EVALUATION OF THE BOTSWANA MINISTRY OF HEALTH'S WORKPLACE WELLNESS PROGRAMME

to Improve Implementation, Utilization, Impact and Sustainability

REPORT

I-TECH Botswana
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Workplace Wellness Programme

BATSWANA AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

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The technical reference group overseeing the project played a key role. It was chaired by Maureen Maretela from the Ministry of Health (MOH) Department of Corporate Services. Other members from the MOH included Heather Mothibedi and Maureen Mpho (National Workplace Wellness Programme – Department of HIV/ADS Prevention and Care [DHAPC]), Siwulani Sebetso (District Health Management Team [DHMT] National Coordination – Department of Clinical Services), O. Maiketso (Gaborone DHMT – Department of Clinical Services), Keeagile Kgoleyamotho (South-East DHMT – Department of Clinical Services), and Lame Seema (Occupational Health – Department of Public Health). Additional members included Beatrice Manda (Seventh Day Adventist Mission Hospital – Kanye), Monametsi Bahudi (Directorate Public Service Management – Office of the President), and Moagi Gaborone (World Health Organization). Also much appreciated was assistance provided by Monica Smith, Mavis Bengtsson, and Wandani Sebonego, technical officers from the Centers for Disease Control and Prevention in Botswana.

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ABBREVIATIONS

BMI	Body Mass Index
CDC	Centers for Disease Control
DHAPC	Department of HIV/AIDS Prevention and Care
DHMT	District Health Management Team(s)
FGD	Focus Group Discussion(s)
HIV	Human Immunodeficiency Virus
IA	Implementation Assessment
IDI	In-Depth Interview(s)
I-TECH	International Training and Education Center for Health
M&E	Monitoring and Evaluation
MOH	Ministry of Health
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SD	Standard Deviation
TB	Tuberculosis
TOT	Training of Trainers, Trainer of Trainers
WWP	Workplace Wellness Programme

EXECUTIVE SUMMARY

In 2007, the Botswana Ministry of Health (MOH) initiated development of the Workplace Wellness Programme (WWP) to help ensure that health workers are equipped to cope with the physical and emotional demands of their jobs. This evaluation was conducted to document the achievements, challenges, and outcomes of the MOH WWP, and to make recommendations for improving implementation, use, impact, and sustainability of the programme. The data collection methods for this multifaceted evaluation are listed in the table below along with information about the target population and sample size.

Table: Data Collection Methods

Data Collection Method	Target Population	Sample Size
Implementation Assessment	WWP district focal persons	27
In-Depth Interviews	Programme implementation personnel at national, district, and facility levels	17 (National) 10 (District) 11 (Local)
National Survey	Health workers in four cadre groupings	1,348
Focus Groups	Health workers in four cadre groupings	10 groups
Desk Review	Documents related to development or implementation of WWP	68 documents

FINDINGS AND RECOMMENDATIONS

The following findings emerged from this evaluation, with specific focus on programme implementation, awareness and participation, job performance, sources of occupational stress, mechanisms for coping with stress, and lifestyle behaviours.

Implementation at District and Local Levels

The basic structures necessary to promote implementation of the national WWP for health workers in Botswana have been put in place across the country. Evaluation results indicate that having a dedicated and diverse WWP committee enabled implementation of the minimum package of services. Other factors included support from national and district management, and organization of the programme into district, facility, and individual performance plans. Such components as health screening, therapeutic recreation, and promotion of health through observation of commemorative events were implemented more often than those related to occupational health and safety or psychosocial services. Rollout of the programme from district hospitals to individual facilities has happened on only a limited basis. Barriers to WWP implementation at both district and local levels include: limited branding of pre-existing health-related activities as part of the WWP, organizational placement of the programme

within the Department of HIV/AIDS Prevention and Care, prioritization of wellness activities that focus on the general community instead of on health workers, and perceptions that programme implementation is voluntary, as well as such general constraints as heavy workloads and limited transport.

Participation in WWP activities

The results for participation in the minimum package of activities were fairly consistent across components. The vast majority of health workers reported that these services were not available at their facilities. However, when these services were offered, health workers generally did participate. The main exception was health screening—health workers were more likely to obtain screening as part of an overall health check-up than as part of the WWP. However, health workers consistently reported that they felt these services would be beneficial.

Sources, symptoms, and levels of Stress

The three most commonly reported sources of stress were shortages of staff, shortages of resources, and too much work. Other common sources of stress were conflict with co-workers, providing support for relatives of patients, and providing care for many HIV/AIDS patients. Providing care for HIV/AIDS patients was perceived as a source of stress by 42.3% of participants in 2013, compared to 76% in 2006. Similarly, fewer participants reported that caring for many patients, too much work, and staff shortages were stressors in 2013 compared to 2006. This suggests that there have been improvements in reducing stress in the workplace since 2006.

Data related to job satisfaction, as determined using the Job Descriptive Index and Job in General tools, indicate a general satisfaction with their work, supervision, and co-workers. Results showed overall dissatisfaction with pay and opportunities for promotion.

Burnout was assessed using the General Survey of the Maslach Burnout Inventory, which assess exhaustion, cynicism, and efficacy. Over half of the health workers surveyed had high levels of professional efficacy. High levels of exhaustion were found in 28.6% of respondents. Cynicism was categorized as high for 37.6% of respondents.

The data suggest that the majority of health workers experience occupational stress. Close to 10% of the respondents indicated that they ‘never’ felt stressed at work, which is similar to data from 2006. Mean values fell above the median for the Stress in General scale, indicating

that the majority of health workers do experience stress at work. Mean values for the general health questionnaire were below the median, suggesting low levels of psychological well-being

Coping with Stress

The most commonly reported stress coping strategy were talking to someone—a family member, friend, co-worker, supervisor, or even a counsellor— and spiritual activities. Nine percent of health workers reported using alcohol to relieve stress, which was similar to the data found in 2006. Overall, the reported use of positive coping strategies increased from 2006 to 2013, suggesting improvements related dealing with stress in the workplace since 2006.

Lifestyle Behaviours

Fruit and vegetable intake was generally poor, with only 11.7% reported having five or more servings of fruits and/or vegetables per day. Almost one-third (31.9%) of respondents reported consuming one or fewer servings per day. Most respondents (95.2%) reported that they did not smoke. The results for alcohol use are similar to those for tobacco use, with 75.9% of respondents reporting they had not had an alcoholic drink in the past 30 days. About 32% of the respondents reported not engaging in any physical activity, 16% reported that they engage in physical activity once a week, 17% engage in some form of exercise daily, and 35.8% participate in physical activity three to six days a week.

Relationship between WWP participation and Stress-related Outcomes

Measures of absenteeism and presenteeism were not significantly associated with WWP participation. However, stress scores, assessed by the Stress in General tool, were significantly lower for health workers with a high participation in WWP activities. Similarly, levels of exhaustion and cynicism, as assessed by the Maslach Burnout Inventory, were significantly lower for health workers with a high participation in WWP activities. This suggests that the WWP is having a beneficial impact on healthcare workers.

WWP RECOMMENDATIONS

Programme Implementation and Use: General recommendations

- Promote stress management and team-building activities to encourage attendance and improve overall quality of work.
- Ensure a systems approach to WWP implementation that takes a holistic view of wellness, instead of being event-driven.
- WWP activities are largely concentrated at district hospitals, with relatively little impact at other health facilities. Promote efforts to roll out WWP activities to local facilities to increase the impact of the programme. Local wellness committees are needed to ensure coordination and implementation of the WWP.
- The importance of the WWP needs to be re-emphasized to the districts and local facilities, so that they clearly understand their responsibilities.
- Promote therapeutic recreation to encourage physical activity.

Programme Implementation and Use: Specific recommendations

- The district structures for WWP implementation are in place and need to be supported. **Periodic reminders to district leadership of the importance of the programme and its objectives are needed**.
- Few district WWP committees had all of the focal-member positions filled. Given the apparent challenge in filling all key positions within the WWP committee, **the number of WWP committee positions should be reduced and roles prioritized.**
- Annual WWP plans are routinely submitted late and the WWP committees seldom complete annual plan projections. Therefore, **the programme should revisit the need for projections in addition to annual plans. Feedback and follow-up related to late submission or non-submission of annual plans is warranted.**
- **The national programme should ensure that key guiding documents are available for both WWP focal persons and committee members**.
- Although health screening services are generally available at district hospitals, only seven local facilities reported having staff clinics. Instead, health workers generally receive screening services as part of the general client population. **There is a need for additional staff clinics to facilitate access to screening**

and other health services. Confidentiality should be inculcated into these services.

- Wellness activities related to health promotion are generally aimed at the community, not specifically targeted to health workers. **An increased focus on health promotion activities targeting health workers is need.**
- **An increased focus on peer education is warranted,** given that this was a weak aspect of WWP activities.
- **The programme should review the usefulness of targeted seminars,** since there was a low prevalence of these activities in the field.
- **Additional materials, such as instructional aides, are needed to facilitate implementation of activities focused on health promotion, stress management, team building activities, occupational health, and safety.**

Impact and Sustainability

- Placement of the WWP under the auspices of the Department of HIV/ADS Prevention and Care (DHAPC) made sense when the programme was being developed. However, because the HIV epidemic, the health care system, and the WWP have since matured, the programme should be placed under a different department to ensure a more holistic approach to wellness.
- Increase human resources for health, and implement staffing norms to reduce stress. Ensure sufficient numbers of health workers at each facility so that health workers are able to access WWP services. Provide feedback on staffing needs to district health management teams (DHMTs) to enable more appropriate workload assignments.
- Health facilities need to review how to best provide health services for their workers. Screening and other wellness events are usually led by health workers for the benefit of the general community, with little or no focus on health workers themselves.
- Promote stakeholder support and buy-in to strengthen WWP branding of WWP activities; this will increase visibility and promote support for the programme me. Coordinate all wellness activities through the WWP to maximize its use.
- Develop a robust monitoring and evaluation system for reporting and feedback.

INTRODUCTION

HIV/AIDS Has Created a Strain on Health-Sector Human Resources

The HIV/AIDS epidemic continues to pose public health and health system challenges for many countries, particularly those in sub-Saharan Africa.[1] As the demand for skilled health service providers has increased to address the growing disease burden, the supply of health workers has simultaneously declined due to health worker morbidity and mortality, as well as workers taking time off to care for ill relatives.[2] In addition to the challenges caused by health worker morbidity and mortality, the expansion of health services needed to address the HIV/AIDS epidemic has put additional professional demands on health workers.[3]

The increase in demand for HIV services is especially evident in Botswana. Although HIV rates have been declining in recent years, data from the 2012 Botswana AIDS Impact Survey indicate that approximately 18.5% of the country's population is living with HIV/AIDS—among the highest rates in the world.[1,4] The national response to the HIV/AIDS epidemic in Botswana has been multifaceted, demonstrating Botswana's international leadership in the implementation of HIV prevention, treatment, and care programmes. For example, the government of Botswana established the first national antiretroviral therapy (ART) and prevention of mother-to-child transmission programmes in Africa.[5,6] Botswana has also been a world leader in the initiation of routine HIV testing.[7] Although these and other HIV/AIDS programmes have resulted in a comprehensive package of HIV services to combat the epidemic through prevention, treatment, and care, they have also created human-resource challenges for the health care system.

As the national response to HIV expanded, new cadres of health workers, such as lay counsellors and monitoring and evaluation (M&E) officers, were created to help manage the workload.[8,9] However, even with these added human resources, health workers assumed additional responsibilities in implementing new HIV-related programmes. These additional responsibilities coincided with an increase in overall caseloads at health facilities, due to higher numbers of patients seeking treatment for HIV and related co-morbidities. For example, tuberculosis case notification rates increased from 199 to 455 per 100 000 between 1989 and 2011.[10,11] The problem of constrained human resources due to increased responsibilities and caseloads was further exacerbated by the psychosocial demands experienced by those health workers who were caring for increasing numbers of acutely and terminally ill patients, while also taking care of family members and friends who were ill. These expanded responsibilities,

increased caseloads, and psychosocial demands are thought to have contributed to occupational stress among health workers.[12]

Health Workers Responding to the HIV/AIDS Epidemic Are Particularly Susceptible to Occupational Stress

It is widely accepted that health professionals are particularly vulnerable to high levels of occupational stress.[13,14] Occupational stress has been defined by the US National Institute for Occupational Safety and Health as 'the harmful physical and emotional responses that occur when job requirements do not match the capabilities, resources, or needs of the worker.'[15] Contributing factors include long hours, heavy workloads, and the mental and physical demands of providing care for ill patients.

Health workers responding to the HIV/AIDS epidemic are especially susceptible to occupational stress.[13,14,16,17] Several unique stressors related to providing HIV/AIDS treatment and care have been identified: the clinical manifestation of AIDS and the course of the illness, the risk of contagion, high mortality rates among patients, ethical concerns about confidentiality and stigma, and coping with on-going loss.[16] Prior to comprehensive treatment programs, inpatient death rates and the limited possibilities of effective care contributed to professional frustration and stress among health workers.[17] Although improvements in patient survival rates may have reduced levels of professional frustration and occupational stress in countries with large-scale ART programmes, stress in the workplace remains a reality for many health workers involved in HIV treatment, care, and support.

Stress-Related Burnout Adversely Impacts the Health System

Extended exposure to occupational stress can lead to burnout, a state of physical, emotional, and mental exhaustion resulting from long-term involvement in work situations that are emotionally demanding.[18] Maslach has characterized burnout as including three constructs: emotional exhaustion, depersonalization, and reduced personal accomplishment.[19] *Emotional exhaustion* refers to the depletion of emotional resources, which leads health workers to feel exhausted by their work, and unable to give of themselves on a psychological level. *Depersonalization* results in negative, cynical attitudes and feelings about clients. Health workers who have a reduced sense of *personal accomplishment* evaluate themselves negatively, particularly with regard to their relationships with clients.

Occupational stress and burnout have adverse effects for both employers and employees. Occupational stress can impact employee job satisfaction. This was shown in a small study

from South Africa, which found that occupational stress adversely impacted job satisfaction among 50 doctors.[20] In addition, stress can contribute to emotional and physical illness; it has been shown to contribute to multiple health problems, including musculoskeletal disorders, cardiovascular diseases, psychological ailments, and reduced immune function.[13,16]

From an organizational perspective, occupational stress can lead to increased absenteeism, which is a physical absence from work. It can also lead to *presenteeism*, in which employees are physically present at work, but have reduced productivity due to physical or emotional distractions. Furthermore, occupational stress can lead to increased staff turnover and decreased work commitment. It can also contribute to poor relationships with clients,[16] which can impact the effectiveness of the health system to adequately address public health needs.

Individual Coping Mechanisms and Organizational Interventions Can Help Manage Occupational Stress and Avoid Burnout

Given the negative effects of occupational stress and burnout on employers and employees, it is important to address these issues in order to improve the effectiveness of the health system.[16] The health of workers is an essential element in determining the long-term success of any organization or company, including health facilities.[21]

Generating a completely stress-free work environment may not be feasible; therefore, the adoption of healthy coping strategies by health workers can be an important step in mitigating the impact of stress and preventing burnout. Individuals can potentially mitigate the effects of stressors through coping strategies. *Coping strategies* refers to specific efforts, both behavioural and psychological, that people employ to master, tolerate, eliminate, or minimize stressful events or their impact.[22] Some examples of coping strategies are talking with co-workers, taking time off, humour, ignoring or denying stress, blaming others, and alcohol use.[23]

Along with the adoption of healthy coping mechanisms by individuals, another important approach to dealing with occupational stress is to identify organizational factors that contribute to stress, and address them through such strategies as hiring more staff, creating flexible working hours, and providing training for employees on stress management, coping strategies, and relaxation techniques.[20] Data from the literature suggest that workplace wellness programmes can result in reduced absenteeism, increased employee retention, and reduced health care costs, and that such programs may have substantial health and economic benefits.[24] *Workplace wellness programmes* are employer-sponsored programs designed to

engage and support employees (and often their family members) in adopting and sustaining behaviours that reduce health risks, improve quality of life, enhance personal effectiveness, and benefit the organization financially.[25]

Occupational Stress and Burnout in Botswana

Relatively little is known about stress and burnout among health workers in Botswana. A study from 2006 found that 89% of health workers in Botswana reported experiencing occupational stress, 69% expressed the need for professional counselling, 75% expressed the need for stress-management services, and 58% suggested on-site provision of health and wellness services for easy access.[12]

Since that study was conducted, several factors have emerged that may have helped to mitigate occupational stress. The nature of HIV/AIDS care and treatment has changed, with declining mortality rates, and the achievement of mother-to-child transmission rates that are among the lowest in the world. Furthermore, the MOH has demonstrated a strong commitment to ensuring that the health workforce is able to cope with the demands of the HIV/AIDS epidemic by establishing the national Workplace Wellness Programme (WWP) for health workers.

WWP for Health Workers in Botswana

In 2000, the Minister of Health highlighted the need to ensure there were appropriate HIV/AIDS interventions for health workers; this led to a national needs assessment, which was completed in 2006.[12] Subsequently, to help ensure that health workers would be equipped to cope with the physical and emotional demands of their jobs, the MOH initiated development of the WWP. Implementation of this comprehensive programme began in 2007, with the goal of empowering health workers with the knowledge and skills necessary to manage and cope with the dynamic demands of the health system, which had been exacerbated by the HIV/AIDS epidemic.[26] The focus of the programme evolved; it broadened its scope to encompass comprehensive wellness services, integrating HIV/AIDS-specific interventions geared towards improving the overall health of health workers.

The programme is coordinated by the national Workplace Wellness Program, under the auspices of the Department of HIV/AIDS Prevention and Care at the Ministry of Health. Implementation of the WWP at the district and facility levels is handled through district focal persons and committees within district health management teams (DHMTs). A ‘training-of-trainers’ (TOT) model has been used to build the programme’s capacity to address stress

management, team building, and occupational health. The recommended minimum package for the programme consists of the following components:

1. *Health screening, treatment, and car*e includes comprehensive health services, from clinical assessments to identify disease before symptoms show to providing necessary medical consultations, treatment interventions, and referrals. Focal areas include, but are not limited to, TB, HIV, and cancer screening and treatment.

2. *Health promotion* addresses health and lifestyle issues through wellness talks, seminars, commemorations, and peer education activities, including activities intended to empower health workers to exercise control over all aspects of their lives (e.g., finances, substance use, and health issues).

3. *Stress management and team building* training and workshops focus on enhancing the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork.

4. *Occupational health and safety* addresses issues of safety in the workplace, focusing on identification of health hazards and their prevention, control, and management. It also addresses occupational exposure, injury, and post-exposure prophylaxis services.

5. *Psychosocial and spiritual care* involves support groups consisting of health workers led by trained group facilitators. It also includes such activities as counselling, prayer, Holy Communion, and the reading of scripture.

6. *Therapeutic recreation* focuses on improving the physical, psychological, emotional, and occupational well-being of health workers through such recreational activities as physical fitness, social recreation, and ‘edutainment’ (e.g., dramas, fashion shows).

With the establishment of the national WWP, there is a need to assess the achievements, challenges, and outcomes of the programme, and to provide recommendations for improving its implementation.

OBJECTIVES

This evaluation was conducted to document the achievements, challenges, and outcomes of the MOH Workplace Wellness Programme (WWP), and to provide recommendations for improving programme implementation. In addition to implementation, use, impact, and sustainability of the WWP, the evaluation covered occupational health issues affecting health workers: stress, coping strategies, lifestyle behaviours, and absenteeism. The specific objectives of this evaluation, along with the corresponding evaluation questions, are listed below:

1. Describe the development and administration of the WWP at national, district, and facility levels from 2007 to 2013.
    a. What have been the key inputs and processes of the WWP at these levels?
    b. What inputs and processes are needed to ensure the sustainability of the WWP and its continued rollout to all facilities?

2. Assess the progress of WWP implementation throughout the country, and identify factors affecting implementation.
    a. Which components of the minimum package of services are being implemented at district and facility levels?
    b. What are the factors affecting implementation of the minimum package of services at district and facility levels?

3. Determine how health workers are using the WWP, and identify factors affecting use.
    a. Which components of the minimum package of services are health workers using? How often?
    b. What are the factors affecting the use of wellness services?

4. Identify sources, symptoms and levels of occupational stress, and mechanisms for coping with occupational stress among health workers in 2013; compare, when possible, with relevant data prior to 2007 (WWP implementation).
    a. What do health workers currently perceive to be sources of stress? How do these compare with those perceived prior to implementation of the WWP?
    b. What symptoms of stress are health workers currently experiencing? How do these compare with those experienced prior to implementation of the WWP?

c. What coping strategies are health workers using to address stress? How do these compare with those used prior to implementation of the WWP?
d. What is the current level of stress among health workers? How does this compare with levels prior to implementation of the WWP?

5. Describe the lifestyle and health behaviours of health workers; use this information to characterize chronic disease risk and inform intervention development.
    a. How can health worker behaviours be characterised in relation to physical activity, diet, alcohol consumption, and tobacco use?

6. Explore how participation in WWP activities correlates to coping strategies used to reduce stress, absenteeism, presenteeism, job satisfaction, stress levels, and burnout among health workers in 2013.
    a. Is health worker participation in workplace wellness activities associated with any of the following outcomes?
        - Increased use of healthy coping mechanisms.
        - Decreased absenteeism.
        - Increased job satisfaction.
        - Lower levels of stress and/or burnout.

METHODS

A reference group comprising key stakeholders was involved in the development and oversight of the evaluation. The reference group included representation from the MOH Departments of Corporate Services, DHAPC, Clinical Services, and Public Health; Seventh Day Adventist Mission Hospital in Kanye; Directorate of Public Service Management – Office of the President; WHO Botswana; and CDC Botswana. (A copy of the terms of reference for the evaluation can be found in Appendix A.) This evaluation was approved by the MOH Health Research and Development Committee; non-research determination was received by the University of Washington's Internal Review Board (Appendix B).

This evaluation used a non-experimental, mixed-methods design to collect quantitative and qualitative data from primary and secondary data sources. The primary data sources were a *national implementation assessment* of WWP activities throughout the country; *in-depth interviews* with programme implementation staff at national, district, and facility levels; a *national survey* of health workers; and *focus group discussions* with health workers. Secondary data was obtained from a *desk review* of pertinent documents.

1. National Implementation Assessment

The national WWP implementation assessment (IA) was administered through telephone interviews with the WWP focal persons in all 27 health districts. The IA was conducted to obtain data on levels of WWP implementation throughout Botswana, as well as all factors affecting programme implementation. A standards-based quantitative interview guide (Appendix C) was developed from the MOH WWP implementation guide and operational guidelines. Informed consent was obtained via fax. Data were used to develop scores reflecting the level of WWP within the district.

2. In-Depth Interviews

In-depth interviews were conducted at the national, district, and facility levels with individuals having historical knowledge of the WWP, as well as with those currently involved in administering the programme. The purpose of the interviews was to better understand the history, political will, implementation, use, rollout, and factors affecting the WWP. Copies of the interview guides can be found in Appendices D, E, and F. A copy of the consent form used can be found in Appendix G. Each interview was conducted face-to-face by a skilled interviewer, with a rapporteur present. With permission, the interviewers also recorded the

interviews with a digital voice recorder. After the interviews, the voice recordings were transcribed, and translated as necessary.

National-level interviews were conducted in Gaborone. With guidance from the technical reference group, purposive sampling was used to select individuals involved in the development and history of the WWP. In total, 17 interviews were conducted at this level. Interviewees included knowledgeable personnel from MOH and WHO, as well as former steering committee members representing the Nurses Association of Botswana, Botswana Defence Force, Botswana Police Service, Botswana Prison Service, and the CDC.

District and facility interviews were conducted in six of the 27 health districts (22%). To ensure maximum variation, purposive sampling was used to select these districts based on the IA scores. Specifically, the three districts receiving the highest and lowest IA scores (demonstrating higher and lower levels of programme implementation, respectively) were selected to enable variability of the data and yield the most relevant information related to factors affecting implementation of the WWP minimum package. The districts selected were Good Hope, Kgalagadi North, Kweneng West, Mabutsane, Palapye, and Southern. Interviewees were selected using a snowball technique, whereby WWP district focal persons were asked to identify other relevant interviewees at the district and facility levels in their districts who were familiar with WWP implementation. In total, 10 interviews were conducted at the district level, and 11 at the facility level. Interviewees included WWP district and facility committee members, as well as district and facility management.

