	Supervisors receive a general training on the issues and policies related to HIV/AIDS, but there is no sensitivity training on how to respond to questions related to HIV/AIDS from employees.	Supervisors receive a general training on the issues and policies related to HIV/AIDS, along with sensitivity training on how to respond to questions related to HIV/AIDS from employees.		

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Work Planning and Performance Review	1	No individual work planning and performance review system is in place.		
	2	A work planning and performance review system is in place for individuals, but it is informal and does not include individual work plans or performance criteria developed jointly by supervisors and supervisees.		
	3	A formal system for work planning and performance review is in place for individuals. Supervisors are required to develop individual work plans and performance criteria with each supervisee and to review past performance, but this is not done consistently.		
	4	Supervisors and supervisees jointly develop individual work plans and performance criteria. These are used to conduct reviews of past performance at least once a year.		

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

Training

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Staff Training	1	There is no organizational staff training plan or ongoing assessment of individual staff's development needs.				
	2	Training is offered on an ad hoc basis but is neither based on staff needs, nor linked to the organization's key priorities.				
	3	Training is a formal component of the organization and is linked to staff and organizational needs, however, it is not implemented to reduce staff absence from their posts during training.				
	4	Training is a valued part of the organization, and opportunities are developed for staff, based on their needs and on the needs of the organization, including HIV/AIDS issues. It is implemented to reduce staff absence from their posts during training.				
Staff Training on HIV/AIDS Protocols	1	There is no staff training plan on HIV/AIDS protocols, reallocation of responsibilities, or HIV-related sensitivity.				
	2	Training on strategies in HIV/AIDS is offered on an ad hoc basis. Training plans do not take into account problems related to absence of staff from their posts during training.				
	3	Training related to questions and strategies in dealing with HIV/AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their post during training. However, not all employees receive the training.				
	4	Training related to questions and strategies in dealing with HIV/AIDS is provided as an official priority of the organization and addresses questions of absence of personnel from their post during training. All employees receive the training.				

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Component	Stages of HRM and Their Characteristics		Evidence	Other Comments
Management and Leadership Development Programs	1	No programs have been developed to increase management and leadership capacity at all levels of the organization		
	2	An emphasis on developing management and leadership capacity exists, but development is done on an ad hoc basis and not linked to addressing the challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.		
	3	Management and leadership development opportunities are available on a regular basis, but they target senior-level staff and are not directly linked to addressing the challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.		
	4	A management and leadership development program is in place for staff at all levels, and everyone has an opportunity to participate based on performance and other established criteria. The program focuses on addressing challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.		
Links to External Pre-Service Training	1	No formal link exists with the pre-service training institutions that prepare employees for the health sector, or with the accreditation organizations that approve their curricula.		
	2	A loose relationship exists between the organization and pre-service training institutions, but they do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector nor to prepare people to work in HIV/AIDS prevention and/or treatment programs.		
	3	The organization and pre-service training institutions work together to ensure that their curricula focus on developing skills, knowledge, and attitudes required by the health sector, including management and other skills for working in HIV/AIDS prevention, care, and/or treatment programs.		
	4	The organization and pre-service training institutions offer regular in-service training for staff in the workplace to upgrade staff skills and knowledge (e.g., management training, HIV/AIDS issues, change management, and partnerships).		

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Addendum J: Human Resource Management Questionnaire
Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean

HRM Data

Please circle the current stage of your organization.

