

**Analysis of sickness presenteeism prevalence among nurses working in selected health facilities in Swaziland.**

A thesis

Submitted to the School of Nursing and Public Health in the College of Health  
Sciences:

University of KwaZulu- Natal

In the requirements of the degree:

Master of Nursing

By BAWINILE T. S. MDZINISO

Supervised by Doctor Jane Kerr

April 2016

# TABLE OF CONTENTS

<b>TABLE OF CONTENTS .....</b>	<b>ii</b>
<b>FIGURES AND TABLES .....</b>	<b>v</b>
<b>DECLARATION .....</b>	<b>1</b>
<b>DEDICATION .....</b>	<b>2</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>3</b>
<b>LIST OF ABBREVIATIONS AND ACRONYMS .....</b>	<b>4</b>
<b>ABSTRACT .....</b>	<b>5</b>
<b>Background .....</b>	<b>5</b>
<b>Purpose of study .....</b>	<b>5</b>
<b>Methodology .....</b>	<b>5</b>
<b>Results .....</b>	<b>6</b>
<b>Conclusion .....</b>	<b>6</b>
<b>CHAPTER 1 INTRODUCTION AND BACKGROUND .....</b>	<b>8</b>
<b>1.1 Introduction .....</b>	<b>8</b>
<b>1.2 Background .....</b>	<b>10</b>
<b>1.2.1 Overview .....</b>	<b>10</b>
<b>1.2.2 Geographic location .....</b>	<b>11</b>
<b>1.2.3 Population of Swaziland according to Central Statistics Office Data of 2007 .....</b>	<b>12</b>
<b>1.2.4 The healthcare system .....</b>	<b>12</b>
<b>1.2.5 Levels of service delivery .....</b>	<b>13</b>
<b>1.2.6 Health Profile .....</b>	<b>13</b>
<b>1.2.7 The Swaziland Wellness Centre and workplace programs .....</b>	<b>14</b>
<b>1.2.8 The Public Service HIV/AIDS Coordination Committee (PSHACC) .....</b>	<b>15</b>
<b>1.2.9 Government policies on sick leave .....</b>	<b>15</b>
<b>1.2.10 Challenges in the nursing fraternity .....</b>	<b>16</b>
<b>1.3. PROBLEM STATEMENT .....</b>	<b>18</b>
<b>1.4 PURPOSE OF THE STUDY .....</b>	<b>20</b>
<b>1.5. RESEARCH OBJECTIVES AND QUESTIONS .....</b>	<b>20</b>
<b>1.6. SIGNIFICANCE OF THE STUDY .....</b>	<b>20</b>
<b>1.7. CONCEPTUAL AND OPERATIONAL DEFINITIONS .....</b>	<b>23</b>
<b>1.7.1 Operational definitions .....</b>	<b>25</b>
<b>1.8 Conceptual model for sickness presenteeism .....</b>	<b>26</b>
<b>1.10 Conclusion .....</b>	<b>28</b>

<b>CHAPTER 2 LITERATURE REVIEW</b> .....	29
2.1 Introduction.....	29
2.2 Demand, control and support model in sickness presenteeism.....	29
2.2.1 Demand.....	29
2.2.2 Control.....	30
2.2.3 Social support.....	30
2.3 Health Problems.....	31
2.4 Dialectical theory in sickness presenteeism.....	33
2.5 The recovery theory in sickness presenteeism.....	33
2.6 Factors contributing to sickness presenteeism.....	34
2.7 Proposed interventions for reducing sickness presenteeism.....	34
2.8 Conclusion.....	36
<b>CHAPTER 3 RESEARCH METHOD</b> .....	37
3.1. Introduction.....	37
3.2 Research design and methodology.....	37
3.2.1 Research Setting.....	38
3.2.2 Population and target population.....	39
3.2. 3 Sample and sampling strategy.....	40
3.2.4 Simple random sampling.....	41
3.2.5 Sampling method: Cluster random sampling.....	41
3.2.6 Sample size.....	42
3.2.7 Sampling frame.....	42
3.2.8 The Pilot study.....	43
3.3. Data collection tool.....	43
3.3.1 Validity and Reliability.....	45
3.3.2. Target population.....	45
3.3.3. Variables measured.....	45
3.3.4. Instrument development process.....	45
3.3.5 Validity and reliability of Part D of the data collection tool.....	46
3.4. Data collection.....	48
3.4.1 Concepts of Part D used for data collection.....	49
3.4.2 Maintaining Confidentiality in the study.....	51
3.5. Data analysis.....	52
3.6. Data management.....	53
3.7. Ethics.....	54
3.8. Conclusion.....	55

<b>CHAPTER 4 DATA ANALYSIS AND FINDINGS .....</b>	<b>57</b>
4.1 Introduction.....	57
4.2 Data analysis.....	57
4.3 Results .....	58
4.3.1 Respondents' characteristics .....	58
4.3.2 The existence of sickness presenteeism .....	62
4.3.3 Sickness presenteeism findings based on Stanford Presenteeism Scale 6 .....	63
4.3.4 Factors contributing to sickness presenteeism .....	65
4.3.5 Job demand.....	66
4.3.6 Locus of control (adjustment latitude) .....	68
4.3.7 Social support .....	69
4.3.8 Social support policy and health-related problems as predisposing factors for sickness presenteeism.....	70
<b>CHAPTER 5 DISCUSSIONS .....</b>	<b>73</b>
5.1 Introduction.....	73
5.2 High job demands in nursing .....	73
5.2.1 Staff shortage .....	74
5.3 Ease of replacement and locus of control .....	75
5.4 Social Support.....	75
5.5 Health problems.....	77
5.6 Limitations of the study .....	78
5.7 Dissemination of findings .....	78
5.8 Conclusion .....	78
5.9 Recommendations .....	80
<b>REFERENCES .....</b>	<b>81</b>
<b>ANNEXURES .....</b>	<b>90</b>
Map of Swaziland      A .....	90
Permission to conduct study      D.....	98
5. Informed consent      E .....	106

## FIGURES AND TABLES

<b>Title of tables</b>	<b>Table number</b>	<b>Table page number</b>
Nurse patient ratios	1.1	11
List of government health facilities	3.1	38
Distribution of nurse respondents per category of health facility	3.2	41
Concepts of the demand, control, social support and health problems and relevant questions in the questionnaire	3.3	49
Respondents' qualifications	4.1	58
Respondent's years of experience	4.2	59
Respondents' characteristics' median	4.3	60
Stanford Presenteeism Scale 6 (SPS 6) statements	4.4	62
Social support as predisposing factors of sickness presenteeism	4.5	67
Social support policy related and /or health problem related	4.6	68
Health problems as predisposing factors for sickness presenteeism	4.7	69
<b>Titles of figures</b>	<b>Figure number</b>	<b>Figure page number</b>
Conceptual framework for sickness presenteeism	1.1	25
Categories of health facilities of Swaziland	3.1	37
Respondents per nursing cadre	4.1	56
Respondents' gender	4.2	56
Respondents' marital status	4.3	57
Respondents' age categories	4.4	57
Prevalence of sickness presenteeism	4.5	61
Stanford Presenteeism Scale 6 Results of sickness presenteeism	4.6	61
Lack of ease of replacement as a causative factor for sickness presenteeism	4.7	64
Staff shortage as a cause of sickness presenteeism	4.8	64
Shift work as a cause of sickness presenteeism	4.9	65
Pressure from managers as a cause of sickness presenteeism	4.10	65
Locus of control as a cause of sickness presenteeism	4.11	66

## DECLARATION

I, Bawinile Treasure Mdziniso, declare that this dissertation titled “Analysis of sickness presenteeism prevalence among nurses working in selected health facilities in Swaziland” is my original work. It has never been submitted before for any other degree or examination in any other University. I also declare that the sources of information used in this work have been acknowledged by means of reference.

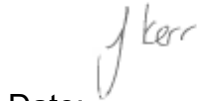
This research project has been read and approved for submission by supervisor, Dr. Jane Kerr.

Date: 23<sup>rd</sup> November, 2015

Mrs. Bawinile T. Mdziniso



Student number: 213527007



Date:

Dr. Jane Kerr (Research Supervisor)

## DEDICATION

The dissertation is dedicated to my family; A.T., Cebolenkhosi, Sihe, Hlobsile and my siblings (Sipho, Ntombikayise and Mduduzi) and their spouses. Support and unwavering love given to me during the course of study and journey of life is highly appreciated.

## ACKNOWLEDGEMENTS

My sincere gratitude and appreciation is expressed towards the Ministry of Public Service and the Ministry of Health in Swaziland for granting me paid study leave that enhanced the outcome of the dissertation. The Ministry of Health senior management, nursing department, management of health facilities and nurses who participated in the study are applauded for their remarkable contribution to my success. It is with great pleasure that acknowledge the support and technical assistance offered by colleagues and friends; Dr. Colile, Mrs. G. Dube, Nonhlanhla, Wisdom, Mandla, Oyeyemi, Agathe, Zandi, Malungisa, Danicia and the Strategic Information Department of the Ministry of Health.

I acknowledge the University of KwaZulu-Natal (UKZN), for offering professional and education development for me, guiding and nurturing me through the academic journey for the realisation of the dissertation. My sincere gratitude is also offered to my supervisor, Dr. Jane Kerr, and to Mrs. Fikile Nkwanyane, for their commitment and support offered throughout the period of study and for the product of academic achievement (dissertation). To the UKZN staff (Caroline, Cebile, ICS Department, and library) and lecturers of post-graduate nursing courses, thank you for assistance offered.



## LIST OF ABBREVIATIONS AND ACRONYMS

Central Statistics Office	CSO
Copenhagen Psychosocial Questionnaire	COPOQ
Demographic Health Survey	DHS
Essential Health Care Package	EHCP
General Orders	GO
Health and Work Questionnaire	HWQ
Human Resource for Health Strategic Plan	HRHSP
Ministry of Health	MOH
Ministry of Public Service	MOPS
National Health Policy	NHP
National Health Sector Strategic Plan	NHSSP
Service Availability Mapping	SAM
Stanford Presenteeism Scale	SPS
Statistical Package for Social Sciences	SPSS
Swaziland Nursing Strategic Plan	SNSP
Swaziland Wellness Centre Policy	SWCP
Wellness Centre Profile	WCP
World Health Organization	WHO

## ABSTRACT

### **Background**

Sickness presenteeism occurs when employees go to work when they would be justified in taking time off for complaints and ill health that can either be physical or mental or both (Johns, 2010; Demerouti, Le Blanc, Bakker, Schaufeli and Hox, 2009; Aronsson, Gustafsson, and Dallner, 2000; Jourdain and Vézina, 2013). Sickness presenteeism has drastic effects to the organization or employer, the health of the employee, the safety of the health care consumers (clients and patients) and families of the employees (Roelen, Jensen, Stapelfeldt Groothoff, Nielsen and Bültmann, 2014; Sendén, Løvseth, Schenck-Gustafsson and Fridner, 2013). Sickness presenteeism has been discovered to be prevalent among human service organizations such as nursing (Johansen, Aronsson, and Marklund, 2014; Leineweber, Westerlund, Hagberg, Svedberg and Alexanderson, 2012; Aronsson et. al., 2000). High job demands, inability to adjust amount and type of work to do in a given period of time, lack of social support and experiencing health problems are cited as some of the predisposing factors of sickness presenteeism (Jourdain and Vézina, 2013; Linnerud, 2013; Demerouti et. al., 2009 and Theorell, 1996). Amongst studies conducted, sickness presenteeism has been assessed based on varying degrees of nurse staffing levels and nursing work schedules of various shifts (Linnerud, 2013 and Zirwatul, Ibrahim, and Ohtsuka, 2012).

### **Purpose of study**

The purpose of the study was to determine the extent of sickness presenteeism among nurses working in selected health facilities, identify predisposing factors and determine the link between job demand, locus of control and social support among nurses working in different health facility types or categories.

### **Methodology**

Using a quantitative descriptive research design, a survey was conducted among nurses deployed in public health facilities and 350 questionnaires were distributed to respondents. A total of 264 completed questionnaires was collected from respondents, reflecting a response rate of **75.4%**.

The study was conducted in Swaziland. The questionnaires were hand delivered by the researcher to various health facilities and later collected by the researcher from

facility based in-service coordinators in sealed boxes. Respondents were from all categories of health facilities that include national referral hospital 66 (25%), regional hospitals 86 (**32.6%**), Health Centres 48 (**18.2%**), Public Health Units 11 (**4.2%**), clinics with maternity 2 (**0.8%**) and clinics without maternity 50 (**19.3%**). Percentages were derived from the total of 264 fully completed and returned questionnaires.

Part A of the questionnaire contained questions that were designed to gather demographic data of research respondents. The researcher adopted Aronsson, Gustafsson and Dallner's (2000) single question (Part B) for determining if employees had gone to work despite having health problems over a time span of twelve months, and the Stanford Presenteeism Scale (SPS 6) in Part C was adopted for the self-reported responses of the nurses on ability to complete tasks and extent of distraction experienced when sick. Part D of the questionnaire were questions developed by the researcher based on concepts of demand, control, social support and health problems.

Data was analysed using the Statistical Package for the Social Scientists (SPSS), version 23. Coded data were entered into the computer. Descriptive statistics were done, measures of central tendency and the range and distribution were computed. Percentages and scores were tabulated for all scales and sub-scales. Analysis of the data was aligned with the objectives of the study to yield results on the extent of sickness presenteeism, predisposing factors and the linkage with job demand, locus of control, social support and health problems.

## **Results**

The extent of sickness presenteeism was **80.7%**. Experiencing health problems that are classified as severe psychological illnesses, severe chronic illnesses and acute illnesses were major predisposing factors for sickness presenteeism accounting for **74.3%**, **63.6%** and **61.7%**, respectively. Predominant causes of sickness presenteeism among nurses were inability to adjust work and amount **58%**, high job demand (average **57.7%**), health problems (average of **47.9%**) and social support at an average of (**44.2%**).

## **Conclusion**

Nurse managers must pay more attention to the health of the nursing workforce in order to have healthy, motivated nurses with high job satisfaction which will translate

to good patient outcomes and provision of safe, high quality and cost effective health services within confines of World Health Organization building blocks.

Keywords: sickness presenteeism, nurses, job demands, locus of control, social support, health problems, and quality of care.

## **CHAPTER 1 INTRODUCTION AND BACKGROUND**

### **1.1 Introduction**

Sickness presenteeism has drastic effects on the organisation or employer, the health of the employee, the safety of the healthcare consumers (clients and patients) and the families of the employees, according to Roelen, Jensen, Stapelfeldt and Groothoff (2014) and Sendén, Løvseth, Schenck-Gustafsson, and Fridner (2013). Sickness presenteeism has been discovered by Aronsson et. al., (2000); Johansen et. al., (2014); and Leineweber, Westerlund, Hagberg, Svedberg and Alexanderson (2012) to be prevalent in human service organisations which include nursing. Among studies conducted to date, sickness presenteeism has been assessed, based on varying degrees of nurse staffing levels and the work schedules of the nurses' various work shifts (Linnerud, 2013; Zirwatul, Ibrahim, and Ohtsuka, 2012).

Vigilant managers who focus on attaining the healthcare system's goal of the provision of healthcare that is of high quality, safe, is responsive to the consumer's needs and is affordable, promote and maintain the health of healthcare providers. Holt and Powell (2014) assert that health and wellbeing in the workplace is a fundamental business case that ensures improved productivity, and a healthy and happy workforce. The authors further state that a healthy workforce has the capacity to maximise performance, which ultimately benefits the organisation. The emergence of the tendency to attend work, despite being ill, undermines the efforts of managers. This practice is referred to as sickness presenteeism. Sickness presenteeism refers to attending work while ill or turning up for one's job, despite complaints and ill health that would have prompted one to rest and or be absent from work (Aronsson, Gustafsson and Dallner, 2000; Johansen, Aronsson and Marklund, 2014; Johns, 2010).

There are several definitions of sickness presenteeism and the definitions that are relevant to the focus area of this study have been extracted from Johns (2010). They are: being unhealthy but exhibiting no sickness absenteeism, going to work despite feeling unhealthy and a reduced productivity at work due to health problems. Inclined towards Johns' perception, occupational health scholars define sickness presenteeism as a decreased job performance as a result of a health problem (Dickson, 2013).

Sickness presenteeism is very common amongst employees, to the extent that its prevalence ranges between 27-88% in several studies (Bergström, Bodin, Hagberg, Lindh, Aronsson and Josephson, 2009b; Johns, 2010; Janssens, Clays, De Clercq, De Bacquer and Braeckman, 2013; Schreuder, Roelen, van der Klink and Groothoff, 2013). Studies by Aronsson et. al., (2000); Johansen et. al., (2014); Leineweber, Westerlund, Hagberg, Svedberg and Alexanderson (2012) have identified that employees working in care professions or working with people in general, for example teachers and nurses, have a greater risk of sickness presenteeism. Supportively, Sendén, Løvseth, Schenck-Gustafsson and Fridner (2013), cite that sickness presenteeism among physicians ranged between 80-90%, compared to 30-70% in other professions. The findings of a study conducted by Linnerud, (2013) among nurses, revealed that 75% of nurses reported to have engaged in sickness presenteeism, with the majority ranging between two and five times over a period of twelve months. Moreover, in a study conducted in Sweden, sickness presenteeism was four times higher among nursing home aids, nurses and midwives (Aronsson et. al., 2000). Despite such high prevalence rates, sickness presenteeism did not receive the attention it deserves.

According to Quazi (2013), a few studies on sickness presenteeism have been conducted in Asia (Singapore, China and Taiwan), but, through literature review, the researcher was able to establish that no studies on the subject have been carried out in the nursing field on the African continent, let alone in Swaziland. This was despite the fact that the improvement of health indicators and good patient outcomes depend on the wellness and quality of life of the healthcare providers (nurses).

Scientific evidence enlightened the researcher to that fact that much attention has been given to sickness absenteeism, with disregard for sickness presenteeism despite its drastic effects on the organisation or employer, the health of the employee, the safety of the healthcare consumers (clients and patients) and the families of the employees. Literature by Roelen, Jensen, Stapelfeldt, Groothoff, Nielsen and Bültmann (2014) revealed that there was a lack of recognition of sickness presenteeism despite its culmination in poor health and sickness absenteeism.

The fear of losing jobs among employees and alterations to the sickness compensation system caused an increase in the number of workers who attended

work despite feeling sick, according to Aronsson et. al.,(2000); Johansen et. al., (2014); and Linnerud (2013). The literature also revealed that researchers' interest in sickness presenteeism was motivated by the desire to identify its effects on job security and production rates (Dickson, 2013; Johns, 2010; Linnerud, 2013). Moreover, productivity rates were the area of focus in terms of the financial implications related to a decline in performance among sick employees (Johns, 2010). Most of these studies calculated the losses incurred due to reduced productivity.

The purely economic focus on sickness presenteeism signified the uncaring attitude of employers towards their employees and the service consumers. A change of attitude in this regard was desirable among managers for the provision of safe, high quality services and for the retention of staff in which the organisations had invested in various ways. In as much as sickness presenteeism was “the biggest drain” on productivity, the health of employees and the safety of service consumers was equally or more important. Attesting to that, Roelen and Groothoff (2010) averred that the quality of life of employees had to be maintained through the identification of trends and the effects of sickness presenteeism, and by effectively managing or controlling predisposing factors and their consequences. Managers were encouraged to address sickness presenteeism because it extended beyond reducing individual employee performance and led to a reduction of collective performance as fellow employees left their tasks to assist their ailing colleagues (Trybou, Germonpre, Janssens, Casini, Braeckman, Bacquer and Clays, 2014).

## **1.2 Background**

### **1.2.1 Overview**

Nurses form the majority of the healthcare workforce in Swaziland. The Swaziland Nursing Strategic Plan (SNSP) of 2008 reveals that 80% of the health workforce is nurses. The nurse patient ratio is 150 per 100 000 of the population, well below the WHO recommendations of 1.73 nurses per 1000 members of the population (Human Resources for Health Strategic Plan (HRHSP), 2012). Fifty percent of the nurses work in the private sector and mission health facilities. According to the National Health Sector Strategic Plan (NHSSP), 2008; and the Essential Health Care Package (EHCP), 2010, the number of nurses available in the public sector is inadequate, due to an inadequate number of qualified nurses being produced and an exodus of qualified staff to economically viable countries

The inadequate production of nurses by local training institutions has led to the inability to balance human resources and job demands, thus exposing the nurses to high workloads that have physical and psychological effects such as exhaustion and burn-out. Other contributing factors to high workloads in some health facilities are the lack of a functional referral system for the rationalising of service delivery, with inadequate categorisation of the types of healthcare to be provided at primary and tertiary level, resulting in service overlap (EHCP, 2010). Notably, there is also a high morbidity that negatively impacts on the quality of healthcare services. The high prevalence of complex conditions associated with HIV/ AIDS, and the high prevalence of tuberculosis (TB), combined with the large numbers of patients seeking healthcare services predisposes nurses to a high risk of contracting diseases such as tuberculosis (SNSP, 2008). In a systematic review of tuberculosis among the healthcare workers of low and middle Income countries by Joshi, Reingold, Menzies and Pai, (2006), nurses were observed to have a 43-87% prevalence rate of latent TB infection versus a 1.3-3.5% prevalence rate observed in other health workers (2006).

The SNSP (2008) states that nurses play a vital role in the provision of healthcare services for the attainment of good health outcomes of the population by rendering nursing services at all levels of healthcare, and by supervising the community-based health cadre or rural health motivators. The profile of the country created by the WHO (2010) and the National Health Policy (2007) identified the Swazi population as being at high risk for non-communicable diseases because of their sedentary lifestyle, unhealthy diet, harmful alcohol consumption, unhealthy bodyweight and obesity. This served to increase the workload of the nurses as a result of the higher numbers of patients requiring treatment. The productivity level and the morale of the nurses have additionally been reduced in relation to the high workload resulting from the increased burden of HIV/AIDS (SNSP, 2008; NHSSP, 2008). Nurses and other healthcare workers are personally affected by HIV/AIDS both at the workplace and at home (Wellness Centre Policy, 2006).

### **1.2.2 Geographic location**

Swaziland is a landlocked country of 17,364 000 square kilometres, surrounded by South Africa on the northern, western and southern borders, and with Mozambique on the eastern boundary. The country has four geographical regions, namely; Hhohho, Manzini, Lubombo and Shiselweni. Data cited in the WHO Country profile of 2012



states that there are 1, 231, 000 people living in Swaziland. Seventy-nine percent of the population live in the rural areas, with twenty-one percent living in urban areas. Refer to Annexure A that presents the Map of Swaziland.

### **1.2.3 Population of Swaziland according to Central Statistics Office Data of 2007**

<b>Regions</b>	<b>Swazi Population</b>	<b>Nurse –patient ratios</b>
Hhohho	331734	183/100000
Lubombo	249153	136/100 000
Manzini	360248	189/100000
Shiselweni	241365	109/100000
<b>Total</b>	<b>1182500</b>	

Table 1.1 Nurse-patient ratios adapted from Human Resource for Health Strategic Plan for 2012

### **1.2.4 The healthcare system**

The healthcare system of the country renders healthcare services as for the model of Western medicine. The concept of primary healthcare and decentralisation form the basis of the healthcare service delivery (National Health Policy, 2007). The National Health Policy (NHP) of 2007 is a fundamental document that guides the Ministry of Health in implementing strategies that address recent developments and it serves as a road map for attaining health outcomes for the population (NHP, 2007). An operation plan of the NHP is the National Health Sector Strategic Plan (NHSSP) that was developed in 2008 and has an implementation period of five years; however this is still being implemented as per the recommendations of the Mid-term Review Report of 2012. The purpose of the strategic plan is to provide a framework for intervention, planning and the performance of activities of the health sector for the Ministry of Health (MOH) and its development partners (NHSSP, 2008). The National Health Policy has three main objectives, and the second objective relates to promoting the effective allocation and management of the health sector resources (NHP, 2007). Nurses are human resources of the health sector; hence they are beneficiaries of activities that are implemented for the attainment of this objective.

### **1.2.5 Levels of service delivery**

The organisation of the healthcare system is in levels, namely; primary, secondary and tertiary levels. The primary level consists of mobile outreach sites, clinics with maternity facilities, clinics without maternity facilities and the public health units. The secondary level consists of health centres and specialised health facilities. The tertiary level consists of regional hospitals and the national referral hospital (EHCP, 2010).

There is one national referral hospital (Mbabane Government Hospital) and two specialised referral hospitals (National Psychiatric Hospital and National Tuberculosis Hospital). The two specialised hospitals are located in the central region of the country (Manzini), and the national referral hospital is located in the hub of health in the Hhohho region. The Ministry of Health has its headquarters in Mbabane in the Hhohho region.

### **1.2.6 Health Profile**

Over the past 20 years there has been economic decline and an increase in poverty (EHCP, 2010). The Swazi population has a life expectancy of 54 years at birth, for both males and females. There is a high adult (15-60 years) mortality rate of 494/1000 (WHO, 2012). The major contributing factors to high morbidity and mortality are communicable diseases, non-communicable diseases and injuries. Communicable diseases impose the largest burden on the health system while the leading outpatient and in-patient conditions are upper respiratory tract infections. There is a high TB-HIV co-infection rate of 80% and there is an increase in dermatological conditions (EHCP, 2010). The high co-infection rate implies a probability of high TB infection rates among nurses, based on the mode of transmission. Supportively, findings by Joshi et al., (2006) of a systematic review of TB among healthcare workers in low and middle income countries revealed that nurses have high levels of patient contact compared to other healthcare workers, and thus the prevalence of latent TB infection among them was high.

