COMMUNITY DEVELOPMENT WORKERS’ PERCEPTIONS OF WELLNESS AT AN HIV/AIDS ORGANISATION IN NELSON MANDELA BAY

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DECLARATION

I, Joshua Bongani Ndlela, declare that this treatise entitled COMMUNITY DEVELOPMENT WORKERS’ PERCEPTIONS OF WELLNESS AT AN HIV/AIDS ORGANISATION IN NELSON MANDELA BAY is my own work and that all the sources that I have used or have quoted from have been indicated and acknowledged by means of complete references.

________________________________________
Joshua Bongani Ndlela                        December 2011
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I would like to express my sincere thanks and deepest gratitude to the following people:

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“I can do all things through Christ who strengthens me”

(Phil 4:13)
Abstract

The general aim of the study was to explore and describe community development workers’ perceptions of wellness at an HIV/AIDS organisation in Nelson Mandela Bay, South Africa. The population of 36 community development workers at the Nelson Mandela Bay office of this organisation participated in this study. The sampling technique employed can be described as a census as it involved sampling an entire finite population that included all community development workers in the organisation. These workers are predominantly Xhosa-speaking adults between the ages of 21 and 60 years, and include both males and females. Qualitative data were gathered by means of audio-recorded focus groups, utilising semi-structured interviews. Tesch’s method was used to analyse the data, while Guba’s guidelines were used to enhance the trustworthiness of the research. Focus group interviews with community development workers revealed seven common themes in the experience of working in the HIV/AIDS organisation: (a) participants’ understanding of wellness; (b) organisational factors that impact on wellness; (c) personal factors that impact on wellness; (d) family and community factors that impact on wellness; (e) participants’ wellness; (f) personal coping strategies; and (g) suggestions regarding organisational strategies to enhance employee wellness. It is envisaged that the research findings of this study will be used in future to direct interventions that will be beneficial for the short and long term planning for the wellness of the community development workers of the HIV/AIDS organisation and those around them. It was recommended that the organisation was to develop a workplace wellness programme, increase management support towards the staff wellness and to increase the staff capacity.

Keywords: Community development workers, employee assistance programme, HIV/AIDS workplace programme, wellness.
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CHAPTER 1

An Introduction to HIV/AIDS and Employee Wellness

AIDS is the acronym for the Acquired Immunodeficiency Syndrome and represents the most serious manifestation of chronic human immunodeficiency virus (HIV) infection. AIDS is an acquired disease and is caused by HIV and although it is referred to as a disease, it is more commonly known as a syndrome, as it is a collection of many different conditions that are the result of a compromised immune system. AIDS is one of the most threatening syndromes known to mankind. Thirty years after its outbreak, AIDS is still not curable. Since the first cases of AIDS were reported in 1981, HIV has grown to pandemic proportions. In 2006 it was estimated that there were 65 million infections and 25 million deaths worldwide. During 2006 alone, an estimated 2.9 million persons died from AIDS, 4.3 million were newly infected with HIV, and 39.5 million were living with HIV worldwide (UNAIDS, 2006).

1.1 HIV/AIDS in South Africa

In South Africa the HIV/AIDS pandemic is significant. A decade ago, UNAIDS estimated that 11.5% of the South African population of 43.8 million were living with HIV/AIDS (UNAIDS, 2001). According to the South African Department of Health (2003) and UNAIDS/WHO (2003), South Africa has the “fastest growing epidemic in the world, with 5.3 million infected” (Department of Health, 2003, p. 17). The Department of Health furthermore stated that the South African HIV prevalence rate was much higher than that of sub-Saharan Africa as a whole (5.9%), and amongst the highest in the world (1%) (Department of Health, 2003; UNAIDS, 2003). UNAIDS (2003) estimated South Africa's HIV/AIDS prevalence rate could be as high as between 18% to 19%. The South African Institute of International Affairs (2004) states that, among the economically active South African population, almost one quarter is HIV positive. Some 290 000 South African children were estimated to be living with HIV/AIDS in 2006, and the country has more than one million AIDS orphans (Media Club South Africa, 2009).

Certain sub-populations appear to be particularly vulnerable to HIV infection. Globally, “HIV primarily infects people aged between 15 and 49 years who are young and should be working” (UNAIDS/WHO, 2003, p. 4). According to the South African Department of Health (2003) prevalence rates are said to be higher among young people, especially teenage
girls. Young women in the townships are particularly vulnerable to HIV infection, and HIV prevalence in girls and young women is more than double that of their male peers (Ubuntu Education Fund, 2010).

Media Club South Africa (2009) mentions that between 1997 and 2004 death rates from all causes increased by about 80%, largely due to HIV/AIDS. According to Media Club South Africa 360 000 South Africans died because of the disease in the year 2001 alone. Nearly half of all deaths for 2006 were due to HIV/AIDS, making it the leading cause of death for the country’s adult population. In line with this, according to the Ubuntu Education Fund’s website (2010), life expectancy in South Africa is 46.9 years for men and 51.3 years for women.

1.2 Employee Wellness in South Africa

Not paying attention to employee wellness and a lack of employee wellness programmes could be a serious threat to employees, employers and the economy of our country. Rothmann (2005) analysed occupational stressors in 14 different occupations in South Africa and concluded that stress levels are particularly high in the health sector (such as hospital pharmacists, nurses and emergency workers), among correctional services officers, university educators, call centre operators and police officers. Statistics show that an average of 10 000 police officers in South Africa are absent from work daily because of high levels of occupational stress (Pienaar & Rothmann, 2005). Educators (specifically in secondary schools) in South Africa also seem to experience high levels of stress, as do executives, whose stress levels are fuelled by the exchange rate volatility, commodity prices, fluctuating interest rates, changing legislation and empowerment charters (Temkin, 2004). Rothmann’s analysis in 2005 shows clearly that both government and employers need to give serious attention to the implementation of employee wellness initiatives in the workplace.

Organisations feel the impact of workplace stress in increased absenteeism, high production errors and accidents, higher staff turnover, lower productivity and high medical costs which ultimately influence the organisation’s bottom-line, and have an adverse impact on the economic growth of the country. Organisations are thus negatively impacted by the effect of stress on the health and wellness of their employees (Sieberhagen, Rothmann & Pienaar, 2009).

Statistics confirm that at any given time one quarter of South Africa’s workforce is affected by problems that contribute to a deterioration in performance at work, and that South
Africa’s workforce productivity is ranked 31st out of 45 countries (Noemdoe, 2002). In 1996, the cost of injuries at work in South Africa amounted to R4.7 billion (Noemdoe, 2002). Furthermore, according to Mead (1998), South African employees are generally unhealthy, due to their poor economic circumstances and consequent unhealthy living conditions in squatter camps and unhealthy lifestyles and diets. In addition, the high HIV infection rate among the economically active population contributes to high labour turnover rates and lower worker productivity and constitutes an increased burden on employee benefit programmes (South African Institute of International Affairs, 2004).

In South Africa, it is estimated that 6.3 days per employee per annum are lost owing to unapproved absences from work (Vaida, 2005). About 4.5% of the South African workforce are absent on any given day, although the absenteeism rate is sometimes as high as 18% in some organisations (Vaida, 2005). South Africa loses an estimated R12 million per year, of which between R1.8 billion and R2.2-billion can be attributed to absenteeism linked to the effects of HIV/AIDS (Human Capital Management, 2006). In spite of this, South African companies have been slow to develop workplace wellness programmes to prevent flu, fatigue, and exacerbation of pre-existing conditions from affecting workplace productivity and increasing costs (BizCommunity, 2006).

1.2.1 Impact of HIV/AIDS in the workplace. According to a study undertaken in 2005, commissioned by AIC Insurance, companies are losing as much as a month’s work each year for every employee with advanced HIV/AIDS, who, on average is absent 32 days a year, generally divided into four stints of about eight days each, which is three times higher than that of people not infected with the virus (James & Katundu, 2006). The impact of HIV/AIDS infected employees in the workplace is spelled out in detail (Department of Public Service and Administration, 2002) as follows:

1.2.1.1 Morbidity and absenteeism. As infected workers become ill they will take additional leave. This will disrupt the operation of the organisation for which they work. The disruption will be amplified when the more qualified and experienced employees are absent. Increases in deaths will lead to increased absenteeism, as employees attend funerals for family members and colleagues. Owing to their socially defined role as caregivers, women employees will have to care for sick children and partners, which will involve time off from work.
1.2.1.2 Mortality or retirement. The impact of the death or retirement of an infected employee is similar to morbidity, although the problems are permanent. The loss of an employee requires that an appropriate replacement be appointed and trained. For highly qualified staff this is often difficult, particularly in developing economies with skills shortages. Training and recruitment are costly and disrupt operations.

1.2.1.3 Staff morale. The epidemic has a negative impact on morale in the workplace. There is fear of infection and death, which may lead to increased suspicion of others as well as resistance to shouldering the additional responsibilities for colleagues who are off sick, away from work or newly recruited and not yet fully functional.

1.2.1.4 Benefits. Employers and employees will feel the impact as the costs of employee benefits increase.

1.2.1.5 Demand for services. Demand for services, particularly health and welfare services, is likely to increase dramatically. This will have major implications for departments that provide these services and even more so if they already face capacity constraints or are short staffed.

It can be seen from the above that workplace programmes to ensure that everyone in the organisation learns how to prevent the spread of HIV and that everyone is confident about health and safety in the workplace are thus essential. Thomas (2004) notes that whilst proactive strides in HIV/AIDS workplace programmes have been taken by big business and multi-nationals, government and in particular local government has been slow in this regard. In the Department of Public Service and Administration’s (2002) guide for managing HIV/AIDS in the workplace, the authors clearly highlight the fact that “strategic planning is an important function for departments (organisations) as it provides an explicit map for guiding the department (organisation) towards achieving its goals and objectives by focusing on its purpose, objectives, structures, expenditure programmes, available resources, deliverable outputs” (p. 61). One of the key challenges noted in the same guide to successful HIV/AIDS programme planning and project implementation is the lack of budget allocation (Department of Health, 2003).
1.3 The Eastern Cape Context

According to the Olive Leaf Foundation (n. d) the Eastern Cape province is one of South Africa's poorest provinces, with the highest infant mortality rate in the country, an estimated 80% of the population unemployed and household income derived through the informal sector and social grants. Nelson Mandela Bay (NMB), comprising the towns of Port Elizabeth and Uitenhage and surrounds, is an area where many people work in the automotive industry, with multinational companies historically having established factories within the townships to exploit cheap, unskilled labour. The area is described by the Olive Leaf Foundation (n.d.) as having a population of approximately 1.3 million, of whom “more than one-third of the population lives in informal settlements, made up of tightly clustered shacks, with the remaining living in overcrowded brick matchbox homes” (para. 3). These townships have little public and private infrastructure and suffer from a general shortage of essential basic services. According to the Ubuntu Education Fund (2005) the population of NMB has difficulty in accessing good service delivery such as adequate nutrition, sanitation, health care, housing and educational facilities in their communities. These socio-economic challenges are the results of the apartheid struggle since “township communities around Port Elizabeth are renowned for their deep engagement in the struggle, organising through strong grassroots community structures” (para. 1). Furthermore, the Fund adds that although NMB has a proud struggle history, the townships today remain “haunted by the legacy of systemic impoverishment and apartheid destabilization and are reeling from the devastation wreaked by the HIV/AIDS epidemic” (para. 2). Ubuntu Education Fund continues to inform that “a 34.5% HIV prevalence rate in Port Elizabeth, every person is our target communities is affected by the HIV/AIDS epidemic” (para. 3). It is remarked on that there is a high level of awareness and general knowledge about HIV/AIDS among this population, but that few people know their own HIV status.

It is clear from the preceding descriptions of the levels of poverty and HIV/AIDS that the stress is carried to the workplace. It is deemed that anyone employed by an organisation in NMB, whose business is working with people from township communities who are infected or affected by HIV/AIDS, could experience a great deal of work-related stress. It is also clear that it should be incumbent upon such an organisation to be concerned about the wellness of their employees, to have a programme in place to help employees deal with the stress in order to remain healthy and productive. And if such a programme were in place, was it in fact fulfilling its function? It is precisely with this in mind that the present study, into the wellness
of community development workers at a non-governmental organization (NGO) dealing with HIV/AIDS in NMB, was initiated.

1.4 The Organisation Where the Research was Undertaken

The NGO is an HIV/AIDS organisation which was founded in 1989 in Soweto, Johannesburg. The organisation has five sites nationally in Johannesburg, Durban, Mthata, Cape Town and in NMB. The NMB office has been active for the past 13 years in eight township communities in the area, viz. Motherwell, Zwide, Veeplaas, Soweto-on-Sea, Helenvale, Malabar, Ezinyoka and Walmer Township. In this time it has initiated and built up a number of departments/programmes, namely: (a) Orphans and Vulnerable Children Department (OVC); (b) Voluntary Testing and Counselling (VCT); (c) Abalingani Gender Programme (AGP); (d) Prevention Department; and (e) Wellness Programme. There are currently 42 community development workers employed here. These workers are divided into three groups, each with its own particular focus in the community, but with the overall aim of enabling sustainable community development to take place.

The first group focuses on mobilising and strengthening communities to meet the needs of vulnerable youth and children. These development workers facilitate psycho-social and life-skills support, make targeted interventions when necessary, and support local educational institutions, to enable all beneficiaries of the services reach their full potential.

The second group focuses on community public health support to enable people to live healthy and productive lives, especially those who are HIV/AIDS infected. These development workers develop sustainable community-owned and driven wellness systems, in collaboration with local government and non-governmental partners. As most of the development workers are from these very same communities, and are thus knowledgeable of community needs, local implementation processes are easier to put into place.

The third group focuses on capacity building among individuals infected and/or affected by HIV/AIDS, organisations and communities, by focusing on skills development, empowerment and relationship-building. Without formal education they train and mentor individuals and organisations that need help through relationship-building, the identification and exploration of community concerns, decision making that leads to action, reflection and review.

Recognizing the positive role that wellness and/or employee assistance programmes can play in HIV/AIDS support, education, and care, and acknowledging the need for an internal
system to mitigate the work stress and other detractors of their staff’s wellness, a Wellness Programme for staff was developed and introduced at the NGO in the NMB office in 2007 (Arend, 2008). It was hoped the programme would help to attain and maintain employee health, this being the goal of such programmes (Brannon & Feist, 1997).

It was noticed that staff’s wellness was affected not only by stress from within the workplace but also from other areas of their lives, such as from the society and environment they lived in, it was felt that a more in depth exploration of the wellness of the community development workers was needed (Arend, 2008).

This is what led to the present research being conducted. As a first step in exploring the wellness of the community development workers in the NMB site, the researcher set out to discover what their understanding of wellness was, as well as what factors affected their well-being.

1.5 Overview of Remaining Chapters

Chapter 2 provides a brief overview of established theories of wellness. Wellness means different things to different people; it is essentially a contested concept. According to Cowen (1994), the understanding of health and wellness is dependent on a variety of factors such as values, culture, age, socio-economic background, and education. The historical development of wellness will be described, and a broader theoretical framework of the concept outlined.

Chapter 3 provides a literature review of various kinds of programmes in place to maintain healthy employees that are relevant for international organisations, South Africa and the Eastern Cape. Employee Assistance Programmes, HIV/AIDS Workplace Programmes and Wellness Programmes will be compared. The rationale behind such programmes and the history of the development and implementation of Wellness Programmes will be outlined, as well as a brief description of the Wellness Programme at the NMB site of the NGO.

Chapter 4 considers the research methodology of this qualitative study. Reference will be made to the sampling technique used in the selection of participants, the use of a semi-structured focus group interview framework for collecting data, and ethical considerations.

In chapter 5, the findings of the study are provided. The themes that emerged from the collected data will be compared with the literature review in chapter three and theories of wellness in chapter two. Group interviews were conducted in English. Some Xhosa was spoken, however, and this was translated into English. One of the original transcripts is
presented in Appendix D. The need for workplace wellness intervention was expressed in all group discussions.

Chapter 6 interprets the findings of the study and their implications for future wellness programming and research.
CHAPTER 2

Models of Wellness

This chapter provides different definitions of wellness and some prominent wellness models are described. The Perceived Wellness Model, The Indivisible Self and The Job Demands Resources Model are discussed to conceptualise and describe the application of wellness in this study.

2.1 Wellness Definitions

According to Van Lingen (2005) the term wellness was coined by Dr Halbert Dunn in the 1950s and first published in 1961. He described wellness as more than the absence of illness and disease, and focused on the maximization of human potential. The concept of wellness originated within the medical field as an alternative to a traditional view of health as merely the absence of disease (Harari, Waehler & Rogers, 2005). Even though the term wellness did not exist prior to 1961, it was not a new concept. As far back as in ancient Greece a healthy person was seen as having “a keen intellect, a well-developed will, and a disciplined body” (Johnson & Wernig, 1986, p.33).

Attempts to define wellness often begin with references to the World Health Organisation’s (1967) definition of health being not just the absence of illness but a state of complete physical, mental, and social well-being. Dunn, for example, emphasized wellness as a positive state, one that is beyond simply nonsickness. He defined high-level wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable” (Dunn, 1961, p. 4).

Cowen (1994) supports the position that the understanding of health and wellness is dependent on a variety of factors such as values, culture, age, socio-economic background, and education. Some authors define wellness as beauty, others fitness, while others again associate the word with recreation and de-stressing (Epstein, 2005). According to Egbert (1980) wellness includes the recognition of a unifying force in one’s life, the ability to cope creatively and to be inspired by hope, and the capability of creative, open relationships.

Bill Hettler (1984) is considered to be the father of the modern wellness movement. He defines wellness as "an active process through which people become aware of, and make choices towards a more successful existence" (p. 14). Myers, Sweeney, and Witmer (2000)
similarly describe wellness as “a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving” (p. 52).