3. National Survey of Health Workers

A self-administered questionnaire (Appendix H) was distributed to randomly selected health workers in public health facilities in each of Botswana's 27 health districts. This included health workers in the following four general categories:

1) Doctors and nurses providing clinical care.
2) Other professionals, including:
    - Social workers, pharmacists, and nutritionists
    - Allied health professionals, such as radiographers and pharmacist technicians
    - Paraprofessionals, such as lay counsellors and health education assistants
3) Administrative personnel (e.g., doctors and nurses acting in an administrative capacity, human resources staff, and data clerks).
4) Support staff (e.g., drivers, cleaners, and gardeners).

A multi-stage sampling procedure was used to first select facilities in which the surveys were to be administered, and then to identify potential participants. All facilities and health workers were included in the sample. Five facilities were randomly selected in each district, representing the following strata: DHMTs, hospitals, clinics with maternity services, clinics without maternity services, and health posts. When there was no facility available in a particular stratum, an additional facility from the next level up was selected in its place. For each of the selected facilities, a staff list was obtained from the DHMT. Employees were categorized according to the four cadre groups listed above; random selection was then used to select participants. Four participants per cadre at each facility were selected, with an additional two selected as alternates in case selected participants were unavailable during the data collection period. (When a facility had fewer than four employees in a cadre group, all were selected.)

District WWP focal persons administered the surveys. These individuals received training on the survey tool and the distribution process to ensure the tasks were performed in a uniform manner, regardless of location. They were also tasked with helping those with limited literacy and English skills to complete the self-administered survey. Study participants were asked to complete the questionnaire, seal it in a confidential envelope, and return it to the district WWP focal person, who then forwarded the envelopes to the research team in Gaborone (through government transport, post, and courier). Completion and submission of the survey questionnaire indicated consent, since a consent form was included in the questionnaire.

The self-administered survey consisted of quantitative, closed-ended questions. Responses to the questionnaire provided information on access to and use of WWP services, absenteeism, presenteeism, job satisfaction, occupational stress, stress coping mechanisms, and lifestyle behaviours (including nutrition and exercise). In total, surveys were distributed to 1,856 health workers; 1,348 completed and returned their surveys, a response rate of 73%.

Sources of stress were measured by asking participants to rate various work-related stressors, and by assessing job satisfaction using the Job Descriptive Index (JDI). The JDI is a well-validated, commonly used tool developed at Bowling Green State University.[27] The JDI looks at satisfaction with co-workers, the work itself, pay, opportunities for promotion, and supervision. The tool measures job satisfaction by asking respondents to think about components of their job, then rate their satisfaction with those components. Additionally, the Job In General scale, which is a companion tool to the JDI, was used to provide a measure of overall job satisfaction.

The JDI was presented in the form of a checklist of adjectives and short phrases. Each item consisted of no more than five words, and was easy to read. Health workers selected '*N'*, '*?'*, or '*Y'* based on how they thought the item applied to their current job. Numerical values ranging from 0–3 were assigned for each variable. Scales were formed by summing across the six variables comprising each job satisfaction facet; values for each facet ranged from 0–18. The median value, nine (9), represented the neutral point. A score above or below the neutral point indicated either general satisfaction or general dissatisfaction. The Job in General scale contained eight items; therefore, its values ranged from 0–24, with 12 representing the neutral point.

Symptoms of stress were assessed by measuring absenteeism, presenteeism, and burnout. Absenteeism and presenteeism were assessed using questions from the WHO Health and Work Performance Questionnaire (HPQ).[28-30] The HPQ was developed by WHO in conjunction with Harvard Medical School for use in community surveys and intervention studies to assess work performance. It is a well-validated tool that has been used to generate nationally representative data in 28 countries around the world.[29] The absenteeism and presenteeism items include 22 brief, closed-ended items assessing time at work and performance self-assessment.

Burnout was assessed using an abbreviated, nine-item version of the Maslach Burnout Inventory (MBI). The MBI, which was developed over 25 years ago to measure burnout in such areas as human services, is recognised as the leading measure of burnout.[18] The abbreviated tool includes three items assessing each of the following constructs: emotional exhaustion, depersonalization, and personal accomplishment.

Coping mechanisms were assessed by asking a series of closed-ended questions, in which participants rated their use of various general mechanisms for coping with stress. Additionally, participants were able to provide write-in responses for additional coping mechanisms.

Stress was assessed by use of the Stress in General scale, which is designed to measure general levels of occupational stress. Participants are asked to think about whether or not particular stress-related descriptors are characteristic of their jobs. Stress was also assessed using the General Health Questionnaire (GHQ), a well-validated, widely used, twelve-item tool for assessing psychological well-being.[31] Sample GHQ questions: *Have you recently been able to concentrate on what you're doing? Have you lost much sleep over worry?* Each item has four possible responses: *not at all*, *no more than usual*, *rather more than usual*, and *much more than usual*.

Health and lifestyle behaviours—e.g., diet, exercise, alcohol consumption, and tobacco use—was assessed using questions adapted from the WHO STEPS Survey on Chronic Disease Risk Factors and the 2005 Botswana Global School-Based Student Health Survey.[32,33]

4. Focus Group Discussions

Focus group discussions were conducted to capture in-depth information from district and facility health workers, in order to better contextualize data from the national survey. One set of focus groups discussed occupational stress, coping mechanisms, and lifestyle behaviours; the other set discussed factors affecting use of the WWP. For each set of focus groups, separate discussions were held with the following four cadre groups of health workers:

1) Doctors and nurses providing clinical care.
2) Other professionals, including:
    - Social workers, pharmacists, and nutritionists
    - Allied health professionals, such as radiographers and pharmacist technicians
    - Paraprofessionals, such as lay counsellors and health education assistants
3) Administrative personnel (e.g., doctors and nurses acting in an administrative capacity, human resources staff, and data clerks).
4) Support staff (e.g., drivers, cleaners, and gardeners).

Table 1 lists the number of focus groups conducted for each cadre by topic.

Table 1. Focus group discussions and participants

Cadre Group	Focus Group Topic	
	Occupational Stress and Lifestyle Behaviours	WWP Use
	Number of Focus Groups	
Nurses providing clinical care	1	1
Other professionals	2	2
Administrative personnel	1	1
Support staff	1	1

Discussions were held separately with each of the four cadre groups to enable participants to be more open in their participation. Eight of the focus groups were held in Gaborone and Francistown, using WWP focal persons and DHMT management to help select the personnel from each cadre group in the district to be invited to participate. Two additional focus groups were conducted as part of a national workshop that had brought health workers from throughout Botswana to Gaborone. The FGD guide related to stress can be found in Appendix

I; the guide covering WWP services can be found in Appendix J. Consent forms can be found in Appendix K.

A skilled focus group administrator ran the focus groups, with a rapporteur present to take notes. Informed consent was obtained from all participants before discussions began. With consent from all participants, discussions were voice recorded, and later transcribed. Four (40%) of the ten focus groups were conducted in English, six (60%) in Setswana. (Those discussions conducted in Setswana were subsequently translated into English.) Of the ten focus groups, two (20%) were conducted with nurses, four (40%) with other professionals, two (20%) with administrative personnel, and two (20%) with support staff. Although two focus group discussions were also scheduled with doctors, neither was conducted, due to scheduling conflicts on the part of the participants.

5. Desk Review

The research team used a desk review to describe the key inputs (e.g., funding, human resources, and training materials) and processes (e.g., governance, administration, capacity development, and M&E) related to the development of the WWP. This was done to compile a comprehensive operational history of the programme. The team obtained documents from the MOH WWP unit, and through research. In total, 68 documents were obtained and reviewed. These included national governance documents, assessment reports, training materials, training reports, health promotion materials, programme reports, M&E data and reporting tools, and international standards and relevant country programme documents. See Appendix L for the desk review tool, and Appendix M for a list of these documents.

Data Analysis

As part of this evaluation, both qualitative and quantitative data were collected. A sequential explanatory strategy was used for data analysis. Quantitative data from the national WWP IA and the survey of health workers were collected and analyzed prior to collection and analysis of the qualitative data. This allowed for the in-depth interviews and focus groups to be tailored to explain findings from the IA and survey. This approach to mixed-methods data collection was selected to compensate for the overall lack of information related to WWP implementation and use.

Qualitative Data

Qualitative data included full transcriptions of in-depth interviews. A general inductive approach was taken for analyzing the interview data. This involved the manual coding of

textual data and identification of common themes, in order to condense the data into a summary format and establish links with the evaluation objectives. Transcripts were reviewed to identify and code themes using ATLAS.ti v7.0 software.

Quantitative Data

Quantitative data included data from the national WWP IA and the national survey of health workers. Databases were created using REDcap,[34] a secure, web-based application; data were then entered and exported to IBM SPSS Statistics version 19 for analysis. For the national WWP IA, descriptive statistics were generated to characterize findings. For the survey, descriptive statistics were generated to characterize the study population. To explore relationships with participation in the WWP program, survey respondents were categorized into the following three groups: high WWP participation (seven or more WWP activities a year), medium WWP participation (1-6 WWP activities a year) or low WWP participation (0 WWP activities per year). Chi-square and ANOVA models were used to explore whether participation in WWP activities was related to demographic characteristics as well as job satisfaction and measures of stress and burnout. Bonferonni correction was applied to adjust for multiple comparisons.

RESULTS

History and Development of the Workplace Wellness Program

This section of the results addresses the following key questions:

1. What have been the key inputs and processes of the WWP at the national, district, and facility levels?
2. What inputs and processes are needed to ensure the sustainability of the WWP and its continued rollout to all facilities?

The WWP for health workers was established in 2005, with its official launch in 2008. The programme was introduced to address the challenges to the health workforce brought on by the effects of HIV/AIDS, as well as in recognition of health system human resources as a pillar and driver of the health care system in Botswana. The programme was developed in response to the results of the needs assessment conducted by the MOH and Ministry of Local Government, which revealed that health workers experience occupational stress, and therefore would benefit from professional counselling services.

The programme has been supported by PEPFAR, coordinated by the MOH and DHAPC, and implemented nationwide in all districts through focal persons and multidisciplinary WWP committees. The programme covers a comprehensive range of wellness services that comprise the following components: health screening, treatment and care; health promotion; occupational health and safety; stress management and team building; psychosocial support and spiritual care; and therapeutic recreation. The goal of the programme is to provide services and support to enhance the well-being and job satisfaction of health workers, in order to improve their emotional and physical health, prevent burnout, enhance staff retention, and have a positive impact on patient care**.**

The objectives of the programme are to:

- Increase health worker knowledge of HIV/AIDS and other related diseases (especially tuberculosis and cancer) as core diseases.
- Improve access to health services by health workers.
- Reduce stigma and discrimination within the health workforce.
- Mitigate the impact of HIV/AIDS by enabling staff to address matters of stress management, team building, occupational health and safety, etc.
- Improve staff morale to enhance productivity.

The programme received PEPFAR support and technical assistance between 2005 and 2011 for programme development (coordinator position, study tour), development of training and promotional materials, TOT and health workers, purchase of equipment and supplies, and supervisory travel. It is now a well-established MOH programme with the full support of the government of Botswana.

To inform the WWP, the MOH (with funding from the CDC) engaged I-TECH to evaluate the WWP to determine its successes and challenges, and to make recommendations for improvement. From the evaluation findings, it is evident that the following inputs and processes need strengthening if the WWP is to achieve its intended objectives:

- Procurement of resources, especially recreational equipment.
- WWP district committees.
- Coordination of all WWP activities under the WWP to maximize the benefits to health workers.
- Maximizing limited resources to promote WWP use.
- Strengthen the TOT model to expand the programme to all facilities in Botswana—including the very remote areas.

WWP Implementation: Implementation Assessment and Key Informant Interviews.

This section of the results addresses the following key questions:

- Which components of the minimum package of services are being implemented at district and facility levels?
- What are the factors affecting implementation of the minimum package of services at district and facility levels?

Planning and Support

In total, 25 of the 27 (93%) districts reported having WWP committees in place (Table 2). Almost half (48%) of the districts reported that these committees were chaired by WWP focal persons. Most districts (81%) reported holding meetings at least monthly. WWP committees ranged in size from 8 to 34 members. The mean ± standard deviation value for committee size was 15 ± 7. Only four districts (15%) reported having all nine recommended key focal members on their WWP committees. Nearly 25% of the districts (n=6) reported having none of these key positions filled. The focal member positions most commonly reported as being filled were therapeutic recreation, publicity, stress management and team building, and TB/HIV. The post most commonly reported as vacant was peer education.

From the in-depth interviews, it was clear that having a dedicated, diverse WWP committee promoted implementation of the activities in the minimum package. Below are statements made by health workers in the three districts with the highest IA scores.

> *'The programme is well known at the [local level] and each facility has a representative at [the] committee level; they also have clusters. In the clusters, they also have focal persons for different components of the WWP.'*

> *'We try as much as possible to get individuals from different locations within the district; however, we centralized the committee [at] the hospital because it is nearer, and other people joined us from outside to make a larger committee.'*

> *'We went around to all of the facilities and tried to [educate] them about wellness, what it entails, what are the components. We invited all the cadres, starting [with] the gardeners and cleaners. From there we had sensitization meetings with them to tell them about wellness, and to choose members who can represent them [on] the committee.'*

Table 2. WWP Committee characteristics (n=27)

Characteristic	n	% of Total
WWP focal person chairs the WWP committee	13	48%
Frequency of committee meetings		
Weekly	4	15%
Fortnightly	4	15%
Monthly	14	52%
Quarterly	1	4%
Annually	2	7%
Total number of members on the wellness committee		
1–10	7	26%
11–20	13	48%
21–30	4	15%
31–40	1	4%
Committees having focal members in recommended key areas:		
Therapeutic recreation	16	59%
Publicity	15	56%
Stress management and team building	14	52%
TB/HIV	14	52%
Occupation health and safety	12	44%
Health screening, treatment and care	11	41%
Health talks	11	41%
Psychosocial support	11	41%
Peer education	7	26%
Number of key focal members on the WWP committee		
9	4	15%
8	4	15%
7	2	7%
6	2	7%
5	1	4%
4	1	4%
3	1	4%
2	1	4%
1	3	11%
0	6	22%

Few districts (n=5, 19%) reported producing annual plan projections (Table 3). None of these districts reported submitting their projections by the prescribed deadline, which is the first week of October. Most districts producing annual plan projections indicated they would submit their projections at the same time as their annual plans. The majority of districts (n=21, 78%) did report developing annual plans—but only eight districts reported submitting these by the prescribed deadline.

Table 3. Development of annual plan projections and annual plans (n=27)

	n (% of Total)
Annual plan projections	
Developed	5 (19%)
Submitted on time (Oct. 7)	0 (0)
Annual plans	
Developed	21 (78%)
Submitted on time (April 21)	8 (30%

Slightly over half of the district interviewees (n=14, 52%) indicated that they knew about the 2012/2013 WWP Implementation Guide, with all of these individuals reporting they had copies. When asked if they received support for WWP activities from district management, 19 (70%) responded affirmatively.

Mobilization scores were created for each district based on the number of the following six criteria met:

- Committee meeting monthly or more often.
- Committee having at least nine members.
- Committee having focal persons for each of the nine priority areas.
- Developing an annual plan.
- Having a copy of the Implementation Guide
- Receiving support from district leadership.

As depicted in Table 4, only three districts reported meeting all six criteria.

Table 4. Summary of district planning and support

Mobilization Score (number of criteria met)	Districts meeting this criteria N (%)
0	2 (7%)
1	0 (0.0)
2	3 (11%)
3	2 (7%)
4	12 (44%)
5	5 (19%)
6	3 (11%)

Component 1 — Health Screening Services

Of the 13 health screening services recommended for implementation as part of the WWP, only blood pressure monitoring and HIV testing were reported as being available at all 27 district hospitals (Figure 1). The health screening services offered by the fewest numbers of district hospitals were those for prostate cancer (9); ears, nose, and throat health (15); breast cancer (18); and cholesterol levels (18).

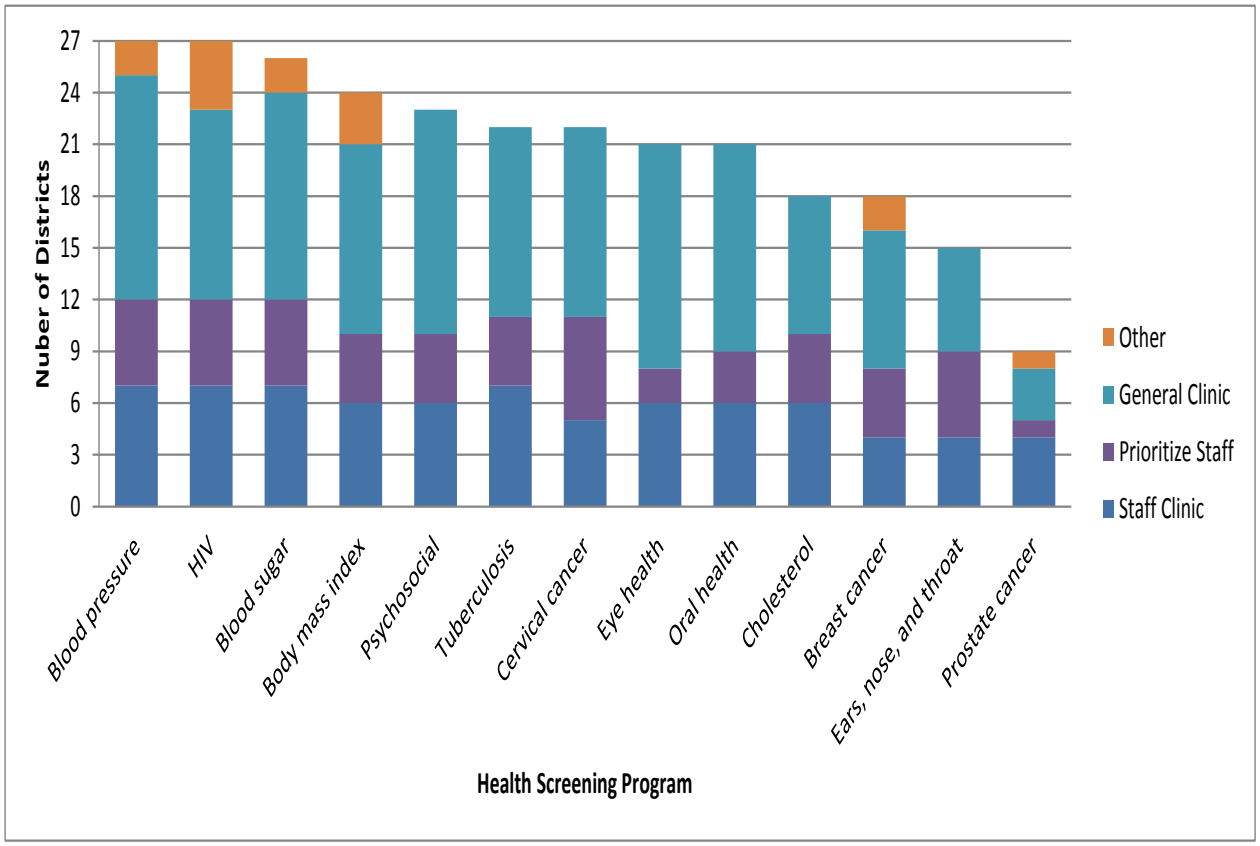
There are multiple ways in which screening services can be made available to health workers: through staff clinics, designated staff clinicians, clinic days designated specifically for staff, prioritizing staff over other clients, attending clinics as ‘regular’ clients, and attending community/commemorative health promotion events. Across all screening services, screening was most commonly offered to health workers through general clinics as ‘regular’ clients. Seven districts reported staff clinics being available to health workers for some of the

screening services. None of the district hospitals reported offering designated clinicians or clinic days for health workers.

One of the barriers to participation in health screening activities identified during the in-depth interviews was confidentiality and trust. As one health worker stated:

> *'When it comes to issues like HIV and TB screening, there is still a lot of self-stigmatization among health workers. This is hindering our progress; we are not able to come together and work as a team. I remember last time when we were talking about HIV testing, they raised concerns regarding confidentiality. They said that sometimes they are not coming forward to test because they don't want their status to be known by other health workers.'*

Figure 1. Health screening services offered by the health districts



Component 2 — Health Promotion

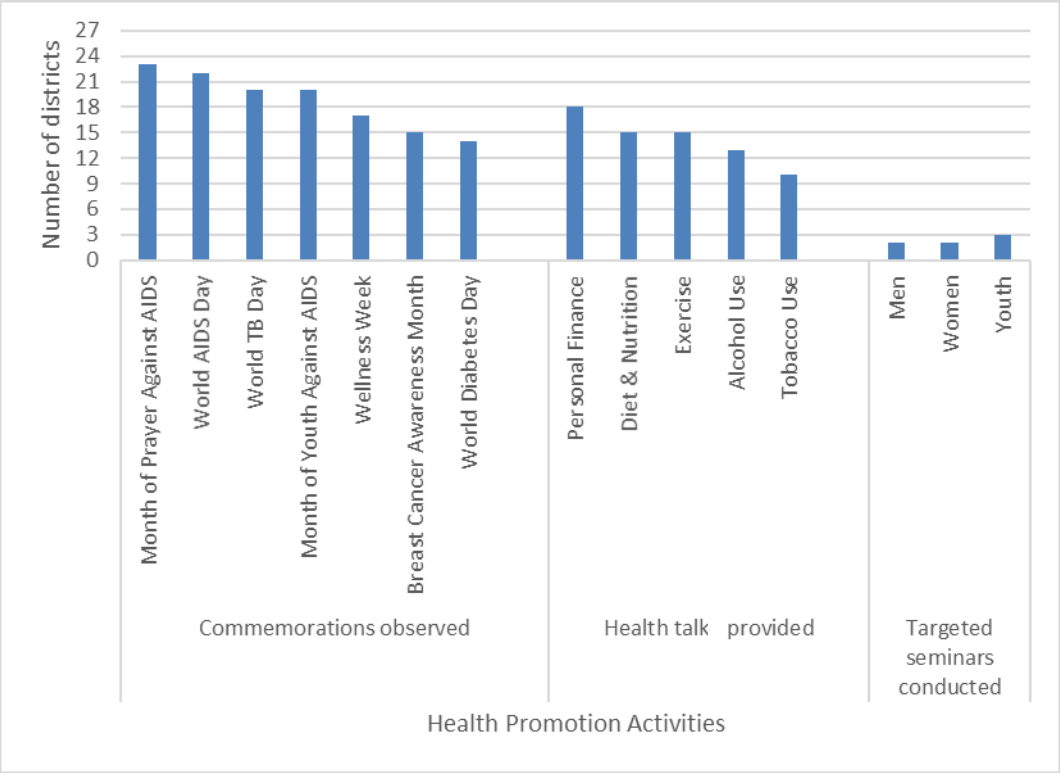
The minimum standard set of activities for WWP health promotion consists of health day commemorations, health talks, and targeted seminars. As depicted in Figure 2, the recommended health commemorations were held in the majority of district hospitals, with Breast Cancer Awareness Month and World Diabetes Day being the least observed.

However, with the except for Wellness Week, commemorations generally targeted the general public as opposed to health workers. The most commonly offered health talk topic was personal finance, which 18 district hospitals (67%) reported offering over the past year. Talks on alcohol and tobacco use were offered the least. Health talks were generally conducted by outside professionals. Only one district reported offering peer education on any of these topics. Targeted seminars were not commonly conducted.

The main barrier to health worker participation in these activities is that they are generally not held specifically for health workers. Instead, they are held for the local community, with health workers expected to attend, including some for the purpose of facilitating the events. As one health worker stated:

> '*You know, in my district people are organizing wellness campaigns. When they do, they always call us for assistance, such as providing lectures or education on such health conditions as hypertension. We are always ready to do that because we are the headquarters [for] health here on behalf of Ministry Of Health.'*

Figure 2. Health promotion activities at district hospitals



Component 3 — Stress Management & Team Building

Twelve districts (44%) reported conducting stress management and team-building activities. Table 5 shows the number of these activities conducted over the previous year. The activities generally targeted all staff, as opposed to those in specific departments, and staff generally participated during work hours. In ten of the districts, activities were led by TOTs and senior staff with experience on the subject.