The prevalence of HIV is 17291/100 000. This is a very high prevalence compared to the African region average of 2774/100 000 and the global average of 511/100 000 (WHO, 2012). The prevalence of TB is 907/100 000 and this is very high compared to the average of the African region, of 303/100 000 and the global average of 169/100 000 (WHO, 2012). The health workforce has not been spared the scourge of the communicable and non-communicable diseases (WHO, 2006).

The effects of HIV/ AIDS, TB and non-communicable diseases on health workers have also manifested themselves in higher absentee rates, morbidity, mortality and higher attrition rates (HRHSP, 2012). According to the Wellness Centre Policy (WCP), 2011, nurses and other healthcare workers are personally affected by communicable diseases and HIV/ AIDS on a similar magnitude as that of the general population.

In response to the increase of both communicable and non-communicable diseases among the health workforce, the first Wellness Centre was established in 2006. It is a non-profit making organisation founded by the Swaziland Nurses' Association, in collaboration with the International Council of Nurses and it was registered with the Ministry of Health in 2006. The Wellness Centre is located in the Manzini region and it provides healthcare services to the health workforce and their families.

### **1.2.7 The Swaziland Wellness Centre and workplace programs**

The Wellness Centre Policy (WCP) stipulates that there are three major objectives, namely; increasing the access of healthcare workers to prevention, treatment, care, support and rehabilitative services; improving the retention rate of healthcare workers and providing a model for best practice in the health sector human resource management. These objectives are aligned with the strategic intervention that was implemented by the World Health Organisation for member countries that were experiencing high HIV/AIDS prevalence. The strategy lists the types of healthcare services offered, for example, screening for sexually transmitted infections, cancer, tuberculosis and HIV/ AIDS. Treatment of diseases and ailments, management of diseases and appropriate referrals are also done (WCP, 2011). These healthcare services are offered within the Wellness Centre and to health facilities in the country, in the form of mobile outreach site visits.

These interventions are done in collaboration with Workplace Wellness Program Officers deployed in all the hospitals and health centres (WCP, 2011). Each regional hospital and health centre has state-registered nurses who are assigned to provide healthcare services to the healthcare workers within the health facility.

The system of service delivery differs among the various hospitals. In one regional hospital that is located in Manzini region, the two state-registered nurses assigned to offer workplace Wellness Program services attend to patients in the wards in the morning, then resume their Wellness Program service provision from after lunch (2.00

pm). This service is available between 2.00pm and 4.45pm on Tuesdays and Thursdays only. On Monday, Wednesday and Friday, they provide healthcare services to patients in the wards. In another regional hospital in the Shiselweni region, there is one state-registered nurse who provides the workplace Wellness Program services during the course of the week between 8.00 am and 4.00 pm. This nurse works in partnership with a medical doctor that works in the Wellness Program and with the antiretroviral therapy unit during the course of the week. This hospital has increased the access of healthcare to other civil servants such as the teachers and the police officers (Workplace Wellness Program officer of the hospitals, 2014).

### **1.2.8 The Public Service HIV/AIDS Coordination Committee (PSHACC)**

The Ministry of Public Service (MOPS) established a committee to lead interventions for mitigating the national plight of HIV/AIDS. The interventions included the development of an HIV/AIDS Policy and the election of a committee in 2008. The Public Service HIV/AIDS Coordination Committee (PSHACC) was elected to coordinate HIV/AIDS related illnesses for all civil servants. Their mandate was to plan and implement interventions to mitigate the effects of communicable diseases such as HIV/ AIDS. These interventions included, among others, the establishment of a health promotion programme that had physical exercise facilities, counselling and testing for HIV and an appropriate referral system (Human Resource for Health Strategic Plan (HRHSP), 2012).

### **1.2.9 Government policies on sick leave**

Nurses are part of the civil service; hence their leave is centrally regulated by the General Orders (GO), 1974. Sick leave is defined as an approved absence of an officer from duty because of illness, including hospitalisation and any period of absence for recuperative purposes immediately following the illness. It is approved and authorised by the Director of Health Services and may be granted on his or her behalf by a medical officer employed by a mission or public hospital. Medical officers employed by the private sector may not grant a sick leave of more than seven days (GO, 1974).

With regard to sick leave, it is stipulated that an employee may take a forty-eight hour leave of absence without having to produce a medical certificate, but the employee has to report and state the reasons of absence using the quickest means of communication. An absence of more than forty-eight hours requires a medical

certificate issued by the medical officer who treated the employee, and failure to produce a medical certificate warrants a disciplinary hearing and unpaid leave (GO, 1974).

An employee who worked for the civil service for a minimum period of three years (36 months) may be granted sick leave of up to six months, with full pay. If it happens that he or she does not recover fully during this period, the employee may then use any vacation leave that is outstanding.

An inability to recover fully during this period would lead to the reduction of monthly earnings by 50%, for a period of six months. The need for more sick leave would require the collaboration of the Principal Secretary of the Ministry of Public Service and the Director of Health Services to grant the employee six more months of sick leave, while the employee continues to earn 50% of his/her monthly earnings. This is more applicable if the cause of the illness is related to an occupational hazard or injury (GO, 1974).

The employee may be considered for incapacity leave if the Head of Department considers the employee not fit to render services fully and permanently, in relation to illness of the mind or body. The Head of Department is required to write a report to the Director of Health Services, proposing that the employee be awarded incapacity leave. The Director of Health Services then discusses the issue with the medical officers who are treating the employee, to ascertain the employee's fitness to practice. Depending on the outcome of the deliberations, the matter may be referred to the medical board for further investigation and for consideration of retirement on medical grounds. In the Swazi context, the members of the Medical Board are also responsible for referring civil servants and the public for specialised medical and surgical services beyond the borders of Swaziland, thus the employee is also considered for such interventions prior to being certified as unfit to practice (GO, 1974). It is of importance to note that the sick leave regulations were amended in February 1988, when the incidence of HIV/AIDS and TB was low.

#### **1.2.10 Challenges in the nursing fraternity**

The challenges of the nursing cadre include, among others, an inappropriate distribution of nurses between urban and rural areas, with 80% serving the few urban

dwellers and 20% serving the majority of the population in the rural areas. There are also imbalances regarding the distribution of nurses within the regions. The nurse patient ratio is 183/100 000 in Hhohho, 189/100000 in Manzini, 136/100000 in Lubombo and 109/100000 in the Shiselweni region (HRHSP, 2012).

The health services are managed at national, regional and facility level, thus lacking coordination across all levels of healthcare service delivery. Inadequate supportive supervision for the nurses and an inadequate skill mix among the staff are some of the challenges worth overcoming for the attainment of good health outcomes. Available resources are inversely proportional to the needs of health facilities for efficiency in service provision (EHCP, 2010; SNSP, 2008).

Challenges facing the nursing profession also include the high attrition rate of the nurses related to high mortality due to TB, HIV/AIDS, and chronic illnesses such as diabetes mellitus and hypertension. It has been previously alluded to that nursing is an occupation of high risk to the health and wellbeing of the nurses, especially due to its work-related stressors. These stressors include the psychosocial effects that emanate from a high workload, shift work, and long working hours that disrupt personal and social lives. Other stressors such as interpersonal and personal factors of incongruence among the staff, unfavourable environments related to consistent conflict among nurse managers, doctors and colleagues, and the high risk of exposure to communicable diseases contribute to a reduction in the quality of life of nurses (Van der Colffand Rothmann, 2009).

The nurse managers are faced with the challenge of ensuring that high quality health services are rendered for patient satisfaction, amid critical human resources shortages, and ailing, overburdened and demotivated nurses. It is therefore imperative to determine the extent of sickness presenteeism among such a vital asset of the health system, and to forge a way to curb the negative effects and promote a better quality of life for the attainment of healthy, productive human resources (Roelen and Groothoff, 2010).

### **1.2.11 Conclusion**

The high HIV/AIDS prevalence rate of 26% and the high co-infection rates of HIV/AIDS and tuberculosis of 80% among the Swazi population pose a threat to the nursing workforce and may lead to increase in sickness presenteeism rates among nurses.

The nurses are part of the population that is affected by HIV/AIDS and tuberculosis. HIV/AIDS, tuberculosis and other communicable disease have physical and psychological effects on the body and may translate to reduced productivity, increased impairment and increased healthcare resource use (DiBonaventura, Gupta, Cho and Mrus, 2012). Furthermore, DiBonaventura et. al., (2012), state that antiretroviral therapy prolongs life for HIV positive people but has side effects such as insomnia, fatigue, abdominal pains, diarrhoea, dizziness and joint pains. These side effects may add to independent health problems that may be acute, episodic and or chronic among individual nurses thus increasing the high inclination for sickness presenteeism related to health problems experienced by nurses. The shortage of nursing staff and inappropriate distribution of nurses among urban and rural health facilities may compel nurses suffering from HIV/AIDS and tuberculosis to attend work while ill in order to provide healthcare services to the vulnerable population that have been exposed to quadruple burden of disease. Moreover, the Wellness Centre Policy, (2011), affirms that nurses and other healthcare workers are personally affected by communicable diseases and HIV/ AIDS on a similar magnitude as that of the general population.

### **1.3. PROBLEM STATEMENT**

Nurses are more likely to present for work while ill, in relation to the nature of their work (Dickson, 2013; Aronsson et. al., 2000). Aronsson et. al., (2000) state that employees in very demanding jobs attend work despite feeling ill, in order to maintain a high performance and to serve the vulnerable population. The responsibility of nurses towards the health and wellbeing of the patients makes sickness presenteeism a serious problem, in that patients' and nurses' wellbeing is compromised. Patients receive healthcare of low quality and their lives are endangered and the nurses' health deteriorates as they are not able to rest and recover (Linnerud, 2013). In the studies that were conducted by Sendén et. al., (2013) and Linnerud, (2013) among nurses, the findings indicate that the performance levels of duties become reduced. There is an increase in medical errors, with the incorrect medicine or incorrect dose of medicine administered, and an increase in the number of patients' falls. Additionally, empathy with patients becomes reduced.

The practice of sickness presenteeism among nurses becomes a public health hazard, especially when nurses have contracted contagious diseases such as the sudden acute respiratory syndrome (SARS) and H1N1 influenza (Linnerud, 2013; Johns, 2010). A study conducted among nursing home residents and staff following an outbreak of viral gastroenteritis is a classic example of a fatality caused by sickness presenteeism. A nurse manifested signs and symptoms of gastroenteritis after few days three nursing home residents also manifested similar signs and symptoms. Within ten days of the onset of the gastroenteritis, the disease had become an outbreak that affected twenty-three home residents and eighteen nurses (Widera, Chang and Chen, 2010). Linnerud (2013) also reported in a study conducted among nurses, that a nurse who had not been absent for a period of twelve months had the highest probability of sickness presenteeism, compared with those who had taken absence days.

Sickness presenteeism has detrimental effects on nurses' health and quality of life. Literature reveals that employees who continuously go to work despite being ill become deprived of resting days that assist them to recover fully, and become further exposed to an accumulation of stress and physical wear and tear on the body (Bergström et. al., 2009b). Subsequently, impairment of the cardiovascular system, brain function and the immune system occurs, and a failure to manage acute and episodic diseases results in complications that will reduce the nurses' quality of life and increase the number of sickness absences (Bergström et. al., 2009b; Aronsson, Gustafsson and Mellner, 2011; Roelen et. al., 2014). In addition, Halbesleben, Whitman, Marilyn, and Crawford, (2013) and Bergström et. al., (2009b) reveal that the nurses' capacity to deliver quality nursing care becomes compromised due to the increased rate of irritability, fatigue and demotivation.

Nurses form the majority of the healthcare workforce in Swaziland, and neglect of such an enormous and critical workforce would result in the delay or failure to attain the health system's goals of safe, high quality care that is responsive to the population needs (WHO, 2010). Based on these discussions, there is a high probability that nurses in Swaziland attend to work while ill and this warrants urgent action in examining the extent and magnitude of the problem.



#### **1.4 PURPOSE OF THE STUDY**

The purpose of the study was to determine the extent of sickness presenteeism and to identify the predisposing factors of sickness presenteeism among the nurses of the selected health facilities in Swaziland.

#### **1.5. RESEARCH OBJECTIVES AND QUESTIONS**

- i. To determine the existence and the magnitude of the sickness presenteeism rate within a nursing workforce in selected nursing services of Swaziland.
- ii. To identify the factors that predispose nurses to sickness presenteeism.
- iii. To establish a possible link between sickness presenteeism and job demands, locus of control and social support within the selected nursing service of Swaziland.

#### **Research questions were:**

- i. What is the rate of sickness presenteeism in the nursing workforce of the selected nursing services in Swaziland?
- ii. What are the factors which predispose nurses to sickness presenteeism in the nursing workforce of the selected nursing services in Swaziland?
- iii. What are the links between sickness presenteeism, job demand, locus of control and social support within the selected nursing service of Swaziland?

#### **1.6. SIGNIFICANCE OF THE STUDY**

The majority of sickness presenteeism studies have been conducted in developed countries, thus leaving a gap for research in developing countries, especially sub-Saharan countries. Researching on sickness presenteeism among people living in developing countries has received little or no attention. The literature reveals that a few studies were conducted in Asia, in Singapore, China and Taiwan (Quazi, 2013). Conducting the study in Swaziland has generated new knowledge, both for Swaziland itself and for a country on the African continent.

##### **1.6.1 Policy development and or review**

The findings of the study will contribute to policy development and/or review for the managers at the health facilities. Strategies for managing sickness presenteeism among employees will be suggested. Holt and Powell (2014) state that the quality of life of employees and the individual employees' wellbeing forms the core of an

organisation's responsibility and commitment to workplace health promotion (WHP), in that its activities and strategies have to have a positive impact on employee health. Policies on human resource management including sick leave, access to healthcare services and workplace wellness programs have to be developed or reviewed. The results and recommendations will contribute to the development or review of unrestricted, paid sick leave policies. Regional and facility based regulations that mandate the exclusion of ill employees from the working environment until fully recovered may be developed. The type of acceptable medical certificate used in validating employee sicknesses may be reconsidered (Jourdain and Vézina, 2013). As a result of this study, knowledge and skills required when conducting research will be improved and nursing practice will be enhanced in a fundamental way. The nurses' health and quality of life may be improved through interventions aimed at the reduction of sickness presenteeism in the health facilities. Nurses' perceptions and outlook regarding their value as employees and the importance of promoting and maintaining health for their own sake will be renewed.

### **1.6.2 Nursing education**

Nursing education will be improved by incorporating content that will reduce sickness presenteeism and improve the quality of life of student nurses, nurses and lecturers. Literature by Jourdain and Vézina (2013) supports the view that a reduction of sickness presenteeism yields positive results to counteract the reduced learning that emanates from sickness presenteeism.

### **1.6.3 Strategies on Healthcare practices**

The health of healthcare consumers will be protected by instituting regulations that will ensure their protection from contagious diseases that spread during the act of sickness presenteeism. Subsequently, public health intervention and effective strategies that promote the safety of the public will be instituted.

The findings of the study will enlighten managers and supervisors about the causative factors of sickness presenteeism, after which effective strategies will be devised to control or curb sickness presenteeism. This will subsequently improve the economic gain of the health organisations. Additionally, managers will be able to recognise and understand the contributing factors and be confident to provide support to employees.

Management of sickness presenteeism will save money in both the short and longer term, and will also contribute to the development of an engaged and productive workforce (Centre for Mental Health, 2011). Maintaining nurses' health will facilitate the delivery of an efficient and high quality healthcare service for the entire population. Pilette (2005), acknowledges that the importance of nurses is exponential, in that they directly impact the healthcare organisations to provide the healthcare needed by the population that contributes to the country's economy.

HIV/AIDS, TB and other communicable disease have physical and psychological effects on the body and may translate to reduced productivity, increased impairment and an increased use of healthcare resources, according to DiBonaventura, Gupta, and Mrus (2012). DiBonaventura et. al., (2012), state further that antiretroviral therapy prolongs life for HIV positive people, but has side effects such as insomnia, fatigue, abdominal pains, diarrhoea, dizziness and joint pains, of which fatigue is the most common. This implies that, although the nurses attend work, they are not physically well, and that there is thus a need to plan and develop strategies that will provide recuperation time and psychological support. In support of this statement, it is observed that implementation of comprehensive occupational health and safety programs, having standard procedures and consistent adequate supplies of medicines and commodities, are priorities in health systems of countries of high HIV/AIDS prevalence (WHO, 2006).

The high financial burden related to the increase in healthcare service use may be alleviated by the development of a national health insurance or health sector specific medical aid, to curtail the financial load that the nurses might be exposed to as they access healthcare services from either public or private facilities. In a study of leadership styles (integrity, inspirational, team integration, autocratic, self-centred) by Nyberg, Westerlund, Hanson and Theorell (2008), it was discovered that women who rated their managers as rarely showing integrity were more likely to engage in sickness presenteeism than women whose managers showed integrity more often. This implies that there are some leadership styles which would encourage disclosure and reduce sickness presenteeism. Findings of this study will assist in improving nurse-manager relationships and provide an opportunity for exploring and implementing effective leadership strategies that will promote an improved quality of life for the nurses.

## 1.7. CONCEPTUAL AND OPERATIONAL DEFINITIONS

### Key concepts

Sickness presenteeism, nurse, job demand, locus of control and social support.

### Conceptual definitions

**Sickness presenteeism** occurs when employees go to work when they would be justified in taking time off for complaints and ill health that could either be physical, or mental, or both (Aronsson et. al., 2000; Demerouti, Le Blanc, Bakker, Schaufeli and Hox, 2009; Johns, 2010; Jourdain and Vézina, 2013).

**Health problem** refers to a range of illnesses, according to Aronsson et al. (2000); Johns (2010) and Zirwatul, Ibrahim and Ohtsuka (2012). The illnesses range from acute to episodic and chronic in occurrence, and include musculoskeletal problems such as back pains, cardiovascular diseases such as hypertension and gastrointestinal problems such as abdominal discomfort, as well as other illnesses.

**Job demands** refers to the physical, cognitive and social features of a job that require prolonged physical and psychological effort and include workload, constraints on task completion and role conflict according to Johns (2010) and Jourdain and Vézina (2013).

**Control** (adjustment latitude or locus of control) refers to the ability to adjust work to suit the current health status, either by reducing the amount of work to be done, by postponing some tasks, or rescheduling activities and job-related decision-making (Johns, 2010; Jourdain and Vézina, 2013; Karasek, Baker, Marxer, Ahlbom and Theorell, 1981; Linnerud, 2013). Munro, Rodwell and Harding (1998) expand further to include the ability to determine when to take rest breaks, alter routine and access leave in the definition.

**Support** refers to the assistance and collaboration that exist within the working environment and includes communication, and trust among colleagues, managers and supervisors. Jourdain and Vézina (2013) and Kiss, De Meester, Kristensen and Braeckman (2014), further define it as instrumental and emotional support that is made available by colleagues and supervisors.

**Social Support** Social support entails the emotional, instrumental, informational and appraisal support provided by close friends, colleagues and neighbours (Cassel, 1976; House, 1981; Munro et. al., 1998).

**A nurse** is a health professional who has acquired a nursing qualification, be it a certificate as a Nursing Assistant, a Diploma in General Nursing, a post-basic Diploma in Midwifery or Community and Psychiatric Nursing, a Bachelor's Degree in Nursing Science or post graduate degrees in nursing (Swaziland Nursing Council Scope of Practice, 2009). In the **context** of this study, the term 'nurse' refers to a nurse who is deployed in a public health facility (in-patient and out-patient departments) in the selected health facilities in Swaziland (Nursing Department Job Description 2000).

**A nursing assistant** is a nurse who possesses a Certificate as a Nursing Assistant, obtained after a two year training period in a nursing college. Duties include providing promotive, preventive, curative, rehabilitative and palliative nursing care to the individual, family and community. She or he functions at operational level under the direction of a registered Nurse (Swaziland Nursing Council Scope of Practice, 2009).

**A General Nurse** in the Swaziland context is a nurse who has undergone a three year course of General Nursing and possesses a Diploma in General Nursing. The equivalence of this nursing cadre in South Africa is the Staff Nurse (SANC, 2005).

**A Staff Nurse** in the Swaziland context is a registered nurse with post-basic diploma in a certain area of specialization such as midwifery, psychiatry and/or community health, paediatrics, ophthalmology (Swaziland Nursing Council Scope of Practice, 2009). This position is equivalent to professional registered nurses possessing a Bachelor's Degree in Nursing or Midwifery, in South Africa (SANC, 2005).

**The Nursing Manager** or Nursing Sister is a management position attained through the appointment and promotions regulations enshrined in the General Orders of 1974. Duties of the nurse manager include planning, developing, implementing and communicating cost effective strategies for improving health care (Swaziland Nursing Council Scope of Practice, 2009).

**Matron** refers to a leadership and management position. The matron functions as part of a management structure in Regional Health Management Team (RHMT) and she

or he establishes plans, leads and directs nursing services activities (Nursing Department Job Description, 2000).

**A workplace wellness program** refers to a program designed to promote the physical and mental health, as well as the wellbeing of employees. It includes components such as counselling, support groups, nutritional supplements, and the provision of treatment for infections and diseases (Barrett, Strode, and Smart, 2002; Grobler, Warnich, Carell, Elbert, and Hatfield, 2006).

### **1.7.1 Operational definitions**

#### **Stanford Presenteeism Scale (SPS6)**

Sickness presenteeism was measured by using an adopted Stanford Presenteeism Scale (SPS 6) that has six questions. The SPS 6 is a self-report tool with questions which determine the nurse's perceptions on how possible it would be to complete tasks despite suffering from a health problem, and how much distraction is anticipated during the performance of the task. . These variables are assessed by a six item Likert-scale with reversed scores. The rate of scores attained ranged between 6 and 30, and the higher score is indicative of sickness presenteeism (Koopman, Pelletier, Murray, and Sharda (2002).

#### **Likert Scale questionnaire determining the causes of sickness presenteeism**

A questionnaire that was developed through the integration of literature related to the predisposing factors of sickness presenteeism was utilised. This is Part D of the with a twenty-item Likert-scale statements The statements are related to psychological and physical health problems, job demands, locus of control, relationships with the Nurse Manager and colleagues, paid sick leave, incapacity leave and the extent of family support. The questionnaire had a Likert-scale of five items, ranging from strongly disagree to strongly agree. The most negative response was allocated a score of 1 and the scores increased to 5 for most positive response. This part of the questionnaire had a total score of 100, where a higher score per item indicates the most probable cause of sickness presenteeism. According to Burns and Grove (2009), the Likert-scale determines the opinion or attitude of the subject and contains a number of declarative statements, with a scale after each statement. The Likert-scale is the most commonly used type of scale for data collection.

## 1.8 Conceptual model for sickness presenteeism.

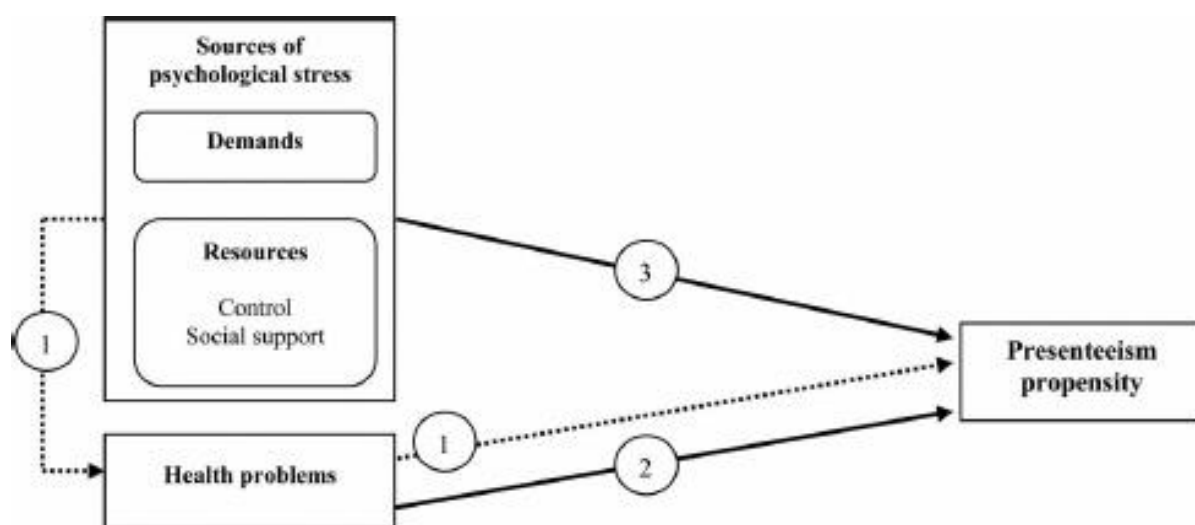


Figure 1.1 *Conceptual framework for sickness presenteeism* (Jourdain and Vézina, 2013).

Figure 1.1, provides the conceptual model of the relationship between job demand, locus of control, social support, health problems and sickness presenteeism.

The above conceptual model is a framework that was used for the study. It depicts the relationship between job demand, locus of control, social support, health problems and sickness presenteeism. Burns and Grove (2009), define a framework as an abstract, logical structure of meaning, serving as a guide to the development of the study and enables linking findings to the body of knowledge used in nursing.