A variety of wellness definitions and models are discussed in the literature by wellness researchers. Van Lingen (2005) views most wellness definitions as focusing on “a striving for the attainment of a state of optimum functioning in all spheres of life, with an emphasis on lifestyle choices” (p. 29). She also refers to Ryff and Singer (1998) who emphasize the individual’s subjective perceptions of wellness rather than only focusing on lifestyle factors, behavioural choices, or the outcomes of these factors. Every nation and culture appears to have a different way of describing the term wellness. For example, according to Ardell (2009), the European Wellness Union defines wellness as including physical and spiritual fitness and movement, mental stamina, positive work positions, harmonious private life and being in balance and harmony with nature. Ardell (2009) explains that the Danish view of wellness includes all of the following, namely: (a) to live more healthily in a fun and relaxed way; (b) to prevent rather than to cure; (c) the possibility of feeling better about oneself without becoming fanatical; (d) building resilience by focusing on one’s personal wellbeing; (e) mental flexibility; (f) the opportunity of gaining a fulfilling life experience, quality surroundings, modern and inviting facilities; (g) and the possibility of relaxing or doing active exercises in conjunction with nature.

It can thus be seen that there are many definitions of the word wellness, each wellness promoter or even culture creating their own understanding of the term (Ardell, 2009). All are similar, and all are useful as guides to the boundaries and issues addressed in this broad area of lifestyle education. Ardell further encourages wellness promoters to consider many varied definitions, and then write their own. In short, different cultures and values always play a role in how people make sense of the term.

2.2 Wellness Models

It is acknowledged by wellness theorists that there are not many existing scientific wellness models and as a result, there are far fewer models of wellness than there are definitions. In fact, the only models to gain much attention over the past 30 years are those that are found in the literature and were promoted by the National Wellness Institute (NWI) (Ardell, 2009). Three of the earlier models are described below.
Bill Hetler, the founder of the NWI, developed a six-dimension model of wellness (1979) which is presented in Figure 1:

![National Wellness Institute Wellness Model](http://www.seekwellness.com/wellness/articles/wellness_models.htm)

The Wellspring (n.d.) describes John Travis’s Illness/Wellness Continuum as “…not to replace the treatment paradigm on the left side of the continuum, but to work in harmony with it. If you are ill, then treatment is important, but do not stop at the neutral point. Use the wellness paradigm to move toward high-level wellness” (para. 2). This continuum is presented in Figure 2.

![Illness-Wellness Continuum](http://www.seekwellness.com/wellness/articles/wellness_models.htm)
Ardell (2009) reported online in his Wellness Report that additional categories in his model seemed to be helpful for classifying articles and he came up with three overall domains and fourteen skill areas, in his Wellness model as shown in Figure 3.

![Figure 3: Don Ardell’s Wellness Model](http://www.seekwellness.com/wellness/articles/wellness_models.htm)

2.3 Fundamental Principles of Wellness Models

Adams, Bezner and Steinhardt (in Els, 2005) describe systems theory and a salutogenetic orientation serve as fundamental principles of all wellness models. Three recent models, which are used in this study, will be described further on in this chapter.

2.3.1 Systems theory. Adams, Bezner and Steinhardt (1997) describe systems theory as the relationship between essential sub-elements of a larger system and an independent system with its own sub-elements. They emphasize that wellness theories promote the importance of viewing the individual as a system composed of various sub personalities or parts and acknowledge that an individual is in constant interaction with the greater contextual environment, involving another system. Rothman (1996) concurs with the above description and believes that the individual cannot be separated from his emotional, social or cultural contexts. Els (2005) quoted Barker(1986), Corsini and Wedding(1989), and Fennel and
Weinhold (1989) in setting out the characteristics of a systems environment and how it is understood. He said the following:

- Systems contain boundaries and are either open or closed. If the system is closed it is subjected to entropy. An open system is more open to experience a flow of interaction in the system.
- Human systems are composed of subsystems and contribute to the health of the bigger system.
- Systems comprise individuals or independent elements that share some common goals and are part of a bigger system, which is part of a supra-system.
- Systems are interrelated, interdependent and influence one another.
- Systems encourage a circular rather than linear understanding in order to promote a systemic wellness.
- Systems strive for equilibrium and create boundaries between systems and subsystems in order to regulate and control the flow of information across the systems.
- Symptoms of one sub-system need to be understood and addressed within the context of interaction with other sub-systems.

Wellness models need to be understood or be considered within the context of interaction with other subsystems. Els (2005) states that systems theory is very useful to understand and define the interrelatedness of wellness dimensions.

### 2.3.2 Salutogenic orientation.

According to Antonovsky (1979) salutogenesis seeks to focus on the origins of health as opposed to the pathogenic model, which seeks to explain illness/disease. Salutogenesis is about how individuals learn to live well with stressors and turn their struggles into an advantage for themselves. The salutogenic model focuses on normality rather than abnormality, adjustment rather than maladjustment, and health rather than illness. Antonovsky (cited in Van Lingen, 2005) recognizes the wide variety of factors that impact on health and he focuses on the effects of these factors on physical health. Van Lingen (2005) explains that Antonovsky’s view of wellbeing “was not adequately reflected in the reference to health, and that Antonovsky’s focus was rather on sources of strength” (p. 21). Van Lingen (2005) states that salutogenesis’s central view is a rejection of the dichotomous classification of people as either diseased or healthy. Van Lingen further explains the dichotomous view as often originating from the pathogenic viewpoint instead of viewing a person from a holistic perspective. Antonovsky (1996), quoted in Van
Lingen(2005), viewed stressors as being omnipresent and used terminology such as heterostasis, disorder and disequilibrium to describe the state of all living organisms.

Three later models of wellness “appropriate for working conditions” (Els & De La Rey, 2006, p. 46) were used in this study, viz. the Perceived Wellness Model (Adams, Bezner & Steinhardt, 1997), the Indivisible Self (Myers & Sweeney, 2005) and the Job Demands Resources Model (Bakker & Demerouti, 2007). They will be described in more detail below.

2.4 The Perceived Wellness Model

Perceived wellness is defined as living in a manner that permits the experience of consistent, balanced growth in the emotional, intellectual, physical, psychological, social and spiritual dimensions of human existence (Rothmann & Ekkerd, 2007). Adams, Bezner and Steinhardt (1997) define perceived wellness as “a multidimensional, salutogenic construct which should be conceptualised, measured and interpreted consistent with an integrated systems view” (p. 36). The Perceived Wellness model is one of the first models to indicate and include the psychological wellness of people as a specific dimension within wellness as a whole.

According to Adams, Bezner and Steinhardt (1997) wellness is commonly conceptualised as having many dimensions, but little effort has been made to evaluate how the spiritual and psychological dimensions are related to overall wellness. The holistic conceptualisation of wellness dimensions by the Perceived Wellness model includes both the spiritual and psychological dimensions. Adams, Bezner and Steinhardt state that the Perceived Wellness model is thus favoured because of its comprehensive, multiple wellness dimensions, and it is noteworthy that this concept of wellness and well-being is increasingly regarded as an important construct in South Africa. As Rothmann and Ekkerd (2007, p.36), quoting Adams, Bezner and Steinhardt (1997) say: “…to best describe and predict individual wellness, models should include several dimensions that are operationalized and interpreted consistent with the systems approach.” The Perceived Wellness model is presented in Figure 4.
The Perceived Wellness model identifies six wellness dimensions that are represented in the form of a cone. The definitions of the components of perceived wellness are as follows (Adams, Bezner & Steinhardt, 1997):

- **Physical wellness**: A positive perception and expectation of physical health.
- **Spiritual wellness**: A belief in a unifying force between the mind and body and a positive perception of meaning and purpose in life.
- **Psychological wellness**: A general perception that one will experience positive outcomes to the events and circumstances of life.
- **Social wellness**: The perception of having support available from family or friends in times of need and to feel valued by those who are around you.
• **Emotional wellness:** The possession of a secure self-identity and a positive sense of self-regard. Self-identity refers to one’s internal image of oneself, whilst self-regard is the value placed on self-identity (i.e. the extent to which one values and likes oneself).

• **Intellectual wellness:** The perception of being internally energised by an optimal amount of intellectually stimulating activity.

According to Harari, Waehler and Rogers (2005), the above integrated wellness model emphasizes how individuals function within the life dimensions as well as across these dimensions. The model further describes that when people perceive themselves as attending to all wellness dimensions equally, they are healthier. For Adams, Bezner and Steinhardt (1997) optimal balance is when an individual has an equivalent positive perception of functioning in each of the six dimensions. Adams, Bezner and Steinhardt’s (1997) perceived wellness is salutogenically oriented and provides multidimensional measures of wellness perceptions in the physical, spiritual, psychological, social, emotional and intellectual dimensions.

### 2.5 The Indivisible Self

The Indivisible Self, referred to as an evidence based model of wellness was developed by Myers and Sweeney in 2004 and was “designed to assess characteristics of wellness as a basis for helping individuals make choices towards healthier living and assess the underlying supporting constructs that enrich its usage for a work wellness model” (Els, 2005, p. 51). As it enables one to describe the different contexts that shape an individual, such as families, communities and economic factors, it was deemed appropriate for use in this study. The Indivisible Self is presented in Figure 5.
The Indivisible Self model is based on endorsement of a single higher-order wellness factor, namely, the indivisible self, five second-order factors, namely, the creative self, coping self, social self, essential self and physical self and 17 third-order factors representing the original areas of wellness from Myers, Sweeney and Witmer’s Wellness Evaluation of Lifestyle Inventory (Myers & Sweeney, 2005). The higher-order wellness factor: In 1954 Adler proposed that:

holism (the indivisible self) and purposefulness are central to understanding human behaviour. Such understanding requires an emphasis on the whole rather than the divided elements, on interaction between the whole and the parts, and on the importance of the social context. The higher-order wellness factor therefore indicates the total wellness of the individual system. (Els, 2005, p. 54).
The 5 second-order factors:

1. **The Creative Self** comprises thinking, emotions, control, work and positive humour. It is explained as the “combination of attributes that each of us forms to make a unique place among others in our social interactions and to positively interpret our world” (Myers & Sweeney, 2008, p. 485).
   - Thinking: An ability to be creative and mentally active at all times (Myers & Sweeney, 2008).
   - Emotions: An ability to experience feelings and express how one is feeling in an appropriate manner (Myers & Sweeney, 2008).
   - Control: The capacity to influence events in one’s surroundings (Myers, 1992).
   - Work: Work fulfilment or satisfaction and the ability to cope with workplace stress (Myers & Sweeney, 2008).
   - Positive humour: The ability to think clearly, perceive accurately and respond appropriately to decrease stress and enhance one’s humour response that medical research has shown effects the immune system positively (Bennett, 1998).

2. **The Coping Self** comprises leisure, stress management, self-worth and realistic beliefs. Myers and Sweeney (2008) describe the coping self as the combination of elements that regulate one’s responses and provide the means to respond to negative circumstances without feeling dysfunctional.
   - Leisure: A coping strategy, essential for continual individual wellness as it opens pathways for growth in both creative and spiritual dimensions (Els, 2005). It is regarded as activities that are done during one’s free time (Myers & Sweeney, 2008).
   - Stress Management: The individual’s ability to handle stress during life challenges; resilience forms part of this behaviour (Els, 2005).
   - Self-Worth: The ability to value and accept oneself and to recognise positive qualities of oneself (Myers & Sweeney, 2008).
   - Realistic Beliefs: An acceptance that perfection and being loved by everyone is impossible; having the courage to face the reality of situations as they come (Myers & Sweeney, 2008).

3. **The Social Self** comprises friendship and love. According to Ulione (1996) friendship and love exist on a continuum and are not always clearly distinguishable in practice. Friendship is explained as the social relationships that exist (Myers & Sweeney, 2008) and
love is the “ability to be intimate, trusting and self-disclose with another person” (Myers & Sweeney, 2008, p. 274).

4. **The Essential Self** comprises one’s spiritual self, gender identity, cultural identity and self-care.

- **Spiritual Self:** Described by Myers and Sweeney (2008, p. 275) as “personal beliefs and behaviours that are practised as part of the recognition that a person is more than the material aspects of mind and body.”
- **Gender Identity:** Satisfaction with one’s gender; feeling supported in one’s gender; transcendence of gender identity (Myers & Sweeney, 2008).
- **Cultural Identity:** The ability to make meaning through a cultural identity (Myers & Sweeney, 2008).
- **Self-Care:** An individual proactively makes “efforts to live long and well. Conversely, carelessness, disregard for health-promoting habits and general ignorance of one’s well-being are potential signs of the presence of despair, hopelessness, and alienation from life’s opportunities” (Els, 2005, p. 53).

5. **The Physical Self** comprises engaging in physical exercise to keep a good physical condition and nutrition, “eating a nutritionally balanced diet and maintaining a normal weight” (Myers & Sweeney, 2008, p. 275).

The Indivisible Self also considers other variables that are fundamentally ecological and includes four contextual factors that form part of an individual’s wellness, viz. local, institutional, global and chronometrical contexts (Myers & Sweeney, 2008). Myers and Sweeney describe these four contextual factors as follows:

- **Local context:** Systems in which one lives most often such as families, neighbourhoods, and communities, and one’s perceptions of safety in these systems. Els (2005) further emphasizes that this includes interactions with, and the central influence of those systems which people most often live in.
- **Institutional context:** Social and political systems that affect one’s daily functioning and serve to empower or limit development in obvious and subtle ways, including education, religion, government and the media.
- **Global context:** Factors such as politics, culture, global events and the environment that connect one to others around the world.
- **Chronometrical context:** Reflects the recognition that people change over time in important ways.
These contextual factors have an impact on the individual, and the individual in turn influences or impacts on the context. These interactions may be positive or negative and determines the wellness of the individual and the collective.

2.6 The Job Demands Resources Model

This is an appropriate and useful wellness model for this study investigating at the wellness of workers in a particular NGO, as the Job Demands Resources Model (JD-R) is used to make sense of the impact of job demands and resources on the wellness of workers. According to Bakker and Demerouti (2007) this model may be applied in various occupational settings, irrespective of the particular demands and resources, or the particular risk factors associated with job stress. The Job Demands Resources model is presented in Figure 6.

![Figure 6](#)

As can be seen in the JD-R figure above, it has two major components, the Job Demands element and Job Resources element. Job Demands refer to various organisational dimensions such as physical, psychological, emotional or organisational aspects of the job that require sustained physical and/or psychological strength in order to prevent unnecessary organisational costs (Bakker & Demerouti, 2007). Job Resources refer to organisational aspects of the job that (a) are functional in achieving work goals; (b) reduce job demands and the associated physiological and psychological costs; and (c) stimulate personal growth, learning, and development. Therefore, “resources are not only necessary to deal with job demands, but they also are important in their own right” (Demerouti, Bakker, Nachreiner & Schaufeli, 2001, p. 5).

In the JD-R model, job strain refers to health impairment caused by the poor design of the job or chronic job demands such as high workload and emotional demands, which have been found to exhaust the various wellness dimensions of employees and their ability to work productively in the workplace (Bakker, Demerouti & Schaufeli, 2003). Motivation assumes “that job resources have motivational potential and lead to high work engagement, low cynicism, and excellent performance” (Bakker & Demerouti, 2007, p. 5). According to Bakker and Demerouti (2007) job resources foster employees to meet their goals particularly when job demands are high. The balance between job demands and job resources is clearly important for motivation. When there is a lack of resources to meet job demands, inefficiency or burnout may result.

Maslach and Leiter (1997) defined the antithesis of burnout as engagement. They further argue that work engagement is characterized by energy, involvement and efficacy – the opposite of the three aspects of burnout. When people experience feelings of burnout energy turns into exhaustion, involvement turns into cynicism and efficacy turns into ineffectiveness.

Maslach (2005) describes the three interrelated aspects of burnout as follows. Exhaustion refers to when people are feeling drained and lack the mental or physical energy to get on with what they need to do. Cynicism is characterized as a negative evaluation and reaction to the job, the work one needs to do and the people one works with. Maslach further explains that cynicism often begins as a response “to the work overload leading to the exhaustion, so people will back off and do less and people begin to think very negatively about the workplace and their colleagues” (p. 6). Ineffectiveness is described as a decline in people's sense of their own professional effectiveness, rather than being negative about the job and their colleagues; people develop a negative sense of who they are and what they are doing.
Organisations that take into account the above concepts in the workplace may be seen as enhancing the wellness of the workforce. According to Xanthopoulou, Bakker, Demerouti, and Schaufeli (2007) organisations that expect to have positive employees, will focus more on job resources than on job demands. As a result employees will experience lower levels of burnout and higher levels of work engagement. Schaufeli, Salanova, Gonzalez-Roma and Bakker (2002) define work engagement in its own right as a “positive, fulfilling work related state of mind that is characterised by vigor, dedication, and absorption” (p. 74). Vigour reflects the readiness to devote effort in one's work, an exhibition of high levels of energy while working and the tendency to remain resolute in the face of task difficulty or failure. Dedication refers to astrong identification with one's work and feelings of enthusiasm, inspiration, pride, and challenge. The last aspect of work engagement is absorption referring to being fully concentrated and happily engrossed in one’s work, whereby time passes quickly and one has difficulties with detaching oneself from work.

Initially it was intended to use only one wellness model as a theoretical framework in this study. The Perceived Wellness model was chosen for this purpose, as the model included psychological and spiritual dimensions. A focus on psychological aspects were deemed important, as it was known beforehand that employees at the NGO where the research was undertaken were suffering from high levels of stress. The spiritual aspect was deemed particularly important as well, as the NGO was a faith-based organisation, and many of the employees adhered to the Christian faith. However, as the research study progressed, it became clear that the Perceived Wellness model was not sufficiently comprehensive to accommodate all the factors that impact on employee wellness. In particular, contextual factors such as families, communities and socio-economic factors were not explicitly addressed by the Perceived Wellness model. For that reason, it was decided to include descriptions of the Indivisible Self and the Job Demands Resources model to complement the Perceived Wellness model in serving as a theoretical framework for the present study. For example, the Indivisible Self integrates contextual factors that have an impact on employee wellness, while the Job Demands Resources model is used to make sense of the impact of job demands and resources on the wellness of workers.
2.7 Conclusion

Various models have been described in an attempt to explain the concept of wellness. Three different models were discussed in the chapter and were described for the purpose of contextualising the research study. The following chapter will discuss a literature review of wellness in an organisational context. It focuses on wellness programmes and summarises important factors in employee wellness.
CHAPTER 3

Relevant Research Related to Employee Wellness

This chapter reviews literature on employee wellness programmes that are relevant for international organisations, South Africa and the Eastern Cape, and that have been implemented in selected private and public sectors. It describes what characterises a healthy workplace, employee wellness, and the history of employee wellness, as well as providing the rationale for workplace employee wellness programmes. It also discusses the benefits of employee wellness in the workplace and provides an overview of employee wellness in the Nelson Mandela Bay office of the NGO where the research was undertaken.

