

**THE DEVELOPMENT AND IMPLEMENTATION OF POLICY
GUIDELINES FOR HEALTH PROMOTION IN THE
WORKPLACE**

**BY
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DEDICATION

**My family, Mthokozisi, Tumi and Sifiso. Thank you for all the sacrifices,
love and sustenance. I love you!**

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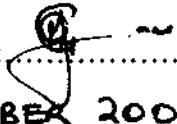
My sincere thanks go to the following people and organizations for their contribution to my work:

- My children, Tumi and Sfiso, God gave me you for a reason. Thank you for your love and understanding when I was not there for you
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- My colleagues at the school of nursing UKZN, thanks for all the support!
- The faculty at Johns Hopkins University, School of Nursing
- All the organizations that participated in the study

DECLARATION

I declare that this is my own unaided work. It is being submitted for the degree of Doctor of Philosophy at the University of KwaZulu-Natal, Durban, South Africa. It has never been submitted for any other purpose. All the references used or quoted have been acknowledged by means of referencing.

Gugu Gladness Mchunu

Signed:  at DURBAN on this 10th day of OCTOBER 2007

This thesis has been read and approved for submission for evaluation.

Professor L. R. Uys.....

Supervisor

ABSTRACT

The three phased study aimed to develop policy guidelines for workplace health promotion based on an exploration of the current status of health promotion in South African workplaces.

In the first phase of the study a case study approach was used to analyse the current situation of health promotion in the workplace. For this phase of the study the particular aim was to determine to what extent the participating workplaces were involved in health promotion, or were salutogenic in nature. A total of 6 organizations participated in the first phase of the study, with a total of 258 participants. The second phase aimed at developing policy guidelines for health promotion in the workplace. The consensus method, using the Delphi technique, was used in this phase, involving seven participants who were experts in the field of occupational health and health promotion. The third phase was an observation of the implementation of the policy guidelines. Implementation analysis, which is part of evaluation research, was the methodology used. Two organizations from phase one participated in the implementation phase.

In summarising the findings on the current situation of employee health promotion programs the study showed that none of the participating organizations emerged as health promoting workplaces. Organizations that offered employee health promotion/wellness programs mainly focused on individual health and on HIV/AIDS and none of them was found to provide comprehensive holistic programs that aimed at providing healthy work environments.

In phase 2 of the study it emerged that there was a very strong concurrence between the findings from the experts and literature in terms of what needs to be included in health promotion policy guidelines. The key elements for health promotion policy documents were (1) organizational philosophy (2) stakeholder involvement and (3) the description of programs to be included in the policy.

During the policy implementation process it emerged that different strategies were used in the policy development process. This process was largely influenced by such factors as organizational size, type and internal structures. Recommendations include an emphasis on more legislative support for health promotion in the workplace, and for more concrete aids such as policy guidelines and educational preparation of occupational health professionals for this component of their role.

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LIST OF ABBREVIATIONS

ARV(s) – Anti-Retroviral(s)

CIPP – Context Input Process Product

CIPP- Context Input Process Product model

EAP – Employee Assistance Program

EWP – Employee Wellness Programs

HFA – Health for All

HIV/AIDS – Human Immunodeficiency Virus and Acquired Immunodeficiency
Syndrome

HP – Health promotion

HR – Human Resources

MOSA – Machinery and Occupational Safety Act (Act No. 6 of 1983)

NIOSH – National Institute for Occupational Safety and Health

OHN – Occupational Health Nurse

OHP – Occupational Health and Safety

OHS Act – Occupational Health and Safety Act (Act No. 85 of 1993)

PHC – Primary Health Care

PPE – Personal Protective Equipment

RSA – Republic of South Africa

SME- Small Medium Enterprise

TB – Tuberculosis

WHO- World Health Organization

WHP – Workplace Health Promotion

CHAPTER 1

STUDY BACKGROUND

INTRODUCTION

The health and safety of workers in the South African workplace is protected by the Occupational Health and Safety Act (OHS Act) (Act 85 of 1993) (Republic of South Africa 1993 a, p.1). This Act covers workers employees in both private and public sector organizations. There appears to be a huge difference in practice as far as the health and safety of employees is concerned in both these sectors. According to Khambula (2003), this problem may be linked to the fact that this Act came into operation only in 1993.

Before the OHS Act was introduced, other Acts focusing on employees' safety were in operation. Between 1941 and 1983 the safety of employees was covered under the Factories Machinery and Building Work Act (Act 22 of 1941) (Piennar, Nathan, Wilson & Morton 1943, p.1). This Act focused mostly on the safety of employees and engineering, in the industry within the private sector. From 1983 until 1993 the Machinery and Occupational Safety Act (MOSA) (Act 6 of 1983) was the only Act that focused on the safety of the employees (RSA 1993 b), but focused also on the private sector as the workplace. Female employees, mostly in the public sector, were covered under the Offices, Shops and Railway Premises Act 1963 (Commencement No 3) Order 1989 (Khambula 2003, Samuels 1963, p. 539). The OHS Act is therefore different in that it focuses on the health and safety of all employees in all work settings.

Current legislation suggests that employees in all sectors have to be treated equally as far as their safety and health is concerned. The OHS Act provides for "the protection of persons at work against hazards to and safety arising out of or in connection with the activities of persons at work" (RSA a

1993, p.1). The employee can be any person who is employed in any sector. The workplace is also defined in the OHS Act as “any premise or place where a person performs work in the course of his employment” (RSA 1993 a, p.1).