The conceptual model underpinning this study was adapted from Jourdain and Vézina's original study conducted in 2007. It is a redefined version of the demand, control and support model of Karasek and Theorell of 1990 and Theorell and Karasek of 1996 which has included social support and health problems of employees. This conceptual model was used in determining the propensity of sickness presenteeism in relation to sources of psychological stress emanating in the workplace. The contextual determinants considered in the conceptual model are the primary sources of psychological stress in the workplace assumed by the Demand, Control and Support model, which could be categorized as either demands or resources. Health problems of an individual nurse whether emanating from workplace or out of the workplace are an independent factor that contributes to attending to work while sick.

## **1.9 The relevance of the conceptual model for the study**

The model presents effects of high job demands, inability to control or manoeuvre the working environment in relation to tasks to be performed, lack of social support from managers and among co-workers and existence of health problems among employees may promote the tendency of going to work while ill. Health problems for employees may arise from sources of psychological stress in the workplace (demands and resources). The resources are further classified into control and social support. Health problems may be as a result of workplace contextual factors and individual employees may have various health problems that may not be related to the demands and resources.

Demands (high strain jobs) cause residual strain that accumulates and ultimately cause exhaustion and health problems that may be physical or mental. Control is an important concept because lacking control when demands are high leads to physical and mental illnesses. Additionally, social support that may either be instrumental, emotional, informational and appraisal is paramount in buffering effects of high job demands on employees. Theorell and Karasek (1996) reveal that lack of social support at work increases the risk of exposure to cardiovascular diseases among employees.

The concepts in the conceptual model are linked by bold lines and broken lines. The broken line, numbered 1, linking sources of psychological stress and health problems, indicates health problems that may arise as a result of high demands and lack of resources (control and social support) in the workplace and add to existing employees health problems. Acute, episodic and chronic health problems that are experienced by employees independent from demands and resources are represented separately in a box below and they may directly contribute to high inclination for sickness presenteeism as indicated by bold line numbered 2 or may indirectly contribute to increase in the rate of sickness presenteeism as indicated by the broken line numbered 1 (linking presenteeism propensity and health problems). As previously mentioned, the negative effects of demands and resources is physical and mental health problems. The bold line numbered 3, indicates a positive relationship between high job demands, lack of control over work tasks and lack of social support (resources). The logic inherent in the conceptual framework is that there is a direct relationship between high demands for the nurses, low locus of control and low social



support for and amongst nurses and this ultimately increase the inclination of attending work while ill. The conceptual model also purports that these employees of compromised health status continue attending work thus increasing the incidence of sickness presenteeism.

The model has been identified as relevant for the study because the key concepts (demands, control, social support and health problems) have been evidently proven to contribute to sickness presenteeism and moreover these concepts have been highlighted as key challenges faced by nurses in Swaziland. Additionally, the objectives of the study were to determine prevalence of sickness presenteeism and identify predisposing factors hence the concepts of the model were identified as relevant. Exploring the concepts (demands, control, social support and health problems) that have proven to be linked with sickness presenteeism serves as a good starting point.

### **1.10 Conclusion**

This chapter gives an introduction to the study, the background of the study, problem statement, research purpose, objectives, significance of the study, operational definitions of used in the study, and the discussions of the conceptual framework.

## **CHAPTER 2 LITERATURE REVIEW**

### **2.1 Introduction**

Literature review refers to reading information from various sources (primary and secondary) in an effort to broaden the researcher's understanding about the knowledge related to research topic. The researcher conducts literature review in order to link findings of the study with findings of previous studies (Polit and Beck, 2004). Chapter 2 presents discussions on the literature that has been reviewed for study and discusses various theories on predisposing factors of sickness presenteeism. The demand, control and support model, dialectical theory of decision making on whether to go to work or become absent and the recovery theory explain about factors causing sickness presenteeism. The high demand, low locus of control and lack of social support that exist in the working environment of nurses promotes high inclination for sickness presenteeism (Linnerud, 2013). The Dialectical theory states that the relationship of an employee with the supervisor plays a role in the employee's decision of whether to be absent from work or to attend to work while ill. The recovery theory supports that there is a need to rest so as to shed of weariness and stress that accompanies hard work. These theories provide sickness presenteeism determinants. For the research study, the demand, control and social support model was used to examine predisposing factors. Additionally, the concept of health problems among employees is discussed because independent health problems experienced by employees may cause an increase in sickness presenteeism rates. The comprehensive discussion of the three theories and proposed strategies for curbing sickness presenteeism is presented.

### **2.2 Demand, control and support model in sickness presenteeism**

**Karasek's demand and control** model of 1979, presents that high demand and low control cause reduction of psychological and physical well-being of employees and the occupations of high job demand and low locus of control are referred to as high strain jobs. Nursing is an occupation of high job demand, low control and low support and thus considered to be a high strain job (Margot and Maes, 1999).

#### **2.2.1 Demand**

Demerouti et. al., (2009), acknowledges that the two categories of job demand common in the nursing profession are patient demands and physical demands.

Linnerud (2013), explains that job demands in the nursing profession come from different angles such as top-bottom (manager to nurse), bottom-up (patient to nurse) and horizontally (among nurses per shift) and this then makes nurses more prone to sickness presenteeism. According to Chiu, Chung, Wu and Ho (2009), high staff turnover that is eminent in nursing contributes in increase of job demand for remaining nurses in that they experience high workload, inadequate time to render quality nursing care and reduces unity among the team of nurses.

According to Mdluli, Calnan, Yohannes, Shongwe, Ndwandwe and Haumba (2012) , the health workers in Swaziland are over-burdened due to the high number of clients that require screening, diagnosis, counselling and treatment. Compounding factors of high workload are the increase in number of patients with TB-HIV that are admitted for care of opportunistic infections in relation to longevity of life offered by HIV and TB treatment (SAM, 2013).

### **2.2.2 Control**

Control (adjustment latitude or locus of control) refers to the ability to adjust work to suit the current health status by either reducing the amount of work to be done or postponing some tasks (Jourdain and Vézina, 2013; Linnerud, 2013; Johns, 2010). Nursing care has low adjustment latitude in that nurses care for people and they experience constant pressure as they provide the care and they are in no position to deny healthcare services to the patients at a given point in time (Linnerud, 2013).

### **2.2.3 Social support**

According to House, (1981), social support includes instrumental support (provision of tangible assistance and services that help a person when in need); emotional support (provision of empathy, love, caring and trust); informational support (provision of advice, problem solving solutions and suggestions) and appraisal support (provision of constructive feedback, self-evaluation and affirmation). Social support provided by primary groups that are important to the recipients of support, become protective factors that cushion the individual from physiologic and psychological consequences of stressors (Munro et. al., 1998).The theoretical foundation of social support and effects to health are laid down by Cassel (1976), by stating that people that have low social support from close family members and relatives experience more stress and are prone to acquiring diseases such as cardiovascular diseases. In a study conducted

in a Dutch hospital among employees with the majority (81%) being nurses, findings were that nurses sought instrumental support such as requesting for guidance and coaching in times of stressful life events (Schreuder et. al., 2013).Theorell, (1996) states that lack of social support at work increases the risk of exposure to cardiovascular diseases among employees. Inadequate social support is detrimental to the health of employees and it is therefore essential to have effective supportive supervision from managers. Research reveals that the nurse managers that are overstretched due to the demand of their responsibilities become inaccessible to provide the support needed by the overburdened nurses and the nurses seeking support for the communicable diseases they are suffering from (Kerr, 2014). Moreover, defensive and unsupportive managers are a source of stress and a major cause of ill health among nurses (Whitehead, 2006). The results of a study that determined the relationship between job demand, control in decision making and supervisor support revealed that high supervisor support for employees with low decision authority weakened the strong link that exist between high job demands and sickness presenteeism (Jourdain and Vézina, 2013).

### **2.3 Health Problems**

Health problems refer to either acute, episodic or chronic illnesses that may be experienced by employees (Johns, 2010). Johns (2010) supports the proposition by stating that a fully engaged employee that contracts sickness that can either be episodic or acute or chronic will have interruption in work attendance whereby the employee may absent himself or herself or attend work even though sick. Furthermore nurses that have health problems that are episodic or acute and or chronic may continue attending to work whereas they would have taken a leave of absence to facilitate full recovery (Johns, 2010). This increases the propensity of sickness presenteeism.

The determining factors of being absent or attending even though sick depend on the job demand, adjustment latitude , degree of available organizational support with regard to absence policies and manager's support (Johns, 2010).

According to Whitehead (2006), health facilities that are under-staffed and do not have health promotion programs for healthcare workers have a large number of sick healthcare workers that continually attend to work. Additionally, there is a positive

relationship between healthy work structures and healthy nurses, especially with management that is patient, caring and supportive. Inversely, an unhealthy working environment yields unhealthy nurses.

The high prevalence of HIV/AIDS among the general population and among nurses increases the workload, causes physical and psychological illnesses and attrition among the staff (Kinghorn et. al., 2011).

Additionally, many nurses go to work suffering from a cold, pains, depression or grief. Janssens et. al., (2013) and Dickson (2013) confirm that having a health problem, chronic conditions and other health conditions such as arthritis, allergies, fatigue and depressive symptoms, overweight and obesity increase the chances of attending to work while sick. The health workers in Swaziland are exposed to stress and anxiety related to the potential of contracting HIV related to needle pricks and possibility of contracting tuberculosis and other nosocomial infections (Mdluli et. al., 2012). The health care workers are also personally affected by both communicable and non-communicable diseases thus likely to engage in sickness presenteeism (WCP, 2006). High mortality related to communicable diseases (HIV and TB) among nurses is a national and regional issue for South African Developing Countries. Kerr (2014), cites that the HIV and TB related mortality that occurs among nurses in South Africa causes strain for nurse managers in that it causes crude human resource shortages and undermine delivery of their core mandate of human resources management. Additionally, nurses in the neighbouring countries such as Zambia, Lesotho, Mozambique and Malawi have felt the negative impact of HIV and TB. It is with this regard that Kerr (2014) recommends that effective wellness workplace programs be established, nurses be supported and encouraged to disclose their HIV/ TB status and access treatment and care services.

Assertions from a Danish study of sickness presenteeism are that poor health, heavy workload, work versus family conflicts, lack of social support, reduced latitude in decision making and obesity cause sickness presenteeism (Johansen et. al., 2014). Furthermore, high degree of job stress is associated with high levels of sickness presenteeism and employees in caring occupations such as nursing are highlighted to be more exposed to job stress than employees in other occupations.

## **2.4 Dialectical theory in sickness presenteeism**

The Dialectical theory states that the relationship of an employee with the supervisor plays a role in the employee's decision of whether to be absent from work or to attend to work while ill. The theory states that sickness presenteeism is a strategy used by employees to navigate the dialectical tensions in the supervisor-subordinate relationship. There are three dialectics namely; autonomy - connection, openness - closedness and predictability - novelty. The connection between the employee and the supervisor is vital. It forms a major part of the employee's identity and higher levels of connection yield job satisfaction and promote overall employee effectiveness (Halbesleben, 2013).

Autonomy-connection dialectic promotes sickness presenteeism in that employees that want to regain connection with their supervisors will attend work even though sick signalling their commitment.

Openness-closedness dialectic deals with willingness to share information between the employee and the supervisor. The risk that is inherent in divulging some information to the supervisor will promote sickness presenteeism in that an employee would maintain closedness by not revealing his or her sickness to the supervisor. The employee will continue attending work though sick until such a time where the illness can no longer be concealable (Halbesleben,et.al., 2013).

Predictability-novelty dialectic relates to the employee's desire for stability in his or her work, in communication with the supervisor, treatment by the supervisor and his or her innate desire to experience new things in life. Sickness presenteeism is promoted in this dialectic in that an employee will go to work while ill if the supervisor and or colleagues sympathise with him or her.

## **2.5 The recovery theory in sickness presenteeism**

The recovery theory explains that deprivation of recuperation time in relation to sickness presenteeism cause physical and psychological imbalances. This causes work related fatigue and prolonged strain (Lu et. al., 2014). Findings from a longitudinal study verify the health risk in that Dutch nurses were found to be exhausted. The theory purports that employees need adequate rest after working hard to obtain an opportunity to recover physically and psychologically (Demerouti et. al., 2009).

## **2.6 Factors contributing to sickness presenteeism**

There are several antecedents of sickness presenteeism presented by previous research. Factors promoting sickness presenteeism include type of occupation, work environmental factors, individual factors, economic factors and policy related factors (Johns, 2010; Aronsson and Gustafsson, 2005).

Other factors that were associated with sickness presenteeism among doctors was the belief that doctors are healthy and it discouraged them from going for screening and treatment from health facilities, instead they engaged in self-prescription of medication (Sendén et. al., 2013). Some doctors revealed that they had difficulties in taking the role of a patient. These behaviours are likely to be present among nurses based on the similarity of the occupation in relation to taking care of patients and providing nursing care such as prescribing medications (Linnerud, 2013). Additionally, Sendén et. al., (2013) and Dellve, Hadzibajramovic and Ahlborg Jr (2011), present a humane explanation where nurses engage in sickness presenteeism due to sense of responsibility, love, loyalty and respect for their colleagues and the patients. Johns (2010), confirms that findings of a study revealed that love of the job and moral obligation are positive contributing factors to sickness presenteeism.

Human resource shortages and high workload are predisposing factors to sickness presenteeism. Belita et.al., (2013) states that the low health worker density of less than 2.5 per 1000 population in Sub-Saharan countries predispose nurses to sickness presenteeism and further cause deterioration of their health status. Attesting to the effects of human resource shortage, Constanze et.al., (2012) reveals that the risk for sickness presenteeism and ill health doubled in times of understaffing in a research conducted among public and private employees that included nursing staff. Additionally, (Bergström, Bodin, Hagberg, Aronsson and Josephson, 2009a), cite that in a study conducted among registered nurses, nursing assistants and home based personal care workers in the public sector, sickness presenteeism substituted sickness absenteeism during times of high work demands.

## **2.7 Proposed interventions for reducing sickness presenteeism**

Quazi (2013), acknowledges that sickness presenteeism impact has been felt by both public and private organizations and employers have embarked on a mission of curtailing its effects by considering proposed interventions. He highlights that health

promotion programs, subsidizing health care services for employees are strategies that have proven to be effective among some organizations. Supportively, Holt and Powell (2014), Cancelliere, Cassidy, Ammendolia and Côté (2011), Johns (2010) and (WHO, 2006) state that workplace wellness programs have proven to be successful in reducing the rate of sickness presenteeism and improving the quality of life for the employees. Workplace wellness programs that involve active participation of supervisor's or managers and they target environmental factors that increase the act of sickness presenteeism are highly effective (Cancelliere et. al., 2011).

The BITC workwell model is a healthy workplace model that provides four strategic interventions that employers can implement for attainment of a healthy workforce that would be less likely to engage in sickness presenteeism (Joshi, 2014). The model explicates that effective management of sickness presenteeism is entirely dependent upon creating a healthy and engaging working environment (better work), promoting communication and social connections (better relationships), providing interventions to manage health and wellness (better specialist support) and creating an environment that promotes healthy behaviours (better physical, psychological health) (Joshi, 2014).

The efforts vested upon having a healthy workforce are complemented by a vigilant proactive management team. Attesting to that, Trybou et. al., (2014) advises that nursing administrators have to recognize the importance of social support, job control, job rewards and they have to monitor and balance nurse's job demands.

Flexible, accommodative workplace policies that enhance access to paid sick leave, incapacity leave and organizational based medical aid or insurance schemes have proven to be effective in the reduction of the act of attending work while sick (Johansen et. al., 2014; Schreuder et. al., 2013; Johns, 2010; Aronsson and Gustafsson, 2005). In summary, Quazi (2013) asserts that reduction of rate of sickness presenteeism in both public and private organization require investment in health programs that will maximise quality of life for the workforce, development, review and implementation of worker friendly sick leave policies and commitment of managers or supervisors in rendering the working environment healthy and providing support to employees.

In August 2012, the University Research Council partnered with the Ministry of Health to host a wellness event where various sporting activities were done, screening of diseases was done and health promotion strategies were implemented. The health



workers expressed their joy for having such an opportunity and some highlighted that beneficial workplace wellness programs would be those that are offered away from their work facilities for promotion of freedom of access and confidentiality (Mdluli et. al., 2012). Reluctance to disclose status with regard to HIV and TB has been identified among nurses of KwaZulu Natal Province and it is recommended that such behaviour be explored through research (Kerr, 2014).

## **2.8 Conclusion**

This chapter presented discussions on literature that give the background of sickness presenteeism, underlying theories, predisposing factors and proposed strategies for preventing and managing sickness presenteeism. Theories that have been discussed include Karasek's demand, control and social support model, the dialectical theory of sickness presenteeism and the recovery theory. The predisposing factors for sickness presenteeism that have been discussed include type of occupation, work environmental factors, individual factors, economic factors and policy related factors. Strategies that have been discussed include commitment of managers or supervisors in rendering the working environment healthy, providing support to employees, developing and reviewing policies that promote employee's health and quality of life and development of effective workplace wellness programs. The next chapter outlines the research methodology that has been adopted for the study.

## **CHAPTER 3 RESEARCH METHOD**

### **3.1. Introduction**

The research methodology refers to techniques used by researchers to structure a study, and to collect and analyse data (Burns and Grove, 2009; Polit and Beck, 2004; Polit and Beck, 2008). This study is underpinned by the positivism paradigm. According to Polit and Beck (2008), the positivism paradigm is a world view or research belief that supports that reality exists in the world, and that reality can be investigated objectively by researchers to produce new knowledge or to validate existing knowledge. The quantitative research approach was utilised to collect numeric data for the generation of new knowledge, using formal and objective instruments. This presents the research method used for the study and it covers research design and methodology, data collection tool, data collection, data analysis, ethics and data management.

### **3.2 Research design and methodology**

Burns and Grove (2009) assert that a quantitative research approach is applicable when measuring objective, purposeful and measurable human behaviour. This approach was suitable for this study, as it enabled this researcher to determine the extent to which the behaviour under investigation was practised, namely that of nurses reporting for work while ill, as well as identifying the predisposing factors for this behaviour.

The descriptive study design was adopted for this study, in line with the study purpose of obtaining information about sickness presenteeism, as it naturally occurs among nurses working in selected public health facilities, in two regions of Swaziland. A descriptive design was used to describe current practices and to recognise problems with the current practice or behaviour (Burns and Grove, 2009). This descriptive study design lends itself to this study as it provides information on the subject of presenteeism which, in addition to being a relatively new concept worldwide, has not been studied in Swaziland before, and will thus provide valuable new information, relative to the Swaziland healthcare setting. (Burns and Grove, 2009; Polit and Beck, 2004).

This chapter outlines the research setting, the target population of the study, the sampling techniques adopted, data collection and analysis, the ethical considerations of the study, and data management.

### 3.2.1 Research Setting

The research setting was health facilities at the primary, secondary and tertiary levels of healthcare service delivery in Swaziland. The categories or types of health facilities selected for the study included a national referral hospital, regional hospitals, health centres, Public Health Units, clinics with maternity facilities and clinics without maternity facilities.

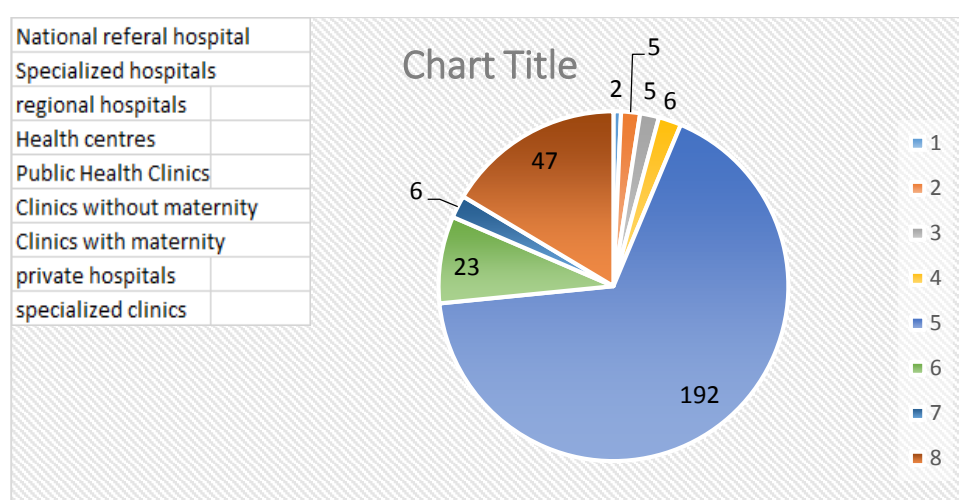


Figure 3.1 Categories of health facilities of Swaziland, SAM (2013).

**Figure 3.1** above, shows the categories of health facilities in Swaziland, thus portraying their distribution in numbers and also revealing that majority of health facilities are clinics without maternity with 192 in a total of 286 health facilities. These health facilities include public health facilities, private, non-governmental and faith-based health facilities. According to the Service Availability Mapping of 2013, 40.1% of the health facilities are owned by the government. The study was conducted in health facilities owned by the government.

**Table 3.1 *List of government health facilities***

<i>Category of Health facility</i>	<i>Hhohho</i>	<i>Manzini</i>	<i>Shiselweni</i>		<i>Lubombo</i>
<b>National Referral Hospital</b>	1	0	0		0
<b>Specialised Hospitals</b>	0	2	0		0
<b>Regional Hospitals</b>	1	1	1		0
<b>Health Centres</b>	2	0	2		1
<b>Public Health Units</b>	2	1	1		1
<b>Clinics with maternity facilities</b>	1	2	0		6
<b>Clinics without maternity facilities</b>	21	31	20		14

**Table 3.1** above, represents the current *status quo* of the government owned health facilities per category, per region, in Swaziland.

### **3.2.2 Population and target population**

According to Burns and Grove (2009), the population refers to a particular type of individuals or elements who are the focus of the research study. The population of the study are nurses in all of the nursing cadres i.e. Matrons, Nursing Sisters or Nurse Managers, Staff Nurses, General Nurses and Nursing Assistants. The total number of nurses in Swaziland is two thousand, two hundred and sixty (2260), of which one thousand, three hundred and sixty four (1364) nurses are employed by the government (SAM, 2013). The population of the study was the one thousand, three hundred and sixty four nurses working in the public service. Accessible population refers to the portion of the target population that is accessible to the researcher (Burns and Grove, 2009). The accessible population consisted of nurses who were working in fifty percent of the randomly selected health facilities in the Hhohho and Shiselweni regions. According to SAM (2013), Shiselweni and Lubombo are the two primarily rural regions and Manzini and Hhohho are primarily urban regions.

The accessible population comprised nurses who were randomly selected from one national referral hospital, two regional hospitals, two health centres, seventeen clinics without maternity facilities and one clinic with maternity facilities (selected in secondary sampling units). The method of sampling used was cluster random sampling, whereby the primary sampling units were the four geographical regions and the secondary sampling units were the health facilities located in the regions. Nurses working in the selected secondary sampling units participated as research respondents.

### **3.2. 3 Sample and sampling strategy**

A sample refers to the people selected to participate in the study, that is the people amongst which data was collected (Burns and Grove, 2009). According to Burns and Grove (2009) and Polit and Beck (2004), a sample is obtained by implementing a sampling plan which stipulates the process that will be followed in selecting the sample from the sample frame and it includes stating essential characteristics or traits that qualifies one to be part of the sample. The inclusion and exclusion criteria are implemented to select a heterogeneous sample that would be representative of the population. Heterogeneity among the sample is encouraged, therefore diversity among the respondents was ensured by including nurses of various ages, genders, qualifications, nursing specialities, working experience, work shifts, responsibilities and types of healthcare services delivered.

Polit and Beck (2004) and Sarantakos (1996) state that sampling is a systematic way of selecting research respondents from the target population, and may be obtained by using probability and non-probability sampling. Probability or random sampling refers to the choosing of the study respondents through either simple, systematic, stratified, or cluster sampling (Polit and Beck, 2004). According to Burns and Grove (2009), randomly selected samples provide a diverse and heterogeneous group of study respondents, thus controlling extraneous variables. Random sampling is important in that every member of the population is given an opportunity (probability higher than zero) to be selected for the study, and the sample obtained becomes representative of the population. Furthermore, random sampling increases the accuracy in determining representativeness. The respondents of this study were selected using the random sampling method; cluster and simple random sampling.

### **3.2.4 Simple random sampling**

Polit and Beck, (2004) cites that simple random sampling is an easy manner of selecting research responds. Simple random sampling includes developing a sampling frame, numbering all the elements and selecting sample elements. The researcher took advantage of an existing nursing staff inventory that is submitted to the Ministry of Health Headquarters on monthly basis. These lists were requested from the management and utilized as list of nurses working in the health facility. In order to have a true reflection of nursing staff currently working in a particular health facility, an inventory list of the month preceding data collection was used. For example in facilities where data collection was done in August a nursing inventory list for July was used.

### **3.2.5 Sampling method: Cluster random sampling**

According to (Polit and Beck, 2004) cluster sampling is a strategy of sampling that involves the step of first selecting large groups, subsequently followed by subdivisions of the groups, until small groups are formed.

The steps listed below were followed.