3.1 Healthy Workplace and Employee Wellness

A healthy workplace, as defined by Sauter, Lim, and Murphy (1996), is any organisation that “maximizes the integration of worker goals for well-being and company objectives for profitability and productivity” (p. 251). The two critical components embedded in this definition are the performance of the organisation and the health of the employees (Jaffe, 1995). Adkins, Quick, and Moe (2000) expanded the definition of a healthy workplace by describing four guiding principles of organisational health.

- The first principle proposes that health exists on a continuum from mortality to vibrant wellbeing. The purpose of organisational health is not merely to avoid ultimate destruction, but rather it is a quest to move toward abundant life. Organisations should focus on promoting positive health outcomes instead of acting only to prevent the negative outcomes of poor health.

- The second principle states that organisational health is a continuous process, not an obtainable state. Vigilance on the part of the organisation is required to constantly maintain good health, even if and when optimal health is achieved. Constant attention, evaluation, and action are needed to maintain a healthy workplace.

- The third principle addresses the systemic nature of health, arguing that organisational health is the result of interconnections between multiple factors. An organisation can only be healthy if all of its parts are free from disease. The organisation must engage in risk assessment, based on its perceived threats and vulnerabilities. Moreover,
damaging factors within the organisation must be minimized in order to reach optimal systemic health.

- The final guiding principle of organisational health is its reliance on fulfilling relationships. Action within an organisation is achieved through constant communication, collaboration, and relationship building.

According to Roslender, Stevenson and Kahn (2006), there is significant gain from regarding employees in general, and their wellness in particular, as more than simply a cost to the enterprise. Thinking of employees as a cost to the enterprise is largely inconsistent with implementing comprehensive programmes designed to provide a safe, low-stress working environment in which employees are provided with helpful information on how they can simultaneously improve their own wellness for the benefit of themselves and those close to them as well as their employers.

According to Keyes and Haidt (2006) employee wellness is a broad concept that encompasses a number of workplace factors such as work engagement, productivity, dedication, commitment and loyalty. Within the overall domain of wellness, it is explained that employee engagement (a combination of cognitive and emotional variables in the workplace) generates a higher frequency of positive affect (job satisfaction, commitment, joy, fulfilment, interest and caring). Positive affect gives rise to efficient application at work, employee retention, creativity and ultimately business outcomes. Danna and Griffin (1999) refer to employee wellness as the individual’s life experiences, such as life satisfaction and happiness, and job-related experiences, such as job satisfaction, job attachment and satisfaction with pay or co-workers. Employee wellness programmes are used by organisations to address these general health related issues in the workplace.

3.2 Employee Health Promotion Programmes

With the introduction of health promotion programmes in workplaces in South Africa it becomes important to evaluate their effectiveness and to learn from the international experience of developed countries (Zungu & Setswe, 2007).

According to Zungu and Setswe (2007) health workplace programmes involve developing a working culture that is based on partnership, organising work tasks and processes so that they contribute to, rather than damage, health, and implementing policies and practices that enhance employee health by making the healthy choices more attractive and accessible. A workplace programmerecognises that organisations have an impact on people and that this
impact is not always conducive to their health and wellbeing. Health promotion programmes can include a number of strategies and activities. Some of the most popular activities include health risk assessments/appraisals, brown bag seminars or training classes on specific topics, newsletters, health fairs, incentive programmes, work/life programmes and exercise facilities. Wellness programmes are on or off-site services sponsored by organisations which attempt to promote good health or to identify and correct potential health-related problems (Wolfe, Parker & Napier, 1994). It has been estimated that 90% of companies provide at least one subset of a worksite wellness programme for their employees in the United States of America (USA) (Aldana, Merrill, Price, Hardy & Hager, 2005). Positive psychology and the organisational application thereof (positive organisational behaviour) focuses on the health and wellness side of the illness-health-wellness continuum.

A well-functioning and effective Employee Assistance Programme (EAP) can reactively and proactively address its employees’ needs and problems through various forms of intervention. According to Petzer and Schoeman (2005) EAPs should not only provide employees with access to professional, confidential counselling – which can bring about long-lasting changes in psychological well-being - and advisory services, but also provide a package of services tailored to the specific workplace environment and situation (Bayne, Bimrose & Horton, 1996). For this a clear analysis is needed of the aims and objectives for the service, how the service will be managed and what controls will be in place to ensure a quality service (Megranahan, 1995).

One of the principal objectives of an EAP is to enhance the general well-being of employees through improvements in the workplace that increase the opportunity for employee wellbeing and enhanced performance (Zungu & Setswe, 2007).

Table 1 adapted from Pillay (2007) shows the differences and similarities between EAPs, HIV and AIDS workplace programmes and wellness programmes.
Table 1

*Comparison of EAP, HIV/AIDS Workplace Programmes and Wellness Programmes*

<table>
<thead>
<tr>
<th>EAP</th>
<th>HIV/AIDS workplace programme</th>
<th>Wellness programme</th>
</tr>
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<tbody>
<tr>
<td>Short term professional intervention that aims at problem resolution to improve, enhance or to maintain optimal level of productivity.</td>
<td>These deal with health promotion that seeks to address diseases of lifestyle. They aim to encourage behaviour change that results in improved physical and mental health. Examples include smoking cessation, weight reduction, HIV and AIDS care support and treatment interventions. At times programmes can include family members such as VCT for partners. In this programme there is an aspect of medical management.</td>
<td>An all-encompassing group of programmes that address employee wellness. These programmes consider psychobiosocial programmes, and look at the individual within the system of his work and home environment. Employee wellness is enhanced by emotional, practical and physical wellness as well as building optimal well-being in all these areas.</td>
</tr>
<tr>
<td>Worksite-based and offsite if use is made of external, outsourced service providers.</td>
<td>Worksite based.</td>
<td>Worksite-based and offsite if use is made of external, outsourced service providers.</td>
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<td>Systems perspective is used.</td>
<td>Systems perspective is used.</td>
<td>Systems perspective is used.</td>
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<tr>
<td>All programmes look at enhanced productivity of the individual and should have a positive effect on organisational functioning.</td>
<td>These programmes aim to prevent new infections and support people infected and affected by HIV and AIDS.</td>
<td>The programmes adopt a holistic approach to general well-being and care of employees and their families.</td>
</tr>
</tbody>
</table>

*Note.* Adapted from “Comparison of the EAP, HIV and AIDS Workplace Programmes and Wellness Programmes” by Pillay, 2007, Department of Social Work and Criminology, University of Pretoria, p. 56.

According to Pillay (2007) some of the characteristics these programmes have in common are the following:

- All these programmes must have a strong sense of a prevention-oriented mission including all levels (from management to workers) in the organisation.
• All programmes focus on enhancement of the employee within a systems model.
• As all these programmes are implemented at the worksite, they also have a common thread of enhancement of employee well-being and productivity.

It is interesting to note that EAPs and wellness programmes are moving from being hands-off and outsourced to being company-owned, with certain deliverables purposefully out-tasked to providers who are then strategically interfaced as business partners (Maiden, 1999).

Initially EAPs were established in the USA as occupational alcoholism programmes for employees during the Second World War (Department of Public Works, 2004; Lentsoe, 2003). There had been growing recognition of occupational stress as a factor in the health of the employee that influences productivity, and in the 1970s stress interventions were included under employee assistance (Murphy, 1995). Most employers came to the realisation that it made good business sense to invest in their employees through occupational assistance programmes (Daniels, 1997). Whether an organisation focuses on the well-being of its workforce by means of an EAP, an AIDS programme or a specific wellness programme that targets one or more dimensions of wellness, such a programme will contribute to a large extent to the wellness of the organisation.

3.3 Rationale for Workplace Wellness Programmes

Common sense tells us that the well-being of employees is in the interest of the individual, organisations and the community, as the workplace is a significant part of an individual’s life and so affects his or her well-being, and that of the family, the workplace and the community. The average adult spends much of his or her life working – as much as a quarter or perhaps a third of his or her waking life. According to Campbell, Converse and Rodgers (1976), as much as a fifth to a quarter of the variation in adult life satisfaction can be accounted for by satisfaction with work. Harter, Schmidt and Keyes (2002) perceive employee well-being as affecting the quality of an individual’s life and his or her mental health, and thereby affecting the productivity of entire communities. A growing number of companies have committed themselves to providing organisational wellness programmes to help improve the health of their employees, control health care, absence and absenteeism costs, and to provide an additional benefit to employees and employers (Bly, Jones & Richardson, 1986). Studies clearly suggest that the well-being of employees may be in the best interest of the employer (e.g., Iaffaldano & Muchinsky, 1985; Judge, Thoresen, Bono &
This is echoed by Goetzel and Ozminkowski (2000) who state: “In this 21st century, greater emphasis than before is going to be placed on workforce productivity, figuring out how to best leverage the human assets of the organisation so that improvements in individual and organisational health can lead to improvements in organisational productivity and, for commercial enterprises, bottom-line profitability” (p. 212).

The emergence of workplace wellness programmes is also recognised locally. According to Arend (2008), workplace wellness programmes are a “growing global phenomenon” particularly in the USA and Europe, where they are seen as the way to reduce health care costs by making workers more aware of healthy behaviours and encouraging them and their families to adopt healthier lifestyles. It is acknowledged that in South Africa, too, specially designed wellness programmes can contribute to the reduction of staff turnover and absenteeism and raise productivity and efficiency within the working environment (BizCommunity, 2006).

Zungu and Setswe (2007) view workplace health promotion as the key to promote adult health. The proportionately large amount of time individuals spend working during their lifetime makes the workplace an arena that is especially amenable to the development and delivery of more integrated approaches to health care. Employers have an increased interest in encouraging and supporting healthy lifestyle choices as they become more aware of the interrelationship of employee health and productivity. Employer costs for these programmes can be offset rapidly by fewer work-related injuries, reduced absenteeism, lower staff turnover and increased morale. Workplace health promotion involves an organisational commitment to improving the health of the workforce, providing employees with appropriate information, establishing comprehensive communication strategies and involving employees in decision-making processes (Megranahan, 1995).

Wilson (1989) states that in order to obtain a level of wellness an individual must live in a healthy manner. He further argues that a logical place to deliver health promotion knowledge and service is at the worksite. The two main benefits of worksite health promotion are health care cost containment and improved productivity. Other benefits include improved corporate image, improved employee satisfaction, decreased absenteeism, decreased employee turnover, improved employee morale, improved recruitment incentives, and decreased job related accidents and injuries. Thus one notes that the expected outcomes of employee assistance programmes and health promotion programmes are similar in nature (Pillay, 2007).
Workplace wellness programmes can be seen “to improve morale, job satisfaction and retention by making a company an employer choice” (Kapp, 2003, p. 40). Thus the benefits to both the employee and employer of a successful EAP are many. Potentially a well-functioning EAP could reduce grievances and disciplinary actions and therefore free up management to deal with other issues. EAPs in government improve the image of government as a caring employer and service provider. Ultimately a healthy workforce is being promoted where the emphasis is on prevention (Megranahan, 1995).

Harter, Schmidt and Keyes (2002) explain that the ability to promote well-being of workers is of considerable benefit, not only to employees and the community, but also to the employer’s bottom line. In particular, well-being in the workplace stems from helping employees do what is right for them through behaviours that influence employees’ engagement and thus increase the frequency of positive emotions.

Short-term fixes, through negative reinforcement that may result in behaviour that benefits the organisation financially in the short-term, may narrow the ownership and creativity of employees, which in turn may limit long-term benefits to the organisation. Alternatively, behaviours that increase the frequency of positive emotions lead to increasing clarity of expectations, an understanding and use of resources that is congruent with company goals, individual fulfilment in work, a bonding of individuals through a sense of caring, ownership for the altruistic and tangible impact of the company, and learning that is in line with a shared mission. In the long run, this is what is good for the employee and the company.

Similarly, Keyes and Grzywacz (2005) see health promotion programmes that identify levels of risk among individuals and that implement interventions to reduce health risks in worker populations as providing meaningful returns on investments. In gaining an understanding of the relationship between wellness and performance at work, home and community, it is essential to discuss how one affects the other. Thus, according to O’Donnell (2000) health improvements from health promotion programmes lead to improved physical and emotional ability to work, which in turn reduces absenteeism. Health promotion programmes also improve organisational climate, which enhances people’s desire to work and directly enhances human performance.

In Human Capital Management (2006), Dr Richard Malkin of Workforce Healthcare, supports the above by pointing out that there are many benefits to be gained from health promotion programmes, particularly those tackling HIV/AIDS in the workplace. Dr Malkin
states that today, the disease is a very manageable one. It is important, first of all, to establish the status of employees through a voluntary testing and counselling programme. The disease can then be managed through support and treatment programmes. AIDS sufferers are going to become ill and unproductive. However, proper management can ensure that their productivity remains at an acceptable level for many years.

According to Arend (2008), many South African corporations and businesses have caught on to the global trend, including the Nelson Mandela Bay municipality, the South African Tourism Company, Nedbank, Absa, as well as South African based multi-nationals such as IBM, DeBeers, Sasol, Toyota, Nissan and Coca Cola. Medical aid companies have also seen the benefit of promoting client wellness, such as Discovery Health, which first implemented preventive health-based strategies to enhance wellness and reduce its cost in 1998. As Discovery Health CEO, Neville Koopowitz, argues: “...we have wellness programmes that work in South Africa. This has been proven to show its positive effects on staff productivity and ultimately the bottom line” (Arend, 2008, p.262). The challenge remains, however, to “persuade South African employers to walk the talk when it comes to employee wellness and get them to enrol in these programmes” (Arend, 2008, p.263). The above-mentioned companies in South Africa are currently using such programmes to try to enhance general wellness and lower the incidence of illness, including HIV. For example, Bavarian Motor Works (BMW) SA hired AID for AIDS as an employee wellness programme service provider that addresses HIV/AIDS-related needs and problems of both skilled and unskilled workers (Whiteside & Sunter, 2000), problems that include the abuse of drugs, excessive alcohol consumption, the disease (HIV/AIDS) itself, and others that are social, psychological, financial, emotional and physical (Human Capital Management, 2006). Participation in employee wellness programmes is voluntary and employees may be referred to the programme by management if any problem they experience affects their work performance. Employee wellness programmes are meant to assist employees across all levels in the workplace to make healthy decisions, including avoiding contracting HIV.

3.4 History of Employee Wellness

Over the past 25 years wellness programmes have been adopted by many organisations in an attempt to develop high functioning employees. Goetzel and Ozminkowski (2000) examined the historical progression of wellness programmes in industry, stating that in the 1970s forward-thinking organisations introduced “wellness” programmes simply because
management felt it was the right thing to do. In the 1980s many more organisations offered worksite-based health promotion and disease prevention programmes, primarily to contain health care costs. In the 1990s the scope of workplace wellness offerings expanded to include health promotion and disease management programmes that were fully integrated with one another.

EAPs started in South Africa during the 1980s as a response to problems that migrant workers encountered by being far away from home, in artificial social settings. More services were added to the EAPs in time, such as anti-smoking campaigns and stress management (Randall, 1997). The EAP initiative started as a private sector initiative to assist and support employees with psychosocial problems (Cavanagh, 1996). It appears, however, that it took the reality of HIV/AIDS and its impact on the workforce in South Africa to lead to the development and establishment of EAPs in the public sector (Department of Social Development, 2006). The stresses of the modern working environment, the many changes in the South African working situation and especially the advent of HIV/AIDS changed the profile of EAPs in the public sector drastically.

EAPs signify the acceptance of social responsibility by the employer for assisting the employee with certain problems. EAPs have become, according to Maiden (1992) the “social conscience of the organisations in which they are ensconced” (p. 5), and are viewed by employees, for the most part, as agents of change in the social conditions of the work environment. Since the 1980s many South African companies have come to recognise the potential of EAPs to improve employee performance by improving their health, mental health and life-management knowledge and skills; and many consider it their social responsibility to put an EAP in place. In South Africa, the primary focus of EAPs, according to Maiden (1999) still tends to be on the individual employee (and his family), whereas internationally EAPs are focused equally on the individual and the organisation as clients, enabling the EAP to contribute to the core of the business.

3.4.1 South African legislation in relation to employee wellness in the workplace. In the South African context, the change of government in 1994, with its introduction of legislation like the Labour Relations Act (Act No 66 of 1995), the Employment Equity Act (Act No 55 of 1998) and the Unfair Discrimination Act (Act No 44 of 2000), has brought about a major transformation in how both governmental and non-governmental organisations view employee wellness. According to Pillay (2007) it is now necessary for the employer to
assist employees also with poor performance and incapacity. The new legislative framework provides for the protection of employees’ rights in the workplace, both in the private and the public sector. It becomes essential, therefore, for the employer to ensure that any problems of employees, private or social, that may impact on their work performance, are addressed.

3.4.2 Eastern Cape legislation in relation to employee wellness programmes. In 2005 Dr Muthwa, Director General in the Eastern Cape Provincial Administration, made it clear that a physically, psychologically, and socially healthy workforce was a more productive workforce, and that therefore the development and implementation of an Integrated Employee Wellness Programme was of paramount importance (Eastern Cape Provincial Administration, 2007). Such an integrated programme would combine the elements of HIV and AIDS prevention, treatment, care and support; EAP Safety, Health, Environment, Risk and Quality (SHE) programmes. The priority of the Eastern Cape government was to do more than merely combine these three programmes. Dr Muthwa believes the ultimate goal of such integration should yield a holistic approach towards people management, improving working conditions and environment, enhancing employer-employee relations, diminishing and mitigating the effects of ill-health/injuries among employees and assisting employees towards a state of wellness that encompasses physical, emotional, social and spiritual health (Eastern Cape Provincial Administration, 2007).