Table 5. Stress management and team-building activities conducted at district hospitals

Number of Activities Conducted	Number of Districts (% of Total)
0	15 (55.5)
1	5 (18.5)
2	3 (11.1)
3	2 (7.4)
4	1 (3.7)
5	0 (0)
6	1 (3.7)

According to interviewees, the low implementation of this component of the WWP can be partially attributed to the need for further expertise in stress management and team building at district hospitals. There did appear to be strong interest in stress management, however. As stated by one local health worker involved with the WWP:

> *'The facilitators were from the hospital… during the discussion [on stress management] you could see people were engaged, and kept saying we should have more of these trainings so that we can be equipped with ways of coping with life stress.'*

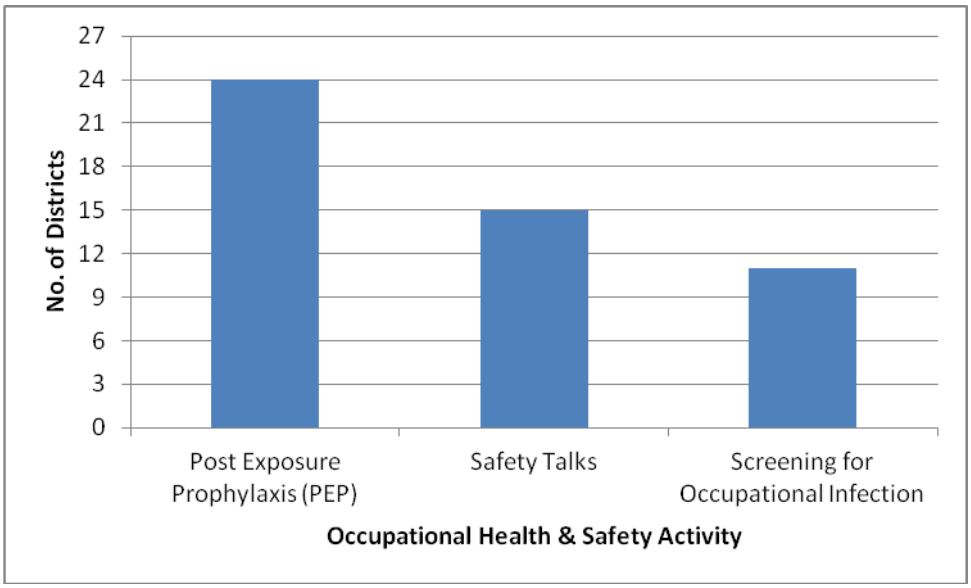
Component 4 — Occupational Health & Safety

Twenty-four of the districts (89%) reported having post-exposure prophylaxis (PEP) for health workers available at district hospitals. Fifteen district hospitals (56%) reported conducting talks on issues of occupational health and safety. In eight of these 15 districts, sessions were led by occupational health officers. Other presenters included master trainers, environmental health technicians, experienced officers, nurses, outside professionals (e.g., MedRescue), and risk-management committee members. Screenings for occupational infections were offered at 11 (41%) district hospitals. These were offered mostly on an as-needed basis.

Interviewees often reported occupational health and safety activities not being conducted because of lack of competence in this area. As one health worker explained:

> '*We never planned any activities under this component. The problem is that we never had training on them before. What we have is just general knowledge.'*

Figure 3. Number of districts offering occupational health and safety activities



Component 5 — Psychosocial & Spiritual Care

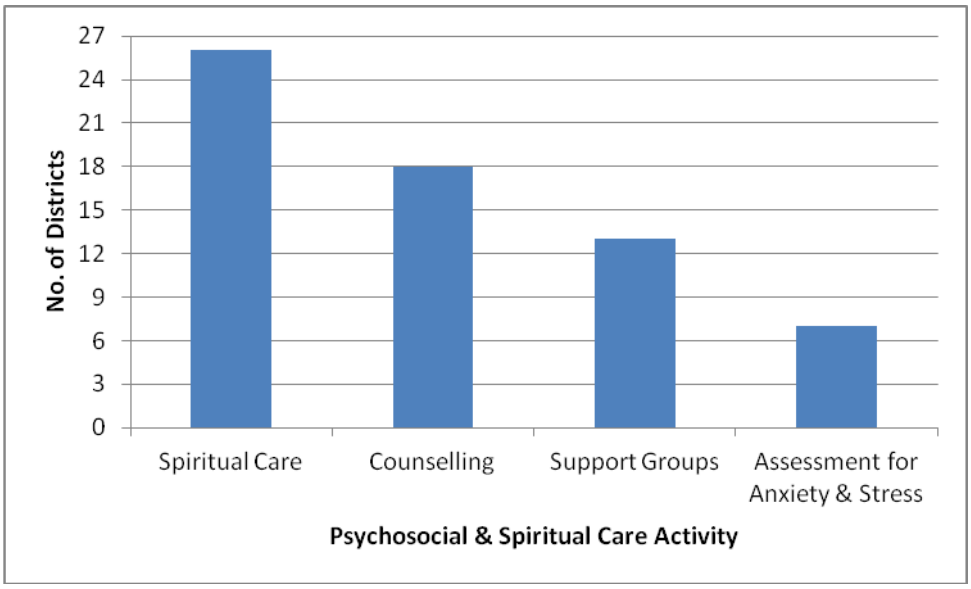
As depicted in Figure 4, 26 of the 27 district hospitals (96%) reported offering spiritual care to health workers as part of the WWP. Sixteen (59%) offered such care daily, with seven (26%) offering it weekly. These activities were most often led by either staff members or outside professionals (e.g., pastors). In 24 of the districts (89%), staff were allowed to attend these activities during work hours.

Eighteen districts (67%) reported offering counselling to health workers. This service, provided by social workers, was generally offered on a daily basis, during work hours, as needed. Thirteen district hospitals (48%) reported having active support groups. These were generally led by TOTs (in five districts), peer educators (three), and general staff (two). Ten districts reported allowing staff to attend support groups during work hours. Only seven district hospitals (26%) reported making anxiety and stress assessments available. In these seven districts, the services were generally provided by a social worker, on an as-needed basis, during work hours.

According to interviewees, spiritual care often encompasses morning prayers. Although counselling services were offered in 18 districts, data from the interviews indicated that counselling services were not felt to be sufficient. At the district level, counselling was generally conducted by social workers, but receiving this service from a colleague was identified as a challenge. Culture was also noted as a challenge. According to one health worker:

'Yes, counselling is available. My observation is that as staff we do not feel comfortable about receiving services from colleagues in the same hospital. Even our Setswana culture influences this nature. There are a few that do come for the counselling services, especially those that understand professionalism. However, other staff can be overly inquisitive about off-duty colleagues seeking services at the facility.'

Figure 4. Number of districts offering psychosocial and spiritual care services



Component 6 – Therapeutic Recreation

Twenty-one districts (78%) reported offering therapeutic recreation in the form of physical fitness activities (Figure 5). Access to a fitness or sporting facility at the district hospital was available in 15 districts (56%), while social and edutainment activities were each offered in 10 districts (37%). In most instances, health workers were allotted time for these activities. These were mostly offered on a daily basis, with edutainment activities more likely to be offered on an as-needed basis.

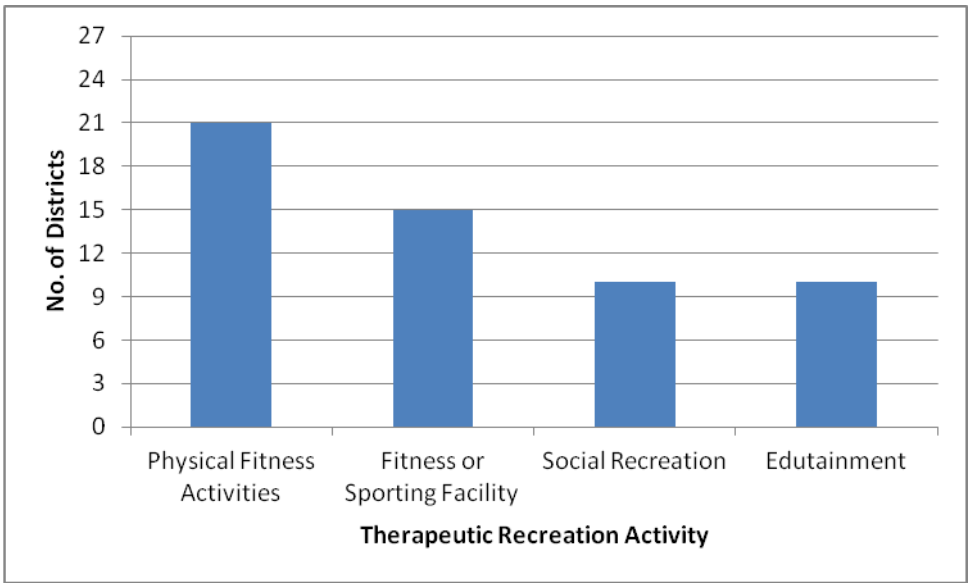
One barrier to use of these services identified by interviewees was lack of equipment. As stated by two respondents:

'*Activities using balls are the only ones available. For things like, dancing we don't have music or equipment.'*

'*We used to have equipment for football, aerobics and netball, but right now I can't tell you where it is.'*

Although stress management and team building are distinctly different in the WWP guidelines from therapeutic recreation, the difference is not necessarily clear to those in the field. In some instances, questions about the former elicited responses about the latter.

Figure 5. Number of districts offering therapeutic recreation activities

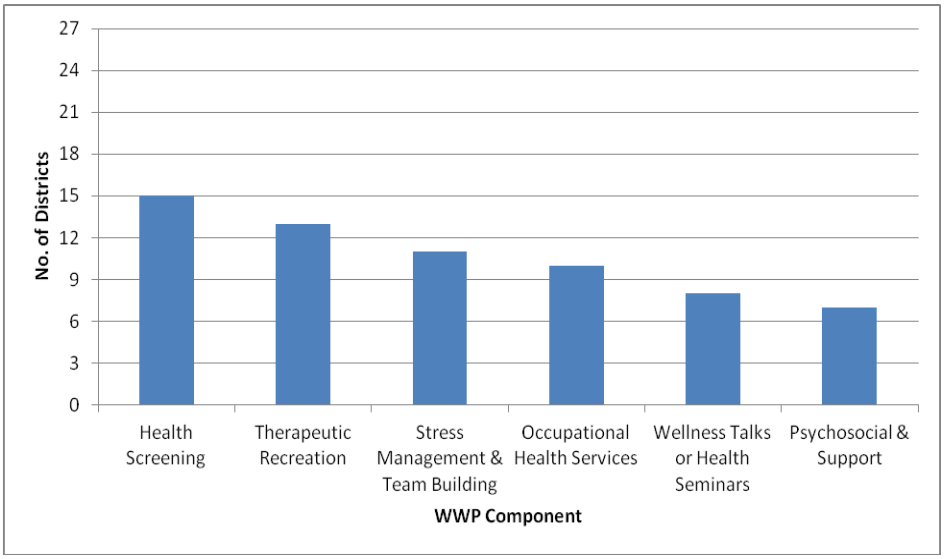


Rollout from District Hospitals to Other Health Facilities

Seventeen districts (63%) have rolled out the WWP to at least one clinic within their jurisdiction. The WWP components most commonly reported being made available to health workers through clinic-based WWPs were health screening and therapeutic recreation. One strategy shared during interviews for rolling out the WWP to facilities was to select a single facility to host an event for the entire district. As one health worker explained:

> *'We create one event and choose where we will host it for the whole district. In this way, programme ownership [remains with] the committee and representatives of facilities, and then we source out help from management and other members of the program. We then call in the rest of staff members so that they provide their expertise.'*

Figure 6. Rollout of WWP components from district hospitals to clinics



During the interviews, several factors affecting both district implementation and local rollout of the WWP were identified. Interviewees often cited barriers to WWP implementation at both district and facility levels that are common barriers to implementation of any health programme such as high workloads and lack of transport. One particularly notable barrier cited by smaller facilities what they often did not have enough people to form their own committees. Another factor noted was lack of commitment to follow through with programme implementation after training.

> *'Time on my part is a challenge. There is a lot of work for me as we have a serious staff shortage. So, this leaves me with little time.'*
>
> *'There is poor meeting attendance because most of us are held up by our core duties. Also our district is vast—from [Village A] to [Village B] is such a huge distance. That presents a challenge, especially when it comes to meetings, because of lack of transport.'*
>
> *'Mind you, we are talking about nurses. Here at [District A] we are short-staffed, so they have other responsibilities. Sometimes they are forced to prioritize…sometimes when there is a client to be attended to, they have to skip the wellness programme activities.'*
>
> *'Most of our ToTs are in health posts…if I take those in the health posts, it means that the health post will close down—so that is a problem for us.'*
>
> *'We train people [to lead WWP activities], then, when perhaps they are requested to go and practice or help other people with team building, they pull back.'*

Another barrier cited was that the WWP committees were not leveraging existing wellness activities at district and local facilities. Many interviewees reported that activities such as health promotion, spiritual care, and occupational health were taking place at their facilities—but that these were not seen as being part of WWP activities. Working collaboratively with the staff implementing these activities to 'brand' them as part of the WWP can be mutually beneficial.

> *'Health promotion is handled by doctors. They choose a topic they will present to the health workers…but then they do it in their capacity as doctors, not as members of the wellness committee.'*
>
> *'I will not say infection control activities are by the wellness committee. By virtue of our positions as nurses and doctors talking about infection control is our responsibility.'*
>
> *'Even though it's not organized by the wellness committee, we do pray…Every Friday we have prayers for anybody in this building. We have a schedule where departments are allocated slots to lead prayers during these Friday sessions.'*

Another barrier to WWP implementation is the programme's placement within the MOH organizational structure. Multiple interviewees suggested that the programme would be better overseen by a different department, such as Clinical Services or Corporate Services.

> *'I am not sure if keeping it [WWP] in the HIV department is a good idea. I think it would benefit if it could be moved to corporate services with personnel from the programme me. … If you really want to have a broad focus and not be attached to a single disease like HIV, they should take it out of that department.'*

> *'I can say the programme started in the wrong place, and [because of the] HIV stigma, the programme is associated with HIV. When people hear about the workplace wellness programme me, they think that it is just another HIV initiative. There are people who may not want to participate that strongly, in case people may think maybe he is HIV-positive. I think decoupling the programme from HIV is a key way forward.'*

> *'Every employer should be responsible for the health and safety of their employees… The WWP needs to be decoupled from HIV/AIDS so that it is something that looks at the entire wellness of a worker and their safety.'*

> *'What I can say is that I believe that maybe it could be worthwhile if this programme were moved out of maybe being an HIV-related programme me, to being a more holistic programme me…if it can be removed from HIV and put maybe under corporate services. Really, if you talk of wellness and safety of the staff in the workplace, that is a human resources issue.'*

> *'So, the wellness programme finds itself within the department of HIV/AIDS... To me that means it hasn't been properly placed. It should have been placed right within the office of the permanent secretary.'*

An additional barrier is that health workers often prioritize wellness activities that focus on the general community over those that focus on health workers. This creates a barrier to health worker participation.

> *'Not only were they [WWP committee members] delivering their mandate to internal stakeholders, but they were also expected to respond to external stakeholders…so, they were often getting calls from outside, and from other ministries, to either assist in developing something or just to come and speak at a wellness day. This was a whole variety of things, which is very good—it was just that they didn't have the capacity to do it all, which may or may not detract them from their main mandate, which was internal staff. I know that was a strain on capacity.'*

One other barrier to WWP implementation was that health workers at all levels often tend to perceive the WWP as a voluntary, add-on programme me.

> *"There is a belief that wellness programme is voluntary. That is what [is] killing the wellness programme: "The wellness programme is on a voluntary basis.""*

> *'Some are trained, then when they go back they decide to focus on their daily duties and forget about this workplace wellness thing because they call it an "add-on"*

responsibility. It is a thing—they are not paid for that. Some decide to forget. Some run with it. Those who have passion, they make sure that whatever knowledge they gained, they put it into practice.'

A clear catalyst of programme implementation was national and district support. Respondents tended to focus on support received from the national level. It was clear, however that administrative support from national, district, and facility management is critical to the success of the programme me. This illustrates the need to ensure that management are well aware of the programme's importance. It also shows the need to have the programme moved to a higher-profile position within the MOH.

'The national level is very supportive. We are very much supported. When it comes to management, I would say perhaps it is a case of 60-40 because we try very much to push the programme me, they recognize that we are pushing the programme me, and they are buying into the programme. [Progress is slow], but they are doing their best, so I would say yes, we get support, both nationally and from the district.'

'The other reason for success is that, as it is a health issue, it is easy to take it up to the management, and management will just run it down through clinic supervisors. It is very easy that way.'

'We have long asked for someone from management to always attend [WWP committee] meetings so that there can be a connection between us and management. This will make communication easier between us and the Ministry.'

'Management should talk to their employees about the workplace wellness programme me so there is buy-in from the employees. Employees should not hear about this programme from the paper, the radio, or committee members. Management should expect department heads to play an active role in the programme me.'

'Every time we have an activity here, they [the national WWP committee] get involved. They literally come and spend time with us, and give us assistance where necessary. Maybe giving us funds and gracing the occasion with their presence.'

'Now we have started to engage supervisors, because when supervisors have a sense of ownership, we hope it will trickle down to everybody at the health facilities.'

Another boost to WWP implementation was integration of the programme into facility operations. A number of specific examples were given during interviews as to how more progress could be made on this front. Several facilities reported setting aside specific times for specific wellness activities on a regular, recurring basis. A simple example of this is the 'Wednesday Prayer'. Another example cited was the inclusion of WWP activities in institutional and district performance plans as well as in individual performance development plans.

'The programme has been rolled out to facilities. They already know what the programme and its mandate are all about. They have brought their workplace wellness

programme facility plans, which have timelines. We are going to evaluate the programme in the coming year. We are yet to meet and incorporate these plans in the district plan.'

'It should form part of the institutional performance plan so that they report on those areas that are used to assess performance on a monthly basis. When you discuss the strategic plan for an institution, this should form part of your plan.'

'I am planning to sit down with management to see how we can schedule my core work and wellness programme me, because this thing now forms part of my PDP [Professional Development Plan] and I want them to help me schedule everything.'

'First, I think everybody who comes into the health profession to practice needs to know about wellness programme. I came here around last year March and knew 6 months later that there is a workplace wellness programme , but I think people should know as soon as they join enter the field that there is wellness programme .'

Conclusion

The basic structures necessary to promote implementation of the national WWP for health workers in Botswana have been put in place across the country. Evaluation results indicate that having a dedicated and diverse WWP committee enabled implementation of the minimum package of services. Other factors included support from national and district management, and integration of the programme into district, facility, and individual performance plans. Such components as health screening, therapeutic recreation, and promotion of health through observation of commemorative events were implemented more often than those related to occupational health and safety or psychosocial services. Rollout of the programme from district hospitals to individual facilities has happened on only a limited basis. Barriers to WWP implementation at both district and local levels include: limited branding of pre-existing health-related activities as part of the WWP, organizational placement of the programme within the Department of HIV/AIDS, prioritization of wellness activities that focus on the general community instead of on health workers, and perceptions that programme implementation is voluntary, as well as such general constraints as heavy workloads and limited transport.

WWP Use: National Survey and Focus Group Discussions.

This section of the results addresses the following key questions:

1. What do health workers currently perceive to be sources of stress? How do these compare with those perceived prior to implementation of the WWP?
2. What symptoms of stress are health workers currently experiencing? How do these compare with those experienced prior to implementation of the WWP?
3. What coping mechanisms are health workers using to address stress? How do these compare with those used prior to implementation of the WWP?
4. What is the current level of stress among health workers? How does this compare with levels prior to implementation of the WWP?
5. How can health worker behaviours be characterized in relation to physical activity, diet, alcohol consumption, and tobacco use?
6. Is health worker participation in workplace wellness activities associated with any of the following outcomes?
    - Increased use of healthy coping mechanisms.
    - Decreased absenteeism.
    - Increased job satisfaction.
    - Lower levels of stress and/or burnout.

Demographics

The mean age ± standard deviation (SD) of survey respondents was 40.0 ± 9.9 years. Table 6 shows the demographic characteristics of the participants. The majority of respondents were female (62.4%). Most reported that they were not married (65.6%). Non-citizens accounted for a small percentage of respondents (5.5%). In terms of duration worked in the health services, the mean was 11.8 ± 8.8 years. Average time spent working at one's current facility was 3.1 ± 1.3 years. Most of the respondents were doctors, nurses, and professionals (59.5%); administrative and support staff accounted for 40.4% of respondents.

Table 6. Demographic characteristics of survey participants (n=1348)

Characteristic	Frequency (n)	Percentage (%)
Gender		
Female	841	62.4
Male	503	37.3
Missing/Not Specified	4	0.3
Marital Status		
Married	455	33.8
Not Married	879	65.2
Missing/Not Specified	14	1.0
Number of Children		
0	221	16.4
1	298	22.1
2	341	25.3
3	245	18.2
4	124	9.2
5	58	4.3
6 or more	43	3.2
Missing/Not Specified	18	1.3
Highest Level of Education Completed		
Primary School	182	13.5
Junior Secondary School	233	17.3
Senior Secondary School	214	15.9
Diploma	498	36.9
Degree	154	11.4
Post-Graduate Degree	25	1.9
Missing/Not Specified	42	3.1
Nationality/Citizenship		
Citizen	1266	94.5
Non-Citizen	73	5.5
Cadre		
Doctor	38	2.8
Nurse	394	29.2
Professional	365	27.1
Administrative	140	10.4
Industrial	370	27.4
Missing	41	3.0
Facility Type		
Hospital	363	26.9
Clinic (with maternity)	336	24.9
Clinic (without maternity)	238	17.7
Health Post	117	8.7
DHMT	265	19.7
Missing/Not Specified	29	2.1

Participation in WWP Activities

Health Screenings

In total, 76.5% of the respondents reported having an HIV test in the past year, with the vast majority of those (61.2%) having done so in the course of a routine check-up, not as part of the WWP. Less than half of respondents indicated they had the following screening conducted in the past year related to body mass index (BMI), cholesterol, TB, or cancer. Most respondents reported not having participated in any screenings in the past year. For those who did, it was generally as part of a routine check-up, rather than as part of a WWP activity.

Figure 7 BMI Assessment

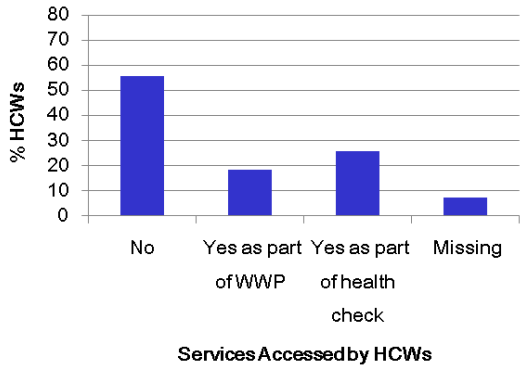


Figure 8 Cholesterol Assessment

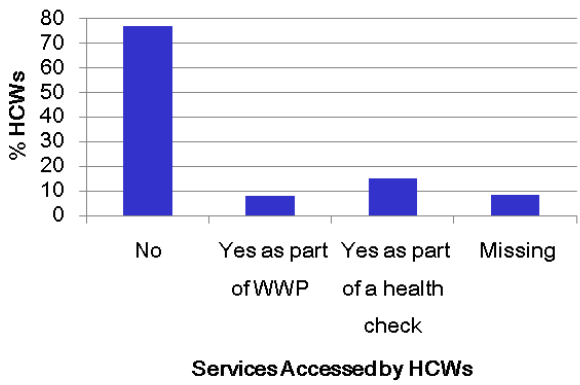


Figure 9 HIV Testing

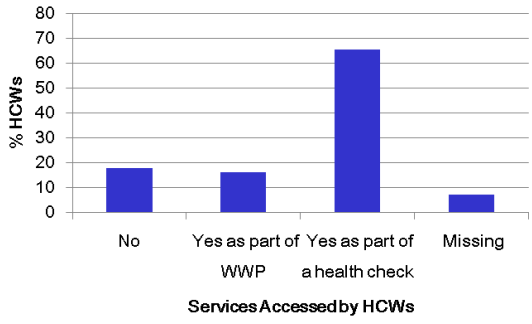


Figure 10 TB Testing

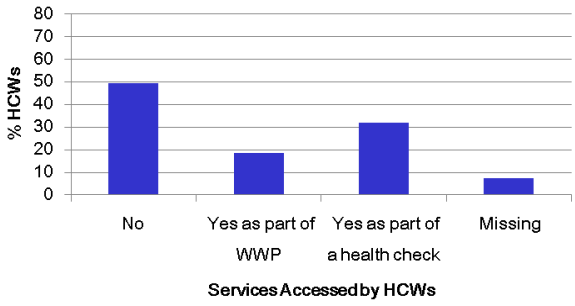


Figure 11 Eye Exam

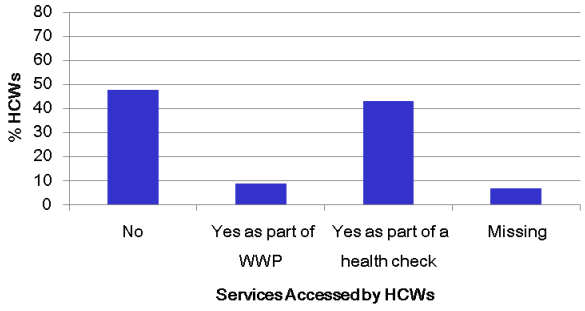


Figure 12 Blood Sugar Assessment

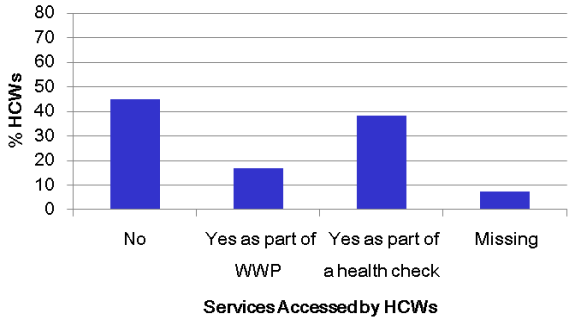
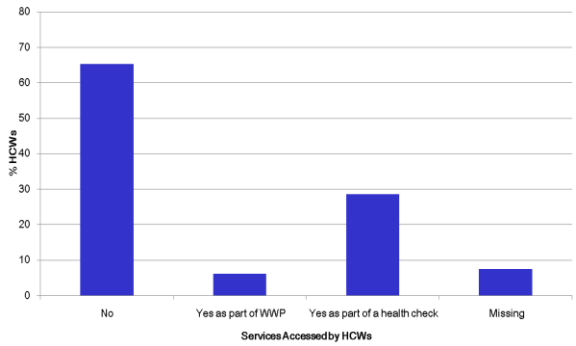


Figure 13 Cancer Screening



*Missing = No response, answer left blank

Health Promotion

Slightly over half of the participants (56.3%) had participated in WWP health promotion activities (wellness talks, health campaigns, seminars, commemorations, and peer education activities) at their facilities over the past year. Most reported one or two activities being offered during that year, with 7.8% reporting six or more activities offered. Of the 759 respondents who reported health promotion activities being offered at their facilities over the past year, 80% reported participating in those activities. Overall, 77.5% of respondents felt that these activities would be very beneficial.