HRM Component	Stages of HRM and Their Characteristics				Evidence	Other Comments
Employee Tracking System (e.g., data on the number of staff, position, location, gender, age, year of hire, salary level, projected HIV/AIDS prevalence, rate of attrition, and absenteeism by cadre)	1	None of these data are collected in any kind of systematic way.				
	2	Although most of these data are collected, there is no system to maintain them or keep them up to date. They are not used to generate reports on attrition, absenteeism, or staff turnover.				
	3	All of these data are available and up to date. They are used to generate reports on attrition, absenteeism, and staff turnover, but are not formally used in human resource planning.				
	4	All of these data are available and up to date. Data collection and reporting systems are in place. Data are formally used in human resource planning.				
Personnel Files (e.g., individual employee records that track performance, promotion, and salary history)	1	No individual employee records exist.				
	2	Limited employee personnel files are maintained, but not regularly updated.				
	3	Personnel files for all employees are maintained and kept up to date, but there is no policy for employee access to or use of these data.				
	4	Both updated personnel files for all employees and policies for appropriate use (e.g., confidentiality, employee access) exist.				

This is the last page, Thank you for your participation

ADDENDUM K : EXCERPT INTERVIEW

Addendum K: Excerpt Interview

ID CODE	
Date of interview	7/30/2010
Interviewer	1
Country	4
District/Parish	3
Institution	11
Tool number	4
Type of tool	2
Interview or Focus group number	7

Demographic Information	
Gender:	Male
Job Description	Professional Nurse
Qualifications	BNSc
Overall Nursing Experience	2 years 6 months
Nurse Manager Experience	N/A Frontline Nurse
Time Worked in Present Position	2 years 6 months

I: Interviewer
R: Respondent

I: Thank you sir for giving me the opportunity to interview you. This interview is regarding HIV/AIDS policy in the workplace. Uhm I'm gonna ask you a few questions about the HIV/AIDS workplace policy. The first question I would like to ask you, I want to know from you why do you think an institution like this do need a HIV/AIDS workplace policy.

R: I think the work related environment, most of the patients, the patients particularly around the villages here in this eh X area and X area, because this patient, they don't know much what happened, they just come and go without anything. But when there is someone whose there, who is, have to sit with the patient and explained to the patient the importance of, of coming here, what are the benefits for doing that, so others they don't know they just, the staff that I work with some of them, they don't even have much time for these patients. They are neglecting to help them, in sometimes for these patients. So I mean for me, if we can have a guidelines that will specifically deal with the situation that will be fine.

I: So if I understand you correctly, you say HIV/AIDS policies are needed to take care of patients. And if you look, eh HIV/AIDS for workplace policies for the employees? Can you maybe think of other factors that contribute, why do you think a workplace need a HIV/AIDS policy for the, for the staff.

R: I think eh you know the, I think, I think, when was, okay before I arriving, okay we do have a, I hear that sometimes ago, there was an office that the, the social worker and psychologist was there to help an infected member to go about, Since I've here I do not seen this help, because when I, when I'm dealing with some of the staff. Some of them they have abscond, other they have (?? Word cannot be identified by both researcher and transcribe, others they, they don't even call when they have problems to be discussed. So I think there was a time when we asks our manager about the eh, eh EAP, this is a program that you

Addendum K: Excerpt Interview

can, the program for the infected members that I work with. They said they were usually writing a referral letter. They just write the referral letter for that staff member and sent it to head office.

I: Uhm so you say the employment assistant program for the HIV affected and infected nurse is not in place, properly in place in the institution currently.

R: Yes, yes. That's what I am saying. Because even, most of the infected they, they don't know that there is a program like this which can help problems experience like financially, alcohol abusing and HIV/AIDS treatment because of the stigma. Because they know when, I work with someone with that problem. When say okay let me take you to the occupational nurse to assist you because that is a manager so they will say no I'm not going to that person because he will know that I have problems and so because there is this thing of gossiping amongst nurses. So that thing is still in their mind.

I: You say a thing about nurses. What is

R: Nurses gossiping. They're talking about other people.

I: Okay. So the nurses don't trust the managers.

R: Yes.

I: Okay but if you look eh, with the HIV, what stressors do you think, uhm eh how did our work environment change since we see more HIV/AIDS patients. You say they are here. What do you think change with regarding to us.

R: I think if we, if each and every institution can have start a program in HIV/AIDS and the policies to, to, to, the policies that will include those affected staff members to know if I have the following problem which way I have to go, because I think the problem again in the institution is that there is, they don't know that there, which way they have to follow.