The Eastern Cape Provincial Administration subsequently put an Integrated Employee Wellness Programme in place in 2006. By 2007 it was in its second year of operation, combining the historically-separate elements of SHE, EAP, and the HIV & AIDS Workplace Programme (Eastern Cape Provincial Administration, 2007).

As stated by the Eastern Cape Provincial Administration (2007), the objective of the Integrated Employee Wellness Programme is “…to provide a collaborative, integrated, sustainable and cost effective package of wellness interventions, which meet the needs of both the employer and employees” (p. 27). These interventions should be determined by events and conditions that may have an adverse effect on the employee's well-being, engagement, and positive motivation in the workplace. Interventions should assist employees to be healthy, safe, productive, and creative contributors to their workplace (Eastern Cape Provincial Administration, 2007).
3.5 Overview of Employee Wellness in the Nelson Mandela Bay Office of the NGO where the Research was Undertaken

In November 2007 a wellness programme for the NGO was developed by a staff member in the Nelson Mandela Bay office and was piloted there and in the Cape Town office for six months. Thereafter it was introduced at the Johannesburg, Durban and Mthatha branches. Research was undertaken in 2008 by Arend, a staff member of the organisation in the Cape Town office, to evaluate the effectiveness of the programme. Arend (2008) found that the organisation’s health policy was limited in scope, as it focused mainly on HIV/AIDS and failed to address other aspects of staff health and wellness. Her conclusion was that the organisation faced numerous challenges in designing and implementing an effective, sustainable wellness programme and health policy.

Arend (2008) recommended that a thorough study of wellness needs among a cross-section of staff, using both qualitative and quantitative data, be conducted. Also that the support of the highest level of management for wellness programme development be obtained, and that management be held accountable. Furthermore, she emphasised the importance of keeping staff needs and the broader community at the centre of programme and policy development through constant monitoring and evaluation of every related activity. Buy-in from staff could be enhanced by actively including them in the process of adapting and improving the programme/policy through anonymous evaluation forms, follow-up focus groups, staff meetings, and eliciting other forms of feedback.

As a first step towards putting Arend’s recommendations into practice, the present research study was undertaken to ensure both the health and wellness of employees and the wellness and sustainability of the NGO as a whole. In other words, such a wellness programme may lay a foundation to foster a trusting, open and accepting NGO culture in which employees feel valued and where employees are able to develop on both professional and personal level.

3.6 Summary and Conclusion

In this chapter the researcher undertook to mark out the historical background of employee wellness in the workplace as a need internationally and in South Africa. Researchers have shown that it is utmost important that workplace programmes are emphasized not only for the reduction of absenteeism but also for the development of human capital in various aspects of workers’ lives.
This chapter ended with reference to the development and implementation of an employee wellness programme at the NGO where the research was undertaken, as well as research findings about the effectiveness of the intervention. The current study was initiated based on these recommendations. The next chapter details the research question and methodology.
CHAPTER 4

Research Approach and Methodology

This chapter describes the research approach and methods employed in this study. The first section describes the problem statement. The second section describes the research aim of the study. The third section clarifies the relationship between the researcher, the organisation where the research was conducted and the participants. The next section addresses the research methods used in the study: the design, participants and sampling, data collection and data analysis. The next section addresses the issues of trustworthiness in qualitative research and the methods employed to enhance the trustworthiness of this study. The last sections describe the procedures and how ethical issues were addressed by the researcher.

4.1 Problem Statement

Management and staff at the non-governmental organisation (NGO), an HIV/AIDS organisation in Nelson Mandela Bay (NMB), had observed that their community development workers were highly stressed. Working with HIV/AIDS-infected and -affected individuals and communities affected their lives and impacted on their overall wellness. The challenge, therefore, was to direct an intervention that would mitigate the harmful effects of this particular working environment on the workers by promoting their wellness. As a first step towards this goal, the wellness of these community development workers, and what influenced it, needed to be established. This was what this research study proposed to do.

4.2 Research Aim

The aim of the study was to explore and describe the perceptions of wellness of the community development workers at the NGO in NMB - perceptions about wellness in general, and their own wellness specifically, focusing on the factors that affected their wellness.

4.3 Relationship between the Researcher, Organisation and Participants

As the researcher had been employed previously by the NGO, his role there and his relationship with the participants in the study needs to be clarified.
The researcher was employed by the NGO at the NMB site from November 2006 to December 2008 as an HIV/AIDS prevention coordinator. During this period his position was changed to that of individual counsellor for staff members, since he had a background in psychology and an interest in staff wellness. The researcher thus knew all the community development workers at the NMB site, both as their coordinator and also as the counsellor they turned to for support.

During this period he undertook to establish a wellness programme for the staff, not only for the NMB site, but for all the sites of the NGO in South Africa. For this purpose a needs analysis was conducted at the NMB site and based on the results a pilot wellness programme was put in place there for six months. The wellness programme was subsequently accepted in principle as part of the organizational programmes although, owing to a lack of funding, it could not be implemented. This was one of the reasons that the researcher elected to carry out a more in-depth investigation into the wellness of the community development workers. The researcher assumed that the pre-existing relationship was invaluable since the participants would probably feel at ease in familiar surroundings, and would be more likely to be open and more willing to discuss with one another.

4.4 Research Methods

4.4.1 Research design. As the study aimed to obtain a description of the participants’ perceptions of wellness and what affected their own wellness, it was important to find out what their experiences meant to them. A qualitative descriptive research design was thus employed in the study as “…qualitative research accepts that there are multiple ways of interpreting experiences, and that it is the meaning of people’s experiences that constitutes their reality” (Bogdan & Biklen, 1992, p. 39). Cresswell (2003) too emphasizes that all human beings are engaged in the process of making sense of their world.

The features of a qualitative research approach, according to Bogdan and Biklen (1992) namely; (a) that it takes place in a natural setting; (b) that it is descriptive, with data collected in the form of words rather than numbers; (c) that it is concerned with process rather than products; (d) that data is analysed logically – ideas are built as the participants are interviewed; and (e) that meaning is essential, made such an approach most appropriate for the present study. It was vital to find out and describe how community development workers perceived their wellness and what affected it. For this purpose the three important strengths of qualitative research, as proposed by Mouton (2005), were really needed, viz. that people
are studied in terms of their own definitions of the world (insiders’ perspective); that it focuses on the subjective experiences of individuals; and that it is sensitive to the contexts in which people interact with each other.

Moreover, according to Struwig and Stead (2001), descriptive research attempts to give a complete and accurate description of a situation, a description which is, according to Leedy and Ormrod (2001), the disclosure of the nature of certain processes, and thus the impact these processes have at the present time. Qualitative research also displays sensitivity to the context in which the study is situated (Smith, 2003); important for the present researcher who believes that human behaviour is strongly influenced by the setting in which it occurs. Qualitative methodology therefore seems relevant for exploring the effect of working with individuals and communities infected and affected by HIV/AIDS on the community development workers at the NMB site of the NGO.

4.4.2 Participants and sampling. A census sampling technique was employed – all 42 community development workers of the NMB site of the NGO were included in the study (Chanimal, n.d., para. 12). Five of the participants were randomly selected from the population of 42 to be part of a pilot study which took place prior to the actual research process. One more participant had to drop out subsequently owing to absence from work at the time of data collection. Most of the community development workers were Xhosa speaking, with four Afrikaans speaking participants from the so-called coloured (mixed race) ethnic group. Their ages ranged from 21 to 60 years. The majority of the community development workers had not passed Grade 12 and was low-paid fieldworkers from the surrounding community. Despite their lack of scholastic qualifications the NGO had managed to develop and enhance the educational skills of the community development workers and most of them had had more than 3 years’ experience in the field of HIV/AIDS community work. Table 2 reflects the demographics of the participants in this study, 36 community development workers from the NMB site of the NGO.
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4.4.3 Data collection. Focus group interviews, where people are informally interviewed in a group discussion setting, were used as the method of data collection. As Neuman (2003) explains, focus groups have certain benefits: in this case they would provide a natural setting for discussion, participants would thus feel comfortable and free to express their opinions. Moreover, participants would feel empowered by having their ideas sought. They would also be able to ask one another questions and explain their answers to one another. Focus group interviews were thus viewed to be the ideal method for gaining insight into how participants perceived their world and themselves in terms of wellness, and what this meant to them.

As groups of between six and ten participants allow everyone to participate, while still eliciting a range of responses (De Vos, 2002), the researcher elected to conduct four focus group interviews, each of one hour duration, each with between eight and ten participants. Participants were requested to be available for two hours to allow for possible delays in

<table>
<thead>
<tr>
<th>DEMOGRAPHICS VARIABLES</th>
<th>NUMBER OF PARTICIPANTS (N=36)</th>
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<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
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<tr>
<td>Female</td>
<td>29</td>
</tr>
<tr>
<td>Ethnic Group</td>
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</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>Coloured</td>
<td>4</td>
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<tr>
<td>Indian</td>
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<tr>
<td>Home Language</td>
<td></td>
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<tr>
<td>Xhosa</td>
<td>32</td>
</tr>
<tr>
<td>English</td>
<td>0</td>
</tr>
<tr>
<td>Afrikaans</td>
<td>4</td>
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<tr>
<td>Nationality</td>
<td></td>
</tr>
<tr>
<td>South African</td>
<td>36</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Years of Experience in HIV/AIDS community work</td>
<td></td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>10</td>
</tr>
<tr>
<td>1-4 years</td>
<td>18</td>
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<tr>
<td>5-9 years</td>
<td>6</td>
</tr>
<tr>
<td>10-14 years</td>
<td>2</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
</tr>
<tr>
<td>Grade 7 or Lower</td>
<td>8</td>
</tr>
<tr>
<td>Grade 8 – 9</td>
<td>20</td>
</tr>
<tr>
<td>Grade 10 – 12</td>
<td>4</td>
</tr>
<tr>
<td>Higher than grade 12</td>
<td>4</td>
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</table>
starting the sessions planned to last one hour 30 minutes each. Prior to the four focus group interviews taking place, a pilot study had been conducted in order to investigate the feasibility of the planned research project and to bring possible deficiencies in the data collection method to the fore. Five community development workers, randomly selected, took part in the pilot interview that took place in the offices of the NMB site of the NGO. The session lasted for 90 minutes.

Participants in each group were asked to discuss the same two questions (see Appendix D), namely:

- What is wellness?
- What factors affect your wellness?

The focus group discussions were conducted in English, and the discussions were audio-taped for later analysis. The tapes were transcribed afterwards by the researcher. This was done in order to ensure valid and reliable data. Normally, if saturation is not reached with the planned number of focus groups interviews, the researcher would conduct more interviews in order to achieve data saturation. However, in this situation, as a census sampling method was used, there were no participants left to sample for more focus group interviews.

4.4.4 Data analysis. Once the audiotapes from the focus group discussions were transcribed, the researcher analysed the data according to Tesch’s principles of qualitative data analysis (Creswell, 1998). Thus all the transcriptions were first read through in order for the researcher to gain a holistic understanding of the data. Any ideas that came to mind while reading were jotted down. One group interview transcript was then scrutinized carefully for the underlying meaning and the various topics that were discussed. A list was made of these topics, similar topics were grouped together and a sense was formed of what topics were major, what were sub-topics and what could be called leftovers. The topics were abbreviated as codes and the codes written next to the appropriate section of text. With this preliminary organising scheme the researcher then went through the transcripts of all the group interviews to see if any additional categories emerged. Descriptive wording was found for each category and sub-category. An attempt was made to reduce the number of categories by grouping related topics together. The interrelationship between topics was explored and indicated in the notes. A final decision was made regarding the categories, and the data belonging to each category were grouped together.
Themes identified by the researcher were verified by an independent coder who was experienced in qualitative research to see if the independent coder would find the same major topics or categories and subtopics as the researcher did (for themes from independent coder see Appendix E).

4.5 Ensuring the Trustworthiness of Qualitative Research

Research needs to be trustworthy – we need to be able to believe the researcher’s findings, to know that they are true. With quantitative research, when the data is clearly measurable and the reliability and validity of the findings can be statistically proven, this is easier than with qualitative research, which is often viewed as being of lesser value owing to various factors such as its subjectivity, its smaller samples and lack of generalisability of findings.

How can one ensure that qualitative research is indeed trustworthy? For any research to be trustworthy, it needs to be evaluated on four generic criteria, viz. truth value, applicability, consistency and neutrality (Guba, in Krefting, 1991). For qualitative research, Babbie and Mouton (2001) interpret these four criteria as the degree to which the study is found to be credible, transferable, dependable and confirmable. Below follows a brief account of strategies employed to enhance the trustworthiness of this study, according to these four criteria. Table 3 summarises the four generic criteria, and the way that they are interpreted in both the quantitative and qualitative research traditions (Van Lingen, 2005. p. 119).

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Interpretation in quantitative research</th>
<th>Interpretation in qualitative research</th>
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</thead>
<tbody>
<tr>
<td>Truth Value</td>
<td>Internal validity</td>
<td>Credibility</td>
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<tr>
<td>Applicability</td>
<td>External validity</td>
<td>Transferability</td>
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<tr>
<td>Consistency</td>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Neutrality</td>
<td>Objectivity</td>
<td>Confirmability</td>
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Note. From Perspectives on Wellness amongst Students at the University of Port Elizabeth, by J. M. Van Lingen, 2005, Department of Psychology, Nelson Mandela Metropolitan University, p. 119.
In this study, Guba’s four generic criteria (in Krefting, 1991) for the assessment of qualitative research was applied.

**Credibility:** According to Lincoln and Guba (1985), credibility is an evaluation of whether or not the research findings represent a “credible” conceptual interpretation of the data. According to Krefting (1991) this is determined by assessing to what extent the findings of the study are a true reflection of the life world of the informants. To enhance credibility in the study, only community development workers were chosen as the study population. Also, the researcher conducted the research in a natural setting, i.e. the offices where the participants worked every day, in order to promote the reality of the respondents’ experiences.

**Transferability:** Transferability is the degree to which the findings of this study can apply or transfer beyond the bounds of the project; the degree to which findings can be applied to other contexts or settings and groups (Lincoln & Guba, 1985). Krefting (1991) was of the opinion that it is essential for comprehensive detail to be provided about the respondents as well as the research context, setting and process, as this will enable others to determine how transferable the results are, or to repeat, as closely as possible, the procedure of this study in their own context. In order to achieve transferability the researcher provided a description of the participants, research methodology used in the study and the research context.

**Dependability:** Dependability is an assessment of the quality of the integrated processes of data collection, data analysis, and theory generation (Lincoln & Guba, 1985). According to Bogdan and Biklen (1982), qualitative researchers tend to view dependability as “a fit between what they record as data and what actually occurs in the setting under study” (p. 100). The researcher used the following strategies to enhance the dependability of the study: the researcher recorded the focus group interviews and noted his qualitative observations to assist with the interview descriptions. The research questions put to the participants in the focus group interviews were tried out during the pilot study. As these questions generated enough data there was no need for the questions to be altered after the pilot study. Furthermore, quotations from participants were used in the text (see Chapter 5) in order to ensure that quotations provided an accurate impression of what transpired during the interviews.

**Confirmability:** This is considered to be the fourth aspect in Guba’s four generic criteria (in Krefting, 1991) for ensuring trustworthiness. Lincoln and Guba (in Krefting, 1991)
suggest that neutrality in qualitative research should consider the neutrality of the data rather than that of the researcher. This refers to the extent to which the research findings are free from bias. The researcher needed to reflect the participants’ views as stated, and remain free from prejudice. In order to enhance confirmability, quotes from the participants were used in reporting the findings to ensure a true reflection of their views.

4.6 Research Procedure

The researcher requested permission from the organisation’s NMB site to conduct research into the wellness of the community development workers. Formal contact was established with the representative of senior management at the organisation in NMB to obtain permission to proceed with the research. Senior management was also requested to provide a database of participants (all the community development workers based in the Nelson Mandela Bay office) and their contact details.

All community development workers were addressed during an information session on the nature and purpose of the research and a letter (see Appendix A) pertaining to ethical issues of the study was issued and discussed. Participants were guaranteed anonymity by the researcher in order to create a safe space for the discussions to take place. Participants were given an opportunity to ask questions and clarify their concerns. Participants were then requested to complete the consent form and complete a biographical questionnaire (see Appendix B). A pilot study was conducted a week before the commencement of the focus group interviews. Audio recordings of the four focus group interviews were made.

The research took place at the offices of the organisation. Feedback was offered to participants on request. A presentation of the research findings was done for the senior management of the NMB site of the organisation, without compromising confidentiality.

4.7 Ethical Considerations

Prior to commencing the study, ethical clearance was obtained from the Faculty Research Technology and Innovation Committee of the Health Sciences faculty (reference number H09 – HEA – PSY – 017). In conducting the study, ethical considerations as outlined by Corey, Corey, and Callahan (1993) were taken into consideration. The participants were given a full explanation of the nature and purpose of the research; therefore consent was informed. Consent was also voluntary, as it was explained that participants were free to withdraw at any time or choose not to participate in the study (see the consent form in Appendix C).
The participants were ensured of confidentiality. As data were audio recorded, and participants were not video recorded, their identity was protected. Moreover, data were kept in a safe place where access could not be obtained by others outside the research study. Anonymity and the participants’ privacy were thus ensured, giving participants the opportunity to share their experiences without fear that anything would be used against them.

4.8 Conclusion

This chapter focused on the research approach and methodology that was used in the present study. The chapter started with the problem statement and research aim, and followed by some comments on the researcher’s relationship with the NMB site of the organisation and the participants. The research methods were subsequently described. This study is explorative-descriptive in nature and it is a qualitative study. Issues of trustworthiness in this qualitative study were discussed as well as research methods such as selection of participants, collection of data and data analysis. Four participants took part in a pilot focus group interview that was done a week before the data collection. All the remaining community development workers took part in focus groups which were conducted in the offices of the NGO. All these focus groups were audio-taped and transcribed, and the researcher used Tesch’s model for the analysis. References were also made to the research procedure and ethical considerations. The next chapter reports and discusses the research findings of the study.
CHAPTER 5

Findings and Discussion

Transcriptions of each focus group discussion were analysed for themes and sub-themes that emerged as a response to the two main questions posed to participants, viz. What is wellness? and What factors affect your wellness? In this chapter these findings are described and discussed with reference to different theories (see Chapter 2) and to other relevant research (see Chapter 3).