Stress Management & Team Building

Most health workers (63.5%; n=856) reported not having stress management and team-building activities offered at their facilities. Of the 432 who did report these activities being offered, 74.3% indicated they had participated in stress management or team-building activities over the past year. Overall, 76.8% of respondents felt that these activities would be very beneficial.

Occupational Health & Safety

Most respondents reported that occupational health and safety activities were not offered at their workplaces (72.7%; n=933). Of the 351 reporting such activities were offered during the past year, 75.2% reported participating. Overall, 75.7% of survey respondents felt these activities would be very beneficial.

Psychosocial Support & Spiritual Care

Over half (52.6%) of the survey respondents reported that psychosocial support and spiritual care were not offered at their facility. Of the 569 respondents working at facilities where they

were offered, 98.8% participated. Overall, the majority of respondents (75.6%; n=1019) felt these activities would be very beneficial.

Therapeutic Recreation

Most respondents reported that recreational activities were not offered at their facilities (64.2%; n=866). Of the 406 respondents reporting that these activities were available, 70% indicated that they had participated. Overall, 75% of survey respondents felt these activities would be very beneficial.

Barriers to Participation in WWP activities

From the focus group discussion, two of the most significant barriers to use of the WWP across all cadres of health workers appear to be lack of time and too much work. Health workers are often burdened with extremely heavy workloads, and are thus unable to take time during the workday to attend wellness activities. Consequently, many respondents reported that, after a long day of work, they were unlikely to want to remain at the clinic for wellness activities scheduled in the evening.

> *'You find out that you don't even have time to participate in those programme s even if they are available. So, that is an issue again.'*

> *'You will find that with these activities such as wellness and talks, people would rather go home and rest after work.'*

> *'That is why you cannot even find time to go and access psychosocial support—we don't have time to play darts. There is absolutely no time for us that is our own.'*

Related to the lack of time and the heavy workloads is the shortage of staff that is prevalent at many facilities; this was cited by the majority of focus group participants. The three factors are interconnected, and together form a significant barrier to use of WWP services—but, at the same time, are the very factors that contribute most to the need for such programmes as the WWP.

> *'Shortage of manpower is also a contributing factor to the failure of the programme me—the appointed focal person cannot find time to attend to wellness issues, because she has to create extra time after her heavy workload to attend to them.'*

Additionally, 'Wellness Week'—or WWP activities in general, for that matter—often involves testing and health screening for health workers, which increases the workload for those performing the tests, particularly lab personnel. As such, these cadres of health workers are unable to participate in the activities because they are too busy implementing them.

'For us, I think it is once a year or something, that wellness programme, and it runs for a week. We run tests, we run every medical exam for all health personnel. That wellness week is hell, because you are running specimens, because you know health workers will ask for any possible tests that could be run. For us, that means work—it is not like doubled, it is more like ten times [the work], including for our own patients. We don't even have time to participate in that programme because we are busy running tests there. That week in general, is not a wellness week for us, but it is just hell, and it is done once a year. That means I have not participated, you see.'

A few participants asserted that neither the WWP in its current state, nor the existing programmes that are being implemented, address the real problems faced by health workers. Another remarked that many of the activities merely shed light on problems faced by health workers, such as the heavy workloads, but do nothing to help overcome them. They hoped that, with this feedback and evaluation of the programme me, practical solutions could be found that will improve the WWP and make it better able to serve the needs of health workers.

'Say for example, wellness programme s within [local] facilities are known for maybe carrying out activities like soccer matches, going out for maybe a weekend by the game reserve. Yes, it is good for the well-being of the employees to relax—also things like aerobics. But, if we look at the major issues, which we are talking about today, those things are not being addressed. [We need] something like an audit system that can help wellness programme s within facilities target issues and be effective, in the sense that when they carry out a programme , they look at what they have managed to achieve. These programmes also need to include everybody.'

'Yes. Let us tackle the stressors, not how we cope with the stressors. You see. If we start there…"Prevention is better than cure.'

'In my view, I think all problems should be treated the same way—like dealing with the root of the problem. Sometimes they deal with the problem, but don't deal with the real cause of the problem. [If] you have a personal problem, you will be wasting energy if you don't deal with the root. Of course, you need to deal with the root and find out what is the source, what is the cause…[F]or instance, the resource shortage problem, that is what needs to be dealt with—and then other stressors caused by shortage of resources will go [away].'

'I think that these strategies are not successful. Most of these efforts are futile because they are not addressing the real issue that [health workers] are struggling with.'

It was also noted during the discussions that WWP activities are implemented in Gaborone, or at larger facilities, but not outside the city, or in smaller, more rural clinics. The reasons for this varied, but usually centred around lack of funding and support, as well as lack of mechanisms to ensure that services are implemented. Directly related was the observation by many

participants that there is a lack of ownership on the part of management with regard to the programme me, and that they often do not follow through with or support programme activities. If the activities do take place, it is only for one day or one week a year, and then wellness is forgotten.

> *'At MOH, they are too alienated, and decisions are made at the central office without engaging any of us in the field. With local government, discussions are held; with MOH, we get directives only. There are no consultations. There is too much bureaucracy.'*

A few of the participants were confused about the purpose of the WWP, and had little exposure to its activities. Some even thought it was a wellness programme for their patients and people in the community; they were unaware that it was intended for health workers. Another barrier cited was health worker attitudes or awareness. One participant observed that health workers often don't put into personal practice the knowledge they are giving to their patients and the community, especially when it comes screening and testing services.

> *'Health screening is very important, because in the health cadres, especially when we are already sick, we [are afraid] to come for screening and treatment until we are bedridden or even [about to] die. It seems like we don't have the knowledge that we are giving to the community. It's like we don't believe that what is happening to the rest of the community can affect us, too.'*

Sources and Symptoms of Stress

Sources of stress

As shown in Table 7, the three most commonly reported sources of stress were shortages of staff, shortages of resources, and too much work. Other common sources of stress were conflict with co-workers, providing support for relatives of patients, and providing care for many HIV/AIDS patients. Providing care for HIV/AIDS patients was perceived as a source of stress by 42.3% of participants in 2013, compared to 76% in 2006. Similarly, fewer participants reported that caring for many patients, too much work, and staff shortages were in 2013 compared to 2006. This suggests that there have been improvements in reducing stress in the workplace since 2006.

Table 7. Sources of occupational stress

Source of Occupational Stress	%	
	2013	2006[a]
Shortage of staff	78.0	91
Too much work	72.7	88
Insufficient resources and supplies	76.7	-
Not being appreciated for the work I do	64.1	76
Non-supportive supervisors	59.5	58
Balancing demands of work and family	51.3	-
Providing care for many patients	49.0	85
Providing care for many HIV/AIDS patients	42.3	76
Providing support for relatives of patients	41.3	55
Conflict with co-workers	39.7	-

a. 2007 data source: Caring for health workers--a national strategy for Botswana: needs assessment report, summary, and recommendations. Gaborone, Botswana, Ministry of Health[12]

Table 8 summarizes data related to job satisfaction, as determined using the Job Descriptive Index and Job in General tools. Mean values fell above the median for work in present job, supervision, co-workers and the Job in General scale, indicating satisfaction in those areas. Results showed overall dissatisfaction with pay and opportunities for promotion.

Table 8. Job satisfaction data

Job Satisfaction Facet[a]	n	Range	Median	Mean	SD
Work in present job	1065	0–18	9	10.3	5.6
Supervision	1059	0–18	9	10.2	5.8
Pay	1055	0–18	9	4.4	4.6
Opportunities for promotion	1037	0–18	9	5.9	4.7
Co-workers	1055	0–18	9	12.1	6.0
Job in General	1037	0–24	12	15.0	6.8

a. Scores for each individual facet ranged from 0–18, with the median value, nine (9), representing the neutral point. Scores above or below the neutral point indicated general satisfaction or general dissatisfaction, respectively. The Job in General scale contained eight items; therefore its values ranged from 0–24, with 12 representing the neutral point

Symptoms of stress

Respondents reported working 52.5 ± 27.0 hours during the previous week, while indicating that their employers expected them to work 44.9 ± 19.7 hours during that period. Absolute absenteeism (hours expected to work minus hours worked) was −7.7 ± 24.7 hours, indicating that respondents generally worked more hours than their employers were requiring. Absolute presenteeism was calculated as percentage of performance based on three questions. The lower bound was 0, representing a total lack of performance during time on the job; the upper bound was 100, representing no lack of performance. Absolute presenteeism was 82.0 ± 14.3.

Burnout was assessed using the General Survey of the Maslach Burnout Inventory, which assess exhaustion, cynicism, and efficacy. As shown in Table 9, over half of the health workers surveyed had high levels of professional efficacy. High levels of exhaustion were found in 28.6% of respondents. Cynicism was categorized as high for 37.6% of respondents.

Table 9. Maslach Burnout Inventory assessments of exhaustion, cynicism and efficacy

MBI Category	N	Mean ± SD	Level		
			Low	Moderate	High
			N (%)		
Professional Efficacy	1273	4.9 ± 1.0	247 (18.3)	316 (23.4)	710 (52.7)
Exhaustion	1276	2.3 ± 1.7	488 (36.2)	402 (29.8)	386 (28.6)
Cynicism	1262	2.4 ± 1.4	212 (15.7)	543 (40.3)	507 (37.6)

Stress Coping Strategies

Table 10 lists coping strategies reported by health workers. The most commonly reported stress coping strategy were talking to someone—a family member, friend, co-worker, supervisor, or even a counsellor— and spiritual activities. Nine percent of health workers reported using alcohol to relieve stress, which was similar to the data found in 2006. . Overall, the reported use of positive coping strategies increased from 2006 to 2013, suggesting improvements related dealing with stress in the workplace since. 2006.

Table 10. Coping strategies for stress (n=1295)

Strategy[a]	2013	2006
	%	
Talking with friends	84.2	68
Talking with family members	82.3	52
Praying, attending church, other spiritual activities	78.6	58
Talking with co-workers	76.9	68
Dealing with problems as they occur	66.9	
Optimism/looking at the bright side of things	56.2	
Exercise	52.7	
Dealing with problems objectively in an unemotional way	46.8	
Seeking support from supervisors	45.9	
Taking leave from work	27.8	37
Visiting a counsellor	21.2	13
Alcohol	8.8	7
Missing/Not Specified	4.6	
Gambling	1.4	2

a. 2007 data source: Caring for health workers--a national strategy for Botswana: needs assessment report, summary, and recommendations. Gaborone, Botswana, Ministry of Health[12]

Levels of stress

Table 11. Frequency of stress at work, 2013 vs 2006

Do you feel stressed when you are at work?[a]	2013		2006	
	n	%	n	%
Always	128	9.5		
Sometimes	841	62.4	194	89.0
Rarely	192	14.2		
Never	131	9.7	20	9.0
Missing/Not Specified	56	4.2	5	2.0

a. 2007 data source: Caring for health workers--a national strategy for Botswana: needs assessment report, summary, and recommendations. Gaborone, Botswana, Ministry of Health[12]

Table 12. Level of stress

Measurement Tool	n	Range	Median	Mean	SD
Stress in General	1022	0–24	12	13.4	7.7
General Health Questionnaire	1294	1–12	6	4.0	2.6

The data suggest that the majority of health workers experience occupational stress. Close to 10% of the respondents indicated that they 'never' felt stressed at work, which is similar to data from 2006. Mean values fell above the median for the Stress in General scale, indicating that the majority of health workers do experience stress at work. Mean values for the General health questionnaire were below the median, suggesting low levels of psychological well-being.

Data from the focus groups support the findings form the survey. Sources and symptoms of stress described by focus group participants generally revolved around shortages of resources and staff, and the heavy workloads—also described above as a barrier to use of the WWP. The components of the wellness programme that health workers were able to access did not do much to target these fundamental sources and symptoms of stress. Stress is caused in the workplace, but it is not dealt with there. Patients cause stress. Lack of resources and staff cause stress. Heavy workloads and low salaries cause stress.

> *'The work meant for 10 people [is] being done [by] two people. Which means really you are just pulling with whatever that you have.'—Other professional*

> *'Lack of resources is a deterrent to our service delivery. It would be helpful to have all resources available, so that when a customer needs to be served, they don't get excuses every day. Today there is no network, tomorrow it's the photocopier has broken down, or we don't have transport—which might lead to them thinking we are not serious about assisting them. It is very stressful to work under those conditions.' —Administrative worker*

A sense of resignation or acceptance of heavy workloads was cited by a few of the participants as something that further cemented the effects of these shortages, and led to many feelings of helplessness or lack of control.

> *'I would say it is institutionalized—that means it is part of the health system in [this] country.' —Other professional*

> *'Yes, they [stressors] are there; our workplaces are different. Some are in the most remote areas where there is no power, no water, and no basic amenities. Then, because nobody else is willing to be deployed to those areas, you stay for a long time without being transferred, and you just give in because it is beyond your control.' —Nurse*

These factors and the resulting stress often have significant impact on the quality of care and services provided by health workers. The stress manifests itself in fatigue and anger, and can lead to absenteeism in some cases, or to poor or negative attitudes towards clients and colleagues.

> *'Maybe I think you can understand that the summary of it is that the output and quality of our service goes down. If we are going to have shortage of staff because people are off sick, or if you are going to have someone not work at full capacity because they are not happy, that means work is not going to be completed on time, and the quality of the service, because we work looking at the turnaround time, output goes down. These are some of the defects of the well-being of health workers, especially in our department and [in] the lab.' —Other professional*

> *'The thing is, you will continue to work with so much stress and have nobody to talk to about it. If you try to tell them that you are not well, they will tell you that there is [a] shortage [of staff]. That response will make you unhappy and demoralized the whole day, and you end up not helping your clients properly.' —Other professiona*

Stress is also caused by poor leadership: health workers often feel discounted and not valued at work. Participants stated that at times management does not listen or respond to feedback or complaints, which makes them feel undervalued. There is poor communication and a lack of transparency between leadership and health workers.

> *'You end up with negative emotions, thank you, so I believe that with proper communication everything can run smoothly. I mean if, like you mentioned, there is shortage of staff, shortage of resources, and too much work, the impact of these can be mitigated by good and well-structured communication channel. There is also a need for transparency, because at the moment a lot of things are done behind closed doors and the only thing we see is when something is been implemented and usually this is done without our input.' —Industrial worker, P5*

Furthermore, in some facilities there are elements of hierarchy among the cadres of health workers. According to some respondents, lower-level workers are expected to assist the

higher-level cadres, but the reverse is not true. Support staff in particular talked about this, and gave examples of not being invited to participate in WWP activities, or given leave when they are sick, whereas those in upper cadres are.

> *'The challenge of not meeting as [a full] staff is serious. We knew that we were to meet every Wednesday or Thursday at the council. That was going to be a good platform to share and discuss issues so that we can plan together. We are really not involved in any meeting with them [higher cadres], and therefore we are alienated. We are just coming to work so that we get a salary, but we wish things were better.' —Support staff*

Lifestyle Behaviours

Nutrition

When asked how many fruits and vegetables they ate each day during the past 30 days, almost one-third (31.9%) of respondents reported consuming one or fewer servings per day. Two servings per day were reported by 34.2% of respondents. Only 11.7% reported having five or more servings of fruits and/or vegetables per day

Tooth Brushing

A large percentage of respondents, 66.4%, reported brushing their teeth twice each day, with 17.3% reporting that they brush their teeth three or more times a day, and 8.4% only once a day. Just 2.2% averaged less than once a day.

Smoking

Most respondents (95.2%) reported that they did not smoke; about 5% reported smoking one or more days a month. Neither is use of other forms of tobacco common among health workers: 98% reported not having used any form of tobacco in the last 30 days (only 1% had). Surprisingly, 68.4% of respondents reported exposure to second-hand smoke (passive smoking), because of people who smoke around them. When asked whether or not they had tried to stop smoking, the majority (n=1079) of respondents consistently reported that they do not smoke. Among those who do smoke, 5% reported having tried to quit; 11% have never tried.

Alcohol Use

The results for alcohol use are similar to those for tobacco use, with 75.9% of respondents reporting they had not had an alcoholic drink in the past 30 days, 13.7% reporting consuming at least one drink one or two days a month, and a smaller percentage (0.5%) having consumed alcoholic drinks every day during the past 30 days. When asked how many drinks

they usually had per day, respondents gave similar answers, with 984 (76.9%) reporting that they do not drink alcohol, a very small percentage (1.7%) consuming less than one drink per day, and 21.4% consuming one or more drinks daily over the past 30 days. Respondents continued to demonstrate consistency in their responses when asked about the types of alcohol they consume: most (n=961; 74.2%) reported not consuming any kind of alcoholic beverage; 14.4% reported drinking beer, lager or stout; and 7.5% reported consuming other types of alcoholic drinks.

Physical Activity

About 32% of the respondents reported not engaging in any physical activity, 16% reported that they engage in physical activity once a week, 17% engage in some form of exercise daily, and 35.8% participate in physical activity three to six days a week. When asked how long they exercise, about 28% of respondents affirmed that they never participated in any form of exercise, whereas 24.1% of respondents reported exercising for 60 minutes one or two days a week. Similarly, 39.2% said they had not walked or ridden a bicycle to work in the past seven days, compared to 27.8% who had. The majority (73.7%) of respondents reported spending one hour or longer each day on sedentary activities—e.g., working on a computer, watching television, talking to friends, playing cards, or listening to the radio—whereas 26.3% reported being sedentary for less than an hour each day.

Relationship between WWP Participation and Stress-related Outcomes

To examine the potential impact of WWP activities on health workers, survey respondents were stratified based on the number of WWP activities they participated in over the past year. As presented in Table 13, males were more likely than females to have a high participation in WWP activities. When examining participation by cadre type, professional staff were the most likely to have a high participation in WWP activities, while nurses were significantly less likely to have a high participation. Those posted at hospitals and the DHMT were more likely to report a high WWP participation than those in clinics.

Measures of absenteeism and presenteeism were not significantly associated with WWP participation. Stress scores, assessed by the Stress in General tool, were significantly lower for health workers with a high than a low participation in WWP activities. Similarly, levels of exhaustion and cynicism, as assessed by the Maslach Burnout Inventory, were significantly lower for health workers with a high than a low participation in WWP activities

Table 13. Demographic and Stress related characteristics of health workers with high, medium, and low participation in WWP activities over the past year

		WWP Participation			
	N (%)	0 Activities	1-6	7 or more	p
Gender (%)					0.04
Male	465 (38.0%)	32.7[a]	39.2[ab]	41.4[b]	
Female	759 (62.0%)	67.3[a]	60.8[ab]	58.6[b]	
Cadre group					0.0001
Doctor	37 (3.1)	2.3	3.3	3.7	
Nurse	371 (31.1%)	37.5[a]	31.7[ab]	24.5[b]	
Professional	334 (28.0)	21.3[a]	28.6[ab]	33.5[b]	
Administrative	123 (10.3)	10.5[ab]	12.8[a]	7.1[b]	
Industrial	327 (27.4%)	28.4[a]	23.6[ab]	31.1[a]	
Facility type					0.0001
hospital	331 (27.6%)	17.6[a]	31.3[b]	32.3[b]	
Clinic (with maternity)	304 (25.3%)	36.2[a]	37.8[ab]	26.0[b]	
Clinic (without maternity)	212 (17.7)	24.4[a]	15.1[b]	14.6[b]	
Health Post	110 (9.2)	11.3	8.9	7.6	
DHMT	243 (20.3)	15.6[a]	19.9[ab]	25.0[b]	
	N				
Age (years)	1190	39.9 ± 10.1[ab]	39.0 ±9.4[a]	40.8 ±10.0[b]	0.03
Absenteeism	1135	-8.1 ± 27.5	-7.9 ± 22.3	-6.8 ± 24.2	0.70
Presenteeism	1176	81.8 ± 14.5	81.0 ± 14.3	82.9 ± 14.0	0.17
Stress in General	956	14.4 ± 8.0[a]	13.5 ± 7.5[ab]	12.3 ± 7.4[b]	0.003
Burnout					
Professional Efficacy	1182	4.9 ± 1.1	4.9 ± 1.1	5.1 ± 0.4	0.09
Exhaustion	1184	2.7 ± 1.8[a]	2.3 ± 1.7[b]	2.1 ± 1.5[c]	0.0001
Cynicism	1173	2.5 ± 1.4[a]	2.4 ± 1.4[ab]	2.2 ± 1.4[b]	0.02

ANOVA for continuous variables (*x* _ SD) and chi-square tests for categorical variables (%) were used for each sex to compare persons within the 3 categories of WWP participation, mean values with different superscript letters are significantly different. Bonferroni correction was applied to adjust for multiple comparisons.

FINDINGS AND RECOMMENDATIONS

The following findings emerged from this evaluation, with specific focus on programme implementation, awareness and participation, job performance, sources of occupational stress, mechanisms for coping with stress, and lifestyle behaviours.

Implementation at District and Local Levels

The basic structures necessary to promote implementation of the national WWP for health workers in Botswana have been put in place across the country. Evaluation results indicate that having a dedicated and diverse WWP committee enabled implementation of the minimum package of services. Other factors included support from national and district management, and organization of the programme into district, facility, and individual performance plans. Such components as health screening, therapeutic recreation, and promotion of health through observation of commemorative events were implemented more often than those related to occupational health and safety or psychosocial services. Rollout of the programme from district hospitals to individual facilities has happened on only a limited basis. Barriers to WWP implementation at both district and local levels include: limited branding of pre-existing health-related activities as part of the WWP, organizational placement of the programme within the Department of HIV/AIDS Prevention and Care, prioritization of wellness activities that focus on the general community instead of on health workers, and perceptions that programme implementation is voluntary, as well as such general constraints as heavy workloads and limited transport.

Participation in WWP activities

The results for participation in the minimum package of activities were fairly consistent across components. The vast majority of health workers reported that these services were not available at their facilities. However, when these services were offered, health workers generally did participate. The main exception was health screening—health workers were more likely to obtain screening as part of an overall health check-up than as part of the WWP. However, health workers consistently reported that they felt these services would be beneficial.

Sources, symptoms, and levels of Stress

The three most commonly reported sources of stress were shortages of staff, shortages of resources, and too much work. Other common sources of stress were conflict with co-workers, providing support for relatives of patients, and providing care for many HIV/AIDS

patients. Providing care for HIV/AIDS patients was perceived as a source of stress by 42.3% of participants in 2013, compared to 76% in 2006. Similarly, fewer participants reported that caring for many patients, too much work, and staff shortages were stressors in 2013 compared to 2006. This suggests that there have been improvements in reducing stress in the workplace since 2006.