- A. A list of health facilities was obtained from the Statistics Information Department of the Ministry of Health. The list of facilities was in a Microsoft Office Excel Spreadsheet.
- B. Fifty percent of the health facilities were selected to represent specific categories of health facilities.
- C. Selection was randomly done by selecting every second entry on the list of health facilities, per category (clinics without maternity facilities, clinics with maternity facilities, Public Health Units, health centres, regional hospitals and national referral hospitals) on the Excel spreadsheet. The list of health facilities was arranged in ascending alphabetical order.
- D. Nurses working in the randomly selected health facilities were requested to become study respondents.
- E. A list of nursing staff members was obtained for each of the selected health facilities, and nurses were randomly sampled by selecting every other name on the list.

### 3.2.6 Sample size

The study was descriptive, and therefore power analysis was not required. In order to attain more information, about thirty percent of the total number of public sector nurses (1364) was targeted to be study respondents. The estimated target of nurses was one hundred (100) at national referral hospital, fifty (50) at regional hospital, thirty (30) at health centre, eight (8) in a public health unit, four (4) in a clinic with maternity facilities and three (3) in a clinic without maternity facilities. The total number of respondents who filled in and returned questionnaires was two hundred and sixty four (264). Table 3.2 presents the actual number and distribution of respondents who filled and returned questionnaires.

Table 3.2 Distribution of nurse respondents per category of health facility

Category of Health Facility	Number of Nurse Respondents	Percentage of Nursing Staff
National Referral Hospital	66	25.0
Regional Hospital	86	32.6
Health Centre	48	18.2
Public Health Unit	11	4.2
Clinic With Maternity Facility	2	0.8
Clinic Without Maternity Facility	51	19.3
Total	264	100.00

### 3.2.7 Sampling frame

Sampling frame is defined as a “list of every member of the population with membership defined by the sampling criteria” (Burns and Groove, 2009). Nurses working in the randomly selected health facilities were the sample frame for the study. As highlighted in the last step (E) of cluster random sampling, a list of nurses working in each health facility were used to select nurses by choosing every second name on the nurses’ monthly inventory.

### **3.2.8 The Pilot study**

A pilot study provides an opportunity to identify and discard irrelevant statements. Pallant (2010), and Burns and Grove (2009) expand further to state that the benefits of conducting a pilot study include: refining the data collection instrument, determining its validity and reliability, checking the representativeness of the sample, implementing the data collection and data analysis method, and acquainting the researcher with setting and making refinements. A pilot study was conducted among nurses working in health facilities in the Manzini region. These nurses were requested to participate in the pilot exercise because Manzini region was not randomly selected for the study.

### **3.3. Data collection tool**

Two existing data collection tools, namely Aronsson et. al., (2000) single question of examining sickness presenteeism and Stanford Presenteeism Scale (SPS 6) were adopted and incorporated in the data collection tool as Part B and Part C, respectively. A new set of Likert-scale questions was developed by the researcher and incorporated as Part D of the data collection tool. The data collection tool comprised of demographic data (Part A), single question for determining sickness presenteeism (Part B), six questions from Stanford Presenteeism Scale (Part C) and twenty questions developed by the researcher for determining predisposing factors to sickness presenteeism (Part D). Aronsson et. al., (2000) single question of determining existence and magnitude of sickness presenteeism has been used by researchers for examining the concept of sickness presenteeism. The Stanford Presenteeism Scale 6 (SPS 6) is a Likert Scale questionnaire that has undergone several validity and reliability tests, with an outcome of Cronbach  $\alpha$  .80 (Huang, 2008). The SPS 6 is ideal for the collection of information related to sickness presenteeism, as per Huang (2008), as it has shorter recall periods of four weeks to facilitate the accuracy of information gathered.

The data collection tool comprised four parts (refer to Annexure B), namely: Part A, which gathered demographic characteristics and had nine questions; Demographic characteristics that were included in the questionnaire were age categories, marital status, professional qualifications, years of working experience nursing cadre, health facility department (in-patient or out-patient) employment status (probation or permanent and pensionable, name of health facility and gender. Part B comprised of a single question that was key in determining the existence of sickness presenteeism



and was adopted from Aronsson et. al., (2000). This question determined whether the nurse had attended work while ill in the previous twelve months. It was in a Likert-scale and the nurse had the option to choose among four responses such as no; (1), yes, once (2), yes 2-5 times (3), yes, more than 5 times (4).

Part C of the questionnaire consisted of 6 item questions on Likert scale (refer to Annexure C). According to Polit and Beck (2004), a Likert-scale is a merged measure of attitude that involves the addition of scores obtained in the rating by respondents of the extent to which they either agree or disagree with a certain statement. Sarantakos (1996), asserts that a Likert-scale comprises of a set of statements that are developed from concepts or variables that are related to a particular issue, and the responses are allocated scores ranging from one to five, in relation to the extent of agreement or disagreement with the written statement. Part C of the questionnaire (refer to Annexure C) had Likert-scale statements that determined the likelihood of, and the extent to which a sick nurse was able to complete work, together with the extent of distractions that he or she experienced. Three statements were assessing ability to complete work and the other three statements were assessing extent of distraction experienced.

Part D of the questionnaire collected data for determining the predisposing factors of sickness presenteeism. The questions were arranged according to categories of sources of psychological stress that emanated from within and outside of the working environment, such as job demand, locus of control, social support and health problems. This part of the data collection tool was developed by the researcher. It had a Likert-scale of twenty statements each with a possible response ranging from strongly disagree to strongly agree. The total score of the Likert-scale was one hundred (100). The researcher was able to develop Part D of the data collection tool with ease, since it was easy to develop and did not require a high level of competency (Sarantakos, 1996). The researcher utilised the Likert-scale questionnaire guide developed by Nemoto and Beglar (2013,), that incorporated five steps which included: “(a) understanding the construct, (b) developing the items or statements, (c) determining the outcome space, (d) specifying the measurement model, (e) gathering feedback and piloting the questionnaire (pg 7)”. The validity of the Likert-scale was attained by conducting a pilot study.

### **3.3.1 Validity and Reliability**

The literature reveals that SPS 6 has undergone several validity tests and the results were good (Arumugam, MacDermid and Grewal, 2013;Koopman, Pelletier, Murray and Sharda, 2002). It had an internal consistency of .80 Cronbach alpha.

The validity of a data collection instrument refers to the degree to which it measures what it is supposed to measure. The validation of a scale involves the collection of empirical evidence concerning its use. Content validity refers to the adequacy with which a measure or scale has sampled from the intended universe or domain of content (Pallant, 2010). Construct validity refers to examining the fit between conceptual and operational definitions of variable and determine if the instrument measures what it has been designed to measure (Burns and Grove, 2009). Construct validity was applied in the study through providing operational definitions and clarifying the link between concepts in the conceptual model and the objectives of the study. The construct validity of SPS 6 that has been incorporated as Part C of the questionnaire was 71%, total response variance (Koopman, 2002).

### **3.3.2. Target population**

According to Koopman, Pelletier, Murray and Sharda (2002), the SPS 6 is ideal for a range of professions and employees that have post-matriculate education and training. It may be used for evaluating the impact of general health issues or specific health problems in relation to the work performance of employees. Furthermore, it also identifies the relationship between sickness presenteeism, health issues and overall work productivity.

### **3.3.3. Variables measured**

SPS 6 assesses the extent to which a sick person may complete work and determines the amount of distraction that may be experienced during the period of work (Koopman et al., 2002).

### **3.3.4. Instrument development process**

The Stanford Presenteeism Scale 6 was developed through a reduction process of the Stanford Presenteeism Scale 32 that was developed in 2001. Research consultants were engaged to conduct the reduction of the SPS 32, and their reduction process included the identification of items that would be applicable to a wide range of

professions. The process was also able to identify two linked factors i.e. completing work and avoiding distraction. The two factors were identified through use of Varimax rotation and Kaizer normalization (Koopman et al., 2002).

### **3.3.5 Validity and reliability of Part D of the data collection tool**

The Likert scale questionnaire is of high validity in that it has single scores among the set of responses, a high internal consistency, allows ranking of responses and is easy to construct (Sarantakos, 1996). Even though development of Likert scale questionnaires has a history of being easy, Nemoto and Beglar (2013) propose that a draft Likert-scale questionnaire be given to at least three people who understand the concepts; to proof-read, to determine the relationship between concepts, to determine the clarity of the statements and to assess the ease of readability. According to Pallant (2010), Likert-scale type of questionnaires provide a wide choice of responses and increases the number of statistical analyses that can be done. It is imperative to establish the validity of the new data collection instrument (Pallant, 2010).

Content validity involves ascertaining if the questionnaire is able to assess the “breadth and the depth” of the construct and it includes a thorough literature review, conducting focus group discussions and seeking advice from experts (Streiner and Norman, 2008).

Content validity of the study was partially established by conducting an intensive literature review. The concepts selected to form statements or items of the Likert- scale questionnaire were derived from the findings of a qualitative study conducted by Ashby and Mahdon in 2010, and from sample questions of the Copenhagen Psychosocial Questionnaire (COPSOQ) developed by Kristensen in 1991 (Kiss et. al., 2014). Ashby and Mahdon’s study was conducted among a staff of 600 at AXA PPP Healthcare, and some of the employees were medical officers. The purpose of the study was to determine the causes of sickness presenteeism. The Likert-scale questionnaire was submitted to the research project supervisor and two statisticians for proof reading and refinement, as part of ensuring content validity.

Pallant (2010), and Streiner and Norman (2008) aver that construct validity is a measure of ensuring that the concepts derived from a particular theory relate well to the concepts being assessed by the questionnaire. Construct validity may include the comparison of the new tool with concepts of an existing instrument, to determine the

existence of a relationship (convergent validity). As previously alluded to with regard to content validity, the concepts were derived from an extensive literature review and were aligned with the conceptual model of demands, control, social support, and health problems, as discussed by Jourdain and (2007). The researcher developed Part D of the questionnaire to be used in this study, as none of the existing data collection instruments were applicable to capturing the various concepts of predisposing factors for sickness presenteeism. An attempt was made to combine various existing instruments that captured different aspects of predisposing factors, but this resulted in a questionnaire several pages long. The excessive length of the instrument reduced its readability and comprehensibility.

Schultz and Edington (2007), also suggested a systematic review of data collection instruments for health problems and sickness presenteeism. A work limitations questionnaire, a work performance questionnaire, work productivity short inventory and the Stanford Presenteeism Scale were identified by Schultz and Edington (2007) as instruments with high validity and reliability, but they were not able to capture all of the concepts of the present study.

The health and work questionnaire (HWQ) captured some of the concepts of the study; such as demand, locus of control, support within the workplace, and productivity levels, but failed to capture health problems as a concept that predisposed nurses to sickness presenteeism. Additionally, the HWQ omitted concepts that form part of the social support within and beyond the workplace, that are cited by Kristensen (1991) such as: the employee's financial situation, a lack of paid sick leave, family life and psychological factors. The omission was also highlighted by Hansen, Lund and Labriola (2011). Concepts that form part of supportive workplace programs, namely entitlement to a specific number of sick leave days (strict control of sickness absence) and the feasibility of accessing incapacity leave were not captured by HWQ. Lastly, in the context of this study, Swaziland has a high burden of diseases that are associated with stigma, namely HIV/ AIDS and TB. The stigma lends itself to an inability to disclose health status and this, together with the lack of effective workplace wellness programmes, may prompt nurses to report for duty while sick. The questions that address issues of trust, justice and fairness in the workplace are also omitted from the HWQ, thus making it an unsuitable instrument for this study. The COPSOQ includes questions that are essential for establishing information related to stigma.

Validity of the Likert-scale questionnaire was attained by conducting a pilot study among ten (10) nurses working in various categories of various health facilities in the Manzini region. Errors that were identified were corrected, and recommended additions were made to the questionnaire:

- A typing error in Part D, statement 9 was corrected, where the word “leaving” was replaced with “living”.
- The word “four” was changed to “five” in Part C.
- The opening statement of Part D, which stated the number of Likert-scale responses that respondents were required to make, was corrected.
- Part A was corrected to include the omitted work experience categories of 6-10, 26-30 years, 36-39 years and 40 years and above.
- The column headings were included at the top of each page to avoid the necessity for respondents to turn back to the previous page in order to avoid recording inaccurate results when selecting the Likert-scale categories.

Nemoto and Beglar (2013) and Sarantakos (1996) state that a pilot study of a Likert-scale questionnaire has to be conducted in order to determine internal consistency. This is confirmed by establishing a relationship between the statements and the concepts of the study.

Quality of evidence in a quantitative study is ensured through the maintenance of reliability, and reliability refers to the precision and stability of data collection instruments in their ability to measure the variables or concepts of the study (Polit and Beck, 2004). In the study, the Likert-scale questionnaire was assessed for internal consistency using the Statistical Package of Social Sciences, version 23, to determine the Cronbach’s coefficient alpha. A Cronbach’s coefficient alpha of 0.8 was attained for the data collection instrument. According to Pallant (2010), assessment of Cronbach’s coefficient alpha is an effective strategy for determining the reliability of a data collection instrument. Pallant (2010) added that a minimum of 0.7 for the Cronbach’s coefficient alpha is sufficient for classifying an instrument as reliable.

### **3.4. Data collection**

Descriptive studies are conducted in natural surroundings, according to Burns and Grove (2009). Data collection was done through the use of hand-distributed questionnaires (survey). Data collection was done over a four week period. The

questionnaires were filled by nurses during working hours. The questionnaires were collected by the in-service coordinators of the various health facilities in envelopes from the various in-patient and out-patient departments. The in-service coordinator kept the different sealed envelopes in a box that was also later sealed for the researcher to collect. The arrangement of data collection with managers was that ample time be given for nurses to fill in the questions, thus the questionnaires were to be collected not later than a month from the day of distribution. This extended time period allowed for an improved response rate, as it allowed the researcher to compensate for, and counteract, any refusals to participate and low return rates of completed questionnaires. The researcher also had adequate time to travel to the widely-spaced health facilities in the two regions. The questionnaires which consisted of four parts, namely; Part A that gathered demographic characteristics, Part B that determined the existence of sickness presenteeism, Part C that determined the tendency of reporting for work while sick, and lastly, Part D for determining the predisposing factors of sickness presenteeism, were collected by the researcher from in-service coordinators in the various health facilities.

#### **3.4.1 Concepts of Part D used for data collection**

It is imperative to provide more information with regard to concepts related to demand, control, social support and health problems. Such information promotes understanding of relevance of questions and provides linkage to objectives of the study. Table 3.3 below provides more information on related concepts.

Table 3.3 Concepts of the demand, control, social support and health problems and relevant questions in the questionnaire.

Concepts that are in Part D of the questionnaire.	Items that addressed the concept	Comments
Demand	1, 2, and 3	<p>1- predisposing factor for attendance was having no one skilled to perform particular tasks.</p> <p>2- predisposing factor for attendance was staff shortage.</p> <p>3- predisposing factor for attendance was being scheduled for night duty (inflexible work schedule).</p>
Control	5	<p>5- predisposing factor for attendance was inability to adjust work tasks and inability to postpone some tasks for later date.</p>
Social support in the workplace (instrumental, emotional, informational and appraisal support).	4, 6, 7, 8, 11,12 and 20	<p>4- predisposing factor was lacking managerial support thus being pressured to attend to work.</p> <p>6- predisposing factor was having responsibility to maintain teamwork and commitment to support colleagues.</p> <p>7- predisposing factor was harsh management of sickness absence and its unacceptability.</p> <p>8- predisposing was inability to handle employees health problems in confidence among managers and colleagues.</p> <p>11- predisposing factor was not condoning sick leave being manifested by salary reduction for those that take sick leave.</p>

		<p>12- predisposing factor was disturbance in carrier progression if sick leave hinders on promotion.</p> <p>20- predisposing factor was seeking medical services from health facilities staff that do not have authority for approved sick leave.</p>
Social support from family members and other people	9,10, 11,	<p>9- predisposing factor is inability to rest at home for recuperation purposes due to family issues.</p> <p>10- predisposing factor is high dependence of beneficiaries requiring continuous production for income.</p>
Health problems	13, 14, 15, 16, 17, 18, and 19	<p>Predisposing factors were:</p> <p>13- suffering from acute illnesses.</p> <p>14- suffering from episodic illnesses.</p> <p>15- suffering from chronic illnesses.</p> <p>16- experiencing severe signs and symptoms of psychological illnesses.</p> <p>17- suffering from illnesses that are associated with HIV/AIDS and pulmonary tuberculosis.</p> <p>18- experiencing long term illnesses that would predispose one to being certified as medically unfit.</p>

Table 3.3 above provides information about the various concepts that were examined through use of questions in Part D of the data collection. The inclusion of the information provides clarity and linkage between objectives of the study, identification of concepts as enshrined in the conceptual model and coherence

### 3.4.2 Maintaining Confidentiality in the study

Sickness presenteeism is a sensitive concept of study in that the respondent is expected to share confidential information related to health, environmental work



factors that negatively impact on employees' quality of life. The principle of confidentiality was adhered to through completing the questionnaire anonymously and the respondents were told about their right for opting out of the study whenever such a need arose. The respondents were not required to fill in information that would assist in the respondents' identification. Moreover, the questionnaires were not directly submitted to the researcher, instead they were delivered to the in-service coordinator in closed envelopes and were kept in a sealed box until the day of collection. The questionnaires were collected by the researcher in the sealed boxes and transported for analysis. The collaborated effort between the in-service coordinator and the researcher during data collection period yielded good results that lead to a response rate of 75.4 % where 264 filled questionnaires were returned out of a total of 350 questionnaires distributed (refer to table 3.2).

### **3.5. Data analysis**

Data was analysed using the Statistical Package for Social Scientists (SPSS), version 23. The coded data was entered into the computer. Frequency distributions, measures of central tendency and measures of dispersion were calculated and presented in graphs and tables. Descriptive statistics facilitate the organisation of data so that meaning can be obtained from the data and they include means, standard deviations and the range of scores (Pallant, 2010; Burns and Grove, 2009). The testing of a statistical hypothesis was not required for the study therefore inferential statistics was not done. Central tendency was determined by selecting the median for each of the variables.

Data analysis was done by the researcher after receiving the Statistical Package for Social Sciences version 23 from the UKZN Information Technology Department. Several face to face and on-line consultative meetings were done by the researcher and the UKZN Statistician. Assistance was offered during the early phase of proposal development. Services rendered included aligning objectives and questions, assessment of data collection tool and determining applicable data analysis methods. In a group meeting we were mentored on how to apply SPSS in our studies. Prior to submission of chapter 4, to the research supervisor consultation was done and coaching was provided by the Statistician.

The first phase of data analysis entailed coding of data, populating it in SPSS version, 23 in the computer and examining respondents' demographic characteristics

The second phase of data analysis included transforming these variables into new variables that represented agreement and disagreement with the statements. The variables for sickness presenteeism had four responses for Aaronson, Gustafsson and Dallner, (2000), single question on sickness presenteeism. Responses that were in disagreement were classified as “no” and were coded as 1. Responses that were in agreement were classified as “yes” and coded as 2. Responses of uncertainty were coded as 0, as for the other variables. The responses of agreement included: Yes, once; yes, 2-5times; and yes, more than 5 times. The responses to the statements of the six variables for the category for sickness presenteeism, as per SPS 6, were re-coded and disagreement with a statement was represented by 1, uncertainty with a statement was represented by 0, and agreement with a statement was represented by 2.

The last twenty variables were re-coded into four groups of variables (job demand, locus of control, social support and health problems). Responses that were in disagreement (somewhat and strongly) with statements were coded as 1 and represented responses of “no”. Responses of uncertainty with a statement were considered to be a neutral response, which was coded as 0. Responses that were in agreement (somewhat and strongly) with statements were coded as 2 and represented responses of “yes”. A sum of scores for each respondent was calculated for SPS 6 results to determine sickness presenteeism. An individual respondent's scores which ranged between 19 and 30 signalled the presence of sickness presenteeism.

### **3.6. Data management**

The collected data was handled by the researcher alone. After entering the raw data into the SPSS program, the completed questionnaires were scanned and saved onto a Compact Disc (CD). The hard copies of the completed questionnaires were shredded and discarded, and the CD was given to the research supervisor for storage according to UKZN policy (five years in a locked filing cupboard). The electronic data was stored on the researcher's personal computer and a security code known only to the researcher was used to access the data. After completion of data analysis and writing of the final report, the files of SPSS data were copied to another CD and stored in a locked filing cabinet by the research supervisor at UKZN. Five years after

completion of the study all electronic data will be permanently removed from computer hard drives, flash drives, clouds and CD's.

### **3.7. Ethics**

Ethical considerations in a study are essential to ensure the safety and confidentiality of research respondents and to determine whether their rights have been taken into consideration (Polit and Beck, 2004). It is imperative for researchers conducting research in developing countries to comply with the ethical research principles for developing countries (Emanuel, Wendler, Killen & Grady, 2004). The important principles that the researcher is expected to adhere to include: collaborative partnerships, social value, scientific validity, the fair selection of the study population, a favourable risk benefit ratio, independent review, informed consent, and respect for recruited respondents and study communities, state Emanuel et al. (2004).

The principle of collaborative partnership for this study was ensured by submission of the research proposal to the Principal Secretary of the Ministry of Health and to the Chief Nursing Officer in Swaziland. A soft copy of the research proposal was provided, in order for the parties to ascertain the significance of the study and evaluate the relevance and benefits of the study for the public health service nurses. Permission to share the proposal with the Ministry's development partners, namely the WHO, the University Research Council (URC) and the International Centre for AIDS Care and Treatment Programs (ICAP) in the country was sought from the Principal Secretary of the Ministry of Health. These partners were selected based on their roles of strengthening the health systems in the country. The WHO offers technical assistance for policy development and review and financial assistance for various programs such as Non-communicable Diseases and TB programs; the URC provides assistance in capacity building for the mitigation of TB and HIV for the public and healthcare workers; and ICAP assists in health provider interventions for the attainment of good health, with family-focused and multi-disciplinary interventions for mitigating HIV/AIDS (<http://www.gov.sz.moh>, 2014). Sharing of the research proposal was done in a quest to create awareness about the study, to provide an opportunity for independent review of the proposal and to have buy-in for future interventions that will be required to benefit the study population.

The social value principle requires that the knowledge generated through the study has to yield tangible benefits for the research respondents, e.g. an improvement in the health status of the study population and/or an improvement of the working environment (WHO, 2012). Involvement of key stakeholders such as the Principal Secretary of the Ministry of Health, the Chief Nursing Officer, the WHO, the University Research Council and the International Centre for AIDS Care and Treatment Programs formed the basis for collaboration that will yield cooperation in the implementation of the recommendations of the study.

The scientific validity of the study was ensured by submitting the proposal to the Ethics and Research Committee of the University of KwaZulu-Natal and the Scientific Research and Ethics Committee in the Ministry of Health in Swaziland, for approval and granting of permission to conduct the study. Ethical clearance letters were issued by the University of KwaZulu-Natal and by the Swaziland Ethics Committee prior to data collection. Letters requesting permission to conduct the study were submitted to the Regional Health Management Team (RHMT) of each region and health facility managers. Permission to conduct the study was granted by health facility managers (matrons) of participating health facilities and the Ministry of Health. Meetings for the clarification of concerns, discussion about the benefits of the study and the planning of suitable dates for data collection were held at regional level.

The principle of respect for the respondents recruited to the study and for the community was addressed by the distribution of written consent forms. Consent forms were completed by the nurses as confirmation of voluntary participation in the study. The research respondents completed the questionnaire anonymously in order to maintain confidentiality and the respondents were told of their liberty to opt out of the study at any time.

### **3.8. Conclusion**

Chapter 3 presents the research methodology of the study that was conducted among nurses of the selected health facilities in Swaziland. Positivism was the research paradigm adopted for the study and a quantitative research approach was utilised. A descriptive research design was adopted and the data collection method used was a survey, whereby questionnaires were handed out by the researcher and then completed by nurses who represented the various nurse cadres in Swaziland. The

health facilities were randomly selected using both cluster random sampling and simple random sampling. The researcher made second visits to the selected health facilities to collect the completed questionnaires. The completed questionnaires were analysed, scanned and saved onto a CD by the researcher.

Data analysis was done through the use of SPSS, version 23, after the data had been coded and entered onto a computer. Data management was also discussed in depth

## **CHAPTER 4 DATA ANALYSIS AND FINDINGS**

### **4.1 Introduction**

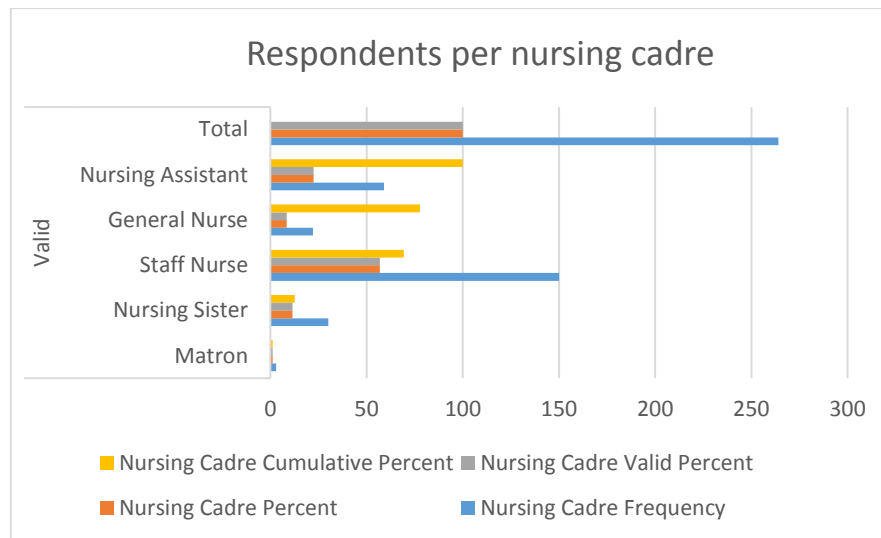
In this chapter, the research findings are presented, in line with the research objectives and according to the concepts related to sickness presenteeism. These concepts were presented in the conceptual model (job demand, locus of control, social support and health problems). The respondents' characteristics have been included, in order to describe sickness presenteeism with a clear picture of the type and calibre of the respondents.