The focus groups were named A, B, C and D based on the chronological order in which they took place. The full text of interview B is attached as an example, as Appendix D. Interview B was decided upon as it represents a typical rather than exceptional example. It was neither the first, nor the last; neither the shortest nor the longest. The transcribed texts of interviews A, C, and D are available from the researcher upon request.

Participants in all four focus group interviews were asked both questions in a semi-structured interview framework. The themes and sub-themes described in this chapter are illuminated through the inclusion of quotations from transcribed interviews. In deciding which quotations to include the researcher selected both typical responses as well as interesting or different responses. Even though questions were put in English and sometimes participants responded in Xhosa, all quotations in this chapter are presented in English. Under each heading (theme) the sub-themes are reported in table and text format. All references to the interview transcriptions in the tables are in the form of the interview indicator (A, B, C or D) followed by the line numbers of the relevant text in the interview transcription. Each section includes a discussion, where the reported results are related to relevant theory and/or other research findings.

According to Morgan (1988) qualitative research should be reported in a way that clearly distinguishes which themes are most important, and these should be emphasized in the writing process. It is hoped that this chapter succeeds in doing this, and also does justice to what Jones (2002) in relation to the presentation of research results, said, viz. that in the end, it is what researchers write that conveys and leaves the trail that research has created.

5.1 Identified Themes and Sub-themes

Seven main themes were identified during the data analysis. They were: (a) participants’ understanding of wellness; (b) organisational factors that impact on wellness; (c) personal
factors that impact on wellness; (d) family and community factors that impact on wellness; (e) participants’ wellness; (f) personal coping strategies; and (g) suggestions regarding organisational strategies for enhancing employee wellness.

5.1.1. Participants’ understanding of wellness. The first main theme relates to the first of the two main interview questions, namely the participants’ understanding of wellness. Table 4 lists the sub-themes that were identified under the main theme of participants’ understanding of wellness.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Participants’ Understanding of Wellness</th>
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<tbody>
<tr>
<td><strong>Main theme 1</strong></td>
<td><strong>Sub-themes</strong></td>
</tr>
<tr>
<td>Understanding of wellness</td>
<td>1. Holistic well-being</td>
</tr>
<tr>
<td></td>
<td>2. Financial wellness</td>
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<td></td>
<td>3. Emotional wellness</td>
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<td>4. Physical wellness</td>
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<td></td>
<td>5. Being respected by others and family</td>
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<td></td>
<td>6. Employee interventions</td>
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<td></td>
<td>7. Balance and interrelatedness</td>
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5.1.1.1 Holistic well-being. An understanding of wellness to encompass various dimensions, such as physical, emotional, environmental, spiritual and others, as a whole, emerged in three of the four focus group interviews. For example, a participant in focus group A said: “I think of physical, mental, emotional health, financially in all aspects of a human being life” (A1). Another participant’s understanding of wellness came from focus
group interview D: “I think wellness means a holistic approach to a person, including that person’s physical, emotional, and psychological health, and how it relates to the workplace” (D 19-21). This reflects an understanding of the systemic nature of wellness, of the interrelatedness of all dimensions of wellness, how they cannot be seen in isolation, but as each affecting others. Another participant from focus group A expressed it well, as follows:

If you are well mentally and you are equally well physically, emotionally, financially and other areas then you reached the stage of being well. If one of the strings strike and hit an off note then something is bound to get wrong (A 66-67).

5.1.1.2 Financial wellness. Two participants in focus group D discussed money and how to improve one’s financial status, but only one participant from focus group D commented on his understanding of what financial wellness really meant, in terms of its affecting stress levels. He understood financial wellness as being economically satisfied and able to meet his basic needs: “financial wellness is to be stress free and moneyed. Financial wellness is to be stress free and be rich; however it includes sending our children to school for them to be educated since we were not privileged” (D10-12).

5.1.1.3 Emotional wellness. Understanding of emotional wellness was not described by the participants in all four focus group interviews. However, their understanding of emotional wellness is pointed out as part of the holistic wellness. For example, a participant from focus group interview B said “I think of physical health. Emotions also fit in. Emotions are our biggest wellness issue at work” (B1-2). This is a holistic wellness view, but also mentions an emotional dimension as part of participants’ wellness.

5.1.1.4 Physical wellness. Two participants in the focus group interviews expressed their understanding of physical wellness. Other participants did not describe physical wellness, though they were able to point out the importance of taking care of one’s physical wellness and its importance as a coping strategy. A participant from Group D understood physical wellness as follows: “physical wellness is to eat well and have a nice home and a car that you can afford” (D5). Another participant from group A reported his understanding of physical wellness to be one’s lifestyle, and having a luxurious living. He said:
It [physical wellness] has to do with how you behave to keep yourself healthy; it might be how you dress. To me physical wellness has to do with what you wear and how do you feel in your outfit and also to be content with yourself.(A 24-26).

5.1.1.5 Being respected by others and family. Two participants from different focus groups associated their understanding of wellness with being respected by others and by family members. They viewed wellness as a positive lifestyle that led people to respect you. The participant from focus group D said:

\[\text{to me wellness is to be able to take care of your family and extended family members. You will not be worried or stressed and you will always feel good and protected by your community and by your family too. (D5-9).}\]

Another participant from focus group A said: “Being able to support your family and be respected by kids and other needy people in our communities, especially to those who do not have something to eat and clothes” (A12-14). The above understanding shows that participants’ ways of understanding issues are influenced by their communal lifestyle and culture.

5.1.1.6 Employee intervention. Only a participant from focus group C viewed wellness as a workplace based wellness intervention. He viewed wellness as meeting workers’ job demands and motivating workers in such a way that they can perform better in the workplace:

\[\text{I think wellness is a sort of intervention that helps employees in their needs. I mean [job] demands of workers, but referring to one’s health at work that is resulted because of work pressure or our relationship at work or demands of managers, your stress level at work and other things that affect your work performance. I think wellness is when you look after your employees, someone’s health status and wellbeing in the organisation.}(C1-8).\]

5.1.1.7 Balance and interrelatedness. Participants understood wellness as meaning to have balance in every aspect of their lives. For example, a participant from group D said: “I
think probably it [wellness] means having a balanced life in every area, and when you’re at home and at work, balanced in whatever you do” (D3-4). This observation shows an understanding of wellness as a striving for positive functioning in all wellness dimensions. Another participant from group A said:

Personally, I am so well financially, if I am too well financially then I might be lacking emotionally or other dimension. Money can be there so financially I am well but emotionally I do not have companions. If you are well financially just see if you are well emotionally, then if you are well emotionally just see if you are well psychologically and if you are well psychologically just also see if you are well socially. Balance is needed. If one of the aspects of wellness hit off all other [aspects] will be affected. (A 69-78).

From their understanding of wellness as expressed during the focus group interviews, it would seem that community development workers’ understanding of wellness is influenced by their own work experience, home environment and social influences. Cowen (1994) supports this position (see Chapter 2), that the understanding of health and wellness is dependent on a variety of factors such as values, culture, age, socio-economic background, and education. As indicated in the table above, participants had varying understandings of what wellness is. The participants did not understand the term wellness in the same way. Ardell (2009) supports this (cited in Chapter 2) when he says that every nation and language has a different way of describing and understanding the term wellness.

The sub-themes in the understanding of wellness that emerged from an analysis of the group discussions relate to the Perceived Wellness model (see Chapter 2), which describes wellness as a sense that one is living in a manner that permits the experience of consistent, balanced growth in the emotional, intellectual, physical, psychological, social and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). Participants’ views on wellness reflect interrelatedness and striving for balance of different dimensions. As viewed by Els (2005) the balance of wellness dimensions is a system and all systems are interrelated. He continued to describe that if something changes in one system it will influence the status of other interrelated systems.
5.1.2 Organisational factors that impact on wellness. Table 5 lists the sub-themes that were identified under the main theme of participants’ perceptions of organisational factors impacting on their wellness.

Table 5

Organisational Factors that Impact on Wellness

<table>
<thead>
<tr>
<th>Main Theme 2</th>
<th>Sub-theme</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>3. Inefficiency of policy and implementation</td>
<td>A120-136</td>
<td>B116-127</td>
<td>D16-17, D75-80, D86-97, D218-233, D238-243, D181-183</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Lack of staff training</td>
<td></td>
<td></td>
<td>D229-249</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Emotional demands of the job</td>
<td>A35-36</td>
<td>B3-4</td>
<td>C68-72, C179-180</td>
<td>D128, D154-155, D191</td>
</tr>
</tbody>
</table>
5.1.2.1 Lack of care and support. The impact of the lack of care and support was discussed in all the groups. The working environment was seen as a negative place to be for the participants’ personal growth in the workplace. In all interview group discussions, participants’ dissatisfaction with the lack of care and support in the workplace was evident. For example, a participant from interview A said:

We all work here in this organisation, there is no care and support in our department, prevention department and OVCs [orphans and vulnerable children]. Here at work there is no synergy or communication. We are not supporting each other. We are discriminating ourselves, that group is that group and people are high minded. In these departments there are coordinators and it seems they were never trained to resolve group or departmental issues. There are issues amongst us which seems were born in this organisation. As a result every day when I come to work it’s not nice because of our unhealthy relationship. (A110-119).

In addition a participant from interview B said in this regard: “...our organisation [is] careless about our wellbeing as long we are doing [the] work” (B61). Another participant viewed her insecurities as the result of a lack of care and support and said: “...it makes one to feel you don’t belong here” (D29). A participant from focus group A commented on the effects of not being taken care of by the organisation and said:

I mean we are uncared for emotionally in this organisation and it ties with your physic [al] wellness. If the organisation is not caring enough for workers because most of us here are sick physically and it makes us feel emotionally unappreciated. If our organisation does not accept who you are, your emotional life and risk you go through in communities, you will never feel safe emotionally and it lowers your self-esteem in relation to work. (A5-8).

5.1.2.2 Insufficient organisational support by management. The participants reported that their work experience led them to discuss and question the credibility of the organisational management style; they expressed it as problematic. The participants reported that organisational management style affected their job morale and they tended to feel discouraged at times. For example, a participant from group C said: “...human resource department of this organisation is lame because there are things as workers that we need and
we were promised by them but they are still unfulfilled” (C181-182). In relation to management style another participant from group A said that:

Management is relaxed and they [management] only send us work as long as they are getting paid by our [organisational] funders. I am not sure whether they do know what is happening in the communities. Sometimes, we are running away from our communities because of management’s empty promises. There is no planning from our coordinators; instead they tell you at the last moment what is needed to be done. (A148-151).

The participants reported unfairness on the part of management towards staff, which led to mistrust between workers. For example a participant from interview C said: “... this favouritism happens within our company. You will find out that I and my colleague are doing the same job but getting different salaries” (C24-25). Further unhappiness with management came from a participant in group A who said: “... they [management] don’t have enough capacity to help and I wish our national management could come and see what is happening on the ground and to feel our feelings” (A198-199). Another participant from focus group interview C said: “...they [management] do not know how to handle stressful situations from us and then we are targeted when one voices things out” (C179-180). However, many of the community development workers were able to rise beyond these challenges and they were able to maintain their motivation to do their job in communities.

5.1.2.3 Inefficiency of policy and implementation. Participants in three focus groups, A, B and D, commented on this sub-theme with many comments coming from group D. A participant from group D who had been a member of the organisation for more than a year was uninformed or ignorant about the existence of a workplace policy and he said:

We don’t know if there’s a law or policy at our organisation, if there is a way you’re supposed to confront these things. I also think it has a lot to do with the coordinator and area manager. Like with me, when I see my colleagues dress inappropriately or acting inappropriately, I feel it’s my responsibility to speak with them. (D75-80).

Another participant from the same interview group commented about his lack of understanding due to the language of the policy and said, “there is a code of conduct, but I
don’t know how well it’s explained. It does not look like it’s followed, based on our staff’s lack of understanding and behaviour” (D86-88).

5.1.2.4 Lack of staff training. Participants criticised the quality of some of the workers who conducted training in community clinics. The lack of quality trainers, and thus the misrepresentation of the NGO in public areas, inhibited the effectiveness of quality of service delivery, as did the absence of evaluation tools. A participant said:

There are some very good manuals but the quality of the training across the board is not the same. You need to make sure the training is being conducted in the right way and the person doing the training is qualified, otherwise quality is compromised. There are also no tools for a training evaluation, there is no evaluation tool.(D244-249).

In the same group interview, participants reported concern about workers’ behaviour during working hours in clinics that went unchallenged by the NGO. As a result of these unchallenged behaviours during working hours, participants questioned the recruitment and induction processes, regarded as problematic in the NGO. One participant said about this:

The crucial issue for me is induction. People need to be guided. You may think someone is familiar with a job and is comfortable in doing it. Six months later, a coordinator may find one is doing the wrong way. Then it is very difficult to change that behaviour.(D234-237).

5.1.2.5 Lack of recognition. Participants in three of the focus group interviews commented on the lack of recognition from their employer which they experienced and which they believed had a negative effect on them, leaving them feeling unappreciated and lowering their self-confidence. One participant said: “…here at work you are not appreciated though you are appreciated somewhere else” (C48-49). A participant from focus group B felt he was understood and recognized better at home and in communities than at work. He said:

Brothers and sisters at home do understand our hardships and recognize our painful experiences, though they are unskilled for professional work. Recognition of our painful experiences in our communities is better than [the] ignorance at work. (B53-54).
Participants felt that the organisation’s lack of recognition of their worth was reflected in their salaries which did not meet their basic needs, and a participant from focus group B said: “I’m stuck with R2500 [salary] that I have to share” (B98). The environment in which community development workers live, where there are minimal chances of alternative employment due to their low educational status, leaves them with no choice but to stay in their current jobs. Many of the employees stay in their jobs as long as they are paid, with little sense of belonging and recognition from the organisation.

5.1.2.6 Emotional demands of the job. Some participants reported on feelings they experienced from emotional demands in the workplace and how they were not able to handle them properly. A participant from focus group D commented on feelings of helplessness and hopelessness that were the results of job demands by saying: “… I get emotional, but I know I can’t show my client how vulnerable I am” (D191). It seems the emotional vulnerability is caused by their caring of clients and their wanting to appear strong and positive towards them. Similarly a participant from focus group B said:

For example, if we are visiting sick people, you may find that they are very emotional because of their sickness. We get stressed, because we are close to our clients. They become our friends, but we can’t let them see us get stressed. (B3-4).

Stress was reported as one of the common emotional feelings in their workplace and was regarded as leading to a highly dysfunctional work force. A participant from focus group A said the following regarding stress in the organisation: “... it seems stress in our organisation is permanent; no one can avoid it because of our working conditions” (A 35-36).

From all the above it can be seen that staff support is vital in the workplace. This is supported by Megranahan (1995), cited in Chapter 3, who promotes employee assistance programmes (EAP) in the workplace and views EAP as the intervention that both parties, the employee and employer, will benefit from. Employers will benefit in different ways such as by increasing productivity, reduced absenteeism, an improved morale amongst employees and the creation of a positive climate at the workplace. The lack of organisational workplace programme support by management causes distress in the workplace (see Megranahan, 1995, cited in Chapter 3), whereas a potentially well-functioning EAP could reduce grievances and disciplinary actions and free up management to deal with other issues in the workplace. Similarly Bakker and Demerouti (2007) cited in Chapter 2, state that an
imbalance between job demands and job resources in the workplace causes job strain and workers lack motivation to work, possibly leading to the organisation not attaining their organisational output.

Demerouti, Bakker, Nachreiner and Schaufeli (2001) (cited in Chapter 2) emphasize that when there is a lack of organisational structure or resources individuals cannot cope with a high job workload. As became clear from participants’ discussions in the focus groups, they felt stressed and rather hopeless owing to the lack of recognition they received from management. Yet because of lack of other employment options, they were obliged to remain in their jobs. Cartwright and Cooper (2002), De Bruyn and Taylor (2006) and Schreuder and Coetzee (2006) (see Chapter 3) all suggest that poor recognition and support of employees may lead to psychological strain and emotional distress, causing employees to see no opportunities in the workplace, this being a major source of emotional distress, particularly in today’s uncertain and unstable workplace.

5.1.3 Personal factors that impact on wellness. Table 6 lists the sub-themes that were identified under the main theme of personal factors perceived by participants as having an impact on their wellness.

Table 6

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub-themes</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Personal Factors that Impact on Wellness</td>
<td>1. HIV/AIDS</td>
<td>A45</td>
<td>B71-72</td>
<td>D156-162</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Personal life choices</td>
<td>B6-11, B71-87, B89, B91</td>
<td></td>
<td>D38</td>
</tr>
</tbody>
</table>

5.1.3.1 HIV/AIDS. Being infected with HIV/AIDS was seen as a factor affecting their wellness by two participants, who revealed their status in the groups. A participant from
focus group A said: “though I am HIV infected I can do a proper job as long I’m not judged” (A45). Another participant who is HIV/AIDS infected reported that “I’m HIV positive. One day I know I will get sick” (B71-72). Although living with the virus, it would seem that this did not affect the overall wellness of these two participants yet. However, a comment from a participant in focus group D suggests otherwise. This participant spoke about the carelessness of those who are HIV infected. It seems HIV infected workers are not careful about their own health, do not know their limits. It was said in this regard:

as a group leader, I see people don’t know their boundaries. They work overtime, and that’s something I talk to them about. It affects their health. They may work their full week and then volunteer their own time for weekends. They don’t know when to say “no”. Then they get so sick, and it’s because they don’t know their boundaries. That’s a problem, and they end up getting sick because they haven’t drawn the line properly. (D156-162).

5.1.3.2 Personal life choices. A participant from focus group interview B spoke about his uneasiness towards himself because of family responsibility. It seems that the love of family responsibility made him to compromise his own personal life condition. The participant expressed his worry and said: “I take my family’s problems and I make my own. Even older relatives, they don’t look after themselves. I’m HIV positive. One day I know I will get sick” (B71-73). The above quote shows that participants are dedicated to their families and do not think of their own health status.