Data related to job satisfaction, as determined using the Job Descriptive Index and Job in General tools, indicate a general satisfaction with their work, supervision, and co-workers. Results showed overall dissatisfaction with pay and opportunities for promotion.

Burnout was assessed using the General Survey of the Maslach Burnout Inventory, which assess exhaustion, cynicism, and efficacy. Over half of the health workers surveyed had high levels of professional efficacy. High levels of exhaustion were found in 28.6% of respondents. Cynicism was categorized as high for 37.6% of respondents.

The data suggest that the majority of health workers experience occupational stress. Close to 10% of the respondents indicated that they 'never' felt stressed at work, which is similar to data from 2006. Mean values fell above the median for the Stress in General scale, indicating that the majority of health workers do experience stress at work. Mean values for the general health questionnaire were below the median, suggesting low levels of psychological well-being

Coping with Stress

The most commonly reported stress coping strategy were talking to someone—a family member, friend, co-worker, supervisor, or even a counsellor— and spiritual activities. Nine percent of health workers reported using alcohol to relieve stress, which was similar to the data found in 2006. Overall, the reported use of positive coping strategies increased from 2006 to 2013, suggesting improvements related dealing with stress in the workplace since 2006.

Lifestyle Behaviours

Fruit and vegetable intake was generally poor, with only 11.7% reported having five or more servings of fruits and/or vegetables per day. Almost one-third (31.9%) of respondents reported consuming one or fewer servings per day. Most respondents (95.2%) reported that they did not smoke. The results for alcohol use are similar to those for tobacco use, with 75.9% of respondents reporting they had not had an alcoholic drink in the past 30 days.

About 32% of the respondents reported not engaging in any physical activity, 16% reported that they engage in physical activity once a week, 17% engage in some form of exercise daily, and 35.8% participate in physical activity three to six days a week.

Relationship between WWP participation and Stress-related Outcomes

Measures of absenteeism and presenteeism were not significantly associated with WWP participation. However, stress scores, assessed by the Stress in General tool, were significantly lower for health workers with a high participation in WWP activities. Similarly, levels of exhaustion and cynicism, as assessed by the Maslach Burnout Inventory, were significantly lower for health workers with a high participation in WWP activities. This suggests that the WWP is having a beneficial impact on healthcare workers.

Programme Implementation and Use: General recommendations

- Promote stress management and team-building activities to encourage attendance and improve overall quality of work.
- Ensure a systems approach to WWP implementation that takes a holistic view of wellness, instead of being event-driven.
- WWP activities are largely concentrated at district hospitals, with relatively little impact at other health facilities. Promote efforts to roll out WWP activities to local facilities to increase the impact of the programme. Local wellness committees are needed to ensure coordination and implementation of the WWP.
- The importance of the WWP needs to be re-emphasized to the districts and local facilities, so that they clearly understand their responsibilities.
- Promote therapeutic recreation to encourage physical activity.

Programme Implementation and Use: Specific recommendations

- The district structures for WWP implementation are in place and need to be supported. **Periodic reminders to district leadership of the importance of the programme and its objectives are needed**.
- Few district WWP committees had all of the focal-member positions filled. Given the apparent challenge in filling all key positions within the WWP committee, **the number of WWP committee positions should be reduced and roles prioritized.**
- Annual WWP plans are routinely submitted late and the WWP committees seldom complete annual plan projections. Therefore, **the programme should revisit the need for projections in addition to annual plans. Feedback and follow-up related to late submission or non-submission of annual plans is warranted.**
- **The national programme should ensure that key guiding documents are available for both WWP focal persons and committee members**.
- Although health screening services are generally available at district hospitals, only seven local facilities reported having staff clinics. Instead, health workers generally receive screening services as part of the general client population. **There is a need for additional staff clinics to facilitate access to screening and other health services. Confidentiality should be inculcated into these services.**
- Wellness activities related to health promotion are generally aimed at the community, not specifically targeted to health workers. **An increased focus on health promotion activities targeting health workers is need.**
- **An increased focus on peer education is warranted,** given that this was a weak aspect of WWP activities.

- **The programme should review the usefulness of targeted seminars,** since there was a low prevalence of these activities in the field.
- **Additional materials, such as instructional aides, are needed to facilitate implementation of activities focused on health promotion, stress management, team building activities, occupational health, and safety.**

Impact and Sustainability

- Placement of the WWP under the auspices of the Department of HIV/ADS Prevention and Care (DHAPC) made sense when the programme was being developed. However, because the HIV epidemic, the health care system, and the WWP have since matured, the programme should be placed under a different department to ensure a more holistic approach to wellness.
- Increase human resources for health, and implement staffing norms to reduce stress. Ensure sufficient numbers of health workers at each facility so that health workers are able to access WWP services. Provide feedback on staffing needs to district health management teams (DHMTs) to enable more appropriate workload assignments.
- Health facilities need to review how to best provide health services for their workers. Screening and other wellness events are usually led by health workers for the benefit of the general community, with little or no focus on health workers themselves.
- Promote stakeholder support and buy-in to strengthen WWP branding of WWP activities; this will increase visibility and promote support for the programme me. Coordinate all wellness activities through the WWP to maximize its use.
- Develop a robust monitoring and evaluation system for reporting and feedback.

REFERENCES

1. World Health Organization. *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access.* 2011.
2. World Health Organization. *The impact of HIV/AIDS on the health workforce in developing countries.* 2006.
3. Turan JM, Bukusi EA, Cohen CR, Sande J, Miller S. Effects of HIV/AIDS on maternity care providers in Kenya. *Journal of obstetric, gynecologic, and neonatal nursing : JOGNN / NAACOG.* 2008;37(5):588-595.
4. Government of Botswana. *Botswana AIDS Impact Survey IV (BAIS IV).* 2012.
5. Creek T, Ntumy R, Mazhani L, et al. Factors associated with low early uptake of a national program to prevent mother to child transmission of HIV (PMTCT): results of a survey of mothers and providers, Botswana, 2003. *AIDS and behavior.* 2009;13(2):356-364.
6. Wester CW, Bussmann H, Avalos A, et al. Establishment of a public antiretroviral treatment clinic for adults in urban Botswana: lessons learned. *Clinical infectious diseases : an official publication of the Infectious Diseases Society of America.* 2005;40(7):1041-1044.
7. Steen TW, Seipone K, Gomez Fde L, et al. Two and a half years of routine HIV testing in Botswana. *J Acquir Immune Defic Syndr.* 2007;44(4):484-488.
8. Ledikwe JH, Kejelepula M, Maupo K, et al. Evaluation of a well-established task-shifting initiative: the lay counselor cadre in Botswana. *PloS one.* 2013;8(4):e61601.
9. Ledikwe JH, Reason LL, Burnett SM, et al. Establishing a health information workforce: innovation for low- and middle-income countries. *Human resources for health.* 2013;11:35.
10. Government of Botswana. *Botswana National Tuberculosis Program Manual.* 2011.
11. Government of Botswana. *National Tuberculosis Control Program Stategic Plan 2014-2017.* Gaborone, Botswana: Ministry of Health;2013.
12. Government of Botswana. *Caring for health workers--a national strategy for Botswana: needs assessment report, summary, and recommendations.* Gaborone, Botswana: Ministry of Health;2006.
13. Felton JS. Burnout as a clinical entity--its importance in health care workers. *Occup Med (Lond).* 1998;48(4):237-250.
14. Mateen FJ, Dorji C. Health-care worker burnout and the mental health imperative. *Lancet.* 2009;374(9690):595-597.
15. Centers for Disease Control and Prevention. *Stress at work. NIOSH publication number 99-101.* 1999.
16. Demmer C. Burnout: the health care worker as survivor. *The AIDS reader.* 2004;14(10):522-523, 528-530, 535-527.
17. Marchal B, De Brouwere V, Kegels G. Viewpoint: HIV/AIDS and the health workforce crisis: what are the next steps? *Tropical medicine & international health : TM & IH.* 2005;10(4):300-304.
18. Schaufeli WB, Greenglass ER. Introduction to special issue on burnout and health. *Psychology & health.* 2001;16(5):501-510.
19. Maslach C, Jackson SE, Leiter MP. *Maslach Burnout Inventory Manual.* Yalo Alte, CA: Consulting Psychologists Press; 1993.
20. Thomas LS, Valli A. Levels of occupational stress in doctors working in a South African public-sector hospital. *South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde.* 2006;96(11):1162-1168.
21. Sparling PB. Worksite health promotion: principles, resources, and challenges. *Preventing chronic disease.* 2010;7(1):A25.
22. Mazzola JJ, Schonfeld IS, Spector PE. What qualitative research has taught us about occupational stress. *Stress and Health.* 2011;27(2):93-110.
23. Lemaire JB, Wallace JE. Not all coping strategies are created equal: a mixed methods study exploring physicians' self reported coping strategies. *BMC health services research.* 2010;10:208.
24. Anderson P, Pulich M. Managing workplace stress in a dynamic environment. *The health care manager.* 2001;19(3):1-10.
25. Berry LL, Mirabito AM. Partnering for prevention with workplace health promotion programs. *Mayo Clinic proceedings. Mayo Clinic.* 2011;86(4):335-337.

26. Government of Botswana. *Botswana workplace wellness program operational guidelines.* Gaborone, Botswana: Ministry of Health;2007.
27. Kinicki AJ, McKee-Ryan FM, Schriesheim CA, Carson KP. Assessing the construct validity of the job descriptive index: a review and meta-analysis. *The Journal of applied psychology.* 2002;87(1):14-32.
28. Kessler RC, Ames M, Hymel PA, et al. Using the World Health Organization Health and Work Performance Questionnaire (HPQ) to evaluate the indirect workplace costs of illness. *Journal of occupational and environmental medicine / American College of Occupational and Environmental Medicine.* 2004;46(6 Suppl):S23-37.
29. Kessler RC, Barber C, Beck A, et al. The World Health Organization Health and Work Performance Questionnaire (HPQ). *Journal of occupational and environmental medicine / American College of Occupational and Environmental Medicine.* 2003;45(2):156-174.
30. Wang PS, Beck A, Berglund P, et al. Chronic medical conditions and work performance in the health and work performance questionnaire calibration surveys. *Journal of occupational and environmental medicine / American College of Occupational and Environmental Medicine.* 2003;45(12):1303-1311.
31. Jackson C. The general health questionnaire. *Occupational Medicine.* 2007;57(79).
32. World Health Organisation. *2005 Botswana Global School-based Student Health Survey.* 2005.
33. World Health Organisation. *STEPS Survey on Chronic Disease Risk Factors.*
34. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)--a metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of biomedical informatics.* 2009;42(2):377-381.

APPENDICES

Appendix A. Evaluation Terms of Reference

Terms of Reference for the Evaluation of the
Health Worker Wellness Programme

Background

The impact of HIV/AIDS on Botswana's healthcare system, coupled with health workforce shortages, has substantially increased the physical and emotional demands on health workers. Throughout the epidemic, health workers have been in the forefront of care and prevention activities, managing greatly increased numbers of severely ill patients and assuming responsibilities for new HIV/AIDS services. At the same time, many health workers have found it more difficult to respond to the demands of work as some are HIV infected or otherwise affected by the epidemic. Although, health workers are generally knowledgeable about HIV/AIDS, many seek prevention and treatment services late mainly due to fear of stigma and discrimination. To respond to the needs of health workers, the Ministry of Health embarked on the development of a workplace wellness programme that was initiated in 2007. With support from PEPFAR, a baseline assessment of health worker needs and available services was conducted and a programme established.

The goal of the programme is to provide services and support to enhance the well-being and job satisfaction of health workers in order to improve their emotional and physical health, prevent burnout, enhance staff retention and have a positive impact on patient care.

The objectives of the programme are to:

- Increase health worker knowledge of HIV/AIDS and other related diseases especially tuberculosis and cancer as core diseases.
- Improve access to health services by health workers.
- Reduce stigma and discrimination within the health workforce.
- Mitigate the impact of HIV/AIDS by building staff capacity in stress management, team building, occupational health and safety etc.
- Improve staff morale to enhance productivity.
- The programme received PEPFAR support and technical assistance between 2005 and 2011 for programme development (coordinator position, study tour), development of training and promotional materials, training of trainers and health workers, purchase of equipment and supplies and supervisory travel. It is now a well-established Ministry of Health programme fully supported by Government.

The purpose of this evaluation is to document the achievements of the programme, understand the challenges and make recommendations to the Ministry that will assist in improving the services in the future to achieve the above-stated goal and objectives.

Objectives

- To document the achievements and challenges of the programme since inception
- To assess health workers' views on the programme , as well as their perceived levels of workplace stress and their access to wellness services
- To provide recommendations to enable Government to improve and sustain the programme and achieve stated objectives

Key Tasks

- Describe the current programme and document the achievements
- Conduct an assessment of health workers' perceived levels of workplace stress, access to wellness services, perceptions of these services and current needs and desires for the programme
- Make recommendations to programme improvements and sustainability

Methodology

This evaluation will require a combination of methods, qualitative and quantitative.

Deliverables

- Inception report with methodology, tools, work plan and timeframe
- Draft and final reports
- Two – three dissemination presentations to stakeholders
- Electronic copy and 100 hard copies of the report

Appendix B. Ethical Approval Documents

TELEPHONE: 363 2766
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REF NO: PPME-13/18/1 Vol VIII (17) 29 April 2013

Health Research and Development Division

Notification of IRB Review: New application

Mr Jenny H.Ledikwe
ITECH Botswana
P O Box AC46
Ach,Riverwalk

Protocol Title:	**EVALUATION OF BOTSWANA MINISTRY OF HEALTH WORKPLACE WELLNESS PROGRAM TO IMPROVE IMPLEMENTATION, UTILIZATION, IMPACT AND SUSTAINABILITY**
Sponsor:	**N/A**
HRU Review Date:	20 April 2013
HRU Expiration Date:	20 April 2014
HRU Review Type:	Expedited Review
HRU Review Determination:	Approved
Risk Determination:	Minimal risk

Dear Sir/Madam

Thank you for submitting a new application for the above referenced study. This approval includes the following:

- Application form
- Proposal
- Data collection tools

This permit does not however give you authority to collect data from the selected site without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

Continuing Review
In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 10 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Amendments
During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting
Other events which must be reported promptly in writing to the HRDC include:
- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at pkhulumani@gov.bw, Tel +267-3914467 or Lemphi Moremi at lamoremi@gov.bw or Tel: +267-3632754

Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

P. Khulumani
For Permanent Secretary

TELEPHONE: 363 2766
FAX: 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

Republic of Botswana

MINISTRY OF HEALTH
PRIVATE BAG 0038
GABORONE

REFERENCE No: PPME: 13/18/1 Vol VIII (434) 11 April 2014

Principal Investigator: Gabrielle O'Mallley

Protocol Title: **Evaluation of Botswana Ministry of Health Workplace Wellness Program to improve Implementation, Utilization, Impact and sustainability**

Review Type: Expedited Review/Health Research and Development Committee

Approval Date: 11 April 2014

Expiration Date: 11 April 2015

This certifies that the continuing review request for the protocol above was reviewed and approved for a period of 1 year, effective 11 April 2014.

___X_ the research poses minimal risk to participants

____ The study has not been activated

_____ Enrollment is still ongoing

___ Study is continuing

___ **X** __Study open for analysis

____ includes only collection of data from voice, video, digital, or image recordings made for research purposes

____research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior)

____Research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Continuing Review

In order to continue work on this study (including data analysis) beyond the expiration date, the Health Research and Development Committee (HRDC) must reapprove the protocol after conducting a substantive, meaningful, continuing review. This means that you must submit a Continuing Report form as a request for continuing review. To best avoid a lapse, you should submit your request 3 months before the lapse date. Please use the forms supplied by our office available on our website: http://www.moh.gov.bw

As a courtesy, the HRDC will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

Reporting

Other events which must be reported promptly in writing to the HRDC include:
- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects

Do not hesitate to contact us if you have any questions.

Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

P. Khulumani
For/Permanent Secretary

MINISTRY OF HEALTH
RESEARCH DIVISION
2014 -04- 11
P/BAG 0038
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REPUBLIC OF BOTSWANA

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RE PUBLIC OF BOTSWANA

PRINCESS MARINA HOSPITAL
P. O. BOX 258
GABORONE
BOTSWANA

REF: PMH 5/79(51a)

23rd September 2013

Heather Mothibedi
Ministry of Health – Dept HIV/AIDS

Dear Ms Mothibedi

RE: Evaluation of Botswana Ministry of Health Workplace Wellness Program to Improve Implementation, Utilization, Impact, and Sustainability

Your application for a research permit for the above stated research protocol refers. The Research and Ethics Committee of Princess Marina Hospital met on the 20th August 2013 and discussed your proposal. **Full approval** to do the aforementioned study is granted.

You are advised to observe the following:

1. You must get permission from head of department in the unit that you intend to do your research.
2. You must at all times get consent from individuals that you are using as subjects in your study.
3. You will not change any aspect of your research without permission from the REC.
4. You need to report any unforeseen circumstances including the termination of the study to the REC.
5. You must allow the REC access to the study at anytime for purposes of auditing.
6. This permit is valid for one year; from 23rd September 2013 to 22nd September 2014.
7. At the end of the study you should give the research and ethics committee a hard copy and soft copy of your report.

Wishing you success in your research.

Sincerely,

Gladness O. Tlhomelang
For Chairman Research and Ethics Committee

TELEPHONE: 2411000
FAX: 2416706/2419387
REFERENCE:

Republic of Botswana

NYANGABGWE HOSPITAL
PRIVATE BAG 127
FRANCISTOWN
BOTSWANA

Ethical Review of Proposed Study: **EVALUATION OF BOTSWANA MINISTRY OF HEALTH WORKPLACE WELLNESS PROGRAM TO IMPROVE IMPLEMENTATION, UTILIZATION, IMPACT AND SUSTAINABILITY.**

Name of Applicant: Mr Jenny H. Ledikwe, ITECH Botswana, P.O. Box AC46, Ach, Riverwalk
Name of Site : Nyangabgwe Referral Hospital
Decision : Approved
Date of Decision : 4 August 2013
Expiration Date : 20 April 2014

The Institutional Review Board (Research & Ethic Committee) for Human Subjects Research for Nyangabgwe Hospital is pleased to inform you that the research protocol named above was approved.

The study involves specimen and data collection from Nyangabgwe Hospital no more than minimal risk. It is a non therapeutic research and doesn't involve the use of devices for which there is limited knowledge. The protection of data collection has been outlined.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Hospital Research and Ethics Committee. In addition you are expected to submit at least one hard copy and an electronic copy of the report to the committee within three months of completion of the study.

Signed: .....

Dr. M. Katengua
Chairperson
Research & Ethics Committee

May 30th, 2013

PI: Gabrielle O'Malley
Global Health

CC: Ellen Wilcox

Re: An evaluation of the Botswana Ministry of Health's Workplace Wellness Program to improve Implementation, utilization, impact, and sustainability

Dear Dr. O'Malley,

Thank you for submitting our project for your review. As the application describes, this project is part of routine program monitoring and evaluation to determine use and implementation of the Workplace Wellness Program.

You have confirmed that:

1. This is a quality improvement activity conducted by one or more institutions whose purpose is limited to collecting patient or provider data regarding the implementation of the practice for clinical, practical, or administrative purposes.
2. These results are not generalizable. The data and/or conclusions are not intended to apply more broadly beyond the individuals studied, or beyond a specific time and/or location, such as to other settings or circumstances.

Based on this information and the definition of "research" under 45 CFR 46.102(d), the UW Human Subjects Division has determined that this activity does not meet the federal definition of "research." This determination means that the activity is not subject to 45 CFR 46 and does not require review by the IRB. Please keep a copy of this letter for your records.

If you have further questions or concerns, please feel free to contact me.

Best regards,

Emily Guthrie
Assistant Director of Operations
ehguth@uw.edu
(206) 543-2305

Appendix C. District Implementation Assessment Tool and Consent Form

DISTRICT IMPLEMENTATION ASSESSMENT TOOL

DISTRICT: _____ INTERVIEWER: _____ DATE: _____

This tool is broken out into five parts and will cover several aspects of the Workplace Wellness Programme (WWP) and its implementation in the district. I want to make it clear that this is not an evaluation of your job performance, but rather an evaluation of the programme and its components.

PART I:

Let us start with questions on human resources.

What is the **total number** of WWP Trainer of Trainers (TOTs) working in your health district? [unique number of people, don't count the same person more than once]	No._____
How many of the following are currently available in your district: Stress management & Team Building TOT? Occupational health & safety TOT? Support group facilitators? Peer educators?	 _____ _____ _____ _____

Now, I will ask some questions on the WWP Committee.

WORKPLACE WELLNESS PROGRAMME COMMITTEE		
Question	**Response**	**Comments**
Is there a WWP committee for the health district? [if no, skip to annual plan questions]	Yes No	
	Yes No	

Is the WWP focal person the chairperson of the WWP committee?		
How often are WWP committee meetings actually held?	Weekly Monthly Quarterly Biannually Annually Other	
How many **total members** are on the WWP committee?	No._____	
Is there a focal member on the committee for each of the following areas…?		
Health screening, Treatment, & Care	Yes No	
TB/HIV	Yes No	
Health Talks	Yes No	
Stress Management & Team Building	Yes No	
Psychosocial	Yes No	
Occupational Health & Safety	Yes No	
Peer Education	Yes No	
Therapeutic Recreation	Yes No	
Publicity	Yes No	

Now I have a few questions related to the WWP annual plan.

ANNUAL PLAN		
Does your district develop an annual plan <u>projection</u> for WWP activities?	Yes No	
When was the 2013-2014 Annual Plan <u>Projection</u> given to the WWP National Office?	_____ mm/yy	
Does your district develop a final annual plan for WWP activities?	Yes No	
When was the Final 2013 – 2014 Annual Plan given to the WWP National Office?	_____ mm/yy	

Now I will ask you a few questions on your resource center.

RESOURCE CENTER		
Is a WWP resource center, information center, or some other variation of disseminating information about WWP established and maintained in the district? [if no, skip to Section II, page 3, 'Six Components of WWP']	Yes No	
If yes, describe it briefly?		

Are you aware of the 2012/2013 WWP Implementation Guide?	Yes No	
Do you have a copy? [soft or hard]	Yes No	
Do you receive support for WWP activities from district management? [e.g., time to schedule, attend meetings, plan events, recognition of activities, etc]	Yes No	

PART II: Six Components of WWP

*Next, we are going to talk about the six components of the WWP. As we discuss these, the questions asked are specific to services at the **district hospital**. You can follow along or refer to page 1 of your guide.*

Component 1: *First, I will ask you some question regarding **health screenings** for health workers for a variety of conditions to better understand what services are available for health workers in the **district hospital**.* [Health screening, treatment, and care services include clinical assessments to identify health-risk factors and disease, early diagnosis and interventions, and referral to appropriate treatment and care services.]

HEALTH SCREENING [**Skip pattern**: for any answer of no, skip to next 'for patient' or 'for health worker' item.]				
Service				**Comments**
Are screening services for	**Available in the district hospital?** 1 –Yes 2 - No	**How do health workers access the screening for ...?** 1- Designated staff clinic 2- Designated clinician 3- Designated days for staff with a focal officer known to refer emergencies on off days 4- Prioritizing staff 5- Part of general clinic/population 6- Other	**How often is ... available for health workers?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually	
Blood Sugar (e.g., diabetes)				
Blood Pressure				
Cholesterol				
Body Mass Index (BMI)				
Breast Cancer				
Cervical Cancer				
Prostate Cancer				
HIV (e.g., testing & monitoring)				
TB				
Eye (e.g, visual charts)				
Ear, Nose, Throat (ENT)				
Oral Health (e.g., dentistry)				
Psychosocial (e.g, stress & anxiety)				

Component 2: *Next, we will discuss* ***health promotion*** *activities at the* ***district hospital****. Refer to page 2 of your guide.*[Health promotion activities address health and lifestyle issues through wellness talks, health campaigns, seminars, commemorations, and peer education activities to address health and lifestyle issues. This includes activities focused on empowering health workers to be in control of all dimensions of their lives such as finances, substance use, and health issues.]