I: Okay and I would like to ask you are you aware that in this institution there is a policy process committee.

R: No I'm not aware of it.

I: Where do your policies come from? Say I mention to you the HIV/AIDS workplace policy which makes provision for if you have an occupational injury you need to check. Where do you receive those policies from? Do you have them in the institution?

R: Yes, yes. Some of them I have read through them. I know them, I know the content of it.

I: Where do they come from?

R: I saw it at the occupational manager office and I mean I went through them, because I went personally and ask for them because I work with the, the HIV

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patients on daily basis. So that I want to know the steps if I prick myself accidentally, the steps I have to follow.

I: So eh during your orientation in this institution, you know you go through an orientation program, did you have an orientation program or not?

R: Yes we do have.

I: But this is not covered during the orientation program.

R: No, no, it did not cover, what I've realise is that they take you, they take you around for, actually they take you around the hospital to those people (managers) and tell you about their importance but other things they don't giving you as a person you don't go for it. You don't go to get it. Because the issue of policies they show you the files, so most of the people they don't go through them. They don't know the, the, the benefits of that policy for them, what are they.

I: And in your ward, eh, eh place you work now, do you have a policy guideline which you have for instance all the policies in.

R: Yes we do.

I: You do.

R: Yes we do.

I: And you, you have a say a staff member get an occupational injury on duty, how do you know how you go about with that.

R: Okay eh immediately when the patient, not the patient but the staff.

I: Yes.

R: The staff happened that happened to, to injury himself on duty, eh whatever we do, first we take the patient, the staff member and then after that I take the, the, the staff to occupational manager and helping the patient facilitate to see to it that the patient that every procedure is followed, what I do I'll take the patient, the staff to the manager of occupational, occupational health nurses eh and the patient which have and check everything have been attended to. Then if I am sure that everything has been attended to then I leave the patient.

I: Okay. Then you mean the staff member. Okay. But say you are the staff member, you needed now to be tested for HIV/AIDS and you know the status and you don't want to test your status, what are the steps then to follow?

R: Eh, I think what I know because there is this practice that is in placing lately in X institution...

I: Can you elaborate for me on that.

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- 140 R: Okay that something I forget the name of it, but there is this campaign that is in
141 place lately. Actually this is in place early in this year. So I couldn't remember
142 the name...
- 143
- 144 I: What does the institution try to reach?
- 145
- 146 R: That aim is to eh, to encourage the, the, the health workers to test and what I
147 normally do I went there myself and ask to test for VCT and after that if, if I want
148 some help again I will just tell her that I want the following and then she will
149 response to it.
- 150
- 151 I: Okay and is this private persons rendering that campaign services to the
152 institution. Say I want to take part on this campaign and I wanted to know my
153 status, is this people working in this institution who will do the VCT for me or is
154 that a person coming from outside?
- 155
- 156 R: No this person is from outside. This people are eh retired nurses. The retired
157 nurses are employed again and they come and assisted, in campaigning VCT
158 and are dealing with this.
- 159
- 160 I: I see. Okay so you can, you can, do you know any other factors which
161 contribute to the development of the HIV/AIDS workplace policy for employees
162 which you can think of?
- 163
- 164 R: Uhm, you said
- 165
- 166 I: You mentioned increase in eh the HIV patients, you mentioned that you are uhm
167 exposed more to the virus. But we can comeback if you remember other factors
168 you're welcome. I'm going over to the next question. You say you are not aware
169 of a policy committee in this institution. So uhm you are not aware of anybody
170 who served on the policy eh, eh policy committee.
- 171
- 172 R: No I don't know of anybody.
- 173
- 174 I: Okay. So the person mainly deal eh if I can think what you've said is the
175 occupational health and safety manager and uhm that is the person when you
176 are involved with the HIV policies regarding the staff.
- 177
- 178 R: Yes.
- 179
- 180 I: Thank you sir. I understand correctly. Okay if uhm how do you think the policies
181 you see, you said you go to the occupational and safety officer and you
182 indicated that you have policy files in your eh ward as well. Uhm do they come
183 from provincial office?
- 184
- 185 R: Eh yes the policy from provincial office. They correlate with the one of the eh, eh
186 you know institution. They are more, they could, what I am saying they are the,
187 the main thing and the vision they are, they are more legally.
- 188
- 189 I: Now do you have a policy for this institution as well.
- 190