Participants from two focus groups indicated the reasons why they were motivated to work extra hours even though they were feeling sick. It would seem they had made a deliberate choice of how to live their lives with HIV. A participant from focus group B was not sure of what to do to support his unemployed family and he asked himself a rhetorical question and said...“What are they [my family members] going to do? (B74). It seems this choice derives more from love of the family than from thinking about oneself.

Facing the impact of HIV/AIDS on the workforce in South Africa, EAPs were developed and established in the workplace (see Chapter 3). In Chapter 3 it is also noted that when organisations are aiming to establish a healthy workplace, vigilance on the part of the organisation is required to constantly promote good employee health; even if and when optimal health is already achieved (Adkins, Quick, & Moe, 2000). Caring for the workforce
in the workplace is essential. One of the reasons to establish an employee health promotion programme is described by Pillay (2007) (see Chapter 3). He explains that employee health promotion programmes seek to (a) address diseases of lifestyle, and (b) encourage the behaviour change that results in improved physical and mental health. Examples of interventions are smoking cessation, weight reduction, HIV and AIDS care support, and treatment interventions. Often these programmes also include family members of employees.

5.1.4 Family and community factors that impact on wellness. Table 7 lists the sub-themes that were identified under the main theme of participants’ perceptions of family and community-oriented factors impacting on their wellness.

<table>
<thead>
<tr>
<th>Main Theme</th>
<th>Sub-themes</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and Community Factors that Impact on their Wellness</td>
<td>1.Lack of understanding and support from family</td>
<td>A90-100, A109</td>
<td>B64-69, B79-80, B88, B90, B95-96, B101-108, B112-113</td>
<td>C98-102, C146-151</td>
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<tr>
<td></td>
<td>2.Lack of understanding and support from communities</td>
<td>A46-50, A53-56, A101-105</td>
<td></td>
<td>C73-76, C90-91</td>
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<tr>
<td></td>
<td>3.Cultural factors</td>
<td>A85-89</td>
<td>B110-111</td>
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<tr>
<td></td>
<td>4.Crime in our communities</td>
<td></td>
<td></td>
<td>C73-77, C82-85</td>
<td>D31-37</td>
</tr>
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</table>

5.1.4.1 Lack of understanding and support from families. Participants in three of the four focus group interviews reported on how the family’s lack of support and lack of understanding of participants’ working conditions impacted on their wellness. A participant from interview A said: “…sometimes I feel like I am financially and emotionally abused by my partner” (A109). Another participant from interview C said in this regard:

>You go home and you don’t feel like doing anything. You have a husband, and you can talk to him, but he doesn’t understand. You can talk maybe
to your sister or mom, but they don’t understand. You think, why don’t we get help at work? (C 148-151).

It was also noticed by a participant that how they felt was the result of ignorance of family members. A participant from focus group interview B said in this regard “…What makes me stressed is that my brother doesn’t help me” (B79). Another participant from the same group commented on her feelings which were the result of a lack of understanding from a family member and said: “I feel sometimes like I’m going to kill myself” (B88).

5.1.4.2 Lack of understanding and support from communities. Participants in two of the focus group interviews reported on a lack of understanding and support from the community. Specific challenges from communities were discussed in terms of how they affected the social wellness of participants. For example a participant from interview C said:

I want to start [to talk about] how our communities affect our wellness; you know to do this job you need to feel safe and secured in your community. The very same people who are doing intervention in our communities are targeted by our own communities. (C73-76).

From the above quote the participants’ feelings of vulnerability as workers are revealed. A participant from focus group interview C said in this regard: “sometimes we are robbed in front of these parents [community members] and they will keep quiet about it since they fear the unknown” (C90-91). Participants thus felt endangered when they needed to go and do their community work in public clinics. They also felt that there was a lack of understanding in the community about the nature of their work among these communities. A participant from interview A said in this regard:

I think it is the time to educate people since they are less empowered about HIV/AIDS. That is why people are separating us from them. But again we are not being empowered as well by our organisation. It’s like you are being told to catch a fish but you were never told [taught] to do so. (A53-56).

5.1.4.3 Cultural factors. Two of the four focus groups discussed cultural factors that impact on participants’ wellness. A major problem in participants’ social wellness appeared to stem from the unacceptability (in Xhosa culture) of a younger person telling an older person what to do. Respect for elders is of primary importance to the point where it is difficult to be
assertive in one’s work, with colleagues or clients, or in expressing emotions. For example, a participant from focus group B said, “...in our culture, you cannot just tell your older brother you are angry with him. Your elders will say that is disrespect. You end up wishing for someone else’s life” (B110-111).

Similarly, a participant from group A said:

> It [cultural norms] can also depend on how or where you grew up, your background. For instance, in the older days you could not speak to your father when you see something on him or you will be beaten up. As the result this behaviour is carried to [the] work [place] and we find ourselves not being assertive to our authorities. Our [Xhosa] culture and how we grew up can affect personal relationships with other colleagues. (A85-89).

Cultural norms play a major role in shaping people’s behaviour in the workplace.

5.1.4.4 Crime in communities. Crime in communities was reported by participants as another factor that impacted on their well-being. This social problem made working conditions difficult, as described by a participant in focus group D, who said:

> There is a lot of crime in the community. House break-ins at night, robbery during the day. So we don’t really feel safe. When they see us carrying bags of food for our programmes they [community members] think we have money. They do not realize it is not our money, it is from work. I have been robbed several times, and we don’t have license for transport. (D31-37).

Similarly, a participant from focus group C said: “we are targeted since we carry big bags, groceries, flip charts and they think we are money people” (C77).

The prevalence of crime in communities and hostility towards the participants, inappropriate considering the nature of the work they do, i.e. caring, supporting, training of people infected and affected by HIV/AIDS, cause participants to feel unsafe when they are doing work duties. The above sub-theme emphasises how important it is for the community development workers’ well-being to have the understanding and support from the communities they serve. It also highlights the importance of the impact of socioeconomic factors, attitudes and family relationships in participants’ well-being. The Indivisible
Selfwellness model as described in Chapter 2, supports the view that holistic wellness should consider other factors such as contextual factors that form part of an individual’s wellness (Myers & Sweeney, 2008). This model is suitable to be used to assess underlying contextual factors that enrich its usage for a workplace wellness model as this approach acknowledges the cultural, organisational and environmental factors as impacting on an individual’s wellness.

5.1.5 Participants’ wellness. Table 8 lists the sub-themes that were identified under the main theme of participants’ interpretation of their own wellness.

<table>
<thead>
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<th>Table 8</th>
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<tbody>
<tr>
<td><strong>Participants’ Wellness</strong></td>
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<tr>
<td><strong>Main Theme 5</strong></td>
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<td>Participants’ Wellness</td>
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5.1.5.1 Stress. In all focus group discussions various negative conditions were mentioned related to worksite conditions. A wide variety of symptoms from physical to emotional were reported. Stress appeared to be the most common, with participants knowing they were stressed, but not doing anything about it. A participant from focus group B said: “I am so used to stressing about work” (B55). Another participant from focus group D commented on feelings of being stressed due to job demands and said: “I am really under stress and as a result, some people lose trust in me” (D111).

5.1.5.2 Feelings of isolation. Participants in three focus group interviews reported on how they feel when there is a lack of sympathy, awareness and understanding from the workplace and in communities. They feel isolated and uncared for, especially those who are HIV/AIDS
infected. A participant from focus group A said in this regard: “...people think that when you are HIV infected you did not live a healthy lifestyle. So this makes us to feel isolated and be neglected by other people in the community” (A47-50). Many participants felt unappreciated by people in the communities and unattended at the workplace.

5.1.5.3 Feelings of anger. Participants seem to experience feelings of anger at the lack of appreciation by the organisation for what they do. It was noticed that a lack of positive feedback toward one another is as a result of anger. A participant from focus group B said: “All that anger comes out on other colleagues who get opportunities” (B 100).

5.1.5.4 Self-doubt. It was reported by participants that work conditions, lack of certainty about work policies and other work related matters all contributed to participants’ self-doubt and lack of well-being. A participant from focus group D said in this regard: “People see me, they think like you have a job, but it is not doing anything for you. You start questioning, am I doing this job well? Is this the right job for me? You feel less confident” (D43-46).

5.1.5.5 Weight loss. A participant from focus group A commented on his weight loss due to work-related conditions; he did not know where to go for help: “I am dropping weight but what do I do to prevent that?” (A55). This statement from the participant confirmed the lack of an employee wellness programme and that workers feel vulnerable in the workplace.

It seems all these symptoms experienced by participants are the result of high job demands and a lack of resources in the workplace. As was noted in Chapter 3, the workplace is a significant part of an individual’s life that affects his or her well-being at work, and that of the family and the community (Campbell, Converse & Rodgers, 1976), and it is thus vital for the organisation to provide programmes to help improve the health of employees. It is also recognized that when there is a lack of organisational resources individuals cannot cope with a high job workload, and employee motivation is reduced (see Chapter 2, Demerouti, Bakker, Nachreiner & Schaufeli, 2001). Participants in the study reported that they suffered from burnout because of the working conditions, i.e. the work overload, lack of care from management, and lack of resources. This confirms what was highlighted by Maslach (2005) (see Chapter 2)that burnout is all about incongruity between the individual and their job, or between the individual and their workplace environment. As was reported by Maslach (2005) (see Chapter 2) negative feelings towards management plus work over load leads to
exhaustion, decreased motivation and productivity, and negative attitudes towards the workplace and their colleagues. From participants’ observations made in the focus groups, it would appear that all the above symptoms of non-wellness stem from a lack of a work wellness intervention. If the NGO could adopt a holistic approach towards employees that was sensitive to the multi-dimensionality of wellness, as described by Adams, Bezner and Steinhardt (1997) (see Chapter 2), much could be achieved in improving the wellness of the community development workers.

5.1.6 Personal coping strategies. Table 9 lists the sub-themes that were identified under the main theme of participants’ personal coping strategies.

<table>
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<th>Table 9</th>
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<tr>
<td><strong>Personal Coping Strategies</strong></td>
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<table>
<thead>
<tr>
<th>Main Theme 6</th>
<th>Sub-themes</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Coping Strategies</td>
<td>1. Family support</td>
<td>A97-100</td>
<td>B56-58, B60</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Colleagues’ support</td>
<td>A11</td>
<td></td>
<td>C161</td>
<td>D170-171, D190</td>
</tr>
<tr>
<td></td>
<td>4. Meaning found at work</td>
<td></td>
<td>B50-51, B57-59, B63</td>
<td>C37-41, C49-50</td>
<td>D184-189</td>
</tr>
<tr>
<td></td>
<td>5. Balance between work and home lifestyle</td>
<td></td>
<td></td>
<td></td>
<td>D119-121, D175-180</td>
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</tbody>
</table>

5.1.6.1 Family support. Encouragement from family members appears to be an important factor enabling participants to carry on working despite stressful working conditions and their own health problems. Participants in focus group interviews felt a need for support from the workplace and they felt that it was not present. One participant in group B viewed family support as better than any support that could come from the organisation: “I speak to my wife and she is like the source of energy and she understands me” (B60).

5.1.6.2 Colleague support. It was noticed that many participants were looking for various ways of coping with work demands. A participant from focus group interview C preferred to seek support from a colleague and he viewed this as better than to wait for the organisation to
start a programme while they are suffering. The participant said, “...the only way to solve the problem is to talk about it as workers” (C161). In addition to this view a participant from interview D shared the same sentiments of trusting one another as colleagues since he felt that they understand one another’s work conditions. A participant from focus group interview D said in this regard, “If you feel it is a serious matter, I go to my coordinator who is my leader to talk, when I see the problem is getting bigger than me” (D170-171).

5.1.6.3 Spiritual wellness. The subject of spirituality was strongly encouraged and practised by participants at work since the NGO is a Christian faith based organisation. Many views on spiritual dependency came from focus group C, not only for when workers experience challenges at work, but as their way of life and faith. It seems many of the participants had a strong relationship with God. A participant said in this regard:

Spiritual wellness heals my soul even though I may be stressed at times but when I am at my church I feel good and relaxed. I make sure I do not lack spiritually that is where I get healed and strength. Since God is my pillar of strength, we [workers] can use this dimension as our source of strength as well. (C119-123).

A participant from focus group A echoed the importance of spirituality as a coping mechanism: “You know when I was jobless, I was praying six times a day, even if I was in the middle of something [challenge] I would call upon God” (A193).

5.1.6.4 Meaning found at work. Three focus groups reported on this sub-theme. Participants felt that the many success stories in their job, successes they had had in working with the community, gave positive meaning to their lives and served as positive coping strategies, even without supportive resources from the workplace. One participant felt encouraged and inspired and he said: “I am working for my family and my child; I thank God that I see a change where I work [community] and that de-stresses me” (C49-50). These statements reflect participants’ love of their community work.

5.1.6.5 Balance between work and home lifestyle. Two participants in one focus group, D, reported on this sub-theme. Participants felt that the need to balance work and home was important if one wanted to be well. One participant said: “I mean, first you have to learn to deal with your own issues, you can’t help other people if you can’t help yourself and I cope
when I do so” (D175-177). Self-awareness was indicated as a contributory factor to this coping mechanism.

The above subthemes reflect participants’ coping strategies when they feel emotionally drained by work conditions. It is thus vital for the workplace to provide support and assist workers to function effectively within their work conditions. As was noted in Chapter 2, engaging workers, workers’ participation in decision making, and support of social resources (i.e. family, friends, and colleague support) are essential to maintain workers’ motivation in the workplace (Demerouti et al, 2007).

5.1.7 Suggestions regarding organisational strategies to enhance employee wellness. Table 10 summarizes the identified sub-themes regarding the main theme of suggestions about organisational strategies for enhancing the wellbeing of employees.

### Table 10

<table>
<thead>
<tr>
<th>Suggestions Regarding Organisational Strategies to Enhance Employee Wellness</th>
<th>Main Theme 7</th>
<th>Sub-themes</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
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<tbody>
<tr>
<td>1. Individual counselling</td>
<td>1. Individual counselling</td>
<td>C177-178</td>
<td>D142-127, D207, D272-274</td>
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<td>5. Team building</td>
<td>5. Team building</td>
<td>A210, A217-218</td>
<td>D275-280</td>
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<td>7. Build stakeholder relationships</td>
<td>7. Build stakeholder relationships</td>
<td>A204-205</td>
<td></td>
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<td>8. Physical work environment</td>
<td>8. Physical work environment</td>
<td>A206-210</td>
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</table>
5.1.7.1 Individual counselling. Two focus group interviews reported on a suggestion for individual counselling for workers that would contribute positively to their wellness. Participants felt that it was the organisation’s responsibility to promote wellness in the workplace. It was also noted that they were in need of an outside professional counsellor who would be objective in this role and be assisted by the management. For example, a participant from interview D said in this regard that “one-on-one psychological support” (D 207) should be provided in the workplace. Another participant from the same group supported the above notion and said:

*It helps to talk to one another, but there should be some form of debriefing available by someone outside the environment so you don’t feel like you’re burdening them [colleagues], and that would make a huge difference.* (D 272-274).

Participants felt that it would be worthwhile for workers to receive counselling from the workplace since they were working under stressful conditions and this would make them feel appreciated by the organisation.

5.1.7.2 Group debriefing. Participants from three of the focus groups reported that group debriefing sessions would enhance their wellness, and some participants, while not specifically mentioning group debriefing, felt that individual counselling was not the only way of dealing with personal and work issues. For example, a participant from focus group interview A said: “*I think every month there should be a meeting or group debriefing for the entire departments*” (A201-203). A participant in group D concurred by saying: “*staffs are in need of debriefing and a ‘care for the caregivers’ programme*” (D 13).

5.1.7.3 Prayer. One participant from focus group interview B felt that prayer would improve working conditions: “*I would like us to pray more often before going for home visits*” (B 47). The suggestion was made because he felt that the NGO was a Christian based organisation. Not everyone was in favour of the above suggestion since not everyone was a member of the Christian faith.

5.1.7.4 Educational empowerment. Lack of education and accredited training was an issue for workers since most of them do not have a formal education. Three participants from different focus group interviews reported on a need for being supported in this area. For
example, a participant from focus group B said: “They [the NGO] can provide scholarships so we can study. Our organisation is not fair” (B 115-116). It was acknowledged by participants that HIV/AIDS workshops were done by the organisation, equipping participants in their work; however, participants felt that they also needed more training that would equip leaders with leadership and management skills. A participant from focus group interview D supported the notion and named the kinds of training such as “computer skills training and language training to expand services to deaf and learning-compromised schools” (D 216-217).

5.1.7.5 Team building sessions. Team building exercises were suggested as a way of building relationships between workers and management. A participant from focus group interview A said: “It will be nice for us all to go out but other departments were against going out with other departments. I think we need to go out like to have a staff camp to encourage team building” (A217-218). The purpose of creating a space for team building exercises in the organisation was commented on by a participant from focus group interview A: “…this will also help us to socialize with different departments and serve as a team building exercise” (A210). However, another participant from focus group interview D reminded workers that team building exercises used to be part of the organisational culture but they had been discontinued due to lack of funds. This was said as follows:

More social things are needed. Other than work, we don’t do anything together. Our organisation does not pay for team building. They used to, but they don’t anymore. The sad thing is, even with flexible funding, money is not allocated for these kinds of activities. I feel like there are always other priorities, but maybe this [wellness] is not a priority. (D275-280).

5.1.7.6 Salary increment. A participant stated his dissatisfaction with what he was earning and felt unrecognised for the work he did in communities. A suggestion that was made by a participant from focus group interview D was the need for an “increase of salary” (D209).

5.1.7.7 Build stakeholders’ relationships. One participant from focus group interview A thought that there was a need for building and strengthening relationships with those
organisations that did similar HIV/AIDS work. “I was thinking of our stakeholders, they should be made aware of our challenges since we disappoint them [other organisations] at times. Maybe they [stakeholders] will also help us where we are lacking” (A 204-205).