HEALTH PROMOTION – HEALTH & LIFESTYLE ISSUES [**Skip pattern**: for any answer of no, skip to next yes/no question in table.]						
	Does the district hospital offer health talks for health workers on issues of..... 1-Yes 2-No	**How often are these health talks provided?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually 6- As needed or on demand 7- Unknown	**Who conducts the health talks?** 1- Peer educator 2- Social worker 3- Staff member 4- Senior staff with experience 5- Outside professional with experience 6- TOT 7- Other (specify)	**Does the district hospital offer peer education to health workers on issues of....?** 1- Yes 2- No	**How often is this peer education offered?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually 6- As needed or on demand 7- Unknown	**Comments**
Personal Finance						
Alcohol Use						
Tobacco Use						
Diet & Nutrition						
Exercise						

HEALTH PROMOTION – TARGETED SEMINARS FOR HEALTH WORKERS **[Skip pattern:** for any answer of no, skip to next item in list/table**]**					
	Does the district hospital provide health workers...? 1- Yes 2- No	**How often are they offered?** 1- Weekly 2- Monthly 3- Quarterly 4- Annually 5- Other	**Who facilitates the seminars?** 1- Peer educator 2- Experienced senior officers 3- External professionals 4- TOT 5- Other (specify)	**Is the targeted group allowed time to attend?** 1- Yes 2- No	**Comments**
Targeted Seminars for **Men**					
Targeted Seminars for **Women**					
Targeted Seminars for **Youth**					

HEALTH PROMOTION – HEALTH DAY COMMEMORATIONS [**Skip pattern**: for any answer of no, skip to next question to right]					
					Comments
Are commemorations for....	**Conducted in the district via the DHMT or district hospital?** 1- Yes 2- No	**How do health workers at the district hospital attend....?** 1- They are allocated time to attend the general public/community event 2- Separate event is conducted for health workers only 3- Other	**Is screening provided during …… to district hospital health workers?** 1- Yes 2- No	**Are health education materials made available during ……. to district hospital health workers?** 1- Yes 2- No	
World TB Day					
Month of Youth Against AIDS (MYAA)					
Month of Prayer Against AIDS					
Breast Cancer Awareness Month					
World Diabetes Day					
World AIDS Day					
Wellness Week					

Component 3: *I will now ask you questions relating to* ***stress management and teambuilding*** *in the* ***district hospital.*** *Refer to page 3 of your guide. [*Stress management and team building training and workshops focus on enhancing the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork].

STRESS MANAGEMENT & TEAM BUILDING [**Skip Pattern**: if answer to first question is '0', proceed to component 4, pg 6]						
[NB: Activities include: training,	**How often are .....activities scheduled**	**How many ..... activities were**	**Who do these activities target?**	**Who conducts or provides the activities?**	**Are health workers able to attend the**	**Comments**

workshop, other activities]	**at the district hospital for health workers?** 0 – They are not 1- Weekly 2- Monthly 3- Quarterly 4- As needed	**conducted for district hospital health workers during the 2012-2013 financial year?**	1– all Staff 2- Department specific	1- Peer educator 2- Staff member 3- Senior staff with experience 4- Outside professional with experience 5- TOT	**activities during working hours?** 1- Yes 2- No	
Stress Management & Team Building						

Component 4: *Now let us discuss **occupational health and safety** services for health workers in the **district hospital**. Refer to page 3 of your guide.*[O**ccupational health and safety** addresses issues of safety in the workplace focusing on identification of health hazards, prevention, control and management of the health hazards. It also addresses care related to occupational exposure, injury, and post exposure prophylaxis services (PEP)]

OCCUPATIONAL HEALTH & SAFETY [**Skip Pattern**: if answer to first question is 'no', proceed to next line]				
	Does the district hospital offer …… for health workers? 1- Yes 2- No	**Who leads, facilitates, or conducts these services?** 1- Peer educator 2- Occupational health officer 3- TOTs 4- Other	**How often are these services provided?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually 6- As needed or on demand	**Comments**
Safety talks or health talks on safety issues				
Screening for occupational infections (e.g., respiratory conditions)				

PEP [Post Exposure Prophylaxis]		[redacted]	

Component 5: *Now let us move on to the **psychosocial and spiritual care** component of the WWP in regards to the **district hospital** staff. Refer to page 3 in your guide.*

[Psychosocial and spiritual care activities include support groups of health workers led by a trained group facilitator, and activities such as counselling, prayer, Holy Communion, and scripture reading.]

PSYCHOSOCIAL & SPIRITUAL CARE [**Skip**: if answer to first question is 'no', proceed to next line]					
	Does the district hospital offer.... for health workers? 1- Yes 2- No	**How often are they provided or offered?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually 6- As needed or on demand	**Are staff allowed time to attend these during working hours?** 1- Yes 2- No	**Who conducts the .....?** 1- Peer educator 2- TOT 3- Social worker 4- Staff member 5- Outside professional with experience, e.g., pastor, counsellor 6- Nurses Association Botswana (NAB) 7- Other (specify)	**Comments**
Spiritual care services (e.g., prayer, scripture reading, anointment)					
Assessment for anxiety & stress					
Counselling (in general/any topic via WWP)					
Support groups (in general/any topic via WWP)					

Component 6: *Let us now talk about* ***therapeutic recreation*** *activities at the* ***district hospital****. Refer to page 4 of your guide.* [Therapeutic recreation activities focuses on improving the physical, psychological, emotional, and occupational well-being of health workers through physical fitness activities, social recreation, and 'edutainment' activities such as drama and fashion shows.]

THERAPEUTIC RECREATION [**Skip Pattern**: if answer to first question is 'no', proceed to next line]					
	Are there ..... for health workers at the district hospital? 1- Yes 2- No	**Who leads, facilitates, or conducts these activities?** 1- Peer educator 2- TOTs 3- Experienced staff member 4- Other (specify)	**How often are these activities provided?** 1- Daily 2- Weekly 3- Monthly 4- Quarterly 5- Annually 6- As needed or on demand	**Are health workers allowed time to attend?** 1- Yes 2- No	**Comments**
Fitness or sporting facilities (e.g., space & equipment for recreation & exercise)					
Physical fitness activities (e.g., aerobics, sport code)					
Social recreation (e.g., dance, weight loss club)					
Edutainment (e.g., drama, music performances)					
Other (specify): _____					

PART III: ROLL OUT

That concludes the six components of WWP. Now that we have spent time discussing these activities and services at the district hospital, I will ask you some questions about how they are rolled out and offered to health workers in other facilities and locations throughout the district. Please refer to page 4 of your guide and the numbers/documents you may have pulled ahead of time.

WWP ROLL OUT IN DISTRICT [**Directions**: for each question, write a numeric answer. If the answer is none, enter '0'.]		
	NUMBER	**COMMENTS**
HOSPITALS *(The following questions will address the hospitals in your district with WWP services and activities;* ***excluding the district hospital****)*		
Other than the district hospital, how many hospitals are there in the district? [if zero, ask next question and then skip to clinics]		
In **addition** to the district hospital, how many hospitals in your district have the WWP?		
Of these, How many provide health screening opportunities for staff?		
How many conduct wellness talks or health seminars for staff?		
How many conduct stress management or team building activities for staff?		
How many provide occupational health services for staff?		
How many offer support groups for staff?		
How many provide opportunities for physical fitness for staff?		
CLINICS *(The following questions will address the clinics in your district with WWP services and activities; both with and without maternity.)*		
How many clinics are in your district, total including those with and without maternity?		
How many total clinics in your district have the WWP?		
Of these, how many provide health screening opportunities for staff?		
How many conduct wellness talks or health seminars for staff?		
How many conduct stress management or team building activities for staff?		
How many provide occupational health services for staff?		

WWP ROLL OUT IN DISTRICT [**Directions**: for each question, write a numeric answer. If the answer is none, enter '0'.]		
	NUMBER	**COMMENTS**
How many offer support groups for staff?		
How many provide opportunities for physical fitness for staff?		
HEALTH POSTS *(The following questions will address the health posts in your district with WWP services and activities.)*		
How many health posts are in your district?		
How many health posts in your district have the WWP?		
Of these, how many provide health screening opportunities for staff?		
How many conduct wellness talks or health seminars for staff?		
How many conduct stress management or team building activities for staff?		
How many provide occupational health services for staff?		
How many offer support groups for staff?		
How many provide opportunities for physical fitness for staff?		
DISTRICT HEALTH MANAGEMENT TEAMS (DHMT) *(The following questions will address the DHMTs in your district with WWP services and activities; both with and without maternity.)* [**Directions**: For DHMT, answer YES / NO instead of number] **YES NO**		
Does the DHMT allow for or provide health screening opportunities for staff? (e.g., time away from work to go to nearby clinic or a designated clinic)		
Does the DHMT have the WWP? [if no, skip to section 4, monitoring and evaluation]		
Does the DHMT conduct wellness talks or health seminars for staff?		
Does the DHMT conduct stress management or team building activities for staff?		
Does the DHMT provide occupational health services for staff?		
Does the DHMT offer support groups for staff?		

WWP ROLL OUT IN DISTRICT [**Directions**: for each question, write a numeric answer. If the answer is none, enter '0'.]		
	NUMBER	**COMMENTS**
Does the DHMT provide opportunities for physical fitness for staff?		

PART IV: MONITORING & EVALUATION

I am now going to ask you questions related to monitoring and evaluation (M&E) of the WWP. The main focus will be on data reporting processes. This is for the whole district, not just the district hospital. The first set of questions assesses district M&E and reporting systems. Please refer to page 4 of your guide.

Is there a WWP M&E focal person for your district? Yes No

[If yes,] Who is the WWP M&E focal person for your district? (note: these are members of the WWP committee) [select one]

_____WWP focal person

_____Health screening, treatment, & care focal person

_____TB/HIV focal person

_____Health talks focal person

_____Stress management & team building focal person

_____Psychosocial focal person

_____Occupational health & safety focal person

_____Peer education focal person

_____Therapeutic recreation focal person

_____Publicity focal person

_____Other (specify)_____

[If no,] Who is responsible for reporting district M&E data to the national-level? [e.g., compile and send the report][select one]

_____Nurse

_____Medical Officer

_____Counselor

_____Auxiliary staff

_____WWP Focal Person

_____Other (specify) _____

[if yes or no] Does this person work with the DHMT M&E officer when compiling and reporting data? YES NO

Now I will ask a few questions on M&E and reporting tools.

M&E & REPORTING TOOLS		
[NB: District report]	**1-–Yes** **2-No**	**Comments**
Do you have the quarterly reports template from WWP national coordinating office?		
Do you have a completed quarterly report for any quarter during the 2012 - 2013 financial year?		
Do you have the workshop/training evaluation form template from WWP national coordinating office?		
Do you have a completed workshop/training evaluation form?		
Are you using any other reporting tools?		
If yes, describe briefly?		

Now I will ask a few questions on reporting and supportive supervision.

REPORTING & SUPPORTIVE SUPERVISION			
	1- Yes **2- No**	**If yes, how often?** 1- Weekly 4- Annually 2- Monthly 5- Other 3- Quarterly	**Comments**
Do you receive WWP reports from facilities in your health district on their WWP activities?			
Is WWP data from your district reported to the WWP national coordinating office?			
Do you get supervisory WWP visits from the WWP national coordinating office?			

Now I will ask a few questions related to data.

Do you compile data received from the facilities or from the district hospital? Yes No

DATA COMPILATION [AGGREGATION] **[Directions:** Tick the appropriate response. One per question]				
Thinking of the data you receive from the facilities in your district, do you experience/see.....	**Always**	**Sometimes**	**Rarely**	**Never**
Incomplete data				
Late reporting				
Poorly presented data [e.g., wrong format, spot on form]				
Incorrect data				
No reporting				

DATA QUALITY ***(****Refer to page 5 of your guide)*		
[NB: Facilities refers to DHMT, district hospital, clinics, health post, etc]	**1- YES** **2- NO**	**COMMENTS**
Do you review the data from facilities for errors or missing data?		
Do you have a procedure that you follow to correct identified errors or missing data in the reports?		
Are sources of data / tools from facilities kept safely for verification?		

Do you periodically verify sources of data?		
Do you feel officers at facility-level are knowledgeable on data collection and the submission process?		
Do you present or share the compiled data to district-level management through reports or meetings?		
Do you share compiled data with facilities in the district? [e.g., feedback, meetings]		

PART V: CLOSING

We have come to the end of the questionnaire and I would like to thank you for your time and for sharing your districts WWP information.

Before I wrap up, I just want to make sure I have captured all of the documents you had for us to view: Refer to page 5 of your guide.

[Verify / review against the separate document, 'Items FP to Bring to Training (The 'see component')]

That completes the interview. Once again, thank you for your support.

I-TECH BOTSWANA

UNIVERSITY OF WASHINGTON

CONSENT FORM

MOH WORKPLACE WELLNESS EVALUATION

NATIONWIDE WWP IMPLEMENTATION ASSESSMENT

Researcher	Institution & Department	Contact Details
Gabrielle O'Malley, PhD Assistant Professor	University of Washington, Department of Global Health	1-206-685-0775 gomalley@uw.edu
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Researchers' statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. We will read the form to you and you can read along using the copy that has been provided to you. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to continue with the interview or not. This process is called "informed consent." This copy of this form is for your records.

PURPOSE OF THE STUDY

Since the roll-out of the Ministry of Health's (MOH) national Workplace Wellness Programme in 2007, there is little known about coverage of the programme across Botswana, how health workers are utilizing the programme , or whether or how it has made a difference in the lives of health workers. In order to make evidence-based decisions for programme matic improvements to enhance implementation and utilization, it is important that data be collected on the achievements, challenges, and outcomes of the WWP.

This implementation assessment is part of an evaluation being undertaken for programme evaluation purposes in order to inform the WWP. We are focusing on factors affecting the WWP activities, use of the programme , and outcomes of the programme . The primary use of the findings from this evaluation will be to improve the implementation of the programme and describe outcomes of the programme.

STUDY PROCEDURES

Implementation assessments are being conducted with the WWP focal person in each of the 29 health district throughout Botswana. If you agree to participate, you will be asked a series of questions related to the WWP in your health district in order to assess programme development, administration, and implementation. The implementation assessment will take approximately one hour. During the implementation assessment you will be asked questions such as:

- *"How many peer educators are currently available in the district?"*
- *"How often are supervisory visits made to the district level to support M&E?"*

You may decline or refuse to answer any question at any time during the implementation assessment or ask for the implementation assessment to be stopped.

RISKS, STRESS, OR DISCOMFORT

You may experience stress, discomfort, or feel that your privacy is being invaded due to the process of this implementation assessment and the questions you are asked. There are no physical risks involved in this study. If you experience stress or discomfort you may discontinue the interview.

You may contact Heather Mothibedi with the MOH at +267-363-2052 or Jenny Ledikwe with I-TECH at +267-390-0925 with questions about the evaluation and the Botswana Health Research and Development Committee at the MOH at +267-363-2775 if you have questions about your rights as an evaluation subject.

BENEFITS OF THE STUDY

There are no immediate or direct benefits to you from this study. This study is evaluating the MOH Workplace Wellness Programme, and as such your input will assist and contribute to the running of the programme in the future.

SOURCE OF FUNDING

This study is being funded by the U.S. President's Emergency Plan for AIDS Relief in Botswana.

CONFIDENTIALITY OF RESEARCH INFORMATION

Information collected during the implementation assessment will be kept confidential. A unique identifier will be created that is linked to this implementation assessment, however your name will not be recorded anywhere. The code for the unique identifier will be kept separate from the implementation assessment. Data will be kept on password protected server for five years and then destroyed. All information included in the report and any subsequent manuscripts or journals will not identify you as a respondent.

OTHER INFORMATION

You may refuse to participate or decline to answer any questions during this implementation assessment without any recrimination or penalty. This is a voluntary study.

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Botswana Ministry of Health's Health Research and Development Committee at 3632775. I have received a copy of this consent form.

Do you agree to participate in this study? _____ (Yes / No)

This signed written consent serves as documentation that the required elements of informed consent have been presented orally to the participant.

Verbal consent to participate in this telephone interview has been obtained by review of this informed consent form with the participant, verbally asking if they consent, and their agreement to proceed with the questions.

Printed name of study staff obtaining consent	Signature	Date

Appendix D. National-Level In-Depth Interview Guide

District:	**Interviewer:**
Date:	**Note-Taker:**

IDI NATIONAL LEVEL

Inputs and Processes

1. Please describe how you have been involved with the Ministry of Health's Workplace Wellness Programme, the WWP? [Probe: development, administration, training, other]

We are going to start with a series of questions about the start-up or initiation of the WWP.

2. Please tell me why it was determined there was a need for a WWP? What were the reasons for developing and initiating a WWP?

This first set of questions will ask you about the specific inputs that were required for the WWP to be established at the MOH.

3. How was the programme funded?
4. What organisations (**key players**) were instrumental in establishing the programme? What were their roles?
5. How would you describe the **political will**?
6. Was there **administrative support**?
7. Were there **other** inputs?

This next set of questions focuses on the processes needed for the establishment of the WWP at the MOH. [Probe: sustainability]

8. What **governance structures**, such as committees, were put in place to facilitate the implementation of the WWP?

9. Please tell me about the **guidelines and operating frameworks** used to guide the programme implementation. [Probe: development]

10. **Capacity development** has been an important part of programme. Can you please describe the processes related to capacity development?
11. What activities have taken place related to **monitoring and evaluation**?
12. Were there other key processes?
13. Have the inputs and process changed since the start-up? If so how?
14. How effective has the rollout to the districts been? [Probe: facilitators, barriers, key inputs and processes needed]

In conclusion,

15. Is there anything you would like to share with us on the utilisation of WWP activities which we might have forgotten to cover in our questions?

Thank you for your time and participation in today's interview.

Appendix E. District-Level In-Depth Interview Guide

District:	Interviewer:
Date:	**Note-Taker:**

PART I: Inputs and Processes

1. **Please describe how you have been involved with the Ministry of Health's Workplace Wellness Programme, the WWP?**

   [Probe: development, administration, training, length of time, other]

This first set of questions focuses on the processes needed, at district-level, for the establishment of the WWP at the district hospital and the district.

2. **How effective is the WWP committee?**

[Probe: structure of the committee, make up – is it effective/efficient, who plans, facilitators, barriers]

3. **Please tell me about the support received for the programme.**

[Probe: Facilitators, barriers, supportive supervision, district-level management]

4. **Can you please describe the process related to capacity development at the district level?**

[Probe: facilitators, barriers, trainings, et.al.]

5. **Tell me about how you monitor and evaluate the implementation of the WWP ''minimum package'' in the district?**

[Probe: tools, facilitators & barriers]

6. **Have the Inputs and Processes changed since the start-up? If so how?**

Rollout and Facility

Now, let's discuss the inputs and process needed for the WWP to be implemented at the facilities other than the district hospitals.

7. **Describe the roll-out of WWP to the facilities in your district?**

   [Probe: facilitators, barriers, processes, inputs]

8. **How successful do you feel the rollout of the WWP activities to facilities in your district has been?**

   [Probe: facilitators, barriers]

9. **Describe the facilitators and barriers to the WWP programme at the district level.**

   [Probe: *sustainability*]

PART II: Health Components

Now let us discuss the six health components of the WWP minimum package and discuss them one by one, focusing on the barriers and facilitators to implementation.

Health screening, treatment, and care:

[Health screening, treatment, and care services include clinical assessments to identify health-risk factors and disease (e.g., TB, HIV, and cancer), early diagnosis and interventions, and referrals to appropriate treatment and care services.]

10. **What has <u>facilitated</u> the implementation of health screening, treatment, and care activities at district hospitals? What has worked well?**
11. **What were the <u>barriers</u> or challenges in relation to health screening, treatment, and care activities at district hospitals?**
12. **How do you think these barriers can be addressed to bring change?**

Health Promotion:

[Let us now talk about Health Promotion. Health promotion activities: wellness talks, health campaigns, seminars, commemorations, and peer education activities to address health and lifestyle issues. Includes activities focused on empowering health workers to be in control of all dimensions of their lives (e.g., finances, substance use, and health issues).]

13. **What has <u>facilitated</u> the implementation of health promotion activities at district hospitals? What has worked well?**
14. **What were the <u>barriers</u> or challenges in relation to health promotion activities at district hospitals?**
15. **How do you think these barriers can be addressed to bring change?**

Stress management and team building:

[Let us now talk about stress management and team building. Stress management and team building trainings and workshops which focus on enhancing the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork.]

16. **What has facilitated the implementation of stress management and team building activities at district hospitals? What has worked well?**
17. **What were the barriers or challenges in relation to stress management and team building activities at district hospitals?**
18. **How do you think these barriers can be addressed to bring change?**

Occupational health and safety:

[Let us now talk about Occupational health and safety. Occupational health and safety addresses issues of safety in the workplace focusing on identification of health hazards, prevention, control and management of the health hazards. It also addresses care related to occupational exposure, injury, and post exposure prophylaxis services.]

19. **What has facilitated the implementation of occupational health and safety activities at district hospitals? What has worked well?**
20. **What were the barriers or challenges in relation to occupational health and safety activities at district hospitals?**
21. **How do you think these barriers can be addressed to bring change?**

Psychosocial and spiritual care:

[Let us now talk about Psychosocial and spiritual care. Psychosocial and spiritual care includes support groups of health workers led by a trained group facilitator. It also includes activities such as counselling, prayer, Holy Communion, and scripture reading.]

22. **What has facilitated the implementation of psychosocial and spiritual care activities at district hospitals? What has worked well?**
23. **What were the barriers or challenges in relation to psychosocial and spiritual care activities at district hospitals?**
24. **How do you think these barriers can be addressed to bring change?**

Therapeutic recreation:

[The last health component is therapeutic recreation. Therapeutic recreation focuses on improving the physical, psychological, emotional, and occupational well-being of health workers. This includes activities such as physical activity programme s, social recreation, edutainment, and exercise facilities.]

25. **What has facilitated the implementation of therapeutic recreation activities at district hospitals? What has worked well?**
26. **What were the barriers or challenges in relation to therapeutic recreation activities at district hospitals?**
27. **How do you think these barriers can be addressed to bring change?**

In conclusion,

28. **Is there anything you would like to share with us on the utilisation of WWP activities which we might have forgotten to cover in our questions?**

Thank you for your time and participation in today's interview.

Appendix F. Facility-Level In-depth Interview Guide

District:	**Interviewer:**
Date:	**Note-Taker:**

PART I: Inputs and Processes

1. **Please describe how you have been involved with the Ministry of Health's Workplace Wellness Programme, the WWP?**
   [Probe: development, administration, training, other]

We are going to start a series of questions about the start-up or initiation of the WWP. Let's discuss the inputs and process needed for the WWP to be implemented at your facility.

2. **Tell me about the facility's WWP committee?**
   [Probe: is there a facility committee? Do they belong to district committee? How is it run? Facilitators & Barriers]

3. **Tell me about the type of support you receive for WWP activities and programme at facility level.** *[Probe: what type of support received, supportive supervision, from whom (district, national, etc), inputs, facilitators, barriers]*

4. **What is done at facility level to monitor and/or evaluate any WWP programme s and activities?**
   [Probe: facilitators, barriers, training, tools]

5. **Thinking about the inputs and process, what do you think are the key inputs and processes needed to ensure the implementation of WWP activities at facility-level?**
   [Probe: successful rollout]

6. **Describe any facilitators and barriers to the WWP implementation and programme s at facility-level**.

PART II: Health Components

Now let us discuss the six health components of the WWP minimum package and discuss them one by one, focusing on the barriers and facilitators to implementation.

Health screening, treatment, and care:

[Health screening, treatment, and care services include clinical assessments to identify health-risk factors and disease (e.g., TB, HIV, and cancer), early diagnosis and interventions, and referrals to appropriate treatment and care services.]

7. **Does your facility offer Health, Screening and treatment of health services for health workers via WWP (e.g., special clinic, events)?**

8. **What has facilitated the implementation of health screening, treatment, and care activities at in your facility? [What has worked well?]**

9. **What were the barriers or challenges in relation to health screening, treatment, and care activities in your facility?**

10. **How do you think these barriers can be addressed to bring change?**

Health Promotion:

[Let us now talk about Health Promotion. Health promotion activities: wellness talks, health campaigns, seminars, commemorations, and peer education activities to address health and lifestyle issues. Includes activities focused on empowering health workers to be in control of all dimensions of their lives (e.g., finances, substance use, and health issues).]

11. **Does the WWP offer health promotion activities for health workers at your facility?**

12. **What has facilitated the implementation of health promotion activities in your facility? [What has worked well?]**

13. **What were the barriers or challenges in relation to health promotion activities in your facility?**

14. **How do you think these barriers can be addressed to bring change?**

Stress management and team building:

[Let us now talk about stress management and team building. Stress management and team building trainings and workshops which focus on enhancing the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork.]