### **4.2 Data analysis**

The data was analysed using the Statistical Package for Social Scientists (SPSS), version 23. Coded data was entered into the computer. Descriptive statistics were carried out, and the measures of central tendency and range and distribution were computed. Percentages and scores were tabulated for all scales and sub-scales. The first nine variables form part of the biographic and demographic information, classified as respondent characteristics. The following nine variables are categorised as sickness presenteeism and have been used for determining the presence of sickness presenteeism. This category is comprised of a single question used by Aaronson, (2000) for determining the presence of sickness presenteeism over a period of twelve months. The six statements, as presented in the Stanford Presenteeism Scale 6 (SPS 6), were used to determine the ability to complete work related tasks without distractions, despite experiencing a health problem. The final twenty variables are categorised as job demands, locus of control, social support and health problems. There are four variables associated with demand (ease of replacement, staff shortage, shift work and pressure from managers); one variable for locus of control; seven variables related to social support and eight variables related to health problems.

## 4.3 Results

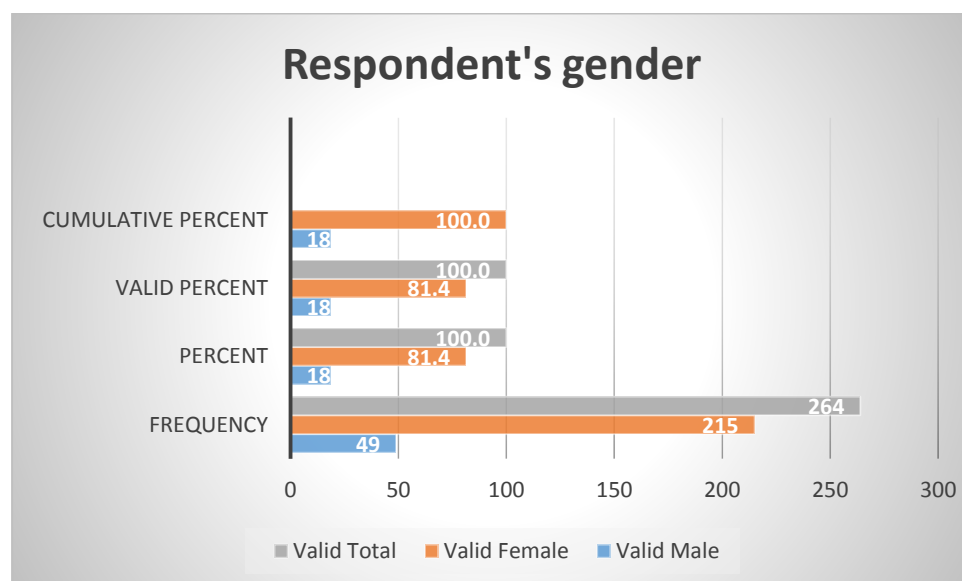
### 4.3.1 Respondents' characteristics



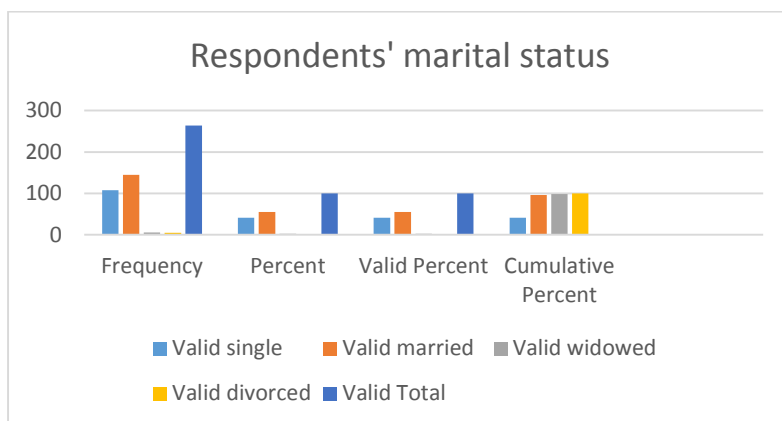
**Figure 4.1 Respondents per nursing cadre**

Staff Nurses (professional registered nurses) made up 150 (**56.8%**), of the respondents in the nursing cadres and they were in the majority .Nursing Assistants (auxiliary nurses) made up 59 (**22.3%**) of the respondents, 30 (**11.4%**) were nursing sisters (Operational Unit Managers or Primary Healthcare Managers), 22 (8.3%) were General Nurses and 3 (**1.1%**) were Matrons (Senior Nurse Managers).

### Respondent's gender

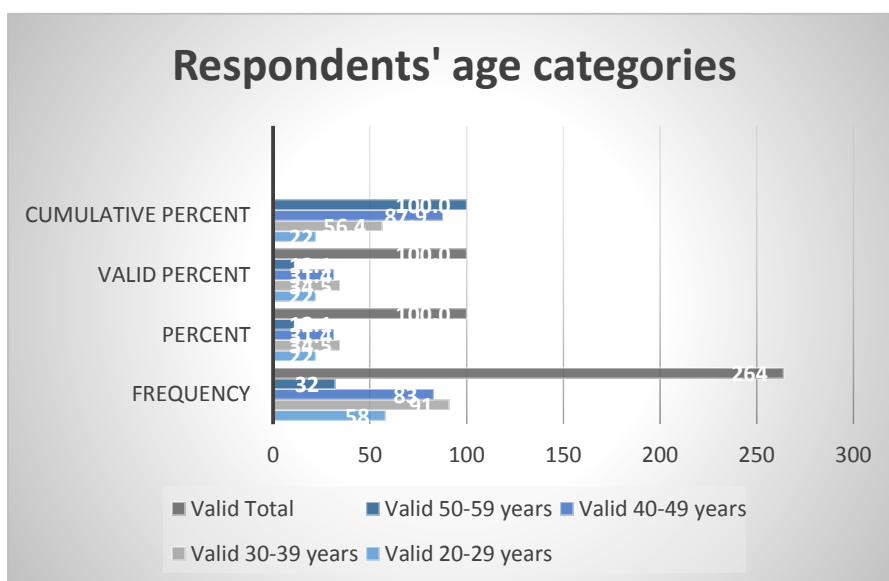


**Figure 4.2 Respondents' gender**



**Figure 4.3 Respondents' marital status**

The majority of the respondents were married 145 (**54.9%**), 108 (**40.9%**) were single, 6 (**2.3%**) were widowed and 5 (**1.9%**) were divorced.



**Figure 4.4 Respondents' age categories**

The age range of the respondents was 91 (**34.5%**) ranging from 30-39 years of age, 83 (**31.4%**) ranged from the ages of 40-49 years, 58 (**22%**) ranged from 20-29 years and 32 (**12.1%**) were between the ages of 50-59 years.



## Qualifications of respondents

Table 4.1 Respondents' qualifications

Qualifications of the Respondents	Frequency	Percent
Diploma in General Nursing	21	8.0
Post-Diploma Certificate in Midwifery	99	37.5
Post-Diploma Certificate in Community Health	3	1.1
Post-Diploma Certificate in Psychiatric Nursing	3	1.1
Bachelor in Health Service Management	12	4.5
Certificate in Nursing Assistant	58	22.0
Bachelor of Nursing Science	59	22.3
Bachelor in Community Health	6	2.3
Master's in Nursing	3	1.1
Total	264	100.0

The qualifications of the respondents ranged from a Certificate in Nursing Assistant to a Master of Nursing Degree. The majority of the respondents possessed a Post-Diploma Certificate in Midwifery Science 99 **(37.5%)**. The other respondents possessed a Bachelor of Nursing Degree 59 **(22.3%)**, a Certificate in Nursing Assistant 58 **(22.0%)**, a Diploma in General Nursing 21 **(8%)**, a Bachelor of Health Service Management 12 **(4.5%)**, a Bachelor of Community Health Nursing 6 **(2.3%)**, a Post-Diploma Certificate in Community Health Nursing 3 **(1.1%)**, a Master of Nursing Degree 3 **(1.1%)** and a Post-Diploma Certificate in Psychiatric Nursing 3 **(1.1%)**.

***Table 4.2 Respondent's years of experience***

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0-2 years	31	11,7	11,7	11,7
	3-5 years	52	19,7	19,7	31,4
	6-10 years	40	15,2	15,2	46,6
	11-15 years	62	23,5	23,5	70,1
	16-20 years	28	10,6	10,6	80,7
	21-25 years	31	11,7	11,7	92,4
	26-30 years	12	4,5	4,5	97,0
	31-35 years	7	2,7	2,7	99,6
	36-40 years	1	,4	,4	100,0
	Total	264	100,0	100,0	

Table 4.2 above presents years of experience for the respondents. The respondents' years of experience ranged from zero years to forty (40) years, with the majority 62 (**23.5%**) having 11-15 years of nursing experience. The other respondents had 0-2 years 'working experience 31 (**11.7%**), 3-5years' 52 (**19.7%**) experience, 5-10 years'40 (**15.2%**) experience, 16-20 years' 28 (**10.6%**) experience, 21-25 years 31 (**11.7%**) experience, 26-30 years'12 (**4.5%**) experience, 31-35 years' 7 (**2.7%**) experience, and 36-40 years' 1 (**0.4%**)experience respectively.

### **Respondents' Employment status**

The majority of the respondents were employed on permanent and pensionable terms 226 (**85.6%**), and 38 (**14.4%**) were employed on probation. Their distribution between in-patient and out-patient departments was 132 (**50%**). In terms of health facility categories or types, 86 (**32.6%**) were working at regional hospitals, 66 (**25%**) at a National Referral Hospital, 48 (**18.2%**) at Health Centres, and 11 (**4.2%**) at Public Health Units, while 2 (0.8%) worked at a clinic with maternity facilities and 50 (**19.3%**) worked at clinics without maternity facilities.

Table 4.3 Respondents' characteristics' median

Respondents' Characteristics' Median						
	Nursing Cadre	Employment status	Gender	Age categories	Marital Status	Work experience in years
Median	3.00	2.00	2.00	2.00	2.00	4.00
	Staff Nurse	Permanent and pensionable	Females	30-39 years	Married	11-15 years' work experience

Table 4.3 above presents the average number of participants based on nursing cadre employment status, gender, age categories, marital status and work experience. The staff nurses were in the majority, most of the respondents were permanent and pensionable, with females were the majority and the age group that ranged between 30-39 years were the majority; most respondents were married and most had a working experience of 11-15 years.

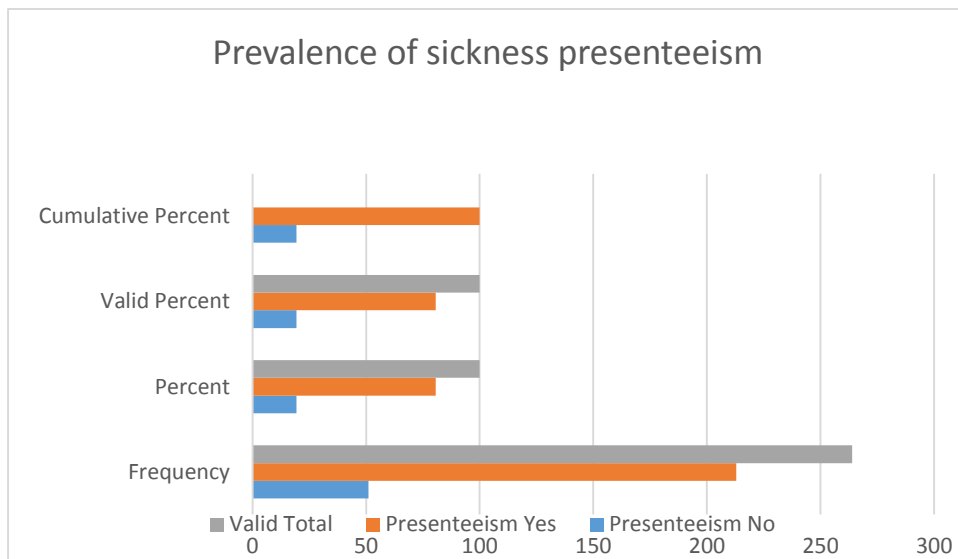
#### **4.3.2 The existence of sickness presenteeism**

Based on Aronsson et.al,' (2000)'s question that has been used several times by researchers:

*“Has it happened over the previous twelve months that you have gone to work despite feeling that you really should have taken sick leave due to your state of health?”*, (see Part B of Annexure B-Data Collection Tool)

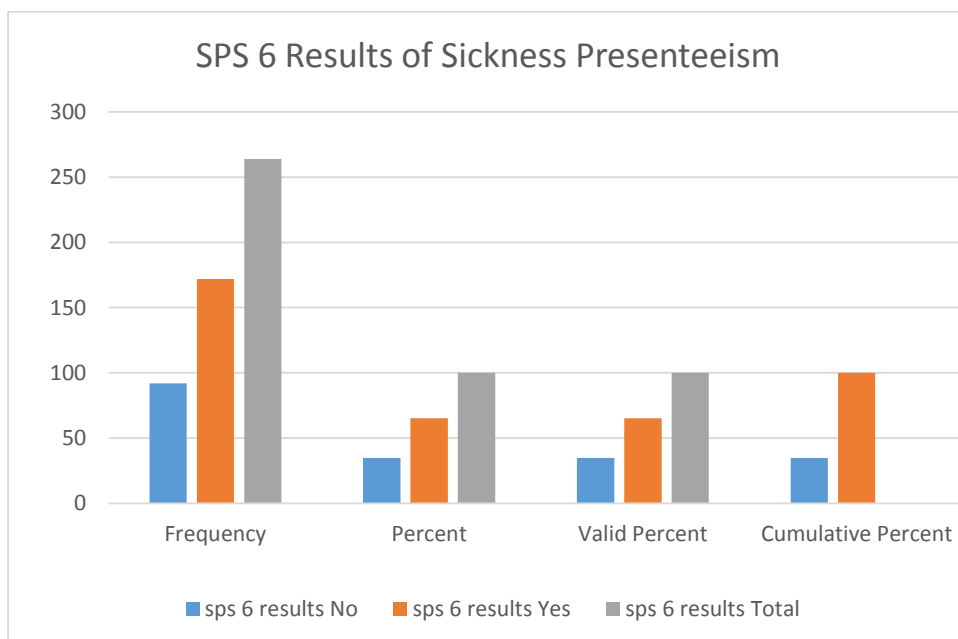
the response provided by 106 (**40.5%**) of the respondents was that it had happened 2-5 times over a duration of twelve months. A further 58 (**22%**) said it had happened once and 48 (**18.2%**) said it had happened more than five times over this period of time. This indicated that sickness presenteeism among nurses working in selected health facilities was at 213 (**80.7%**). Notably, 51 (**19.3 %**) of the nurses indicated that

they had not gone to work while feeling that they should have taken sick leave due to their state of health.



**Figure 4.5** *Prevalence of sickness presenteeism*

### 4.3.3 Sickness presenteeism findings based on Stanford Presenteeism Scale 6



**Figure 4.6** *Stanford Presenteeism Scale 6 Results of Sickness Presenteeism*

Figure 4.6 above presents the results of the Stanford Presenteeism Scale 6 (SPS 6). The results were attained by coding responses with a total score of 18 and less as 1, which represented "no", as having not been able to complete work tasks without distractions when having health problems. Scores with a total of more than 18 per

respondent were coded as 2, which represented “yes,” as being able to complete work tasks without distraction even though having health problems. The respondents whose behaviour confirmed sickness presenteeism (yes-response) comprised 172 (**65.2%**) of the total, and those who responded with “no” comprised 92 (34.8%) of the

respondents, thus giving a sickness presenteeism of 65.2%, based on SPS 6 results.

Table 4.4	Strongly disagree		Somewhat disagree		Uncertain		Somewhat agree		Strongly agree	
<b>Stanford presenteeism scale 6 statements (SPS 6)</b>	Frequency	Percentage	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Stresses of the job were much harder to handle due to health problems	49	18.6	28	10.6	35	13.3	88	33.3	64	24.2
The nurse was able to finish hard tasks in spite of health problems	38	14.4	24	9.1	22	8.3	80	30.3	100	37.9
Health problems distracted nurse from having pleasure at work	49	18.6	27	10.2	37	14.0	61	23.1	90	34.1
The nurse felt hopeless about finishing work tasks due to health problems	75	28.4	35	13.3	37	14.0	68	25.8	49	18.6
The nurse was able to focus on achieving goals despite health problems	41	15.4	19	7.1	34	12.8	78	29.3	92	34.6
The nurse felt energetic enough to complete all work	82	30.8	45	16.9	39	14.7	49	18.4	49	18.4

Table 4.4 Stanford presenteeism scale statements (SPS 6)

### **Sickness presenteeism results presented from SPS 6**

**Table 4.4** above presents the findings of sickness presenteeism according to the concepts of ability to complete and experiencing distraction when working while sick as portrayed in SPS 6 scale. The SPS 6 Likert-scale determined the employees' ability to focus on work without being distracted by health problems. Items 2, 5 and 6 referred

to completion of work (work outcomes) and items 1, 3 and 4 catered for avoiding distractions (work processes). It measured self-rated work performance while affected by presenteeism, with higher scores indicating that performance was less affected by having health problems. Nurses were thus more likely to attend work despite having health problems (Koopman, Pelletier, Murray and Sharda, 2002; Martinez and Ferreira, 2012).

According to the results obtained, 57.5% of the respondents had higher scores for the statement regarding the job being hard to handle, with 33.3% scoring 4 points each, and 24.2% scoring 5 points each. In relation to the statement regarding being able to finish hard tasks at work in spite of having health problems, 68.2% of the respondents attained higher scores, with 30.3% scoring 4 points each and 37.9% scoring 5 points each. Higher scores of 5 and 4 in the Likert-scale were attained by 57.2% of the respondents, confirming that health problems distracted nurses from deriving pleasure at work. A total of 44.4% of the respondents scored higher points of 5 and 4 for being hopeless regarding finishing work tasks due to health problems, and 63.9% had higher scores for being able to focus on achieving work goals. On a different note, only 36.8% of the nurses said they would be energetic enough to complete work tasks even though having health problems. A further 14.7% were uncertain and 47.7% said they would not feel energetic enough to complete work tasks when having health problems. This was indicated by few higher scores of 4 and 5, and more respondents having scored 3, 2 or 1.

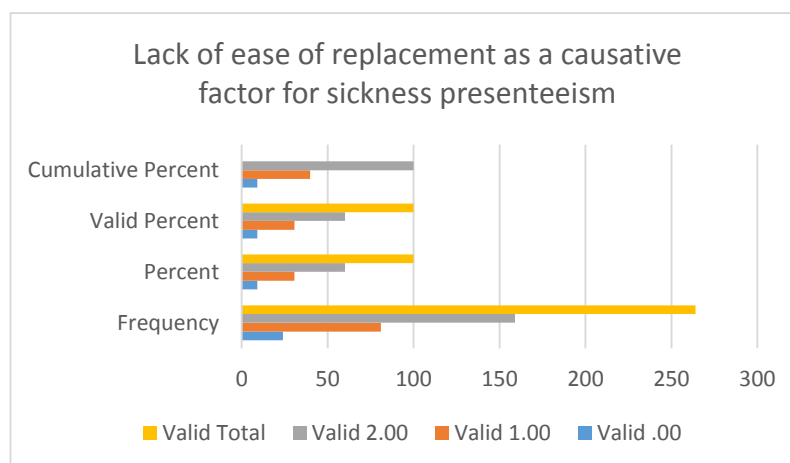
#### **4.3.4 Factors contributing to sickness presenteeism**

There are several predisposing factors for sickness presenteeism, such as the type of occupation, for example nursing, how high the demands of the job are, whether or not the staff member has the ability to adjust his/her work in terms of the type of work to be done and/or the amount to be done (locus of control), the amount of social support given and the extent or severity of the health problems being experienced. Social support encompasses: instrumental support (the provision of tangible assistance and services that help a person when in need); emotional support (the provision of empathy, love, caring and trust); informational support (the provision of advice, problem solving solutions and suggestions) and appraisal support (the provision of constructive feedback, self-evaluation and affirmation).

The study findings with regard to job demand, locus of control, social support and health problems were as follows:

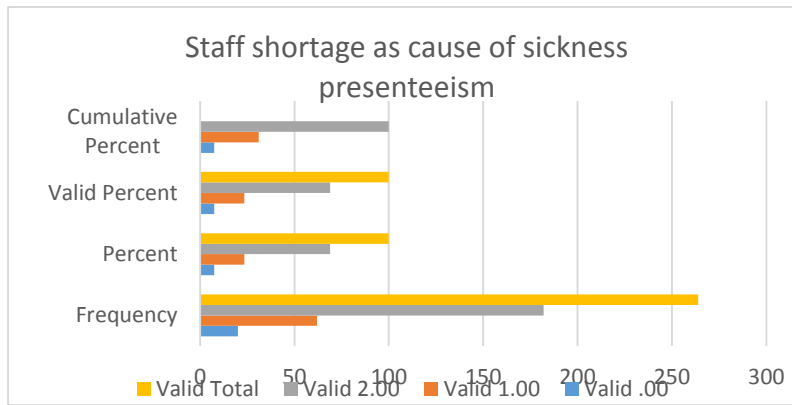
#### 4.3.5 Job demand

The high job demands inherent in nursing proved to be a contributing factor towards sickness presenteeism, in that 60.2% of the nurses declared that they would go to work when there was no one to do their tasks. In addition to this, 69% of the respondents indicated that they would go to work in spite of having a health problem when there was a shortage of staff. A total of 40.9% of the respondents declared that they would go to work despite having a health problem when they had been scheduled for night duty.



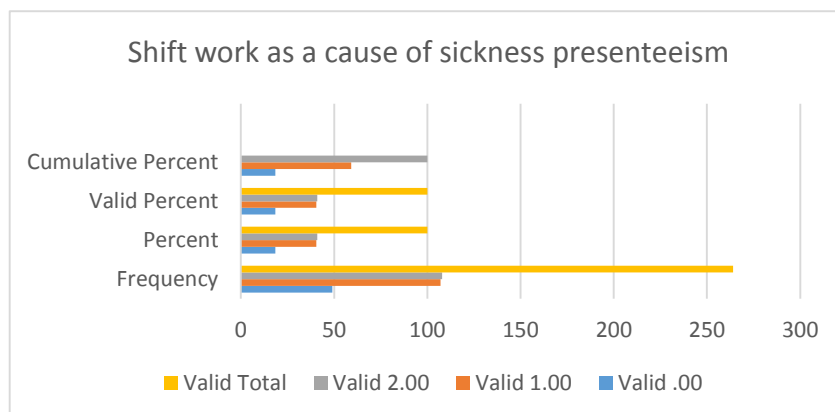
**Figure 4.7 Lack of ease of replacement as a causative factor for sickness presenteeism**

Lack of ease of replacement accounted for 60.2% that states that they would attend to work even though ill if there was a challenge of replacement of an individual nurses' specialized skills whereas 30.7% declared that they would not attend to work ill in relation to lack of ease of replacement . 9.1 %of nurses declared that they were not sure about the action they would take, if one was not easily replaceable and yet ill.



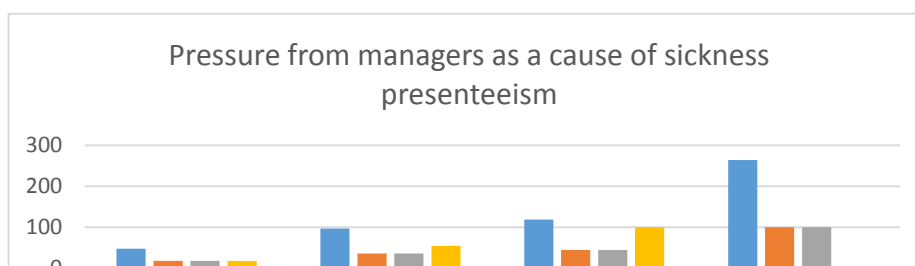
**Figure 4.8 Staff shortage as a cause of sickness presenteeism**

Shortage of staff yielded a result of 68.9% for nurses that stated that they would attend to work ill if there was shortage of staff whereas 23.5% of nurses stated that they would not attend to work while ill when there is staff shortage. The nurses that were not sure whether they will attend to work while in relation to staff shortage accounted for 7.6%.



**Figure 4.9 Shift work as a cause of sickness presenteeism**

The responses for shift work as a predisposing factor for attending work while ill was that 108 (**40.9%**) would attend to work, whereas 107 (**40.5%**) would not attend to work. Uncertainty prevailed among some nurses when 49 (**18.2 %**) were not sure if they would attend to work or not.