5.1.7.8 Physical work environment. One participant from focus group interview A suggested that office space could be improved. The physical appearance of offices was discussed. The participant felt that they could not cope in their present office environment. He felt that they became disorganised and poor in administration due to their office space. The participant from focus group interview A said:

I think we need a bigger space since we were promised to move out [of] these premises. One of the reasons for the spiritual wellness to lack is we do not have a space to meet and pray because we are over populated. Our offices are small. We need space for synergy, prayers and feedbacks. (A 206-210).

5.2 Summary

In this chapter the findings of the four interviews were discussed with reference to seven primary themes and their related sub-themes that emerged from the process of data analysis. These findings were reported in a descriptive format and themes and sub-themes were subsequently compared with relevant literature. Themes and sub-themes were supported by appropriate quotations from the transcriptions of the data.

The seven primary themes that emerged were labelled as follows: (a) participants’ understanding of wellness; (b) organisational factors that impact on wellness; (c) personal factors that impact on wellness; (d) family and community factors that impact on wellness; (e) participants’ wellness; (f) personal coping strategies; and (g) suggestions regarding organisational strategies to enhance staff wellness. Taken together, these themes consequently appeared to represent several aspects of perceived wellness (Adams, Beznner & Steinhardt, 1997), contextual concerns (Myers & Sweeney, 2008) as well as Bakker and Demerouti’s (2007) model of job demands and resources.

The first theme that was discussed was the participants’ understanding of wellness. Different views of wellness included: (a) holistic well-being; (b) financial wellness; (c) emotional wellness; (d) physical wellness; (e) being respected by others and family; (f) employee interventions; and (g) balance and interrelatedness. The holistic approach promotes
a consistent balanced growth in the emotional, intellectual, physical, psychological, social and spiritual dimensions of human existence. However, a few participants from the study view wellness differently from the literature as they hold that wellness is to be respected by community and family members. This finding affirms the opinion of authors such as Cowen (1994) and Adams, Bezner and Steinhardt (1997). These authors assert that the understanding of health and wellness is dependent on a variety of factors such as values, culture, age, and socio-economic background. Thus, it is important to take into account participants’ understanding of wellness.

The second theme was termed “organisational factors that impact on wellness.” In this theme six sub-themes were identified and discussed, namely: (a) lack of care and support; (b) insufficient organisational leadership support; (c) inefficiency of policy and implementation; (d) lack of staff training; (e) lack of recognition; and (f) emotional demands of the job. The third theme was identified as personal factors that impacted on participants’ wellness and only two sub-themes emerged from data analysis: (a) HIV/AIDS; and (b) personal life choices. The fourth theme was named family and community factors that impact on wellness. In this theme the sub-themes that were referred to were: (a) the lack of understanding and support from families; (b) lack of understanding and support from communities; (c) cultural factors; and (d) crime in communities. The above three themes relate to the second of the two main interview questions which is What factors affect your wellness? On analysis of the themes that emerged from the group interviews, it becomes clear that the community development workers in the NGO do not feel that they themselves are well. Their overall feeling seems to be one of vulnerability, caused by the work situation they are in (viz. an organisation which does not have the resources needed to support its workers adequately, and does not have the infrastructure needed in terms of workplace programmes to enhance workers’ wellness) and the type of work which they have to do.

The fifth theme revolved around the wellness of the participants. These were: (a) stress; (b) feelings of isolation; (c) anger; (d) self-doubt; and (e) weight loss. It is evident that, when reporting on their wellbeing, participants invariably referred to negative states of mental and physical wellbeing – states that are indirect contrast to descriptions of wellness found in the literature. Despite their lack of wellness the participants also feel fulfilment by helping people in communities while they are experiencing stress, burnout and anger (see theme six).

The sixth theme that emerged during the focus group interviews was termed “personal coping strategies.” In this theme five sub-themes were identified and discussed. These sub-
themes represented participants’ coping strategies, namely: (a) family support; (b) colleague support; (c) spiritual wellness; (d) meaning found at work; and (e) balance between work and home lifestyle. The above finding is in keeping with the literature in Myers and Sweeney (2008) (cited in Chapter 2), that all the above features provide the means to respond to negative circumstances without feeling dysfunctional. However, the participants’ coping strategies come from others or externally such as from family members, colleagues and from the work they do rather than they do from themselves or internally.

The last theme that was identified was the suggestions regarding organisational strategies to enhance employee wellness. Sub-themes were: (a) individual counselling; (b) group counselling; (c) prayer; (d) educational empowerment; (e) team building; (f) salary increment; (g) building stakeholder relationships; and (h) physical work environment. All above sub-themes are contextually based and in keeping with the literature that emphasizes the importance of taking into account contextual factors impacting on individual wellness (Adams, Bezner & Steinhardt, 1997; Bakker & Demerouti, 2007; Myers & Sweeney, 2008; see Chapter 2).

The conclusions and recommendations for enhancing staff wellness of community development workers, based on these findings, are discussed in the next chapter.
CHAPTER 6

Conclusions, Limitations and Recommendations

Based on an analysis of the discussions held in the four focus groups, discussions as to what the community development workers in the Non-Governmental Organisation (NGO) in Nelson Mandela Bay (NMB) understood wellness to be and what they felt hindered their wellness, it became clear that there was a need of improving workers’ wellness and in how the organisation cared about its workers. The purpose of this chapter is to consider the above, and to offer recommendations as to what the NGO in NMB, an HIV/AIDS organisation, could do to improve the wellness of its workers. The chapter also reflects on both the value and the limitations of the present study and offers suggestions for further research that could be undertaken.

6.1 Recommendations for Improving the Wellness of Community Development Workers at the HIV/AIDS NGO in NMB

In the previous chapter the findings of this study were described in terms of seven themes, namely (a) participants’ understanding of wellness; (b) organisational factors that impact on wellness; (c) personal factors that impact on wellness; (d) family and community factors that impact on wellness; (e) participants’ wellness; (f) personal coping strategies; and (g) suggestions regarding organisational strategies to enhance participants’ wellness. From these themes three broad areas needing attention were identified, viz. the need for an effective workplace wellness programme, increased support from management and increasing staff capacity. They are discussed below.

6.1.1 Workplace wellness programme. From participants’ inputs during the group discussions, it appeared that many of the ways in which they felt the NGO could help them feel better about their work and improve their performance, would fall under what a workplace wellness programme would encompass. Participants commented on topics and services that they thought would be worthwhile for workers, such as individual counselling, group debriefing, a family and social awareness day and many other activities that relate to different wellness dimensions. They were aware of the benefit they would reap if the NGO in NMB incorporated and implemented a wellness policy, and felt it important that the wellness policy be made known to all management as well as to employees as the management would
have to play a major significant role in promoting a new wellness policy. It was noted that many of the participants were Xhosa speaking and did not have a Higher Education qualification and thus felt it was not easy for them to comprehend organisational policies. Some participants suggested that the organisation should make use of outside wellness service providers for services such as individual counselling and group debriefing. Specific recommendations regarding a workplace wellness programme are listed below:

- Establishment of a workplace wellness programme with a holistic approach to wellness, i.e. which considers the total wellness of everyone in the organisation.
- The workplace wellness policy shall be made known to all employees and management as the latter will have to play a major significant role in promoting a new wellness policy.
- The workplace wellness policy should be written in a language that will be easily understood by all employees.
- The organisation should have a designated person for designing and implementing the workplace wellness programme, who would be skilled and knowledgeable about workplace wellness programmes.
- The minimum qualification for such an employee should be that he or she is registered as a member of the Employee Assistant Programme relevant association or group.
- Outside providers should conduct individual counselling and group debriefing continuously for all staff members who are in need.
- The outside providers should also conduct accredited training sessions, and an educational and awareness programme related to all spheres of wellness.
- It is recommended that team building exercises include all community development workers in the NGO.
- An after-hours crisis helpline service should be made available for staff and their family members.

6.1.2 Increased support from management. Workers observed a management style that was not consistent and fair towards all employees. This sense of being unfairly treated affected workers’ performance and also inter-colleague relationships. The findings revealed that workers felt dissatisfied because of the posts and salary levels
allocated to them by the organisation. They revealed that their salary level was insufficient when compared to other HIV/AIDS organisations in the area of Nelson Mandela Bay, and they wanted Human Resources to take note of their situation and intervene. A large percentage of the NGO employees in NMB worked in high risk locations without having satisfactory support from the organisation. Part of their dissatisfaction was to do with a lack of office space which caused poor administration. They could not cope well in their present environment. The specific recommendations regarding management support are as follows:

- It is recommended that managers should show visible support to all employees. This includes being visible when the organisation runs workshops/sessions on family and social awareness and HIV/AIDS awareness. It further implies being supportive financially, i.e. budgeting for providing compensation for overtime work and for setting up a wellness programme.
- It is recommended that the organisation creates senior and junior posts, i.e. a differential post structure, for remuneration purposes.
- It is recommended that workshop attendance be recognised as part of staff development in view of the fact that many employees were unable to go for formal education in Higher Education institutions.
- It is recommended that when the organisation increases its workforce it needs to consider a feasible physical environment as well.

6.1.3 Increasing staff capacity. Employees felt that the organisation did not support the professional development of its workers – it was careless about educational support. They admitted that they had attended training sessions and workshops that were relevant to HIV/AIDS as part of their work, but not for personal development. Employees were in favour of personal development skills that included employability skills, such as computer skills, assertiveness skills, stress management, anger management and resilience skills. It was also noted that the work of the employees in their respective communities placed huge emotional demands on them, leading to feelings of helplessness and stress. Specific recommendations regarding the increase of staff capacity are as follows:

- It is recommended that the organisation should view their employees in a holistic way and thus organise quality educational workshops with a view to helping
employees deal with all aspects of their lives, i.e. their emotional, intellectual, financial, spiritual, environmental and social well-being.

- It is recommended that these workshops should be recognised by the organisation to support those who do not have a formal education.
- It is recommended that the organisation trains internal workers for employability opportunities as to increase staff capacity within the organisation.
- It is recommended and encouraged that employees should share work with other stakeholders or form partnerships with other HIV/AIDS organisations in order to lower work burdens in their respective communities.
- It is further recommended that managers should make contact with employees especially with regard to issues pertaining to human and financial resources.

6.2 Value of the Study

Since the research study was conducted at a Nelson Mandela Bay HIV/AIDS organisation, it was evident that contributory factors which were mentioned in the study were not carefully looked at by management in supporting staff wellness. The findings of this study will add value to the existing body of knowledge regarding the state of employee wellness within HIV/AIDS organisations in South Africa. The findings of this study can serve as a means of comparison with other HIV/AIDS organisations, providing a theoretical and practical framework for future research initiatives.

In addition, by highlighting the contextual factors and the positive impact of a wellness programme in relation to employee wellness, the findings can also serve to inform the development of an organisational workplace programme, and possible interventions to improve the state of employee wellness could be established. The findings also point to areas of functioning and development on which an organisational programme may need to place greater emphasis in order to fully develop the workers. The study findings thus have value for other HIV/AIDS organisations in the area, and possibly nationally.

6.3 Limitations

Regardless of the recommendations for improving the wellness of the community development workers from the NGO in NMB, and possibly for other HIV/AIDS organisations in the NMB area, that could be made on the basis of the research findings, it is acknowledged
that the study had some limitations, in particular regarding the researcher’s lack of interview experience, the timing of the focus group interviews, the use of a qualitative research approach, the lack of relevant literature and the choice of a wellness model. These are discussed below.

6.3.1 Lack of interview experience. The researcher considers his experience of facilitating focus group interviews as a limitation of the study as it impacted on the quality and quantity of the data. Reflecting on the present study transcriptions, it was difficult to encourage focus groups to talk to one another or exchange each other’s experiences. There is little evidence of this type of interaction in all focus group interviews. Such research understanding of facilitating focus groups is valuable and vital for facilitating the focus group interviews. The researcher was not able to probe effectively and to reflect on the dynamics that occurred in each of the groups. For example, it was not easy for the researcher to encourage the quieter participants to contribute whilst restraining the dominant ones.

6.3.2 Timing of the focus group interviews. The focus group interviews were scheduled for the last week of the year, when end-of-year functions took place. This timing was unfortunate as some workers were on leave. For this reason it was decided to hold an additional focus group for these workers early in the new year (2010). Thus three focus group interviews with community development workers took place in the last week of a long, hard working year and it is possible that these workers were feeling exhausted. The workers in the fourth group, held early in the new year, after a holiday break, might have felt fresher and less tired. However, the timing did not seem to affect the credibility of the study as the responses from the last group did not differ notably from those of the first three groups.

6.3.3 Use of a qualitative research approach. One of the major difficulties of qualitative research is generalisation of research findings. As this study was conducted on a small number of HIV/AIDS workers from one site of the NGO in NMB, it is not possible to generalise the findings to its other sites in different towns, each town having its own particular context. The relevance of the findings is thus limited to the NMB site of the NGO, and possibly to other HIV/AIDS organisations in Nelson Mandela Bay.
6.3.4 Lack of relevant literature. There is a scarcity of literature available on HIV/AIDS workplace wellness programmes in South Africa, especially from HIV/AIDS NGOs in Nelson Mandela Bay. There is so much of workplace wellness research done pertaining to South African governmental departments. It was thus difficult to write about workplace wellness programmes in Nelson Mandela Bay and to compare workplace programmes in various non-governmental HIV/AIDS organisations.

6.3.5 Choice of wellness model. The Perceived Wellness Model was initially chosen as the framework of the study, although it did not accommodate variables relating to the particular context of employees. It was difficult to find a perfect wellness model that would fit the study for these various variables such as culture, family, community, and other contextual wellness domains. For this reason, three diverse but relevant models were used. The findings of this study have highlighted the importance of including contextual factors when one conducts wellness-related research.

6.4 Recommendations for Further Research

The findings of this study have contributed to the existing knowledge base regarding the understanding of wellness and the perceptions of factors hampering the wellness of community development workers in the HIV/AIDS organisation in NMB. As the organisation has offices and operates in other areas in South Africa too, replication of the study at each of these sites is recommended so that a comparison between findings can be made – do community development workers at other sites have a similar or different understanding of wellness, and what particular area-specific factors impact on their wellness? Further research could thus show the relationship between the findings in this study and community development workers’ wellness perceptions and the factors contributing to their wellness at other sites. It is further recommended to develop the kind of wellness model that would be relevant for South African HIV/AIDS organisations that would take into account the particular stressful nature of their community development workers’ work. It is further recommended to include programmes that would recognise the particular context in which employees worked or find a model or theory of wellness that emphasises the effect of the particular environment that HIV/AIDS workers are in.
The present research was conducted on predominantly Xhosa speaking community
development workers. Further research incorporating workers from other prominent language
groups, such as English and Afrikaans, would provide useful information on perceptions of
wellness, enabling one to build up a knowledge base that reflected the views of the diverse
population of our country.

Further research into the development of a South African wellness model as a tool would
be of great value in the South African context, where wellness research is seriously limited. It
is particularly important that such a wellness model framework is fully representative of the
South African population, as the present study suggests that this might be a limitation of
current models.

6.5 Conclusion

The final chapter of the present study began by presenting, on the basis of the research
findings, recommendations for improving the wellness of workers who participated in the
study. This was followed by a discussion of the value of the study, the limitations experienced
and finally, recommendations for future research. Despite some limitations to the study, the
findings were thought to contribute in a valuable way to furthering knowledge regarding the
interest of community development workers in the workplace and to help the employer’s
investment in human capital. It further provides research base data that will be useful in the
establishment of a wellness programme.
References


APPENDICES
Appendix A

Written information given to participants prior to participation

November 2009

Contact person: Joshua Bongani Ndlela

Dear Participants

You are being asked to participate in a research study. We will provide you with the necessary information to assist you to understand the study and explain what would be expected of you (participant). These guidelines would include the risks, benefits, and your rights as a study subject. Please feel free to ask the researcher to clarify anything that is not clear to you.

To participate, it will be required of you to provide a written consent that will include your signature, date and initials to verify that you understand and agree to the conditions.

You have the right to query concerns regarding the study at any time. Immediately report any new problems during the study, to the researcher. Telephone numbers of the researcher are provided. Please feel free to call these numbers.

Furthermore, it is important that you are aware of the fact that the ethical integrity of the study has been approved by the Research Ethics Committee (Human) of the university. The REC-H consists of a group of independent experts that has the responsibility to ensure that the rights and welfare of participants in research are protected and that studies are conducted in an ethical manner. Studies cannot be conducted without REC-H’s approval. Queries with regard to your rights as a research subject can be directed to the Research Ethics Committee (Human), Department of Research Capacity Development, PO Box 77000, Nelson Mandela Metropolitan University, Port Elizabeth, 6031.
Participation in research is completely voluntary. You are not obliged to take part in any research. If you do partake, you have the right to withdraw at any given time, during the study without penalty or loss of benefits. However, if you do withdraw from the study, you should return for a final discussion or examination in order to terminate the research in an orderly manner.

If you fail to follow instructions, or if your medical condition changes in such a way that the researcher believes that it is not in your best interest to continue in this study, or for administrative reasons, your participation maybe discontinued. The study may be terminated at any time by the researcher or the Research Ethics Committee (Human) that initially approved the study.

Although your identity will at all times remain confidential, the results of the research study may be presented at scientific conferences or in specialist publications.

This informed consent statement has been prepared in compliance with current statutory guidelines.