15. **Does the WWP offer stress management and team building activities for health workers in your facility?**

16. **What has facilitated the implementation of stress management and team building activities in your facility? [What has worked well?]**

17. **What were the barriers or challenges in relation to stress management and team building activities in your facility?**

18. **How do you think these barriers can be addressed to bring change?**

Occupational health and safety:

[Let us now talk about Occupational health and safety. Occupational health and safety addresses issues of safety in the workplace focusing on identification of health hazards, prevention, control and management of the health hazards. It also addresses care related to occupational exposure, injury, and post exposure prophylaxis services.]

19. **Does the WWP offer occupational health and safety activities for health workers at your facility?**

20. **What has facilitated the implementation of occupational health and safety activities in your facility? [What has worked well?]**
21. **What were the barriers or challenges in relation to occupational health and safety activities at in your facility?**

22. **How do you think these barriers can be addressed to bring change?**

Psychosocial and spiritual care:

[Let us now talk about Psychosocial and spiritual care. Psychosocial and spiritual care includes support groups of health workers led by a trained group facilitator. It also includes activities such as counselling, prayer, Holy Communion, and scripture reading.]

23. **Does your WWP offer psychosocial and spiritual care activities for health workers at your facility?**

24. **What has facilitated the implementation of Psychosocial and spiritual care activities in your facility? [What worked well?]**

25. **What were the barriers or challenges in relation to Psychosocial and spiritual care activities in your facility?**

26. **How do you think these barriers can be addressed to bring change?**

Therapeutic recreation:

[The last health component is therapeutic recreation. Therapeutic recreation focuses on improving the physical, psychological, emotional, and occupational well-being of health workers. This includes activities such as physical activity programme s, social recreation, edutainment, and exercise facilities.]

27. **Does the WWP offer therapeutic recreation activities for health workers at your facility?**

28. **What has facilitated the implementation of therapeutic recreation activities at in your facility? [What has worked well?]**

29. **What were the barriers or challenges in relation to therapeutic recreation activities in your facility?**

30. **How do you think these barriers can be addressed to bring change?**

In conclusion,

31. **Is there anything you would like to share with us on the utilisation of WWP activities which we might have forgotten to cover in our questions?**

Thank you for your time and participation in today's interview.

Appendix G. In-Depth Interview Consent Form

Researcher	Institution & Department	Contact Details
Gabrielle O'Malley, PhD Assistant Professor	University of Washington, Department of Global Health	1-206-685-0775 gomalley@uw.edu
Maureen Mpho Co-Investigator Workplace Wellness Evaluation	Botswana Ministry of Health, Department of HIV/AIDS Prevention & Care – Workplace Wellness Programme Head	363-2242 mumpho@gov.bw
Heather Mothibedi Co-Investigator Workplace Wellness Evaluation	Botswana Ministry of Health, Department of HIV/AIDS Prevention & Care	363-2052 hmothibedi@gov.bw
Jenny Ledikwe, PhD Director of Monitoring, Evaluation, and Research Clinical Assistant Professor	International Training & Education Center for Health (I–TECH – Botswana) University of Washington, Department of Global Health	390-0925 ledikwe@uw.edu

Researchers' statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. We will read the form to you and you can read along using the copy that has been provided to you. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to continue with the interview or not. This process is called "informed consent." We will give you a copy of this form for your records.

PURPOSE OF THE STUDY

Since the roll-out of the Ministry of Health's (MOH) national Workplace Wellness Programme (WWP) in 2007, there is little known about coverage of the programme across Botswana, how health workers are utilizing the programme, or whether or how it has made a difference in the lives of health workers. In order to make evidence-based decisions for programmatic improvements to enhance

implementation and utilization, it is important that data be collected on the achievements, challenges, and outcomes of the WWP.

This interview is part of an evaluation being undertaken for programme evaluation purposes in order to inform the WWP. We are focusing on key inputs and processes related to WWP activities, as well as barriers and facilitators to programme implementation. The primary use of the findings from this evaluation will be to improve the implementation of the programme and describe outcomes of the programme.

STUDY PROCEDURES

Interviews are being conducted at national-, district-, and facility-levels with individuals who have been historically involved or are currently involved with the development or administration of the WWP. You have been identified as one of those persons.

If you agree to participate, you will be asked a series of questions taking you through your knowledge and experience in the development and implementation of the MOH Workplace Wellness Programme. The interview will take approximately one to two hours. You will be asked questions such as:

- *"What were the key challenges you encountered in rolling out the WWP?"*
- *"What should be done to ensure success of the WWP activities?"*

Your responses will be recorded by a rapporteur. In addition, we will voice record the interview using a digital voice recorder upon your consent, however you may refuse to be voice recorded. The voice recording and notes will be used to create a transcription of this interview.

You may decline or refuse to answer any question at any time during the interview or ask for the interview to be stopped.

RISKS, STRESS, OR DISCOMFORT

You may experience stress, discomfort, or feel that your privacy is being invaded due to the process of this interview and the questions you are asked. There are no physical risks involved in this study. If you experience stress or discomfort you may discontinue the interview.

A digital voice recording will be made of this interview, upon your consent. We will not share the voice recording with other researcher or use it in presentations. The content will be used to assist in the report writing only of this study.

You may contact Maureen Mpho with MOH at +267-363-2242 or Jenny Ledikwe with I-TECH at +267-390-0925 with questions about the evaluation and the Botswana Health Research and Development Committee at the Ministry of Health at +267-363-2775 if you have questions about your rights as an evaluation subject.

BENEFITS OF THE STUDY

There are no immediate or direct benefits to you from this study. This study is evaluating the MOH Workplace Wellness Programme, and as such your input will assist and contribute to the running of the programme in the future.

SOURCE OF FUNDING

This study is being funded by the US President's Emergency Plan for AIDS Relief in Botswana.

CONFIDENTIALITY OF RESEARCH INFORMATION

Information collected during the interview will be kept confidential. A unique identifier will be created that is linked to this interview, however your name will not be recorded anywhere. The code for the unique identifier will be kept separate from the interview transcript. Both the voice recordings and the transcripts will be kept on password protected servers for five years and then destroyed. All information included in the report and any subsequent manuscripts or journals will not identify you as a respondent.

OTHER INFORMATION

You may refuse to participate or decline to answer any questions during this interview without any recrimination or penalty. This is a voluntary study.

Printed name of study staff obtaining consent Signature Date

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Botswana Ministry of Health's Health Research and Development Committee at 3632775. I have received a copy of this consent form.

Signature of subject Date

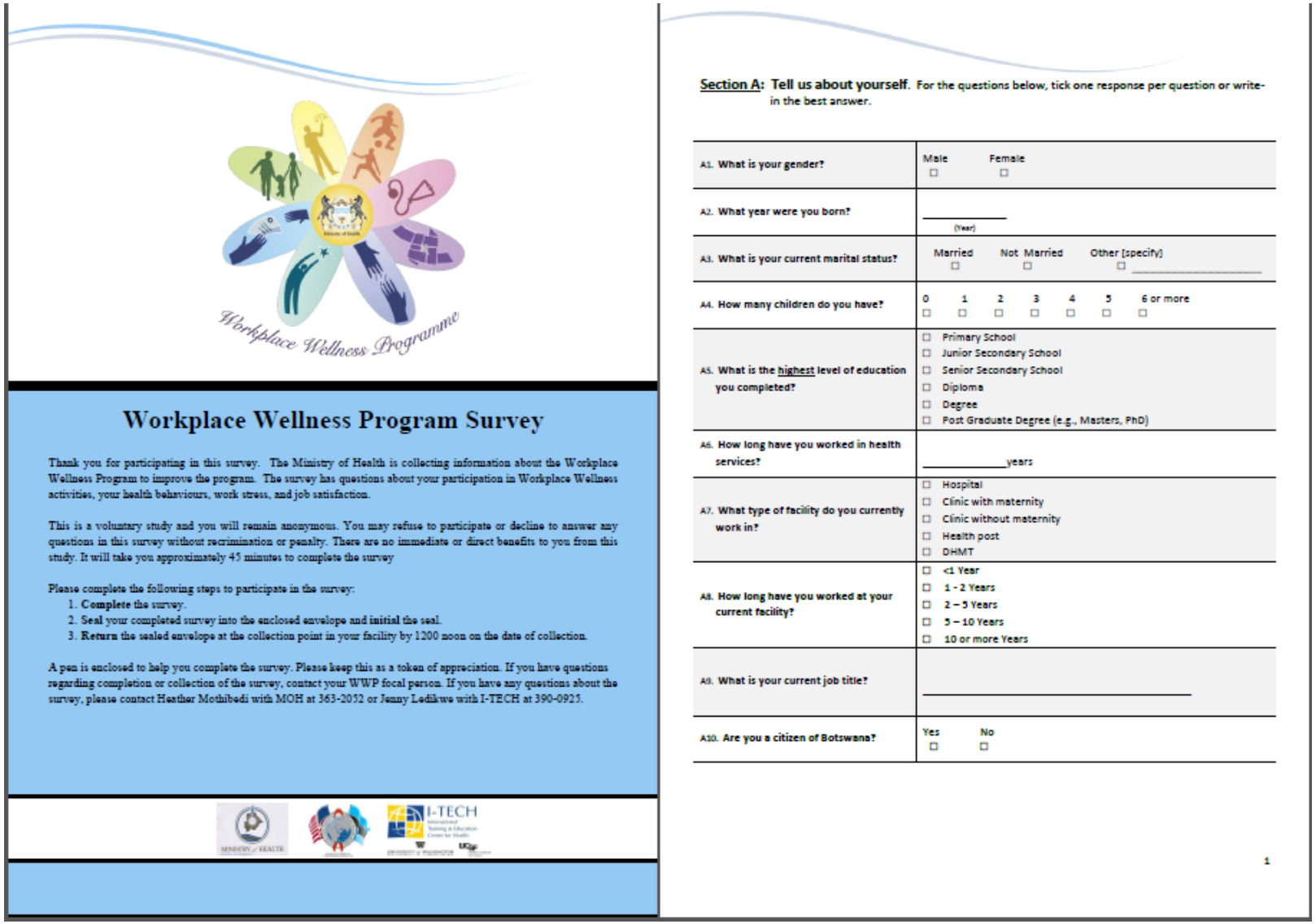
I consent to have this interview voice recorded and understand what this entails.

_____

Signature of subject

Copies to: Researcher
Subject

Appendix H. Workplace Wellness Programme National Survey of Health Workers



Workplace Wellness Programme

Workplace Wellness Program Survey

Thank you for participating in this survey. The Ministry of Health is collecting information about the Workplace Wellness Program to improve the program. The survey has questions about your participation in Workplace Wellness activities, your health behaviours, work stress, and job satisfaction.

This is a voluntary study and you will remain anonymous. You may refuse to participate or decline to answer any questions in this survey without recrimination or penalty. There are no immediate or direct benefits to you from this study. It will take you approximately 45 minutes to complete the survey

Please complete the following steps to participate in the survey:

1. **Complete** the survey.
2. **Seal** your completed survey into the enclosed envelope and **initial** the seal.
3. **Return** the sealed envelope at the collection point in your facility by 1200 noon on the date of collection.

A pen is enclosed to help you complete the survey. Please keep this as a token of appreciation. If you have questions regarding completion or collection of the survey, contact your WWP focal person. If you have any questions about the survey, please contact Heather Mothibedi with MOH at 363-2052 or Jenny Ledikwe with I-TECH at 390-0925.

Section A: Tell us about yourself. For the questions below, tick one response per question or write-in the best answer.

A1. What is your gender?	Male ☐ Female ☐
A2. What year were you born?	_____ (Year)
A3. What is your current marital status?	Married ☐ Not Married ☐ Other [specify] ☐ _____
A4. How many children do you have?	0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more ☐
A5. What is the highest level of education you completed?	☐ Primary School ☐ Junior Secondary School ☐ Senior Secondary School ☐ Diploma ☐ Degree ☐ Post Graduate Degree (e.g., Masters, PhD)
A6. How long have you worked in health services?	_____ years
A7. What type of facility do you currently work in?	☐ Hospital ☐ Clinic with maternity ☐ Clinic without maternity ☐ Health post ☐ DHMT
A8. How long have you worked at your current facility?	☐ <1 Year ☐ 1 - 2 Years ☐ 2 – 5 Years ☐ 5 – 10 Years ☐ 10 or more Years
A9. What is your current job title?	_____
A10. Are you a citizen of Botswana?	Yes ☐ No ☐

1

Section B: Your Job. Please tell us about how often you work and how you feel about your job.

B1. About how many hours altogether did you work in the past 7 days (week)? _____ hours

B2. How many hours does your employer expect you to work in a typical 7 day week? _____ hours

For questions B3 – B5; Tick one answer using the scale from 0 to 10, where 0 is the worst job performance anyone could have at your job and 10 is the performance of a top worker.

B3. How would you rate the usual performance of most workers in a job similar to yours?

Worst job performance	0	1	2	3	4	5	6	7	8	9	10	Best job performance
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

B4. How would you rate your usual job performance over the past year or two?

Worst job performance	0	1	2	3	4	5	6	7	8	9	10	Best job performance
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

B5. How would you rate your overall job performance on the days you worked during the past 4 weeks?

Worst job performance	0	1	2	3	4	5	6	7	8	9	10	Best job performance
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

B6. These questions relate to your work. Tick one response that describes how often your experience each of the following.	All the time	Most of the time	Some of the time	A little of the time	None of the time
How often was your performance higher than most workers on your job?					
How often was your performance lower than most workers on your job?					
How often did you do no work at times when you were supposed to be working?					
How often did you find yourself not working as carefully as you should?					
How often was the quality of your work lower than it should have been?					
How often did you not concentrate enough on your work?					
How often did health problems limit the kind or amount of work you could do?					

Please continue on the next page

Section C: Please tell us about your participation in Workplace Wellness activities.

Tick one response per item which best describes your participation in workplace wellness activities and services.

C1. Within the last year have you had:	NO	YES, as part of a WWP activity	YES, as part of a health check-up
...your body mass index (BMI) assessed?			
...your cholesterol assessed?			
...an HIV test?			
...a TB test?			
...a screening for cancer?			
...your blood sugar assessed?			
...your eyes checked?			

Tell us about **health promotion activities for health workers** such as wellness talks, health campaigns, seminars, commemorations, and peer education activities.

C2. In the past year, how many times were health promotion activities for health workers offered at your facility?

0 ☐ 1-2 ☐ 3-6 ☐ 6-12 ☐ 13 or more ☐

C3. In the past year, how many times did you participate in health promotion activities for health workers?

0 ☐ 1-2 ☐ 3-6 ☐ 6-12 ☐ 13 or more ☐

C4. How beneficial do you feel these activities are for the health workers?

Very beneficial ☐ Somewhat Beneficial ☐ A little beneficial ☐ Not beneficial at all ☐

Think about **stress management and team building activities** such as trainings, workshops, programs, social events, and team building exercises to improve the physical, psychological, or emotional well being of health workers.

C5. In the past year, how many times were stress management and team building activities for health workers offered at your facility?

0 ☐ 1-2 ☐ 3-6 ☐ 6-12 ☐ 13 or more ☐

C6. In the past year, how many times did you participate in stress management and team building activities for health workers?

0 ☐ 1-2 ☐ 3-6 ☐ 6-12 ☐ 13 or more ☐

C7. How beneficial do you feel these activities are for the health workers?

Very beneficial ☐ Somewhat Beneficial ☐ A little beneficial ☐ Not beneficial at all ☐

Think about occupational health and safety such as the management of health hazards activities in the workplace.

C8. **In the past year, how many times were occupational health and safety activities conducted at your facility?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C9. **In the past year, how many times did you participate in occupational health and safety activities?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C10. **How beneficial do you feel these activities are for the health workers?**

Very beneficial	Somewhat Beneficial	A little beneficial	Not beneficial at all
☐	☐	☐	☐

Tell us about psychosocial and spiritual care activities such as support groups, counselling, prayer, and Holy Communion.

C11. **In the past year, how many times were psychosocial and spiritual care activities for health workers offered at your facility?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C12. **In the past year, how many times did you participate in psychosocial and spiritual care activities for health workers?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C13. **How beneficial do you feel these activities are for health workers?**

Very beneficial	Somewhat Beneficial	A little Beneficial	Not beneficial at all
☐	☐	☐	☐

Now think about therapeutic recreation activities such as social recreation, edutainment, exercise facility, and physical fitness programs to improve the physical, psychological and occupational emotional well being of health workers.

C14. **In the past year, how many times were therapeutic recreation activities for health workers offered at your facility?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C15. **In the past year, how many times did you participate in therapeutic recreation activities?**

0	1-2	3-6	6-12	13 or more
☐	☐	☐	☐	☐

C16. **How beneficial do you feel these activities are for the health workers?**

Very Beneficial	Somewhat Beneficial	A little beneficial	Not beneficial at all
☐	☐	☐	☐

Please continue on the next page

Section D: Your lifestyle behaviours. The next set of questions asks about the foods you eat, smoking, alcohol use, and physical activity. In the tables below, tick the corresponding answer for each question.

D1. During the past 30 days, how many times per day did you…	None	<1 per day	1 per day	2 per day	3 per day	4 per day	≥5 per day
…eat fruit, such as oranges, apples, bananas, grapes, peaches, moretologa, morula, or mmopudu.							
…eat vegetables such as cabbage, spinach, chomolia, rape, pumpkin, butternut, morogo wa dinawa, rothwe, thepe, or lerotse?							
…clean or brush your teeth?							

D2. During the past 30 days, how many days did you…	0 days	1 or 2 days	3 – 5 days	6 – 9 days	10 – 19 days	20 – 29 days	All 30 days
…smoke cigarettes?							
…use another form of tobacco such as snuff, chewing tobacco, cigar, or zolo?							
…have people smoked in your presence?							
…have at least one drink containing alcohol?							

D3. **During the past 12 months, have you ever tried to stop smoking cigarettes or using other forms of tobacco?**

- ☐ Yes
- ☐ No
- ☐ I have never smoked cigarettes or used tobacco
- ☐ I did not smoke cigarettes or use tobacco products during the past 12 months

D4. **During the past 30 days, on the days you drank alcohol, how many drinks did you usually drink per day?**

- ☐ I did not drink alcohol during the past 30 days
- ☐ Less than one drink
- ☐ 1 drink
- ☐ 2 drinks
- ☐ 3 drinks
- ☐ 4 drinks
- ☐ 5 or more drinks

D5. **What type of alcohol do you usually drink? Select only ONE response.**

- ☐ I do not drink alcohol
- ☐ Beer, lager, or stout
- ☐ Wine
- ☐ Spirits such as brandy, whisky, rum, or amarula
- ☐ Khadi, setopoti, chibuku, or traditional beer
- ☐ Hunters Gold/Dry, Esprit, Brutal Fruit, Smirnoff Spin/Ice, or Klipdrift Cola
- ☐ Some other type

D6. The next set of questions asks about **physical activity**. Physical activity is any activity that increases your heart rate and makes you get out of breath some of the time. Some examples of physical activity are running, fast walking, biking, aerobics, volleyball, football, jogging, and dancing.	0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
During the past 7 days (week), on how many days were you physically active for a total of at least 60 minutes per day?								
During a typical or usual week, on how many days are you physically active for a total of at least 60 minutes per day?								
During the past 7 days (week), on how many days did you walk or ride a bicycle to and from work?								

D7. **How much time do you spend during a typical or usual day sitting and working on a computer or at desk, watching television, playing computer games, talking with friends, or doing other sitting activities such as listening to the radio, playing cards, diketo, or morabaraba?**

- ☐ Less than one hour per day
- ☐ 1 to 2 hours per day
- ☐ 3 to 4 hours per day
- ☐ 5 to 6 hours per day
- ☐ 7 to 8 hours per day
- ☐ More than 8 hours per day

Please continue on the next page

Section E: Your work environment. In the blank beside each word below, write:

In the blank beside each word below, write:

Y for "Yes" if it describes your work
N for "No" if it does not describe your work
? for "?" if you cannot decide

E1. Work on present job

Think of the work you do at present. How well do each of the following words describe your work?

_____ Fascinating
_____ Satisfying
_____ Good
_____ Exciting
_____ Rewarding
_____ Uninteresting

E2. Supervision

Think of the supervision that you get on your job. How well do each of the following words or phrases describe this?

_____ Praises good work
_____ Tactful
_____ Influential
_____ Up to date
_____ Annoying
_____ Knows job well

E3. Pay

Think of the pay you get now. How well do each of the following words or phrases describe your present pay?

_____ Barely live on income
_____ Bad
_____ Well paid
_____ Underpaid
_____ Comfortable
_____ Enough to live on

E4. Opportunities for promotion

Think of the opportunities for promotion you have. How well do each of the following words or phrases describe these?

_____ Good opportunities for promotion
_____ Opportunities somewhat limited
_____ Dead-end job
_____ Good chance for promotion
_____ Fairly good chance for promotion
_____ Regular promotions

In the blank beside each word below, write:

Y for "Yes" if it describes your work
N for "No" if it does not describe your work
? for "?" if you cannot decide

E5. People on your present job

Think of the majority of people with whom you work or meet in connection with your job. How well do each of the following words describe these people?

_____ Boring
_____ Slow
_____ Responsible
_____ Smart
_____ Lazy
_____ Frustrating

E6. Job in General

Think of your job in general. All in all, what is it like most of the time?

_____ Good
_____ Undesirable
_____ Better than most
_____ Disagreeable
_____ Makes me content
_____ Excellent
_____ Enjoyable
_____ Poor

E7. Your stress at work

Do you find your job stressful?

_____ Demanding
_____ Pressured
_____ Calm
_____ Many things stressful
_____ Hassled
_____ Nerve-racking
_____ More stressful than I would like
_____ Overwhelming

Please continue on the next page

Section F: Your Health. We would like to know how your health has been in general. Please read the questions below and tick the box for the response that best applies to you over the past few weeks.

F1. Have you recently...	Better than usual	Same as usual	Less than usual	Much less than usual
...been able to concentrate on what you are doing?				
...lost much sleep over worry?				
...felt that you are playing a useful part in things?				
...felt capable of making decisions about things?				
...felt constantly under strain?				
...felt you could not overcome your difficulties?				
...been able to enjoy your normal day-to-day activities?				
...been able to face up to your problems?				
...been feeling unhappy or depressed?				
...been losing confidence in yourself?				
...been thinking of yourself as a worthless person?				
...been feeling reasonably happy, all things considered?				

The following table lists items that are potential sources of stress. Please indicate how strongly you agree or disagree that these are source of stress for you.

F2. Sources of my work-related stress include...	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
...too much work.					
...shortage of staff.					
...balancing work and family demands.					
...conflicts with co-workers.					
...insufficient resources and supplies.					
...not being appreciated for the work I do.					
...non-supportive supervisors.					
...supporting care for many patients.					
...supporting care for many HIV/AIDS patients.					
...supporting relatives of patients.					

F3. **The table below lists coping strategies for managing stress. Please select any copying strategies that you have used.**

	Place a tick (√) in this column if <u>you have ever used this coping mechanism</u> when dealing with stress. (tick all that apply)
Visit a counsellor	
Talk with friends	
Talk with co-workers	
Talk with family members	
Seek support from supervisors	
Deal with problems as they occur	
Deal with problems objectively in an un-emotional way	
Being optimistic/look at the bright side of things	
Exercise	
Pray, attend church, or other spiritual activities	
Drink alcohol	
Take leave from work	
Gamble	
Other (Specify): _____	
Other (Specify): _____	
Other (Specify): _____	
Other (Specify): _____	

F4. **Do you feel stressed when you are at work?**

Always	Sometimes	Rarely	Never
☐	☐	☐	☐

Please continue on the next page

F5. **Instructions:** Below are 16 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way.

How often:	**0** Never	**1** A few times a year or less	**2** Once a month or less	**3** A few times a month	**4** Once a week	**5** A few times a week	**6** Everyday

How often 0 - 6	**Statements:**
1._____	I feel emotionally drained from my work.
2._____	I feel used up at the end of the workday.
3._____	I feel tired when I get up in the morning and have to face another day on the job
4._____	Working all day is a strain for me.
5._____	I can effectively solve the problems that arise in my work.
6._____	I feel burned out from my work.
7._____	I feel I am making an effective contribution to what this organization does.
8._____	I have become less interested in my work since I started this job.
9._____	I have become less enthusiastic (very happy/proud) about my work.
10._____	In my opinion, I am good at my job.
11._____	I feel exhilarated when I accomplish something at work.
12._____	I have accomplished many worthwhile things in this job.
13._____	I just want to do my job and not be bothered.
14._____	I have become more cynical (sceptical) about whether my work contributes anything.
15._____	I doubt the significance of my work.
16._____	At my work, I feel confident that I am effective at getting things done.