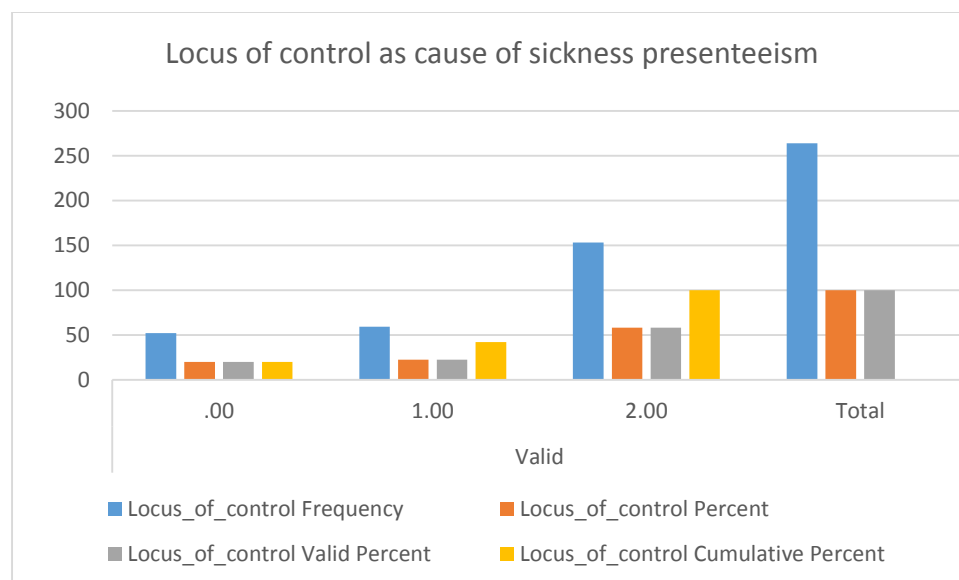




**Figure 4.10 Pressure from managers as a cause of sickness presenteeism**

Figure 4.10 above shows results for being pressurized to attend to work by managers. With regard to pressure being applied by Nurse Managers for nurses to attend work, responses indicated that 45% of the respondents would go to work despite having health problems if senior and line managers pressurised them into doing so. Conversely, 36.8 % of the respondents stated that they would not go to work when ill in spite of being pressured to do so, and 18.2% of the respondents were not sure what their response would be.

#### **4.3.6 Locus of control (adjustment latitude)**



**Figure 4.11 Locus of control as a cause of sickness presenteeism**

With regard to the locus of control, 58% of the respondents indicated that they would attend work while ill if they had the ability to adjust the type and amount of work to be done when affected by a health problem. Of the nurses, 22% indicated that they would

not go to work when ill, even if they were in a position to adjust their workload, and 19.7% of the nurse respondents were not sure whether they would go to work or not in this situation.

#### 4.3.7 Social support

Social support has been assessed by the use of five questions which included: the responsibility to maintain teamwork, the harsh management of sickness absenteeism or the unacceptability of sick leave, confidentiality in the keeping of personal and health-related information for nurses, the impact of taking sick leave on promotions and the support obtained from family members when nurses have health problems.

Table 4.5 Social support as predisposing factors of sickness presenteeism

Social support as predisposing factors of sickness presenteeism	Strongly disagree	Somewhat disagree	Uncertain	Somewhat agree	Strongly agree
Having responsibility to maintain teamwork and or support for colleagues would compel one to attend work despite having health problems	16.3%	12.1%	11.7%	31.4%	28.4%
Unacceptability and harsh management of sickness absenteeism by managers would prompt one to attend work despite having health problems	31.1%	10.2%	18.9%	18.6%	21.2%
Inability of managers and colleagues to handle information of personal problems and health-related issues confidentially would prompt me to attend work despite having health problems.	23.1%	11.7%	17.8%	23.9%	23.5%
If taking sick leave impacts negatively on my promotion I would be prompted to attend to work despite having a health problem	31.8%	12.1%	22.3%	18.6%	15.2%
If I am unable to rest at home due to family issues or living arrangements, I would be prompted to attend to work despite having health problems	37.5%	15.5%	14.8%	15.9%	16.3%

Table 4.5 above presents results for social support as a predisposing factor for sickness presenteeism.

Where nurses were responsible for maintaining teamwork and supporting colleagues, 59.8% were highly inclined to go to work despite being ill, 31.4 % of the respondents declared that they were somewhat inclined to go in, and 28.4% strongly agreed that they would go in to work.

Where harsh management for sickness absenteeism and an unacceptability of sickness absenteeism by managers was observed, 39.8% of the respondents agreed

that this contributed to sickness presenteeism. A further 31.3% of the respondents indicated that these factors would not compel them to go to work while ill and 18.9% of the respondents were not sure what their response to harsh management of sickness absence would be.

A total of 47.4% of the nurse respondents agreed that a manager's and their colleagues' inability to keep information regarding personal problems and health related issues confidential would be a predisposing factor for sickness presenteeism, while 34.8% of the nurses disagreed that this would be a predisposing factor. A further 17.8 were not sure if they viewed this as a predisposing factor or not.

When asked if they would attend work, even while ill, if the taking of sick leave would impact negatively on their chances of promotion, 33.8% of the nurses agreed that they would go to work. 43.9% disagreed and indicated that they would not go to work and 22.3% were not sure what they would do in that situation.

An inability to rest at home due to family issues or living arrangements was discovered not to be a predisposing factor for sickness presenteeism, as 32.2% were in agreement, 53% disagreed that this would be a predisposing factor and 14.8% were uncertain if it would influence them to go in to work.

#### **4.3.8 Social support policy and health-related problems as predisposing factors for sickness presenteeism**

Four variables were classified as policy issues that predisposed nurses to sickness presenteeism. The variables included suffering from illnesses that may be associated with stigma, such as pulmonary tuberculosis and HIV/AIDS; seeking healthcare services from health care providers that were not authorised to grant sick leave; seeking healthcare services from a pharmacy and or nurses and prescribing their own medications for the treatment of health problems and suffering from long term illnesses which predisposed nurses to being certified as medically unfit.

**Table 4.6 Social support policy related and/or health problem related**

Social support policy related / health problem related	Strongly disagree	Some what agree	Uncertain	Somewhat agree	Strongly agree
Suffering from illnesses associated with stigma e.g. pulmonary TB and HIV/AIDS	43.9%	20.1%	14.8%	11.7%	9.5%
Seeking health services from health providers that are not authorized to grant sick leave	32.6%	9.5%	18.9%	15.2%	23.9 %
Use of self-prescribed medication and or pharmaceutical supplies	26.9%	13.3%	17.8%	25.0%	17.0 %
Suffering from long term illnesses that predispose nurses to be certified as medically unfit	47.3%	14.4%	14.0%	12.1%	12.1 %

Suffering from illnesses associated with stigma was not associated with an increase in sickness presenteeism. This was confirmed by disagreement with the variable by 64% of the nurses. Long term suffering that predisposed nurses to being medically unfit to practice was confirmed not to be a predisposing factor of sickness

presenteeism, with 61.7% selecting disagreement responses. Self-prescription of medication and the use of over-the-counter medications and supplies for self-treatment had no influence on the nurses' sickness presenteeism, with 40.2% in disagreement, 42% in agreement and 17.8% being uncertain. With regard to seeking healthcare services from health providers that were not authorised to grant sick leave; 42.1% of the nurses declared that they would not be prompted to attend work; 39.1% stated that they would go in and 18.9% were uncertain. The findings are outlined in Table 4.6 above.

**Table 4.7 Health problems as predisposing factors for sickness presenteeism**

Health problems that are acute, episodic, chronic and psychological in nature predispose nurses to sickness presenteeism. The findings of the study were that acute illnesses accounted for 61.7% of sickness presenteeism, episodic illnesses for 46.2% of sickness presenteeism, chronic illnesses for 63.6% and psychological illnesses for 74.3% of instances of sickness presenteeism.

#### 4.4 Conclusion

The chapter presented data analysis of the study. The questionnaires that were fully completed and returned to the researcher for analysis were 264. The total number of questionnaires distributed was 350. The response rate of nurses was 264 (**75.4%**) The extent of sickness presenteeism was 213 (**80.7%**). Experiencing health problems that are classified as severe psychological illnesses, severe chronic illnesses and acute illnesses were major predisposing factors for sickness presenteeism accounting for 196 (**74.3%**) 167 (**63.6%**) and 163 (**61.7%**), respectively. Predominant causes of sickness presenteeism among nurses were the ability to adjust work and amount (**58%**), high job demand (average **57.7%**), health problems (average of **47.9%**) and

Health problems as predisposing factors for sickness presenteeism	Strongly disagree	Somewhat agree	Uncertain	Somewhat agree	Strongly agree
<b>Experiencing signs and symptoms of acute illness such as gastro-enteritis or diarrhoea</b>	14.4%	10.2%	13.6%	17.4%	44.3%
<b>Experiencing signs and symptoms of episodic illness such as common cold, allergies</b>	21.2%	17.8%	14.8%	28.8%	17.4%
<b>Experiencing severe signs and symptoms of chronic illness such as diabetes mellitus or hypertension</b>	12.9%	11.0%	12.5%	19.7%	43.9%
<b>Experiencing severe signs and symptoms of psychological illness such as depression</b>	9.1%	5.7%	11.0%	22.0%	52.3%

social support at an average of (**44.2%**).

## **CHAPTER 5 DISCUSSIONS**

### **5.1 Introduction**

The research study findings were similar to the results obtained in studies conducted before, such as those by Johns (2010); Jourdain et. al., (2013) and Martinez et.al. (2012), whose research findings revealed that job demand, locus of control, social support, health problems, ease of placement and absence policies were antecedents to sickness presenteeism. Similarities were identified in studies that revealed that staff working in care professions, or working with people in general, e.g. nurses, had a greater risk of sickness presenteeism (Aronsson et. al., 2000; Johansen et. al., 2014; Leineweber, Westerlund, Hagberg, Svedberg and Alexanderson, 2012). Pilette (2005) confirmed that nursing was a high risk profession with regard to sickness presenteeism, by stating that the risk was associated with the demanding nature of the job and health problems such as mental and other related illnesses.

According to the results of this study, 80.7% of the nurses attended work despite ill health and this reflected a high rate of sickness presenteeism. Other studies that revealed high sickness prevalence rates among nurses include the 75% reported by Linnerud (2013), who used Aaronson's question to determine the rate of sickness presenteeism. Similarly, Martinez et. al., (2012) confirmed that sickness presenteeism was high and associated the phenomenon with health problems such as backache and depression.

The conceptual framework of sickness presenteeism portrays psychological stress, job demand, locus of control, social support and health problems as antecedents of sickness presenteeism (Jourdain et. al., 2013). Additionally, the conceptual framework used by Martinez et. al., (2012) in a study of sickness presenteeism and absenteeism, states that a health event that may be acute, episodic or chronic serves as an antecedent in the occurrence of sickness presenteeism. The author included other contributory factors such as the context of the working environment and personal factors.

### **5.2 High job demands in nursing**

Linnerud, (2013) contends that nurses have high job demands emanating from the type of occupation. Nurses have to attend to top-down demands with tasks that Nurse Managers require of them; horizontal demands whereby colleagues require some

tasks to be done and bottom–up demands where patients have healthcare needs that have to be attended to by the nurse. The high disease burden resulting from the communicable, non-communicable diseases and injuries increase the number of patients seeking healthcare services for complex illnesses, and this places strain on the remaining few nurses prompting them to engage in sickness presenteeism. As reported by Schreuder et. al., (2013) the high job demands of the nursing profession make staying away from work detrimental to patients, clients and colleagues, and nurses are pressured over time to work through their illnesses. These findings are consistent with the outcomes of studies conducted by Aronsson, Gustafsson and Dallner (2000), and Demerouti, Le Blanc, Bakker, Schaufeli and Hox (2009).

### **5.2.1 Staff shortage**

Shortages of staff, reflected by ratios of 150 nurses to 100 000 members of the population in Swaziland, exposed nurses to high workloads, resulting in nurses reporting for work despite having health problems (HRHSP, 2012). Literature revealed that health facilities that were under-staffed and did not have health promotion programs for the healthcare workers had a large number of sick healthcare workers who continually went to work (Whitehead, 2006). Staff shortages accounted for 69% of sickness presenteeism and the difficulty in finding replacement staff accounted for 60.2% of the sickness presenteeism rate. The findings are consistent with the high sickness presenteeism rate reported by Belita et. al., (2013) where it was stated that the low health worker numbers of less than 2.5 workers per 1000 member of the population in sub-Saharan African countries, predisposed nurses to sickness presenteeism. The sickness presenteeism, in turn, caused the further deterioration of the nurses' health status. The findings suggest that vigilant managers have to make an effort to curb staff shortages and ensure the appropriate staff mix and distribution of nurses to counteract the effects of a lack of skill and staff shortages. The workload indicator for staffing needs has to be calculated to determine the staffing status and human resource needs of health facilities, and reports should be used to mitigate staff shortages (Nayak, 2014). It is also imperative that nurse retention strategies be introduced and that good working conditions be introduced and maintained. The highlighted strategies may be effective for Swaziland, based on the high attrition rates related to the exodus of nurses scouting for lucrative remuneration packages in neighbouring countries and abroad.

### **5.3 Ease of replacement and locus of control**

Lack of ease of replacement, or the lack of sufficient skilled nurses to perform the tasks was another predisposing factor of sickness presenteeism. Nursing is a profession with clear task allocation, depicted through a scope of practice and job descriptions. Clients and patients are deprived of some services if a Staff Nurse (professional nurse) exits the work area and leaves a Nursing Assistant to continue providing the nursing services, since the Nursing Assistant's professional qualification limits their scope of practice. The research findings revealed that 60.2% of nurses declared that they would go to work when there was no one to perform their duties. The lack of replacement of staff to perform duties in the absence of the routine staff would prompt other nurses to go in to work despite being ill. Studies by Heponiemi, Elovainio, Pentti, Virtanen, Westerlund, Virtanen, Oksanen, Kivimaki and Vahtera (2010) confirmed that low replaceability was one of the contributors for sickness presenteeism. The inability to adjust the type and amount of work to be done when nurses have a health problem accounted for 58% indicating that nursing is a human service occupation that does not allow postponement or time adjustment of scheduled healthcare services or nursing procedures. The findings were consistent with Johansson and Lundberg's (2004) results that revealed that adjustment latitude and attendance requirements were associated with sickness presenteeism.

### **5.4 Social Support**

House (1981) proposed that there were four categories of social support. They included providing tangible assistance for an employee in need (instrumental); the provision of empathy, love, caring and trust (emotional support); the provision of advice, problem solving solutions and suggestions (informational support) and the provision of constructive feedback, self-evaluation and affirmation (appraisal support). The findings of the study presented in Table 4.4 revealed that a lack of instrumental and emotional social support was a predisposing factor for sickness presenteeism. Just over half of the nurse respondents, 59.8%, indicated that teamwork and a responsibility to support colleagues provided a form of instrumental support, and rated this as a predisposing factor for sickness presenteeism. A manager's inability to handle nurses' personal problems and health-related information in a confidential manner indicates a lack of emotional support (trust) and 47.4% of the respondents in the study agreed that this was a predisposing factor for sickness presenteeism.



Unacceptability and harsh management of sick leave by managers was seen as a sign of a lack of sympathy on the part of the manager. This was classified as a lack of emotional support and was also shown to be a predisposing factor for sickness presenteeism with a 39.8% agreement with the relevant statement. Experiencing pressure from managers to report for duty despite having health problems was indicative of a lack of caring and emotional social support. Informational and instrumental support are lacking if employees are pressured to work despite having problems, and 45% of nurses agreed that they would report for work when pressured to do so by the managers. Managers have to be encouraged to embrace social support as a remedy to nurses' challenges, including sickness presenteeism. Psychiatric nurses related that non-work-related emotional social support played just as vital a role in the improvement of their wellbeing and job satisfaction as that of work support, in a study conducted by Munro et al. (1998).

Promotion and salary increments can be classified as appraisal support. According to the findings of the study, a lack of appraisal support, that is, forfeiting promotion and reduction in salary would not compel nurses to attend work when ill. This was evidenced by a disagreement rate of 43.9%, in response to the questionnaire, while 22.3% of the nurses were uncertain if they would feel compelled to come to work under those circumstances, and 33.8% agreed that they would present themselves for duty even though unwell.

Other insignificant forms of support were informational support which included sick leave policies (authority for sick leave, and guidelines for self-prescription of medication and the use of over-the-counter medication and pharmaceuticals). The study found that 39.1% of the nurses agreed that seeking healthcare services from healthcare providers that were not authorised to grant sick leave would prompt them to attend work despite having health problems, yet 42.1% of the nurses disagreed with this statement. With regard to the approval of self-prescription of medication and the use of over-the-counter medications and pharmaceuticals, 42% of the nurses agreed that they would report for work when ill, whereas 40.2% of the nurses declared that they would not. The latter findings are contrary to the results of a study conducted among doctors by Sendén et al. (2013) which made known that self-prescription of medication by doctors was one of the major contributory factors for sickness presenteeism.

Oddly, 61.7 % of the participating nurses disagreed that suffering from a long term illness would prompt them to continue working every day while suffering from illness; whereas 24.2% of nurses agreed with the statement and declared that they would continue working. The findings revealed that a sick leave policy (incapacity leave) is not a predisposing factor to sickness presenteeism.

In conclusion, providing social support to employees decreases the risk of exposure to health problems, improves job satisfaction and reduces sickness presenteeism.

This finding is congruent with those of Johnson, Hall and Theorell (1989) and Martinez and Ferreira (2012).

### **5.5 Health problems**

The findings presented in Table 4.6 confirm that health problems were leading predisposing factors of sickness presenteeism. Health problems that are acute, episodic, chronic and psychological in nature predispose nurses to sickness presenteeism. The findings of the study revealed that acute illnesses accounted for 61.7% of sickness presenteeism, episodic illnesses accounted for 46.2%, chronic illnesses for 63.6% and psychological illnesses for 74.3% of sickness presenteeism. The findings were consistent with previous research which revealed that chronic medical conditions, particularly depression and low back pain, were leading causes of sickness presenteeism (Martinez & Ferreira, 2012; Schreuder et al., 2013).

Nurses have been identified as being personally affected by the high burden of diseases. This requires that managers utilise transformational leadership to identify the root causes of health problems among staff and further engage in research to attain evidence-based interventions for implementation, in order to promote a healthy and motivated workforce. Roelen and Groothoff (2010), build on this, alluding that the quality of life of the employees has to be maintained with the identification of trends, the effects of sickness presenteeism and by effectively managing or controlling the predisposing factors and consequences. Managers are encouraged to address sickness presenteeism because it goes beyond reducing individual employee performance, leading to a collective reduction of performance as employees leave their tasks to assist the ailing employee (Trybou, Germonpre, Janssens, Casini, Braeckman, Bacquer 2014).

## **5.6 Limitations of the study**

The use of a self-reporting tool for data collection was a limitation in that the individual nurse's preconceived notions towards attending work despite having health problems may have been false. Nonetheless, nurses were the only source of information with regard to the subject matter.

## **5.7 Dissemination of findings**

The research findings will be disseminated at one of the monthly meetings held by the senior nurses of the clinics (with and without maternity facilities) that are routinely scheduled for each region. The findings will subsequently be presented in facility-based meetings that are held on a monthly basis in the health centres and hospitals of the Hhohho and Shiselweni regions.

A slot will be sought for presentation of the findings at the weekly Senior Staff meeting of the Ministry of Health. These meetings are attended by the Principal Secretary, the Director of Medical Services, the Deputy Director of Medical Services, the Chief Nursing Officer, the Deputy Principal Secretary for the Human Resources Department, the Manager for the Economic Planning Department, the Financial Controller, the Manager for the Strategic Information Department, and the Manager for the Monitoring and Evaluation Department. Lastly, stakeholders' (departmental heads of various cadres, program managers, nurses and development partners) meetings will be conducted and the findings of the study disseminated. The study will be published within the UKZN Research Space, and, with the assistance of the research supervisor, it may be published in other relevant journals.

## **5.8 Conclusion**

The study yielded results that addressed the objectives of determining the existence of and magnitude of sickness presenteeism; identifying predisposing factors and establishing the link between job demands, locus of control and social support.

Sickness presenteeism exists among nurses of the selected health facilities in Swaziland. The majority (40.5%) of nurses reported that they had engaged in sickness presenteeism between 2 and 5 times within a period of twelve months, with a total sickness presenteeism prevalence of 80.7%. The high prevalence of sickness presenteeism has adverse effects on the health of nurses and on the quality of the

nursing care rendered. The literature reveals that working while ill may have adverse long-term effects on health, which confirms the seriousness of sickness presenteeism.

The predisposing factors of sickness presenteeism include high job demand, a shortage of staff, a lack of ease for the replacement of nurses, an inability to adjust work to suit the health status of nurses, a lack of social support (instrumental, emotional and informational) and health problems that are either acute, episodic, chronic and/or psychological.

Trustworthy Nurse Managers, supportive working environment and the provision of privacy and confidentiality is essential to promote the openness of nurses about health problems and personal matters, so as to curb sickness presenteeism. This conclusion is based on a report by healthcare workers in Swaziland that stated that beneficial workplace wellness programs would be those that are offered away from their work facilities, for promotion of freedom of access to treatment and confidentiality (Mdluli et. al., 2012). Acknowledging the value attached to maintaining confidentiality, it is cited that the lack of privacy in the consultation and examination rooms makes HIV/ TB related healthcare services inaccessible to the nurses, and they thus opt for self-medication (WHO, 2006). According to House (1981), emotional support includes the provision of empathy, love, caring and trust. The instilling of the importance of maintaining confidentiality among Nurse Managers and their subordinates would reduce the occurrence of sickness presenteeism.

Effective strategies for reducing sickness presenteeism include increased supportive supervision of nurses and the provision of job satisfaction programs, according to Martinez and Ferreira (2012). Mitigation of staff shortages through the appropriate recruitment of nurses, the utilisation of workload indicator staffing needs calculations and the ensuring of the appropriate numbers, distribution and skill mix of nurses is essential. Moreover, vigilance when assigning staff for night duty is also a necessity, so as to counteract the effects of the job demands associated with shift work.

Additionally, literature suggests that accommodative workplace policies that increase access to organisational-based medical aid or insurance schemes have proven to be effective in the reduction of the act of attending work while sick (Aronsson and Gustafsson, 2005; Johansen et al., 2014; Johns, 2010; Schreuder et. al., 2013). Pilette (2005) suggests health-awareness programs, subsidies for general health screening

and counselling for employees as possible ways that the employers may take action to reduce sickness presenteeism within their own organisations.

There is a need to build the Nurse Managers' capacity to improve employee engagement. This will promote the discussion of work-related improvements, the improvement of employee performance through improved health and wellness programs and an increasingly effective engagement among employees (Nayak, 2014). Nayak (2014) expounds further, suggesting that the Business in the Community (BITC) Healthy Workplace Model encourages managers to provide safe, motivating and healthy working environments that support healthy behaviours; encourage positive relationships between employees and managers and have strategies for the improvement of employee health and wellness.

## **5.9 Recommendations**

The following recommendations emanated from the results of this study:

- Conduct a qualitative study to determine the lived experiences of nurses displaying sickness presenteeism and explore solutions for sickness presenteeism.
- Create vital awareness about the consequences of sickness presenteeism among nurses and Nurse Managers, in so far as it impacts on the health and wellbeing of the nurses themselves; nursing services rendered to patients and/or clients become compromised; and the attrition rate of nursing staff rises.(Linnerud, 2013).
- Implement health systems strengthening interventions that will improve leadership and governance among Nurse Managers.
- Benchmark wellness programs for the health workforce, as it is essential that they are effective.
- Encourage Nurse Managers to recognise the importance of social support, job control and job rewards, and monitor and balance the nurses' job demands (Trybou et., al., 2014).
- Create awareness among nurse education institutions about negative impact of sickness presenteeism on mental and cognitive aspect of learners and discuss prevention strategies.

## REFERENCES

- Aronsson, G. and Gustafsson, K. (2005). Sickness presenteeism: prevalence, attendance-pressure factors, and an outline of a model for research. *Journal of Occupational and Environmental Medicine*, 47(9), 958-966.
- Aronsson, G., Gustafsson, K. and Dallner, M. (2000). Sick but yet at work. An empirical study of sickness presenteeism. *Journal of Epidemiology and Community Health*, 54(7), 502-509.
- Aronsson, G., Gustafsson, K. and Mellner, C. (2011). Sickness presence, sickness absence, and self-reported health and symptoms. *International Journal of Workplace Health Management*, 4(3), 228-243. Retrieved from <https://www.questia.com/library/p61983/international-journal-of-management>
- Arumugam, V., MacDermid, J. and Grewal, R. (2013). Content analysis of work limitation, stanford presenteeism, and work instability questionnaires using international classification of functioning, disability, and health and item perspective framework. *Rehabilitation Research and Practice*, (1), 1-12.
- Ashby, K. and Mahdon, M. (2010). Why do employees come to work when ill? An investigation into sickness presence in the workplace. AXA PPP Healthcare. The Work Foundation.
- Barrett, K., Strode, A. and Smart, R. (2002). *Managing HIV/AIDS in the Workplace: A Guide For Government Departments*. Pretoria. The Department of Public Service and Administration. Retrieved from <http://www.gsdr.org/go/display/document/legacyid/592>
- Bergström, G., Bodin, L., Hagberg, J., Aronsson, G. and Josephson, M. (2009a). Sickness presenteeism today, sickness absenteeism tomorrow? A prospective study on sickness presenteeism and future sickness absenteeism. *Journal of Occupational and Environmental Medicine*, 51(6), 629-638.