Addendum K: Excerpt Interview

- 191 R: Yes.
192
193 I: And where does that policy came from?
194
195 R: I, I think the, the, it was translated in, in the eh from, from the management.
196
197 I: Okay, but you are not aware who are involved there. So, so there is a policy
198 process ongoing here but management is dealing with that. Do I understand you
199 correctly now?
200
201 R: Yes, yes.
202
203 I: Okay than you. Do you, can you think of other uhm HIV/AIDS policies which you
204 think needs to be developed in this institution.
205
206 R: Eh, I think uhm not for the institution, but really for the affected HIV personnel,
207 we need a policy for staff dealing with compliance, because most of them, they,
208 they don't comply with the treatment, for example if the personnel knows that he
209 has to complete the treatment, he want even try to comply to the treatment.
210 Because there is this thing that they don't know much.
211
212 I: What do you mean by they know much?
213
214 R: Because they will tell you that know I am fine, I have completed the, the
215 treatment. Then with follow up you ask why you not came to collect treatment
216 because treatment was only provided for one month, they didn't come back.
217 Then that means the treatment that you prescribed to them, they didn't even
218 complete it. That is why you still have some treatment.
219
220 I: And what do you think personally why, why do staffs not comply with the
221 treatment. What could be some of the reasons?
222
223 R: I think the reason might be that there is no one who, who motivate them or who
224 regularly can tell them about this HIV/AIDS or any treatment that the patient
225 have to complete the treatment.
226
227 I: Okay and according to you the employment assistant program, can that play
228 maybe a role? I'm just asking what do you think is the solution for this?
229
230 R: The solution for this is that the, the EAP, it should be active in this institution.
231 Because most of the employees don't know that there is a program like this, that
232 could be approving their lives.
233
234 I: Thank you sir. Anything else you want to add?
235
236 R: Eh I think and another thing about this eh EAP program is that it need to be
237 reinforced mostly, especially to, to the people that not know about it, not the
238 nurses only but to cleaners, boiler workers and other staff, other sections. That
239 is where I think that needs to be reinforced.
240
241 I: Thank you sir. Thank you for your time, I appreciate it.

Addendum K: Excerpt Interview

242

243 R: Thanks.

244

245 FIELDNOTES

246

247 1. ARRANGEMENTS

248

249 • Participant was contacted two weeks before the interview, the interview date
250 was confirmed a week as well as a day before the interview.

251

252 2. ENVIRONMENT

253

254 • Interview was held in a office in the outpatients department. No interruptions
255 were experience.

256

257 3. PARTICIPANTS INTERACTION

258

259 • Participant was relax and willing to give his opinion.

260

261 4. INTERVIEWER'S REFLECTION

262

263 It was nice to interview the participant; because I felt he speaks openly and it
264 seems that he have a sound knowledge of what is going on in the field of rural
265 management of HIV and AIDS clients, their needs and neglecting on the side of
266 nurses with times. It was a concern for the researcher that he indicates that he
267 needs to go and look for the HIV and AIDS workplace policy as the researcher
268 inspects policy guidelines before interviewing. In the institution there is a policy
269 committee who discuss health policies received from national DoH and
270 provincial guidelines, however it seems to the researcher that the committee
271 take note of policies and guidelines and see that policies are implemented. The
272 researcher could find no prove of an internal policy developed within the
273 institution. Members served on the policy committee are not known to frontline
274 nurse as well as their contribution towards the policy process.