THE END - THANK YOU

Appendix I. Focus Group Discussion Guide: Stress and Health Behaviours

Today we will be discussing any occupational stress that **you and your colleagues** face, and the coping mechanisms used to handle stress, ways to reduce stress, as well as lifestyle behaviours such as diet and exercise.

It is important to note that **we are not focusing on your individual stress and lifestyle behaviours**. Instead we want you to think about yourself and other health workers in your associated cadres [for example, allied, professional, industrial, administration, nurse, doctor] when we ask the following questions and answer accordingly. **We are asking these questions about you and your co-workers so that we can make generalizations about health workers, and not have it be personal or about you specifically**.

Are there any questions? [Address any questions or concerns]

If there are no questions, let us begin the questions.

1a. ICEBREAKER Question: What do you know of the MOH WWP?

PART I: Occupational Stress and Coping Mechanisms
Let us start with discussing **occupational stress and coping mechanisms.** When I say occupational stress I am specifically referring to stress related to work, and not from personal life. Based on the national health worker survey that was conducted last year, it was found that shortage of staff, insufficient resources and supplies, and too much work were the top three most commonly reported sources of occupational stress.

1. Thinking about you and other health workers in your cadre, do you agree with this?
2. Are there any other common occupational stressors we should discuss?
   [give just a few minutes and write on flip chart, then rank top 3]

Ok, now let us break down some of these findings and gather more information on these main areas of occupational stress.

Shortage of staff

3. Why is <u>shortage of staff</u> a source of stress?
4. What steps could be taken to make this less stressful or manageable?
   a. Probe: Steps your cadre can take?
   b. MOH or WWP can take?
5. How does stress related to <u>shortage of staff</u> usually show itself (manifest)?

Insufficient resources and supplies.

6. Why is <u>insufficient resources and supplies</u> a source of stress?
7. What steps could be taken to make this less stressful or manageable?
   a. Probe: Steps your cadre can take?
   b. MOH or WWP can take?
8. How does stress related to <u>insufficient resources and supplies</u> usually show itself (manifest)?

Too much work.

9. Why is <u>too much work</u> a source of stress?
10. What steps could be taken to make this less stressful or manageable?
    a. Probe: Steps your cadre can take?

b. MOH or WWP can take?

11. How does stress related to <u>too much work</u> usually show itself (manifest)?

[ask these for each of the top 3 answers given on the flipchart earlier]

12. Why is (this)..... a source of stress?
13. What steps could be taken to make this less stressful or manageable?
    a. Probe: Steps your cadre can take?
    b. MOH or WWP can take?
14. How does stress related to .... usually show itself (manifest)?

Positive Coping Mechanisms

As a result of the national health worker survey conducted last year, the top three reported **positive coping mechanisms** for addressing stress that are being practiced by health workers were talking with friends, co-workers, and family members; prayer, attending church, and other spiritual activities; and dealing with problems as they occur.

15. Thinking about you and other health workers in your cadre, do you agree with this?
16. Are there any other common positive coping mechanisms we should discuss?
    [give just a few minutes and write on flip chart, then rank for top 3]

Ok, now let us break down some of these findings and gather more information on these positive coping mechanisms.

Talking with friends, co-workers, and family members.

17. Why is talking with friends, co-workers, and family members an effective coping mechanism for dealing with occupational stress?
18. How does talking with friends, co-workers, and family members decrease occupational stress?

Pray, attend church, and other spiritual activities.

19. Why prayer, attending church, and other spiritual activities and effective coping mechanism for dealing with occupational stress?
20. How does it decrease occupational stress?

Dealing with problems as they occur.

21. Why is dealing with problems as they occur an effective coping mechanism for dealing with occupational stress?
22. How does dealing with problems as they occur decrease occupational stress?

[Now ask these questions for each of the top three identified on the flipchart earlier]

23. Why is (this)..... an effective coping mechanism for dealing with occupational stress?
24. How does ..... decrease stress occupational stress?

Negative Coping Mechanisms

We found common **negative coping mechanisms** that are used by health workers in order to deal with stress. The top three negative coping mechanisms reported were drinking alcohol, gambling, and avoidance.

25. Thinking about you and other health workers in your cadre, do you agree with this?
26. Are there any other common negative coping mechanisms we should discuss?
    [give just a few minutes and write on flip chart, then rank for top 3]

Ok, now let us break down some of these findings and gather more information on negative coping mechanisms.

Drinking Alcohol.

27. Why is drinking alcohol an in-effective (negative) coping mechanism for dealing with occupational stress?
28. How does drinking alcohol decrease or increase occupational stress?

Gambling.

29. Why is gambling an in-effective (or negative) coping mechanism for dealing with occupational stress?
30. How does gambling decrease or increase occupational stress?

Avoidance.

31. Why is avoidance an in-effective (or negative) coping mechanism for dealing with occupational stress?
32. How does avoidance decrease or increase occupational stress?

[Now ask these questions for each of the top three identified on the flipchart earlier]

33. Why is..... an in-effective (or negative) coping mechanism for dealing with occupational stress?
34. How does ..... decrease or increase occupational stress?

PART II: Lifestyle and Health Behaviours

Now let us change focus a little and move away from stress and talk instead about **lifestyle and health behaviours** of health workers. By this we are referring to diet, physical activity, use of alcohol, use of tobacco, and other lifestyle and health behaviours.

Thinking about yourself and other health workers in your cadre, let us discuss some primary lifestyle and health behaviours of health workers.

35. How do you think occupational stress influences you and your co-workers' lifestyle and behaviours?

Probe:/E.g., how would the usage of alcohol and tobacco or amount of physical activity and type of diet be amongst you and your co-workers if they had no occupational stress or it was less?

36. How can the WWP activities address **dietary measures**?
    a. E.g., eating well, eating fruit and vegetables
37. How can the WWP activities address **physical activities**?
    a. E.g., physical activity at least 60 minutes, riding bike or walking to work
38. How can the WWP address **alcohol use**?
39. How can the WWP address **tobacco use**?
    a. E.g., snuff, cigarettes, cigars, and other forms
40. Is there anything else you would like to share about occupational stress, coping mechanisms, lifestyle and health behaviours that we have not addressed?

Thank you. Please take the pen you used to sign your consent form as a sign of appreciation for your time and participation in today's focus group.

Appendix J. Focus Group Discussion Guide: Use of WWP Services

WWP FOCUS GROUP DISCUSSION:
UTILIZATION OF THE WWP SERVICES

Introduction

Today we are going to discuss the use of the Workplace Wellness Programme (or WWP) services and activities as they apply to your facilities, as well as the barriers, facilitators, and suggestions for each of the six components of the WWP. The six components are:
[refer to flipchart where they are written already]

1. Health screening, treatment, and care
2. Health promotion
3. Stress management and team building
4. Occupational health and safety
5. Psychosocial and spiritual care
6. Therapeutic recreation

We are not focusing on your individual use, but want you to think about yourself and other health workers in your associated cadres [allied, professional, industrial, administration, nurse, doctor, and so forth] when we ask the following questions and answer accordingly. We are asking these questions about you and your co-workers so that we can make generalizations about health workers, and **not have it be personal or about you specifically**.

Are there any questions? [address any questions or concerns]
If there are no questions, let us begin.

1a. ICEBREAKER Question: what do you know of the MOH WWP?

First, let us discuss **Health screening, treatment, and care** services. [refer to handout]

> *Health screening, treatment, and care services include clinical assessments to identify risk factors for diseases such as TB, HIV, and cancer; early diagnosis and interventions; and referral to appropriate treatment and care services as necessary.*

Based on the national health worker survey that was conducted last year, it was determined that **assessments of body mass index (BMI) and blood sugar, as well as testing for TB and HIV** are the most commonly utilized health screening and, treatment services for health workers.

Thinking about yourself and other health workers [in your cadre]:

1. What encourages the use of these services when they are provided at the facility for health workers?
2. Which of the above services have been utilised most by health workers?
    - Probe: Why (facilitators)
3. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?

4. What are your suggestions towards improving the health screening, treatment, and care services for health workers?

Next, let us discuss **health promotion** activities at your facility. [refer to handout]

Health promotion activities include wellness talks, health campaigns, seminars, commemorations, and peer education activities to address health and lifestyle issues. This includes activities focused on empowering health workers to be in control of all dimensions of their lives such as finance, substance use, and health issues.

Based on the national health worker survey that was conducted last year, it was determined that **health promotion activities for health workers are offered at facilities 0-6 times a year and most people participate in them 0-2 times a year but believe they would be very beneficial to health workers.**

Thinking about yourself and other health workers [in your cadre]:

5. What encourages the use of these services when they are provided at the facility for health workers?
6. Which of the above services have been utilised most by health workers?
    - Probe: Why (facilitators)
7. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?
8. What are your suggestions towards improving the health promotion activities for health workers?

Let us now talk about **stress management and team building services**. [refer to handout]

These services have been in the form of trainings and workshops on stress management and team building in order to enhance the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork.

Based on the national health worker survey that was conducted last year, **most participants indicated that stress management and team building trainings were not offered at their facilities but would be beneficial or very beneficial if offered to health workers.**

Thinking about health workers [in your cadre]:

9. What encourages the use of these services when they are provided at the facility for health workers?
10. Which of the above services have been utilised most for health workers?
    - Probe: Why (facilitators)
11. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?

12. What are your suggestions towards improving the stress management and team building trainings and workshops for health workers?

Now, let us now talk about **occupational health and safety**. [refer to handout]

Occupational health and safety addresses issues of safety in the workplace focusing on identification of health hazards, prevention, control and management of the health hazards. It also addresses care related to occupational exposure, injury, and post exposure prophylaxis services [PEP].

Based on the national health worker survey that was conducted last year **most respondents indicated that occupational health and safety activities were not conducted at their facility and they did not participate, but that these activities would be highly beneficial to health workers.**

Thinking about yourself and other health workers [in your cadre]:

13. What encourages the use of these services when they are provided at the facility for health workers?
14. Which of the above services have been utilised most by health workers?
    - Probe: Why (facilitators)
15. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?
16. What are your suggestions towards improving the occupational health and safety activities for health workers?

Let us now talk about **psychosocial and spiritual care**. [refer to handout]

Psychosocial and spiritual care includes support groups of health workers led by a trained group facilitator. It also includes activities such as counselling, prayer, Holy Communion, and scripture reading.

Based on the national health worker survey that was conducted last year, **most respondents indicated that psychosocial and spiritual care services are not offered at their facilities, while some say they are offered 1-3 times a year, with the vast majority stating these would be very beneficial to health workers.**

Thinking about yourself and other health workers [in your cadre]:

17. What encourages the use of these services when they are provided at the facility for health workers?
18. Which of the above services have been utilised most by health workers?
    - Probe: Why (facilitators)
19. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?

20. What are your suggestions towards improving the psychological and spiritual care activities for health workers?

Last, let us discuss **therapeutic recreation. [refer to handout]**

Therapeutic recreation focuses on improving the physical, psychological, emotional, and occupational well-being of health workers. This is refers to activities such as physical activity programme s, social recreation, edutainment, and exercise facilities.

Based on the national health worker survey that was conducted last year, **the majority of respondents indicated that therapeutic recreation activities were not offered at their facilities with a few indicating they were. Most participants believed these activities would be very beneficial to health workers.**

Thinking about health workers [in your cadre]:

21. What encourages the use of these services when they are provided at the facility for health workers?
22. Which of the above services have been utilised most by health workers?
    - Probe: Why (facilitators)
23. What discourages the use of these services when they are provided at the facility for health workers?
    - Probes:
        - Why?
        - What are some of the factors that lead to underutilisation of these services? (barriers)
        - Are they are provided at your facility?
24. What are your suggestions towards improving the therapeutic recreation activities?
25. Is there anything else you would like to add about why people do or do not use the Workplace Wellness Programme services that you feel we have not discussed?

Thank you very much for your time and participation in today's focus group discussion. Please keep the pen we gave you when you signed your consent as a sign of appreciation for your time and energy today.

Six Components of the Ministry of Health Workplace Wellness Programme Handout for FGD Participants

1. **Health screening, treatment, and care** services include clinical assessments to identify risk factors for diseases such as TB, HIV, and cancer; early diagnosis and interventions; and referral to appropriate treatment and care services as necessary.

2. **Health promotion** activities include wellness talks, health campaigns, seminars, commemorations, and peer education activities to address health and lifestyle issues. This includes activities focused on empowering health workers to be in control of all dimensions of their lives such as finance, substance use, and health issues.

3. **Stress management and team building**: These services have been in the form of trainings and workshops on stress management and team building in order to enhance the physical, psychological, emotional, and occupational well-being of health workers, reducing stress, and strengthening teamwork.

4. **Occupational health and safety** addresses issues of safety in the workplace focusing on identification of health hazards, prevention, control and management of the health hazards. It also addresses care related to occupational exposure, injury, and post exposure prophylaxis services [PEP].

5. **Psychosocial and spiritual care** includes support groups of health workers led by a trained group facilitator. It also includes activities such as counselling, prayer, Holy Communion, and scripture reading.

6. **Therapeutic recreation** focuses on improving the physical, psychological, emotional, and occupational well-being of health workers. This is refers to activities such as physical activity programme s, social recreation, edutainment, and exercise facilities.

Appendix K. Focus Group Discussion Guides: Consent Forms

I-TECH BOTSWANA
UNIVERSITY OF WASHINGTON
CONSENT FORM

MOH WORKPLACE WELLNESS EVALUATION
FOCUS GROUP DISCUSSION

Researcher	Institution & Department	Contact Details
Gabrielle O'Malley, PhD Assistant Professor	University of Washington, Department of Global Health	1-206-685-0775 gomalley@uw.edu
Maureen Mpho Co-Investigator Workplace Wellness Evaluation	Botswana Ministry of Health, Department of HIV/AIDS Prevention & Care – Workplace Wellness Programme Head	363-2242 mumpho@gov.bw
Heather Mothibedi Co-Investigator Workplace Wellness Evaluation	Botswana Ministry of Health, Department of HIV/AIDS Prevention & Care	363-2052 hmothibedi@gov.bw
Jenny Ledikwe, PhD Director of Monitoring, Evaluation, and Research Clinical Assistant Professor	International Training & Education Center for Health (I–TECH – Botswana) University of Washington, Department of Global Health	390-0925 ledikwe@uw.edu

Researchers' statement

We are asking you to be in a research study. The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. We will read the form to you and you can read along using the copy that has been provided to you. You may ask questions about the purpose of the research, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When we have answered all your questions, you can decide if you want to continue with the focus group discussion or not. This process is called "informed consent." You will each be given a copy of this form for your records.

PURPOSE OF THE STUDY

Since the roll-out of the Ministry of Health's (MOH) national Workplace Wellness Programme (WWP) in 2007, there is little known about coverage of the programme across Botswana, how health workers are utilizing the programme, or whether or how it has made a difference in the lives of health workers. In order to make evidence-based decisions for programmatic improvements to enhance implementation and utilization, it is important that data be collected on the achievements, challenges, and outcomes of the WWP.

This focus group discussion is part of an evaluation being undertaken for programme evaluation purposes in order to inform the WWP. We are focusing on factors affecting the WWP activities, use of the programme, and outcomes of the programme. The primary use of the findings from this evaluation will be to improve the implementation of the programme and describe outcomes of the programme.

STUDY PROCEDURES

Focus group discussions are being conducted with five different groups of health workers, including

1. doctors providing clinical care;

2. nurses providing clinical care;
3. other professionals including,
    a. health professional other than doctors and nurses such as social workers, pharmacists, and nutritionists;
    b. allied health professionals such as radiographers and pharmacist technicians; and
    c. paraprofessionals such as lay counsellors and health education assistants;
4. administrative personnel (e.g., doctors and nurses in administrative capacity, human resources, and data clerks); and
5. Industrial class personnel (e.g., drivers, cleaners, and gardeners).

If you agree to participate, you will be asked a series of questions related to either your perceptions of WWP activities or your perceptions of work-related stress and lifestyle behaviours. The focus group discussion (FGD) will take approximately 90 minutes. You will be asked a series of questions such as:

- *"How do you feel about utilizing health screening services at the facility that you work at?"*
- *"From your perspective, what are the reasons why people do not utilize the capacity development services that are offered at their facility?"*
- *"What are some strategies that health workers use to cope with stress?"*

Your responses will be recorded by a rapporteur. In addition, we will voice record the FGD using a digital voice recorder upon your consent, however you may refuse to be voice recorded. If anyone participating in the FGD does not consent to be voice recorded, the FGD will not be voice recorded. Voice recording and notes will be used to create a transcription of this FGD.

You may decline or refuse to answer any question at any time during the FGD or ask for the voice recording to be stopped.

RISKS, STRESS, OR DISCOMFORT

You may experience stress, discomfort, or feel that your privacy is being invaded due to the process of this FGD and the questions you are asked. There are no physical risks involved in this study. If you experience stress or discomfort you may leave the focus group.

A digital voice recording will be made of this FGD, upon your consent and the consent of everyone else in the group. We will not share the voice recording with other researchers or use it in presentations. The content will be used to assist in the report writing only of this study.

You may contact Maureen Mpho with MOH at +267-363-2242 or Jenny Ledikwe with I-TECH at +267-390-0925 with questions about the evaluation and the Botswana Health Research and Development Committee at MOH +267-363-2775 if you have questions about your rights as an evaluation subject.

BENEFITS OF THE STUDY

There are no immediate or direct benefits to you from this study. This study is evaluating the MOH Workplace Wellness Programme, and as such your input will assist and contribute to the running of the programme in the future.

SOURCE OF FUNDING

This study is being funded by the U.S. President's Emergency Plan for AIDS Relief in Botswana.

CONFIDENTIALITY OF RESEARCH INFORMATION

All information collected during the FGD will be kept confidential by the study team. Participants are strongly encouraged to maintain the confidentiality of these discussions. A unique identifier will be created that is linked to this FGD, however your name will not be recorded anywhere. The code for the unique identifier will be kept separate from the FGD transcript. Data will be kept on password

protected server for five years and then destroyed. All information included in the report and any subsequent manuscripts or journals will not identify you as a respondent.

OTHER INFORMATION

You may refuse to participate or decline to answer any questions during this FGD without any recrimination or penalty. This is a voluntary study.

Printed name of study staff obtaining consent Signature Date

Subject's statement

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, I can ask one of the researchers listed above. If I have questions about my rights as a research subject, I can call the Botswana Ministry of Health's Health Research and Development Committee at +267-363-2775. I have received a copy of this consent form.

Signature of subject Date

I consent to have this focus group discussion voice recorded and understand what this entails.

_____

Signature of subject

Copies to: Researcher
Subject

Appendix L. Desk Review Tool

WORKPLACE WELLNESS PROGRAMME EVALUATION
DESK REVIEW TOOL

DOCUMENT TITLE: _____

DOCUMENT CODE: _____

DATE DOCUMENT CREATED: _____

REVIEW DATE: _____

NAME OF REVIEWER: _____

PURPOSE OF THE DOCUMENT: _____

INPUTS

Does the document specify inputs towards implementation?

INPUTS	Inputs specified Yes / No	If yes, give a brief description of the findings from the document.
Funding		
Human resources		
Equipment		
Supplies *(e.g., IEC materials, condoms)*		
Training materials		
Other: (Specify) _____		

PROCESSES

Does the document specify processes related to implementation?

PROCESSES	Processes specified Yes / No	If yes, give a brief description of the findings from the document.
Governance		
Political Support		
Administration		
Capacity development		
Monitoring & evaluation		
Other (Specify): _____		

Appendix M. Desk Review Items

WORKPLACE WELLNESS PROGRAMME
DESK REVIEW ITEMS

NATIONAL GOVERNANCE DOCUMENTS
1. Operational Guidelines: Workplace Wellness Programme for Health Workers (WHW)
2. WHW Implementation Plan: 2006-2009
3. Workplace Wellness Programme (WWP) Implementation Guidelines: 2012/2013
4. WWP National Steering Committee Terms of Reference
5. Workplace Wellness Programme - Implementation Guide - Brochure
ASSESSMENT REPORTS
6. Attraction and retention strategy baseline assessment report: 2009-2010
7. Caring for Health Workers: National Strategy for Botswana Needs Assessment Report: (Big Book)
8. Caring for Health Workers: National Strategy for Botswana Needs Assessment Report: (Little Book)
9. Wellness Center Readiness Assessment Report
10. Caring for Health Workers: A National Strategy for Botswana Needs Assessment Report
11. Rapid TOT Assessment
12. Report of PEP Situational Rapid Assessment
TRAINING MATERIALS
13. Occupational Health and Safety: Facilitator Manual
14. Occupational Health and Safety: Participant Journal
15. Occupational Health and Safety: Workbook
16. Stress Management: Facilitator Manual
17. Stress Management: Participant Journal
18. Stress Management: Workbook
19. Stress Management: Workbook
20. Team Building: Facilitator Manual
21. Team Building: Participant Journal
22. Team Building: Workbook
23. Facilitator Training Guide
24. Support Group: Facilitator Guide
25. Support Group: Member Guide
26. Death and Dying: Health Worker Journal
TRAINING REPORTS
27. Stress Management and Team Building Training Report: Nov. 2007-March 2008
28. Training/Capacity Building conducted by WWP National Office 2007-2012 (Report)
29. Stress Management, Team Building, and Occupational Health & Safety Training Report 2008-2009
30. Support Groups for Health Workers Facilitator Training Evaluation Report: 2008/2009
HEALTH PROMOTION MATERIALS
31. Occupational Health Hazards: A Handbook for the Workforce
32. Staff Morale: A Handbook for Supervisors and Managers
33. Stress Management: A Handbook for the Workforce
34. Team Building: A Handbook for the Workforce
35. Support Groups in the Workplace (Brochure)
36. WWP Facility Resource Toolkit
PROGRAMME REPORTS
37. Workplace Wellness Programme PEPFAR Annual Report: October 2007-September 2008

38. WWP Annual Report 2007-2008
39. WWP Annual Report 2008-2009
40. WWP Annual Report 2009-2010
41. BOTUSA Quarterly Report: Q2 2007-2008
42. BOTUSA Quarterly Report: Q4 2007-2008
43. Government of Botswana Cooperative Agreement Quarterly Report: Q2 2008 - 2009
44. Government of Botswana Cooperative Agreement Quarterly Report: Q4 2008 - 2009
45. Government of Botswana Cooperative Agreement Quarterly Report: Q3 2009 - 2010
46. Government of Botswana Cooperative Agreement Quarterly Report: Q4 2009 - 2010
47. Government of Botswana Cooperative Agreement Quarterly Report: Q1 2010 - 2011
48. Government of Botswana Cooperative Agreement Quarterly Report: Q2 2010 - 2011
49. Government of Botswana Cooperative Agreement Quarterly Report: Q3 2010 - 2011
50. Government of Botswana Cooperative Agreement Quarterly Report: Q4 2010 - 2011
51. Government of Botswana Cooperative Agreement Quarterly Report: Q1 2011 - 2012
52. Government of Botswana Cooperative Agreement Quarterly Report: Q2 2011 - 2012
53. Government of Botswana Cooperative Agreement Quarterly Report: Q3 2011 - 2012
ROUTINELY COLLECTED MONITORING & EVALUATION DATA
54. Facility Annual and Quarterly Report TEMPLATE
55. WWP Annual DHMT Activity and Summary
OTHER MATERIALS
56. WWP Posters and Brochures Tribute to Health Workers (poster) Support Groups (poster) Wellness Programme for Health Workers (poster) Wellness Programme for Health Workers - English (Brochure) Wellness Programme for Health Workers - Setswana (Brochure)
57. Workplace Wellness Logo & Definition
58. PEPFAR Partners Meeting Presentation
59. WWP Perpetual Calendar
INTERNATIONAL STANDARDS & COUNTRY PROGRAMME DOCUMENTS
60. Guidelines for Managing HIV and AIDS and Employee Wellness in the Public Service in Botswana
61. Employee Health and Wellness Strategic Framework for the Public Sector - RSA
62. Limpopo Employee Health and Wellness Policy
63. Botswana National HIV & AIDS Treatment Guidelines (MOH)
64. World Health Organization Healthy Workplace Framework and Model: Background and Supporting Literature and Practice
65. The Bangkok Charter for Health Promotion in a Globalized World
66. World Health Assembly Resolution on Health Promotion: 51st World Health Assembly: Health Promotion
67. Guidelines on Occupational Safety and Health Management Systems
68. A Guide to HIV and AIDS Workplace Programmes- Republic of Namibia