Bergström, G., Bodin, L., Hagberg, J., Lindh, T., Aronsson, G. and Josephson, M. (2009b). Does sickness presenteeism have an impact on future general health? *International archives of occupational and environmental health*, 82(10), 1179-1190.

Burns, N. and Grove, S. (2009). *The Practice of nursing research: Appraisal, synthesis and generation of evidence*(6th ed.) Saunders : Elsevier.

Cancelliere, C., Cassidy, J. D., Ammendolia, C. and Côté, P. (2011). Are workplace health promotion programs effective at improving presenteeism in workers? A systematic review and best evidence synthesis of the literature. *BMC Public Health*, 11(1), 395.

Cassel, J. (1976). The contribution of the social environment to host resistance. *American Journal of Epidemiology*, 104 (2), 107-123. Centre for Mental Health (2011). *Managing presenteeism: a discussion paper*. London.

Chiu, Y.L., Chung, R.G., Wu, C.S. and Ho, C.H. (2009). The effects of job demands, control, and social support on hospital clinical nurses' intention to turn over. *Applied Nursing Research*, 22(4), 258-263.

Constanze, L., Hugo, W., Jan, H., Pia, S. and Kristina, A. (2012). Sickness presenteeism is more than an alternative to sickness absence: results from the population based SLOSH study. *Occupational Environmental Health*, 85, 905-914.

Dellve, L., Hadzibajramovic, E. and Ahlborg Jr, G. (2011). Work attendance among healthcare workers: prevalence, incentives, and long- term consequences for health and performance. *Journal of Advanced Nursing*, 67(9), 1918-1929.

Demerouti, E., Le Blanc, P., Bakker, A., Schaufeli, W. and Hox, J. (2009). Present but sick: a three-wave study on job demands, presenteeism and burnout. *Career Development International*, 14(1), 50-68.

Dibonaventura, M., Gupta, S., and Mrus, J. (2012). The association of HIV/AIDS treatment side effects with health status, work productivity, and resource use. *AIDS Care*, 24(6), 744-755.

Dickson, V. (2013). Presenteeism among older workers ( $\geq 45$  years) with coronary heart disease: an integrative literature review. *Open Public Health Journal*, 6, 31-41.

Emanuel, E., Wendler, D., Killen, J. and Grady, C. (2004). What makes clinical research in developing countries ethical? The benchmarks of ethical research. *Journal of Infectious Diseases*, 189(5), 930-937.

Grobler, P., Warnich, S., Carell M., Elbert, N. and Hatfield, R. (2006). *Human Resource Management in South Africa*(3rded.) Berdford Row: Pat Bond.

Halbesleben, J., Whitman, M., Marilyn, V. and Crawford, W. (2013). A Dialectical theory of the decision to go to work: bringing together absenteeism and presenteeism. *Human Resource Management*, 24, 177-192.

Hansen, C., Lund, T. and Labriola, M. Is it masculine to turn up ill at work?: A study on the association between traditional male role norms and sickness presenteeism amongst Danish ambulance workers. *European Public Health Conference*, 2011. Oxford Univ Press.

Halbesleben, J., Whitman, M., Marilyn, V. and Crawford, W. (2013). A Dialectical Theory of the decision to go to work: bringing together absenteeism and presenteeism. *Human Resource Management*, 24, 177-192.

Heponiemi, T., Elovainio, M., Pentti, J., Virtanen, M., Westerlund, H., Virtanen, P., Oksanen, T., Kivimäki, M. and Vahtera, J. (2010). Association of contractual and subjective job insecurity with sickness presenteeism among public sector employees. *Journal of Occupational and Environmental Medicine*, 52(8), 830-835.

Holt, M. and Powell, S. (2014). Health and wellbeing in small and medium-sized enterprises (SMEs). What public health support do SMEs really need? *Perspectives in Public Health*. Retrieved from <http://www.sagepublications.com>.

House, J. S. (1981). *Work Stress and Social Support*. Social Research. 2nd Edition. Addison-Wesley.

Huang, D. (2008). A new tool to measure the relationship between health-related quality of life and workforce productivity. Georgia Institute of Technology. Atlanta.



Janssens, H., Clays, E., De Clercq, B., De Bacquer, D. and Braeckman, L. (2013). The relation between presenteeism and different types of future sickness absence. *Journal of Occupational Health*, 55(3), 132-141.

Johansen, V., Aronsson, G. and Marklund, S. (2014). Positive and negative reasons for sickness presenteeism in Norway and Sweden: a cross-sectional survey. *BMJ Open*, 4(2),1-6.

Johns, G. (2010). Presenteeism in the workplace: areview and research agenda. *Journal of Organisational Behavior*, 31(4), 519-542.

Johnson, J. V. Hall, E. and Theorell, T. (1989). Combined effects of job strain and social isolation on cardiovascular disease morbidity and mortality in a random sample of the Swedish male working population. *Scandinavian Journal of Work, Environment and Health*, 15, 271- 279.

Joshi, H. G. (2014). Employee engagement-a global perspective. *International Journal of Exclusive Management Research*, 7(4) p.1.

Joshi, R., Reingold, A. L., Menzies, D. &Pai, M. (2006). Tuberculosis among health-care workers in low-and middle-income countries: a systematic review. *PLoS medicine*, 3(12), e494.

Jourdain, G. and Vézina, M. (2013). How psychological stress in the workplace influences presenteeism propensity: A test of the demand–control–support model. *European Journal of Work and Organisational Psychology*, 1-14.

Karasek, R., Baker, D., Marxer, F., Ahlbom, A. and Theorell, T. (1981). Job decision latitude, job demands, and cardiovascular disease: a prospective study of Swedish men. *American Journal of Public Health*, 71(7), 694-705.

Kerr, J. (2014).An Analysis of Nurse Managers Human Resources Management Related to HIV/AIDS and Tuberculosis Affected/Infected Nurses in Selected Hospitals in Kwazulu-Natal, South Africa – An Ethnographic Study.University of KwaZulu-Natal. Durban.

Kinghorn, A., Smart, M. R., Baumann, M. J., Mashimbye, M., Kinghorn, A. and House, M. (2011). HIV and AIDS Impact Assessment in the Botswana public service. Draft Final Report July 2011. Gaborone.

Kiss, P., De Meester, M., Kristensen, T. and Braeckman, L. (2014). Relationships of organisational social capital with the presence of “gossip and slander,” “quarrels and conflicts,” sick leave, and poor work ability in nursing homes. *International archives of occupational and environmental health*, 1-8.

Koopman, C., Pelletier, K., Murray, J. and Sharda, C. (2002). Stanford presenteeism scale: health status and employee productivity. *Journal of Occupational and Environmental Medicine*.

Leineweber, C., Westerlund, H., Hagberg, J., Svedberg, P. and Alexanderson, K. (2012). Sickness presenteeism is more than an alternative to sickness absence: results from the population-based SLOSH study. *International Archives of Occupational and Environmental Health*, 85(8), 905-914.

Linnerud, S. (2013). Sickness presenteeism among nurses. Norway: Norwegian University of Science and Technology.

Lu, L., Lin, H. and Cooper, C. (2013). Unhealthy and present: motives and consequences of the act of presenteeism among Taiwanese employees. *Journal of Occupational Health Psychology*, 18 (4), 406.

Lu, L., Peng, S., Lin, H. and Cooper, C. (2014). Presenteeism and health over time among Chinese employees: The moderating role of self-efficacy. *Work and Stress*, 28(2), 165-178.

Martinez, L. F. and Ferreira, A. I. (2012). Sick at work: presenteeism among nurses in a Portuguese public hospital. *Stress and Health*, 28(4), 297-304.

Mdluli, N., Calnan, M., Yohannes, G., Shongwe, N., Ndwandwe, N. and Haumba, S. (2012). Wellness Day for Swaziland's Health Workers Focusing on Workplace Safety and Family Health. Mbabane: University Research Council.

MOH (2010). Essential Healthcare Package. Mbabane: Ministry of Health.

MOH (2014). [Online] The Government of the Kingdom of Swaziland. Retrieved from <http://www.gov.sz.moh>.

MOH (2012). Human Resource for Health Strategic Plan. Mbabane: Ministry of Health.

MOH (2012). Mid-term Review Report. Mbabane: Ministry of Health.

MOH (2007). National Health Policy. Mbabane: Ministry of Health.

MOH (2008). National Health Sector Strategic Plan. Mbabane : Ministry of Health.

MOH (2000). Nursing Department Job Description. Mbabane: Ministry of Health

MOH (2008). Swaziland Nursing Strategy. Mbabane : Ministry of Health.

MOH (2006). Swaziland Wellness Centre Policy. Mbabane: Ministry of Health.

MOH (2011). Wellness Centre Profile. Mbabane: Ministry of Health.

MOPS (1974). General Orders. Mbabane: Ministry of Public Service.

Munro, L., Rodwell, J. and Harding, L. (1998). Assessing occupational stress in psychiatric nurses using the full job strain model: the value of social support to nurses. *International Journal of Nursing Studies*, 35(6), 339-345.

Nayak, S. and Joshi, H.G. (2014). Employee Engagement : A Global Perspective. *International Journal Exclusive Management Research* .Volume 4, (7), 1-10.

Nemoto, T. and Beglar, D. (2013). Developing Likert-scale questionnaires. *Conference Proceedings*. Tokyo: JALT.

Nyberg, A., Westerlund, H., Hanson, L. L. M. and Theorell, T. (2008). Managerial leadership is associated with self-reported sickness absence and sickness presenteeism among Swedish men and women. *Scandinavian Journal of Public Health*, 36(8), 803-811.

Pallant, J. (2010). *SPSS survival manual: A step by step guide to data analysis using SPSS*. McGraw-Hill International.

Pilette, P. (2005). Presenteeism in nursing: a clear and present danger to productivity. *Journal of Nursing Administration*, 35(6), 300-303.

Polit, D. and Beck, C. (2004). *Nursing research: principles and methods*. Lippincott Williams and Wilkins.

Polit, D. and Beck, C. (2008). *Nursing research: Generating and assessing evidence for nursing practice*, Lippincott Williams and Wilkins.

Quazi, H. (2013). *Presenteeism: The Invisible Cost to Organisations*. Kings Cross London: Palgrave Macmillan.

Roelen, C. and Groothoff, J. (2010). Rigorous management of sickness absence provokes sickness presenteeism. *Occupational Medicine*, 60(4), 244-246.

Roelen, C., Jensen, C., Stapelfeldt, C., Groothoff, J., Nielsen, C. and Bültmann, U. (2014). The Added Value of Sickness Presenteeism to Prediction Models for Sickness Absence. *Journal of Occupational and Environmental Medicine*, 56(7), e58-e59.

Sarantakos, S. (1996). *Social Research*. South Melbourne. Macmillan Education Australia (PTY LTD).

Schreuder, J., Roelen, C., Van Der Klink, J. and Groothoff, J. (2013). Characteristics of zero-absenteeism in hospital care. *Occupational Medicine*, 63(4), 266-273.

Schultz, A. and Edington, D. (2007). Employee health and presenteeism: a systematic review. *Journal of Occupational Rehabilitation*, 17(3), 547-579.

Sendén, M., Løvseth, L., Schenck-Gustafsson, K. and Fridner, A. (2013). What makes physicians go to work while sick: a comparative study of sickness presenteeism in four European countries (HOUPE). *Swiss Medical Weekly*, 143.

SAM (2013). *Service Availability Mapping Report*. Mbabane: Ministry of Health.

SANC (2005). *Scope of practice of the nurse and the midwife*. South African Nurses Association.

SNC (2009). *The Scope of Nursing Practice*. Mbabane: Swaziland Nursing Council.

Streiner, D. and Norman, G. (2008). Health measurement scales: a practical guide to their development and use. Oxford: Oxford University Press.

Theorell, T and Karasek, R., (1996). Current issues relating to psychosocial job strain and cardiovascular disease research. *Journal of occupational health psychology*. 1, 1-9.

Trybou, J., Germonpre, S., Janssens, H., Casini, A., Braeckman, L., Bacquer, D. and Clays, E. (2014). Job-related stress and sickness absence among Belgian nurses: A prospective study. *Journal of Nursing Scholarship*, 46(4), 292-301.

Van Der Colff, J. J. and Rothmann, S. (2009). Occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa. *SA Journal of Industrial Psychology*, 35(1), 1-10.

Whitehead, D. (2006). Workplace health promotion: the role and responsibility of healthcare managers. *Journal of Nursing Management*, 14(1), 59-68.

WHO (2006). Treat, train, retain: the AIDS and health workforce plan: report on the Consultation on AIDS and Human Resources for Health. Geneva: WHO. Retrieved from <http://www.who.int/hiv/pub/meetingreports/TTRmeetingreport2.pdf>

WHO (2012). World Health Organization-Swaziland Profile. Geneva : World Organisation Press.

Widera, E., Chang, A. and Chen, H. L. (2010). Presenteeism: a public health hazard. *Journal of general Internal Medicine*, 25(11), 1244-1247.

World Health Organization (2010). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva : World Organization Press.

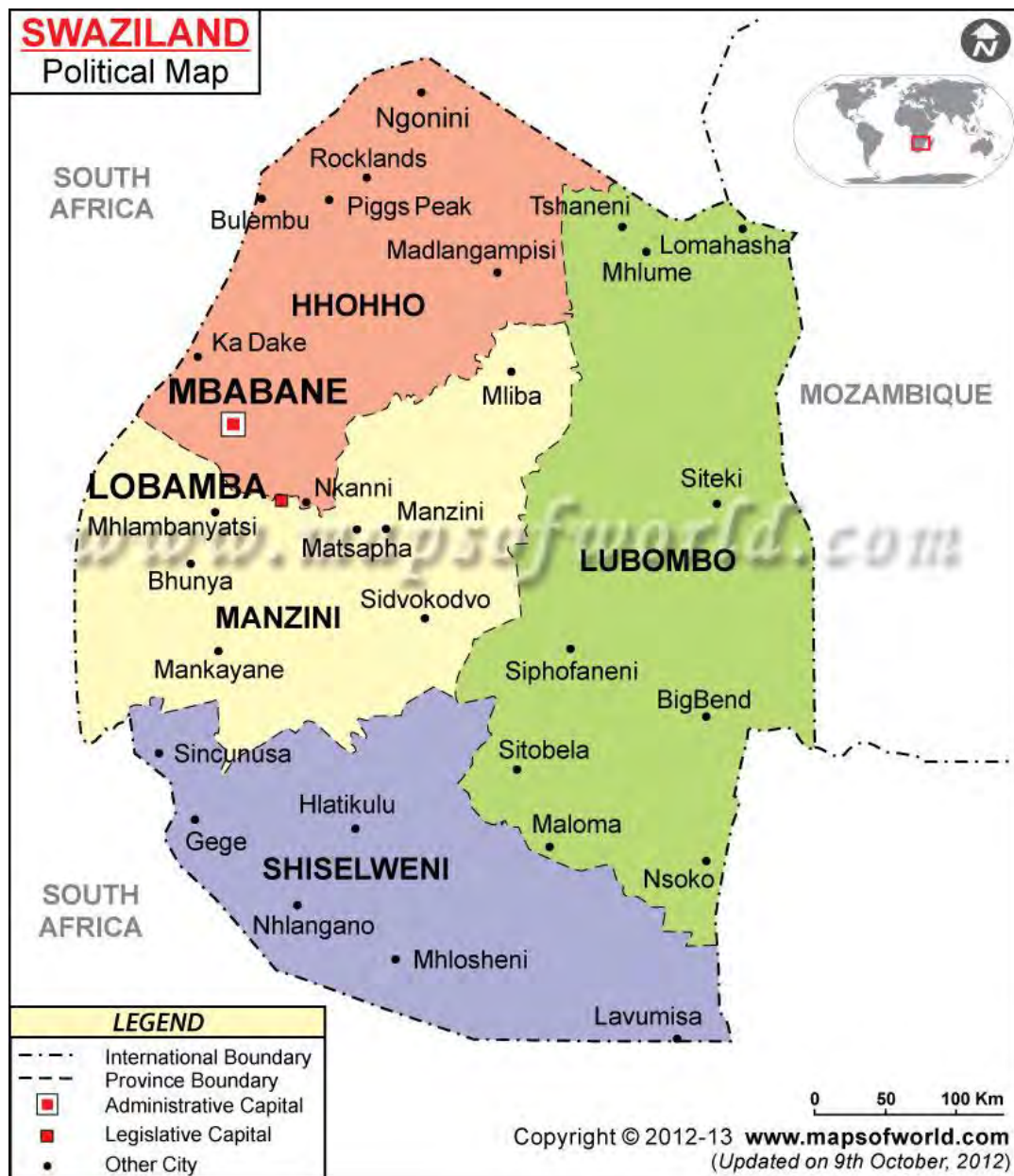
Zirwatul, R., Ibrahim, A. and Ohtsuka, K. (2012). Review of the job demand-control and job demand-control-support models: elusive moderating predictor effects and cultural implications. *Southeast Asia Psychology Journal*, 1, 10-21.



## ANNEXURES

### Map of Swaziland

A



# DATA COLLECTION TOOL

## DATA COLLECTION TOOL FOR THE STUDY

**B**

**Thank you for being part of the study participants**

- Please write on the lines provided below.
- Please use a tick in the boxes provided.

### PART A

#### DEMOGRAPHIC DATA

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of Health Facility \_\_\_\_\_

Department: In-patient Department ☐  
 Out-Patient Department ☐

Nursing Cadre		Employment Status	
		Probation	Permanent and pensionable
Matron			
Nursing Sister or Nurse Manager			
Staff Nurse			
General Nurse			
Nursing Assistant			

#### A. What is the *highest* educational qualification that you currently possess?

- |  |  |
|--|--|
| <input type="checkbox"/> Diploma in General nursing                      | <input type="checkbox"/> Bachelor of Nursing Science     |
| <input type="checkbox"/> Post diploma certificate in Midwifery           | <input type="checkbox"/> Bachelor in Midwifery Science   |
| <input type="checkbox"/> Post diploma certificate in Community Health    | <input type="checkbox"/> Bachelor in Community Health    |
| <input type="checkbox"/> Post diploma certificate in Psychiatric Nursing | <input type="checkbox"/> Bachelor in Psychiatric Nursing |
| <input type="checkbox"/> Bachelor in Health Service Management           | <input type="checkbox"/> Bachelor in Nursing Education   |

Other Nursing specialities \_\_\_\_\_

\_\_\_\_\_

Honours Degree: \_\_\_\_\_ Master's Degree: \_\_\_\_\_



Gender

Male

Female

**Marital Status**

Single	
Married	
Widowed	
Divorced	

**Age categories and years of working experience**

<b>Please indicate your age category</b>	<b>Tick in relevant row</b>
20-29 years	
30-39 years	
40-49 years	
50-59 years	
60 years or above	

<b>Please indicate level of work experience</b>	<b>Tick in relevant row</b>
0-2 years	
3-5 years	
6-10 years	
11-15 years	
16-20 years	
21-25 years	
26-30 years	
31-35 years	
36-40 years	
Above 40 years	

## **PART B**

**Please select the one most appropriate response among the four options presented in the options below. Indicate your response with a tick/cross in the relevant block**

Question	Response			
Has it happened over the previous 12 months that you have gone to work despite feeling that you really should have taken sick leave due to your state of health?	No	Yes, once	Yes, 2-5 times	Yes, more than 5 times

## **PART C**

**Please select the one most appropriate response among the five options presented in the options below. Indicate your response with a tick/cross in the relevant block**

Statements	Strongly disagree	Somewhat disagree	Uncertain	Somewhat agree	Strongly agree
1. Because of my (health problem), the stresses of my job were much harder to handle					
2. Despite having my (health problem), I was able to finish hard tasks in my work.					
3. My (health problem) distracted me from taking pleasure in my work.					
4. I felt hopeless about finishing certain work tasks, due to my (health problem).					
5. At work, I was able to focus on achieving my goals despite my (health problem).					
6. Despite having my (health problem), I felt energetic enough to complete all my work.					

## **PART D**

**Please select the one most appropriate response among the five options presented in the options below. Indicate your response with a tick/cross in the relevant block**

Statements	Strongly disagree	Somewhat disagree	Uncertain	Somewhat agree	Strongly agree
1. I can attend to work despite feeling that I should have taken sick leave due to my state of health if there is no one to do the work when I am not at work					
2. I can attend to work despite feeling that I should have taken sick leave due to my state of health if there is staff shortage in my department or ward					
3. I can attend to work despite feeling that I should have taken sick leave due to my state of health if scheduled for night duty					
4. I can attend to work despite feeling that I should have taken sick leave due to my state of health if I am feeling under pressure from senior managers or line managers					
5. I can attend to work despite feeling that I should have taken sick leave due to my state of health if I have an ability to adjust the amount and type of work to do					
6. I can attend to work despite feeling that I should have taken sick leave due to my state of health if I have a responsibility of maintaining teamwork or commitment to support other colleagues					
7. I can attend to work despite feeling that I should have taken sick leave due to my state of health if sickness absence is considered unacceptable or managed harshly by managers					
8. I can attend to work despite feeling that I should have taken sick leave due to my state of health if personal problems and or health related information to be given out would not be handled with confidentiality					

9. I can attend to work despite feeling that I should have taken sick leave due to my state of health if I am unable to rest at home due to family issues or leaving arrangements					
10. I can attend to work despite feeling that I really should have taken sick leave due to my state of health, many people are entirely dependent on my earnings					
11. I can attend to work despite feeling that I really should have taken sick leave due to my state of health if taking leave of absence causes reduction of salary.					
12. I can attend to work despite feeling that I really should have taken sick leave due to my state of health if taking sick leave impacts negatively on my promotion					
13. Experiencing signs and symptoms of acute illnesses such as gastro-enteritis or diarrhoea can prompt me to take sick leave					
14. Experiencing signs and symptoms of episodic illnesses such as common cold, allergies can prompt me to take a sick leave					
15. Experiencing severe signs and symptoms of chronic illness such as diabetes mellitus or hypertension would prompt me to take a sick leave					
16. Experiencing severe signs and symptoms of psychological illness such as depression would prompt me to take a sick leave					
17. Suffering from illnesses that is associated with stigma such as HIV/AIDS and or pulmonary tuberculosis will prompt me to attend work even though feeling sick					
18. Experiencing long term sickness that exposes me to being certified as medically unfit would prompt me to attend work even though feeling sick					
19. Use of self-prescribed medications and or over the counter pharmaceutical medications when experiencing a health problem can prompt me to attend work even though sick					

20. Seeking health care services from health workers who do not have authority to write an approved medical certificate for sick leave may prompt me to attend work even though feeling sick					
--	--	--	--	--	--

## Sample of Stanford Presenteeism Scale 6

### Stanford Presenteeism Scale (SPS-6)

**Directions:** Please describe your work experiences **in the past month**. These experiences may be affected by many environmental as well as personal factors, and may change from time to time. For each of the following statements, please check one of the following responses to show your agreement or disagreement with this statement in describing *your* work experiences **in the past month**.

1. Because of my (health problem)\*, the stresses of my job were much harder to handle.
2. Despite having my (health problem)\*, I was able to finish hard tasks in my work.
3. My (health problem)\* distracted me from taking pleasure in my work.
4. I felt hopeless about finishing certain work tasks, due to my (health problem)\*.
5. At work, I was able to focus on achieving my goals despite my (health problem)\*.
6. Despite having my (health problem)\*, I felt energetic enough to complete all my work.

**Strongly disagree**  
**Strongly agree**  
**Uncertain**  
**Somewhat disagree**  
**Somewhat agree**

***Please use the following scale:***

- . . . I strongly disagree with the statement
- . . . I somewhat disagree with the statement
- . . . I am uncertain about my agreement with the statement
- . . . I somewhat agree with the statement
- . . . I strongly agree with the statement

***\* Note that the words 'back pain,' 'cardiovascular problem,' 'illness,' 'stomach problem,' or other similar descriptors can be substituted for the words 'health problem' in any of these items.***

\* The Stanford Presenteeism Scale (SPS-6; 2001 version) is jointly owned by Merck & Co., Inc., and Stanford University School of Medicine.



13 July 2015

Mrs BTS Mdziniso 213527007  
School of Nursing and Public Health  
Howard College Campus

Dear Mrs Mdziniso

Protocol reference number: HSS/0887/015M

Project title: An analysis of sickness presenteeism prevalence among nurses working in selected health facilities in Swaziland

**Provisional Approval - Expedited**

I wish to inform you that your application received on 10 July 2015 in connection with the above has been granted provisional approval, subject to the following:

- Gatekeeper permission being obtained.
- Timelines to be amended.

Kindly submit your response / documents to Dr Shenika Singh (Chair), as soon as possible.

This approval is granted provisionally and the final approval for this project will be given once the above condition has been met. Research may not begin until full approval has been received from the HSSREC.