Yours sincerely

Joshua Bongani Ndlela
RESEARCHER
### Appendix B

#### BIOGRAPHICAL INFORMATION

Please indicate your choice with (x)

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<tr>
<td>Principal investigator</td>
<td>Mr. Joshua Bongani Ndlela</td>
</tr>
<tr>
<td>Address</td>
<td>Department of Psychology</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 77000</td>
</tr>
<tr>
<td></td>
<td>Nelson Mandela Metropolitan University</td>
</tr>
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### A. DECLARATION BY OR ON BEHALF OF PARTICIPANT

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<td>(full names)</td>
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<tr>
<td>ID number</td>
<td></td>
</tr>
<tr>
<td>Address (of participant)</td>
<td></td>
</tr>
</tbody>
</table>
A.1 **HEREBY CONFIRM AS FOLLOWS:**

<table>
<thead>
<tr>
<th>I, the participant, was invited to participate in the above-mentioned research project</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>that is being undertaken by Mr. Joshua Bongani Ndlela</td>
<td></td>
</tr>
<tr>
<td>from Department of Psychology, Faculty of Health Sciences</td>
<td></td>
</tr>
<tr>
<td>of the Nelson Mandela Metropolitan University.</td>
<td></td>
</tr>
</tbody>
</table>

**THE FOLLOWING ASPECTS HAVE BEEN EXPLAINED TO ME, THE PARTICIPANT:**

<table>
<thead>
<tr>
<th>2.1 <strong>Aim:</strong> The investigators are studying: Community development workers’ perceptions of wellness at an HIV/AIDS organisation in Nelson Mandela Bay.</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 <strong>Procedures:</strong> I understand that participating in this study will aid in achieving the above-mentioned objective. I will be required to participate in a group interview with my colleagues.</td>
<td></td>
</tr>
<tr>
<td>2.3 <strong>Risks:</strong> None.</td>
<td></td>
</tr>
<tr>
<td>2.4 <strong>Possible benefits:</strong> As a result of my participation in this study I will not receive any monetary benefits.</td>
<td></td>
</tr>
<tr>
<td>2.5 <strong>Confidentiality:</strong> My identity will not be revealed in any discussion, description or scientific publications by the investigators.</td>
<td></td>
</tr>
<tr>
<td>2.6 <strong>Access to findings:</strong> Any new information or benefit that develops during the course of the study will be shared as follows: Feedback on research findings is available on request</td>
<td></td>
</tr>
<tr>
<td>2.7 <strong>Voluntary participation / refusal / discontinuation:</strong> My participation is voluntary</td>
<td>YES</td>
</tr>
<tr>
<td>My decision whether or not to participate will in no way affect my present or future care / employment / lifestyle</td>
<td>TRUE</td>
</tr>
</tbody>
</table>
3. **THE INFORMATION ABOVE WAS EXPLAINED TO ME/THE PARTICIPANT BY:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Initial</th>
</tr>
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<tbody>
<tr>
<td>Afrikaans</td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>✓</td>
</tr>
<tr>
<td>Xhosa</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Mr Joshua Bongani Ndlela

and I am in command of this language, or it was satisfactorily translated to me by

(name of translator)

I was given the opportunity to ask questions and all these questions were answered satisfactorily.

4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

5. Participation in this study will not result in any additional cost to myself.

---

**A.2 I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT:**

<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th>on</th>
<th>20</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of witness:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full name of witness:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature or right thumb print of participant</th>
</tr>
</thead>
</table>
**B. STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)**

<table>
<thead>
<tr>
<th>I, Mr. Joshua Bongani Ndlela</th>
<th>declare that:</th>
</tr>
</thead>
</table>

1. I have explained the information given in this document to
   (name of patient/participant)
   and / or his / her representative (name of representative)

2. He / she was encouraged and given ample time to ask me any questions;

3. This conversation was conducted in
   [ ] Afrikaans  [ ] English  [ ] Xhosa  [ ] Other
   And no translator was used OR this conversation was translated into
   (language) by (name of translator)

4. I have detached Section D and handed it to the participant
   [ ] YES  [ ] NO

Signed/confirmed at on 20

---

**Signature of interviewer**

---

**Signature of witness:**

**Full name of witness:**

---

**C. DECLARATION BY TRANSLATOR (WHEN APPLICABLE)**

<table>
<thead>
<tr>
<th>I, (full names)</th>
</tr>
</thead>
</table>

ID number

Qualifications and/or

Current employment

confirm that I:

1. Translated the contents of this document from English into (language)

2. Also translated questions posed by (name of participant) as well as the answers given by the investigator/representative;

3. Conveyed a factually correct version of what was related to me.
<table>
<thead>
<tr>
<th>Signed/confirmed at</th>
<th>on</th>
<th>20</th>
</tr>
</thead>
</table>

I hereby declare that all information acquired by me for the purposes of this study will be kept confidential.

<table>
<thead>
<tr>
<th>Signature of translator</th>
<th>Signature of witness:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full name of witness:</td>
</tr>
</tbody>
</table>

**D. IMPORTANT MESSAGE TO PATIENT/REPRESENTATIVE OF PARTICIPANT**

Dear participant/representative of the participant

Thank you for your/the participant’s participation in this study. Should, at any time during the study:

- an emergency arise as a result of the research, or
- you require any further information with regard to the study, or
- the following occur

(Indicate any circumstances which should be reported to the investigator)

<table>
<thead>
<tr>
<th>Kindly contact</th>
<th>Mr. Joshua Bongani Ndlela</th>
</tr>
</thead>
<tbody>
<tr>
<td>at telephone number</td>
<td>073 4598 429/ 041 504 2330</td>
</tr>
</tbody>
</table>
Appendix D

Research Interview Questions

1. What is wellness?
2. What factors affect your wellness?
Appendix E

Sample Focus Group Interview Transcript

Focus Group B

Q. What is wellness?
1. “I think of physical health. Emotions also fit in.”
2. “Emotions are our biggest wellness issue at work. Traumatised and uncared for.

Q. What do you mean by being traumatised and uncared for?
3. For example, if we are visiting sick people, you may find that they are very emotional because of their sickness.
4. We get stressed, because we are close to our clients.
5. They become our friends, but we can’t let them see us get stressed.”
6. “It is similar in OVC [Orphans and Vulnerable Children], because we work with kids.
7. They have so many problems, and at the end of the day, you ask, what are you doing in that situation?
8. You sit alone with that, you eat when you know that child is not eating,
9. you sit knowing they do not have transport money for school,
10. they are caring for a sick mother,
11. and you feel there’s nothing I’m doing with that.”
12. “It’s not easy to keep it to yourself,
13. but you have to because what is happening for that child must be confidential.
14. Sometimes when you ask after a child, you hear he’s taking care of a sick parent,
15. and you know you can’t help that kid...you get stressed.”
16. “The work we do is not enough, but it helps.
17. Like when you buy food, you know they take it home to have dinner with the family.
18. Or you talk to a child about some of her problems.
19. But when they can’t come to school because they have no transport,
20. then I can’t do anything about it.”
21. “Kids expect us to come up with solutions,
22. but that’s not what counselling is about.
23. In counselling, you help the person come up with their own solutions.
24. But they expect us to come up with solutions.
25. If you give them options, they think it doesn’t help.
26. Kids don’t understand we have a limit to what we can do.”
27. “Like for one of my kids who is HIV positive, even if I do something, it will only help for today.
28. A food parcel would only be mealie meal, but she needs fruit and healthy food to make the medication work.”
29. “You take that child’s problem and you make it your own.
30. You don’t debrief with someone professional.
31. You can talk to someone in your program who you work with,
32. but they’re dealing with the same things.”
33. “You think ‘I need to be strong for this person and smile,’
34. even though you are not happy, you need to give them hope.”
35. “Sometimes you feel like leaving what you’re doing.
36. The stress is too much for me, I can’t sleep,
37. I am always thinking about the kids. But I think about leaving [name of the NGO].”
38. “OVC is stressful.

Q. Are you always stressed at work?

39. All you’ve got is stress, especially during home visits.
40. You see the way they are living, you see the mother sick,
41. and you don’t know what to do.
42. You say you will try to help, but they want you to help right away.”
43. “When I meet the HIV-positive children, I just wonder what is going to happen in their lives.”

Q. What do you do to cope?

44. “I think it is difficult to say because we are unable to access wellness centres
45. However there is a need for us to focus at work.”
46. “Only God knows how we can survive in this organisation.
47. I would like us to pray more often before going for home visits though
48. You cannot because you will feel discouraged by others.
49. What I do to cope is to sleep after work
50. because there is no support at work and we are used to sleeping as to run away from stress,
51. chatting to people about work with relatives helps at times though it’s not enough.
52. I rather go to church for a prayer meeting at least God hears us”
53. “Brothers and sisters do understand our hardships and recognizes our painful experiences though they are unskilled for professional work.
54. Recognition of our painful experiences in our communities is better than ignorance at work
55. hmmm I am so used to stressing about work and I do not have ways to cope,
56. I just work and I get sick because of burnout and I will tend to shut my door closed all the time
57. however I think of my children and because of my children I get energised to go to work,
58. they need to get something to eat regardless I am stressed or not at work.
59. It doesn’t matter anymore
60. I speak to my wife and she is like the source of energy and she understands me
61. Our organisation is careless about our wellbeing as long we are doing work
62. As a result I depend upon God though we need something to be done at work to help us cope with work stress.
63. The only thing Josh we do to cope is to have hope about tomorrow and complaining will affect our job performance because we love our work.

Q. What factors affect your wellness?
64. “There are problems with our families.
65. For me, I stay with cousins who work, but at the end of the month, they do not give money for groceries.
66. The cousins are also drinking, one was stabbed one night, and he promised he won’t drink but he hasn’t stopped.
67. These things are stressing me.
68. Early in the morning, he came to the door and he almost died.
69. And I was just screaming. The neighbours helped him, but I was worried about his funeral insurance. I’m a child just like them, I don’t know how to deal with these problems.
70. I’ve been carrying stress, I don’t know how many years now. Since my grandmother died, I’ve been the only one to take care of us.”
“I take my family’s problems and I make them my own.

Even older relatives, they don’t look after themselves. I’m HIV positive.

One day I know I will get sick.

What are they going to do?

I wish I could go to sleep and wake up a new person, without all these problems.

One thing that makes me want to commit suicide is my burden.”

I have a niece, I have one brother, a mom and my sister.

These people are depending on me.

What makes me stressed is that my brother doesn’t help me.

I end up hating my brother, he lets me carry everything by myself.

I care for my mom,

I pay school fees for my niece,

and I pay for her transport.

I think if I have to sell my body, I will do it, if I will be able to care for my niece and give her the education I never received.

The worst part is that I am the youngest, and he [brother] is expecting me to do everything.

I wouldn’t mind if I had the money, but I don’t.

I can’t go out with my friends like I’m supposed to, I’m young, because I have this responsibility.

I feel sometimes like I’m going to kill myself.”

“It all comes down to funeral cover. When you are the only one looking after the family, you have to pay for it...I can’t pretend they don’t exist anymore, they’re my family.

But you never get a ‘thank you’ for looking after your mom.”

I failed matric due to volunteering at [name of the NGO]

“I told myself if I fail, I will not go back.

I have to work, I have to make money and support my family.

Now I don’t have my matric, and if I apply for other jobs, they say you must have a degree.

My family doesn’t know what I suffer to give my niece the education I give her.”

“I dropped out in grade 11 because my mom couldn’t keep paying.

[name of the NGO] gave me a lot of skills, but I can’t use them in life because I don’t have a degree or certificates.
I’m stuck with R2500 [salary] that I have to share.

I don’t know what to do. The R2500 I get does not help with the problems I’m having at home.”

“All that anger comes out on other colleagues who get opportunities.”

Q. One participant mentioned anger arising out of her situation, and engaging in unhealthy behaviours. What other unhealthy behaviours come from your situations?

“I wish I could just sleep and not talk to anyone, but you can never get that kind of privacy.

Especially when you have kids, you can’t just tell them to go play when they need you.

I am always afraid of hurting the kids.

I scream a lot, it’s the way I relieve my burden. I hope I don’t hit them accidentally. It’s not easy.”

“Our situations make us do wrong things.

I hate my cousin who has more money,

and I get jealous because her life is easy.

I have so much to do, but she is only working for herself.

I know what I’m doing is wrong, and hating is a sin against God, but our situations make us angry with life.

And in our culture, you cannot just tell your older brother you are angry with him.

Your elders will say that is disrespect. You end up wishing for someone else’s life.

My whole family is poor. Who am I going to ask for help?”

“You want to finish your studies, but who will support your family?”

“With these medical aid talks...I do want to deduct medical aid, but then at the end of the month, I would have nothing!”

Q. What can [name of the NGO] do to improve your wellness?

“They can provide scholarships so we can study.”

“Our organisation is not fair.

They want people who have degrees, but I have experience.

I know I can do the work of, for example, a team leader.

But I know someone else will come in with a degree and get the job, and I will be training them!”
120. “You know you deserve the position, but because you don’t have a degree... working with kids has nothing to do with a degree!”

121. “You with your failed matric, you need to teach those people. I’m the one who wishes I could get that training [opportunity], but they give the training to people who are already educated.”

122. “I’m the one doing all the hard work, and here’s the person with the degree, just writing the report.

123. She [coordinator] is not appreciating what I am doing. What is she doing? The person who is more educated does nothing, just writes a report.

124. They are only here for a year for the experience, and then they move on.”

125. “Why don’t they see the skills that they gave me?

126. They want degrees! Why can’t they see the experience?

127. Why can’t they see we need more than just moving from one programme to another?”

128. “Recognition doesn’t have to come in the form of money.

129. It’s not even necessary to have an employee of the month.

130. It would be enough to be recognized within your program, from another individual.

131. People will be jealous [about the employee of the month] but they will not express it.”

132. “It’s not fair to cut out the volunteers.

133. They do the exact same job as the permanent staff, and they earn nothing, but they [NGO] do not even say ‘thank you”

134. “It’s very painful. You’re not appreciated.

135. The only people who are appreciated are permanent staff.”

136. “People may complain to a team leader, but what if it gets back to a coordinator?

137. The fear is then you will not be hired for another position.”

I want to say thank you very much for everything and for contributing in the focus group. It was good hearing your views and opinions. Ndiyabulela ngenxaso yenu.
Appendix F

Independent Coder Themes

The following themes emerged from the interviews as the main themes:

1. **What is Wellness:**

<table>
<thead>
<tr>
<th>Sub theme</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>A1-A11</td>
<td>B1</td>
<td>D20</td>
<td></td>
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<tr>
<td>mental</td>
<td></td>
<td></td>
<td>D20</td>
<td></td>
</tr>
<tr>
<td>emoional health</td>
<td>B2</td>
<td></td>
<td>D20</td>
<td></td>
</tr>
<tr>
<td>financial</td>
<td></td>
<td></td>
<td>C9</td>
<td>D9,10</td>
</tr>
<tr>
<td>work life balance</td>
<td>A12</td>
<td></td>
<td></td>
<td>D3,D21-D23</td>
</tr>
<tr>
<td>Support</td>
<td>A13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>employee intervention</td>
<td></td>
<td></td>
<td>C1</td>
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</tr>
<tr>
<td>health</td>
<td></td>
<td></td>
<td>C2</td>
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<td>stress levels</td>
<td></td>
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<td>C4</td>
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<td>well being</td>
<td></td>
<td></td>
<td>C6</td>
<td>D1</td>
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<tr>
<td>distressed</td>
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<td></td>
<td>C8</td>
<td></td>
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<tr>
<td>healthy diet</td>
<td></td>
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<td></td>
<td>D5</td>
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<tr>
<td>Stress free</td>
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<td>D11-D12</td>
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<td>holistic approach</td>
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2. **Contributing Factors: (impeding on Wellness)**

<table>
<thead>
<tr>
<th>Sub theme</th>
<th>Interview A</th>
<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
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</thead>
<tbody>
<tr>
<td>HIV/AIDS Stigma</td>
<td>A45</td>
<td></td>
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<tr>
<td>Financial matters</td>
<td>A70</td>
<td>B80</td>
<td></td>
<td>D25</td>
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<tr>
<td>Salary</td>
<td></td>
<td></td>
<td>C33</td>
<td></td>
</tr>
<tr>
<td>feeling unappreciated</td>
<td></td>
<td></td>
<td>C35</td>
<td></td>
</tr>
<tr>
<td>low self esteem</td>
<td>A9,10</td>
<td></td>
<td></td>
<td>D49</td>
</tr>
<tr>
<td>lack of coping skills</td>
<td></td>
<td></td>
<td></td>
<td>D98</td>
</tr>
<tr>
<td>Work life balance</td>
<td>A12,13</td>
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<td></td>
<td>D122</td>
</tr>
<tr>
<td>absenteeism</td>
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<td></td>
<td></td>
<td>D154</td>
</tr>
<tr>
<td>overtime work</td>
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<td>D157</td>
</tr>
<tr>
<td>Family problems</td>
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3. **Coping:**

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<th>Sub theme</th>
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<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
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<tbody>
<tr>
<td>support from companion</td>
<td>A97</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>sleep</td>
<td></td>
<td>B49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prayer</td>
<td>B52</td>
<td></td>
<td>C111-134</td>
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<tr>
<td>positive thinking</td>
<td></td>
<td></td>
<td>C137</td>
<td></td>
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<tr>
<td>talking about it</td>
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<td></td>
<td>C161</td>
<td>D173-190</td>
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<tr>
<td>deal with own issues</td>
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<td></td>
<td>D176</td>
</tr>
<tr>
<td>support from team</td>
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<td></td>
<td></td>
<td>D185</td>
</tr>
<tr>
<td>Exercise</td>
<td>A37-38</td>
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4. Improving Wellness:

<table>
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<th>Interview B</th>
<th>Interview C</th>
<th>Interview D</th>
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<tbody>
<tr>
<td>meetings and one on one’s</td>
<td>A201</td>
<td></td>
<td>D184</td>
<td>D207</td>
</tr>
<tr>
<td>Debriefing</td>
<td>A202</td>
<td></td>
<td>C173</td>
<td>D214</td>
</tr>
<tr>
<td>team building</td>
<td>A221</td>
<td></td>
<td></td>
<td>D215</td>
</tr>
<tr>
<td>more recognition and appreciation</td>
<td>A224</td>
<td>B123,128</td>
<td></td>
<td></td>
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<tr>
<td>Scholarships</td>
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<td></td>
<td>B115</td>
<td></td>
</tr>
<tr>
<td>Financial skills training</td>
<td>A21-23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>management skills</td>
<td></td>
<td></td>
<td>C169</td>
<td></td>
</tr>
<tr>
<td>add more staff</td>
<td></td>
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<td></td>
<td>D206</td>
</tr>
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<td>overtime work</td>
<td></td>
<td></td>
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<td>D157</td>
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<tr>
<td>transport to sites</td>
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<td>D208</td>
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<tr>
<td>Increase salary</td>
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<td>D209</td>
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<tr>
<td>more training</td>
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<td>D210, D216-217</td>
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<td>more social things</td>
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<tr>
<td>work and home satisfaction</td>
<td>A12-15</td>
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