Yours faithfully

Dr Shenika Singh (Chair)  
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Dr Jane Kerr  
cc Academic Leader Research: Professor M Mars  
cc School Administrator: Mrs Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee

Dr Shenika Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag 54001, Durban 4000

Telephone: +27 (0) 31 260 5657/5658/5659/ Facsimile: +27 (0) 31 260 4800 Email: [hssrec@ukzn.ac.za](mailto:hssrec@ukzn.ac.za) / [academic@ukzn.ac.za](mailto:academic@ukzn.ac.za) / [humanities@ukzn.ac.za](mailto:humanities@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

1951-2014  
160 YEARS OF ACADEMIC EXCELLENCE

Howick Campus

Sogwagwi

Howard College

Medical School

Pietermaritzburg

Westville

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)



MINISTRY OF HEALTH  
P.O. BOX 5  
MBABANE  
SWAZILAND

THE KINGDOM OF SWAZILAND

8<sup>th</sup> August, 2015

Bawinile Mdziniso  
Principal Investigator  
**MBABANE**

REF: MH/599C/FWA 000 15267/ IRB 000 9688

Dear Ms Mdziniso,

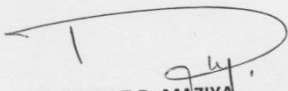
**RE: AN ANALYSIS OF SICKNESS PREVALENCE AMONG NURSES WORKING IN  
SELECTED HEALTH FACILITIES IN SWAZILAND.**

The committee thanks you for your submission to the Swaziland Scientific and Ethics Committee.

In view of the importance of the study and the fact that the study is in accordance with ethical and scientific standards, the committee grants you authority to conduct the study. You are requested to adhere to the specific topic and inform the committee through the chairperson of any changes that might occur in the duration of the study which are not in this present arrangement.

The committee requests that you ensure that you submit the findings of this study (**Electronic and hard copy**) and the data set to the Secretariat of the SEC committee.  
**The committee further requests that you add the SEC Secretariat as a point of contact if there are any questions about the study on 24047712/24045469.**

Yours Sincerely,

  
**RUDOLPH T.D. MAZIYA**  
THE CHAIRMAN, SEC  
cc: SEC members







22 July 2015

Mrs Bawile TS Mdzinise (213527007)  
School of Nursing and Public Health  
Howard College Campus

Dear Mrs Mdzinise,

Protocol reference number: HSS/0887/015M

Project title: An analysis of sickness presentism prevalence among nurses working in selected health facilities in Swaziland

**Full Approval – Expedited Application**

With regards to your response received on 22 July 2015 to our letter of 13 July 2015, the Humanities & Social Sciences Research Ethics Committee has considered the above-mentioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/departments for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr. Shonuka Singh (Chair)  
Humanities & Social Sciences Research Ethics Committee

/ms

Co-Supervisor: Dr. Jane Kerr  
Co-Academic Leader Research: Professor M. Mars  
Co-School Administrator: Ms Caroline Dhanraj

Humanities & Social Sciences Research Ethics Committee

Dr. Shonuka Singh (Chair)

Wreyville Campus, Goven Mbeki Building

Postal Address: Private Bag X54021, Durban 4002

Telephone: +27 (0) 31 261 5567/5568/5569/5570/5571/5572/5573/5574/5575/5576/5577/5578/5579/5580/5581/5582/5583/5584/5585/5586/5587/5588/5589/5590/5591/5592/5593/5594/5595/5596/5597/5598/5599/5600/5601/5602/5603/5604/5605/5606/5607/5608/5609/5610/5611/5612/5613/5614/5615/5616/5617/5618/5619/5620/5621/5622/5623/5624/5625/5626/5627/5628/5629/5630/5631/5632/5633/5634/5635/5636/5637/5638/5639/5640/5641/5642/5643/5644/5645/5646/5647/5648/5649/5650/5651/5652/5653/5654/5655/5656/5657/5658/5659/5660/5661/5662/5663/5664/5665/5666/5667/5668/5669/5670/5671/5672/5673/5674/5675/5676/5677/5678/5679/5680/5681/5682/5683/5684/5685/5686/5687/5688/5689/5690/5691/5692/5693/5694/5695/5696/5697/5698/5699/5700/5701/5702/5703/5704/5705/5706/5707/5708/5709/5710/5711/5712/5713/5714/5715/5716/5717/5718/5719/5720/5721/5722/5723/5724/5725/5726/5727/5728/5729/5730/5731/5732/5733/5734/5735/5736/5737/5738/5739/5740/5741/5742/5743/5744/5745/5746/5747/5748/5749/5750/5751/5752/5753/5754/5755/5756/5757/5758/5759/5760/5761/5762/5763/5764/5765/5766/5767/5768/5769/5770/5771/5772/5773/5774/5775/5776/5777/5778/5779/5780/5781/5782/5783/5784/5785/5786/5787/5788/5789/5790/5791/5792/5793/5794/5795/5796/5797/5798/5799/5800/5801/5802/5803/5804/5805/5806/5807/5808/5809/5810/5811/5812/5813/5814/5815/5816/5817/5818/5819/5820/5821/5822/5823/5824/5825/5826/5827/5828/5829/5830/5831/5832/5833/5834/5835/5836/5837/5838/5839/5840/5841/5842/5843/5844/5845/5846/5847/5848/5849/5850/5851/5852/5853/5854/5855/5856/5857/5858/5859/5860/5861/5862/5863/5864/5865/5866/5867/5868/5869/5870/5871/5872/5873/5874/5875/5876/5877/5878/5879/5880/5881/5882/5883/5884/5885/5886/5887/5888/5889/5890/5891/5892/5893/5894/5895/5896/5897/5898/5899/5900/5901/5902/5903/5904/5905/5906/5907/5908/5909/5910/5911/5912/5913/5914/5915/5916/5917/5918/5919/5920/5921/5922/5923/5924/5925/5926/5927/5928/5929/5930/5931/5932/5933/5934/5935/5936/5937/5938/5939/5940/5941/5942/5943/5944/5945/5946/5947/5948/5949/5950/5951/5952/5953/5954/5955/5956/5957/5958/5959/5960/5961/5962/5963/5964/5965/5966/5967/5968/5969/5970/5971/5972/5973/5974/5975/5976/5977/5978/5979/5980/5981/5982/5983/5984/5985/5986/5987/5988/5989/5990/5991/5992/5993/5994/5995/5996/5997/5998/5999/6000/6001/6002/6003/6004/6005/6006/6007/6008/6009/6010/6011/6012/6013/6014/6015/6016/6017/6018/6019/6020/6021/6022/6023/6024/6025/6026/6027/6028/6029/6030/6031/6032/6033/6034/6035/6036/6037/6038/6039/6040/6041/6042/6043/6044/6045/6046/6047/6048/6049/6050/6051/6052/6053/6054/6055/6056/6057/6058/6059/6060/6061/6062/6063/6064/6065/6066/6067/6068/6069/6070/6071/6072/6073/6074/6075/6076/6077/6078/6079/6080/6081/6082/6083/6084/6085/6086/6087/6088/6089/6090/6091/6092/6093/6094/6095/6096/6097/6098/6099/6100/6101/6102/6103/6104/6105/6106/6107/6108/6109/6110/6111/6112/6113/6114/6115/6116/6117/6118/6119/6120/6121/6122/6123/6124/6125/6126/6127/6128/6129/6130/6131/6132/6133/6134/6135/6136/6137/6138/6139/6140/6141/6142/6143/6144/6145/6146/6147/6148/6149/6150/6151/6152/6153/6154/6155/6156/6157/6158/6159/6160/6161/6162/6163/6164/6165/6166/6167/6168/6169/6170/6171/6172/6173/6174/6175/6176/6177/6178/6179/6180/6181/6182/6183/6184/6185/6186/6187/6188/6189/6190/6191/6192/6193/6194/6195/6196/6197/6198/6199/6200/6201/6202/6203/6204/6205/6206/6207/6208/6209/6210/6211/6212/6213/6214/6215/6216/6217/6218/6219/6220/6221/6222/6223/6224/6225/6226/6227/6228/6229/6230/6231/6232/6233/6234/6235/6236/6237/6238/6239/6240/6241/6242/6243/6244/6245/6246/6247/6248/6249/6250/6251/6252/6253/6254/6255/6256/6257/6258/6259/6260/6261/6262/6263/6264/6265/6266/6267/6268/6269/6270/6271/6272/6273/6274/6275/6276/6277/6278/6279/6280/6281/6282/6283/6284/6285/6286/6287/6288/6289/6290/6291/6292/6293/6294/6295/6296/6297/6298/6299/6300/6301/6302/6303/6304/6305/6306/6307/6308/6309/6310/6311/6312/6313/6314/6315/6316/6317/6318/6319/6320/6321/6322/6323/6324/6325/6326/6327/6328/6329/6330/6331/6332/6333/6334/6335/6336/6337/6338/6339/6340/6341/6342/6343/6344/6345/6346/6347/6348/6349/6350/6351/6352/6353/6354/6355/6356/6357/6358/6359/6360/6361/6362/6363/6364/6365/6366/6367/6368/6369/6370/6371/6372/6373/6374/6375/6376/6377/6378/6379/6380/6381/6382/6383/6384/6385/6386/6387/6388/6389/6390/6391/6392/6393/6394/6395/6396/6397/6398/6399/6400/6401/6402/6403/6404/6405/6406/6407/6408/6409/6410/6411/6412/6413/6414/6415/6416/6417/6418/6419/6420/6421/6422/6423/6424/6425/6426/6427/6428/6429/6430/6431/6432/6433/6434/6435/6436/6437/6438/6439/6440/6441/6442/6443/6444/6445/6446/6447/6448/6449/6450/6451/6452/6453/6454/6455/6456/6457/6458/6459/6460/6461/6462/6463/6464/6465/6466/6467/6468/6469/6470/6471/6472/6473/6474/6475/6476/6477/6478/6479/6480/6481/6482/6483/6484/6485/6486/6487/6488/6489/6490/6491/6492/6493/6494/6495/6496/6497/6498/6499/6500/6501/6502/6503/6504/6505/6506/6507/6508/6509/6510/6511/6512/6513/6514/6515/6516/6517/6518/6519/6520/6521/6522/6523/6524/6525/6526/6527/6528/6529/6530/6531/6532/6533/6534/6535/6536/6537/6538/6539/6540/6541/6542/6543/6544/6545/6546/6547/6548/6549/6550/6551/6552/6553/6554/6555/6556/6557/6558/6559/6560/6561/6562/6563/6564/6565/6566/6567/6568/6569/6570/6571/6572/6573/6574/6575/6576/6577/6578/6579/6580/6581/6582/6583/6584/6585/6586/6587/6588/6589/6590/6591/6592/6593/6594/6595/6596/6597/6598/6599/6600/6601/6602/6603/6604/6605/6606/6607/6608/6609/6610/6611/6612/6613/6614/6615/6616/6617/6618/6619/6620/6621/6622/6623/6624/6625/6626/6627/6628/6629/6630/6631/6632/6633/6634/6635/6636/6637/6638/6639/6640/6641/6642/6643/6644/6645/6646/6647/6648/6649/6650/6651/6652/6653/6654/6655/6656/6657/6658/6659/6660/6661/6662/6663/6664/6665/6666/6667/6668/6669/6670/6671/6672/6673/6674/6675/6676/6677/6678/6679/6680/6681/6682/6683/6684/6685/6686/6687/6688/6689/6690/6691/6692/6693/6694/6695/6696/6697/6698/6699/6700/6701/6702/6703/6704/6705/6706/6707/6708/6709/6710/6711/6712/6713/6714/6715/6716/6717/6718/6719/6720/6721/6722/6723/6724/6725/6726/6727/6728/6729/6730/6731/6732/6733/6734/6735/6736/6737/6738/6739/6740/6741/6742/6743/6744/6745/6746/6747/6748/6749/6750/6751/6752/6753/6754/6755/6756/6757/6758/6759/6760/6761/6762/6763/6764/6765/6766/6767/6768/6769/6770/6771/6772/6773/6774/6775/6776/6777/6778/6779/6780/6781/6782/6783/6784/6785/6786/6787/6788/6789/6790/6791/6792/6793/6794/6795/6796/6797/6798/6799/6800/6801/6802/6803/6804/6805/6806/6807/6808/6809/6810/6811/6812/6813/6814/6815/6816/6817/6818/6819/6820/6821/6822/6823/6824/6825/6826/6827/6828/6829/6830/6831/6832/6833/6834/6835/6836/6837/6838/6839/6840/6841/6842/6843/6844/6845/6846/6847/6848/6849/6850/6851/6852/6853/6854/6855/6856/6857/6858/6859/6860/6861/6862/6863/6864/6865/6866/6867/6868/6869/6870/6871/6872/6873/6874/6875/6876/6877/6878/6879/6880/6881/6882/6883/6884/6885/6886/6887/6888/6889/6890/6891/6892/6893/6894/6895/6896/6897/6898/6899/6900/6901/6902/6903/6904/6905/6906/6907/6908/6909/6910/6911/6912/6913/6914/6915/6916/6917/6918/6919/6920/6921/6922/6923/6924/6925/6926/6927/6928/6929/6930/6931/6932/6933/6934/6935/6936/6937/6938/6939/6940/6941/6942/6943/6944/6945/6946/6947/6948/6949/6950/6951/6952/6953/6954/6955/6956/6957/6958/6959/6960/6961/6962/6963/6964/6965/6966/6967/6968/6969/6970/6971/6972/6973/6974/6975/6976/6977/6978/6979/6980/6981/6982/6983/6984/6985/6986/6987/6988/6989/6990/6991/6992/6993/6994/6995/6996/6997/6998/6999/7000/7001/7002/7003/7004/7005/7006/7007/7008/7009/7010/7011/7012/7013/7014/7015/7016/7017/7018/7019/7020/7021/7022/7023/7024/7025/7026/7027/7028/7029/7030/7031/7032/7033/7034/7035/7036/7037/7038/7039/7040/7041/7042/7043/7044/7045/7046/7047/7048/7049/7050/7051/7052/7053/7054/7055/7056/7057/7058/7059/7060/7061/7062/7063/7064/7065/7066/7067/7068/7069/7070/7071/7072/7073/7074/7075/7076/7077/7078/7079/7080/7081/7082/7083/7084/7085/7086/7087/7088/7089/7090/7091/7092/7093/7094/7095/7096/7097/7098/7099/7100/7101/7102/7103/7104/7105/7106/7107/7108/7109/7110/7111/7112/7113/7114/7115/7116/7117/7118/7119/7120/7121/7122/7123/7124/7125/7126/7127/7128/7129/7130/7131/7132/7133/7134/7135/7136/7137/7138/7139/7140/7141/7142/7143/7144/7145/7146/7147/7148/7149/7150/7151/7152/7153/7154/7155/7156/7157/7158/7159/7160/7161/7162/7163/7164/7165/7166/7167/7168/7169/7170/7171/7172/7173/7174/7175/7176/7177/7178/7179/7180/7181/7182/7183/7184/7185/7186/7187/7188/7189/7190/7191/7192/7193/7194/7195/7196/7197/7198/7199/7200/7201/7202/7203/7204/7205/7206/7207/7208/7209/7210/7211/7212/7213/7214/7215/7216/7217/7218/7219/7220/7221/7222/7223/7224/7225/7226/7227/7228/7229/7230/7231/7232/7233/7234/7235/7236/7237/7238/7239/7240/7241/7242/7243/7244/7245/7246/7247/7248/7249/7250/7251/7252/7253/7254/7255/7256/7257/7258/7259/7260/7261/7262/7263/7264/7265/7266/7267/7268/7269/7270/7271/7272/7273/7274/7275/7276/7277/7278/7279/7280/7281/7282/7283/7284/7285/7286/7287/7288/7289/7290/7291/7292/7293/7294/7295/7296/7297/7298/7299/7300/7301/7302/7303/7304/7305/7306/7307/7308/7309/7310/7311/7312/7313/7314/7315/7316/7317/7318/7319/7320/7321/7322/7323/7324/7325/7326/7327/7328/7329/7330/7331/7332/7333/7334/7335/7336/7337/7338/7339/7340/7341/7342/7343/7344/7345/7346/7347/7348/7349/7350/7351/7352/7353/7354/7355/7356/7357/7358/7359/7360/7361/7362/7363/7364/7365/7366/7367/7368/7369/7370/7371/7372/7373/7374/7375/7376/7377/7378/7379/7380/7381/7382/7383/7384/7385/7386/7387/7388/7389/7390/7391/7392/7393/7394/7395/7396/7397/7398/7399/7400/7401/7402/7403/7404/7405/7406/7407/7408/7409/7410/7411/7412/7413/7414/7415/7416/7417/7418/7419/7420/7421/7422/7423/7424/7425/7426/7427/7428/7429/7430/7431/7432/7433/7434/7435/7436/7437/7438/7439/7440/7441/7442/7443/7444/7445/7446/7447/7448/7449/7450/7451/7452/7453/7454/7455/7456/7457/7458/7459/7460/7461/7462/7463/7464/7465/7466/7467/7468/7469/7470/7471/7472/7473/7474/7475/7476/7477/7478/7479/7480/7481/7482/7483/7484/7485/7486/7487/7488/7489/7490/7491/7492/7493/7494/7495/7496/7497/7498/7499/7500/7501/7502/7503/7504/7505/7506/7507/7508/7509/7510/7511/7512/7513/7514/7515/7516/7517/7518/7519/7520/7521/7522/7523/7524/7525/7526/7527/7528/7529/7530/7531/7532/7533/7534/7535/7536/7537/7538/7539/7540/7541/7542/7543/7544/7545/7546/7547/7548/7549/7550/7551/7552/7553/7554/7555/7556/7557/7558/7559/7560/7561/7562/7563/7564/7565/7566/7567/7568/7569/7570/7571/7572/7573/7574/7575/7576/7577/7578/7579/7580/7581/7582/7583/7584/7585/7586/7587/7588/7589/7590/7591/7592/7593/7594/7595/7596/7597/7598/7599/7600/7601/7602/7603/7604/7605/7606/7607/7608/7609/7610/7611/7612/7613/7614/7615/7616/7617/7618/7619/7620/7621/7622/7623/7624/7625/7626/7627/7628/7629/7630/7631/7632/7633/7634/7635/7636/7637/7638/7639/7640/7641/7642/7643/7644/7645/7646/7647/7648/7649/7650/7651/7652/7653/7654/7655/7656/7657/7658/7659/7660/7661/7662/7663/7664/7665/7666/7667/7668/7669/7670/7671/7672/7673/7674/7675/7676/7677/7678/7679/7680/7681/7682/7683/7684/7685/7686/7687/7688/7689/7690/7691/7692/7693/7694/7695/7696/7697/7698/7699/7700/7701/7702/7703/7704/7705/7706/7707/7708/7709/7710/7711/7712/7713/7714/7715/7716/7717/7718/7719/7720/7721/7722/7723/7724/7725/7726/7727/7728/7729/7730/7731/7732/7733/7734/7735/7736/7737/7738/7739/7740/7741/7742/7743/7744/7745/7746/7747/7748/7749/7750/7751/7752/7753/7754/7755/7756/7757/7758/7759/7760/7761/7762/7763/7764/7765/7766/7767/7768/7769/7770/7771/7772/7773/7774/7775/7776/7777/7778/7779/7780/7781/7782/7783/7784/7785/7786/7787/7788/7789/7790/7791/7792/7793/7794/7795/7796/7797/7798/7799/7800/7801/7802/7803/7804/7805/7806/7807/7808/7809/7810/7811/7

Telegrams:  
Telex:  
Telephone: (+268 24316501)



**MKHUZWENI HEALTH  
CENTRE**  
Private Bag  
Piggs Peak  
SWAZILAND

## **THE KINGDOM OF SWAZILAND**

---

7<sup>th</sup> August, 2015

**Ms. Bawinile Mdziniso**

Faculty of Health Sciences  
School of Nursing and Public Health  
Howard College, Durban  
South Africa

Dear Madam

**RE: REQUEST TO CONDUCT A STUDY ON "AN ANALYSIS OF SICKNESS  
PRESENTATION PREVALENCE AMONG NURSES WORKING IN SELECTED  
HEALTH FACILITIES IN SWAZILAND"**

---

Correspondence dated 4th August, 2015, has been received by the health facility management in relation to seeking permission to conduct a study at the Mkhuzweni Health Centre. With reference to the objectives of the study, we consider it appropriate to allow you to collect data in the various departments of the health facility.

Find time to come and discuss with the in-service coordinator about the data collection process.

Yours Sincerely

A handwritten signature in dark ink, appearing to read 'Margaret Lubhedze'.

**Margaret Lubhedze**  
**MATRON 2**

Telegrams:  
Telex:  
Telephone: (+268 24371111)



NHLANGANO HEALTH  
CENTRE  
P.O. BOX 29  
NHLANGANO  
SWAZILAND

## THE KINGDOM OF SWAZILAND

7<sup>th</sup> August, 2015

**Ms. Bawinile Mdziniso**

Faculty of Health Sciences  
School of Nursing and Public Health  
Howard College, Durban  
South Africa

Dear Madam

**RE: PERMISSION ON CONDUCTING RESEARCH ON "AN ANALYSIS OF SICKNESS PRESENTATION PREVALENCE AMONG NURSES WORKING IN SELECTED HEALTH FACILITIES IN SWAZILAND"**

We acknowledge receipt of your correspondence dated 4th August, 2015 on the above subject matter and attachment of UKZN Research Ethics Committee provisional approval. The Nhlanguano Health Centre has considered your request to conduct research in the various departments of the health facility. The study is significant and will contribute towards human resource management systems of the country and permission is hereby granted to conduct research in at the Health Centre.

Kindly bring with you a Research Clearance letter from The Swaziland Scientific and Ethics Committee on the first of data collection.

Yours Sincerely

A handwritten signature in dark ink, appearing to be 'Phindile Mavuso'.

**Phindile Mavuso**  
**MATRON**

Telegrams:  
Telex:  
Telephone: (+268 221  
76111)



HLATHIKHULU  
GOVERNMENT  
HOSPITAL  
P.O. BOX 21  
HLATHIKHULU  
SWAZILAND

## THE KINGDOM OF SWAZILAND

7<sup>th</sup> August, 2015

**Ms. Bawinile Mdziniso**

Faculty of Health Sciences  
School of Nursing and Public Health  
Howard College, Durban  
South Africa

Dear Madam

**RE: PERMISSION TO CONDUCT A RESEARCH TITLED "AN ANALYSIS OF SICKNESS PRESENTATION PREVALENCE AMONG NURSES WORKING IN SELECTED HEALTH FACILITIES IN SWAZILAND"**

Reference is made to your correspondence dated 4th August, 2015 requesting to be granted permission obtain information on the above subject matter at the Hlathikhulu Government Hospital. The health facility management has accepted your request and hereby grants you permission to conduct the research. Note that, you have to report to the In-service Coordinator's Office on the first day of data collection for discussion about best approach of disseminating the questionnaires.

Kindly bring with you a Research Clearance letter from The Swaziland Scientific and Ethics Committee on the first of data collection.



Telegrams:  
Telex:  
Telephone: (+268 24371111)



**PIGGS PEAK  
GOVERNMENT  
HOSPITAL**  
P.O. BOX 46  
PIGGS PEAK  
SWAZILAND

## THE KINGDOM OF SWAZILAND

6<sup>th</sup> August, 2015

**Ms. Bawinile Mdziniso**

Faculty of Health Sciences  
School of Nursing and Public Health  
Howard College, Durban  
South Africa

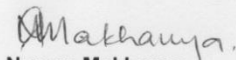
Dear Madam

**RE: PERMISSION FOR CONDUCTING RESEARCH ON "AN ANALYSIS OF  
SICKNESS PRESENTTEEISM PREVALENCE AMONG NURSES WORKING IN  
SELECTED HEALTH FACILITIES IN SWAZILAND"**

We refer to your letter dated 4<sup>th</sup> August, 2015, whereby you were requesting for permission to conduct a study in the above mentioned hospital. The study on sickness presenteeism has been considered as important by the health facility management. We therefore, anticipate that new information will be generated and shared in order to contribute to the welfare of health workforce. It is with this regard that you have been granted permission to conduct the study.

Be reminded to bring a copy of Research Clearance letter from The Swaziland Scientific and Ethics Committee when you come for data collection.

Yours Sincerely

  
**Nomsa Makhanya**  
**MATRON 2**

Telegrams:  
Telex:  
Telephone: (+268 404 2431)  
Fax: (+268 404 2092)

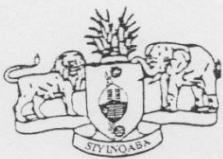


**MINISTRY OF HEALTH**  
P.O. BOX 5  
MBABANE  
SWAZILAND

## 5. Informed consent

E

Telephone: 404-2111/9  
Fax: 404-6471



Mbabane Government  
Hospital  
P.O.Box 8  
Mbabane  
Swaziland

THE KINGDOM OF SWAZILAND  
14<sup>th</sup> August 2015

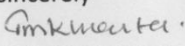
Bawinile Mdziniso  
Box 3577  
Manzini

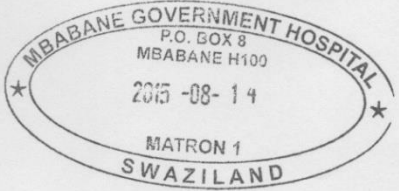
Dear Bawinile

**RE: YOUR REQUEST FOR PERMISSION TO CONDUCT A RESEARCH  
TITLED "ANALYSIS OF SICKNESS PREVALENCE AMONG NURSES  
WORKING IN THE PUBLIC HEALTH SERVICE IN SWAZILAND".**

I refer to your letter dated 4<sup>th</sup> August 2015 requesting to be granted permission to obtain information on the above mentioned subject at the above mentioned health facility. I am pleased to inform you that the Hospital Management has accepted your request as stated above. I would however appreciate if findings and recommendations could be communicated back to the hospital.

Thank you

Yours sincerely  
  
MATRON T. MKHONTA

  
HOSPITAL MANAGEMENT (FOR)

## 5. Informed consent

E

### DECLARATION

I..... (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

### SIGNATURE OF PARTICIPANT

.....

DATE: .....