Men and women, in both public and private sectors are exposed to similar health hazards.. Literature reveals that men and women are equally exposed to heart diseases such as coronary heart disease, except that the incidence in women triples after menopause (Cheek & Cesan 2003, p.39). Due to the gender orientation of most workplaces, which focus mostly on men, health programs offered for the employees often do not focus on women’s health issues. These issues include the need for such programs as those focusing on breast cancer, cancer of the cervix, cardiovascular disease, reproductive health and so on. Some organizations, such as the health sector, have more female than male employees. These organizations still do not provide health promotion programs which target women’s health problems, but the programs are generalized, such as HIV/AIDS programs and disease management programs. In the health sector, health promotion programs also focus more on clients than on employees. It might be argued that hospital employees know their health needs owing to being in the health care industry, but not all hospital employees are health care professionals. The needs of clerical staff, porters, general assistants and others need to be addressed.

The South African workplace is divided into public, private and parastatal sectors. The parastatal are a combination of both public and private sectors. The health services may fall under any of these sectors. The study will explore health promotion interventions in all these sectors.

BACKGROUND TO THE PROBLEM

Adult health is influenced mainly by three factors, namely, environmental impacts, risk behaviour and the lingering effects of health or ill health developed during childhood (Benatar, Doherty, Heunis, McIntyre, Ngwena, Pelsler, Pretorious, Redelinghuys & Summerton, 2004, p.239). In South Africa, unlike in the developed countries, the main causes of morbidity and mortality in adult population are a combination of lifestyle diseases, such as cardiovascular diseases, diabetes, HIV/AIDS and infectious diseases. In 2006 Statistics South Africa announced that obesity has reached epidemic rates in South Africa, with women more at risk of dying of obesity-related diseases than men. This revelation is different from the statistics in the United States, where the leading cause of death, amongst others, is cardiovascular disease, cerebrovascular disease and diabetes (National Center for Health Statistics 1999, p. 2). Research has linked these diseases to sedentary lifestyles, poor eating and lack of exercise (O'Donnell 2002, p. 4). Furthermore literature shows that much of the disease burden in South Africa is due to preventable causes (Benatar et. al. 2004, p.242). In addition to this disease burden the South African population is faced with a very high number of HIV/AIDS related deaths, as this epidemic is the number one cause of death in South Africa.

The health of the South African workforce is put at risk due to their exposure to environmental risk factors and risky behaviours. Implementing employee health programs in the workplaces could be one way of assisting in targeting this adult population group for health promotion activities. Other related interventions can also be vital to curb the growing preventable disease burden. The OHS Act which formed the basis of this study aims to target workplace health and safety for all employees equally. This Act, which is meant to protect employees' health and safety, states that "every employer shall provide and maintain as far as reasonably practicable, a working environment that is safe and without risk to the health of his employees" (RSA 1993, p.1).

Health promotion is arguably the most essential component of effective health care provision, at individual, family, community and society levels. It is debatable, however, whether the practice of this concept has been implemented to the same extent as it has been applauded. Five different approaches to health promotion have been identified, and these include (a) medical/preventive (b) social change (c) behaviour change/lifestyle (d) empowerment, and (e) settings approaches. The settings approach is considered as the most important approach in achieving the goals of health promotion and health for all (Cullen 2003, p.1, Ewles and Simnett 1995, p. 36, Naidoo and Wills 2000, p. 261, WHO 1997 p.5). The settings approach to health promotion calls for the utilization of such settings as mega cities, islands, cities, municipalities, local communities, markets, schools, the workplace and health care facilities as settings for health promotion (WHO 1997, p.3, Chu, Breucker, Harris, Stitzel, Gan, Gu, and Dwyer 2000, p. 155). This approach suggests that any place where there are people interacting can be considered as a suitable environment for health promotion activities.

Since there is an interaction between the individual and his/her work environment (WHO 1988), health promotion interventions should not only be directed towards the individual but to the work environment as well. Chu et al. (2000) suggest that health promotion in the workplace should increasingly address individual, organizational and environmental risk factors. The proponents of workplace health promotion therefore strongly feel that health promotion programs should focus on the individual and his workplace.

The University of California Irvine (UCI) (2003, p. 2) health promotion centre argues that employees who are exposed to more health risks utilize more medical care and have more health related costs. Their assumption is that improvement in health behaviour will benefit both the

individual employees and the company. Most research done on health promotion interventions has hitherto focused on individual health behaviour and interpersonal behaviour and not much on the health behaviour within groups, organizations and even the whole community (Oldenburg, Glanz, & French 1999, p. 503). Glanz and Rimer (1995, p. 35) argued that contemporary health promotion should focus not only on educational activities but also on advocacy, organizational change efforts, policy development, economic supports, environmental change and multi-method program.

With the South African workplaces, both public and private health and corporate sectors having undergone tremendous changes since 1994, it is not clear if settings approach to health promotion has been incorporated in the implementation of occupational health and safety programs in the workplace. Through informal conversation with representatives from different organizations, it emerges that most South African organizations (private and/or public) offer only some of the health promotion programs and there appear to be no fixed policies on health promotion in the workplace.

The South African Department of Health itself has failed to produce a formal health promotion policy document, although a draft policy has existed since 1994. So far, this department has tried to initiate health promotion programs in schools and most recently in the workplace, but again these projects are new and the department is still working out what needs to be done to make them successful (Strachan 2000, p.1).

South Africa is embroiled in the war against communicable diseases such as HIV/AIDS and Tuberculosis, which affect workers in all sectors. There is therefore a need for health promotion interventions focusing on improving the status of South African workplaces to be more health promoting. Presently, in South Africa, there is a dearth of research focusing on the evaluation of

health promotion initiatives or interventions in the workplace. The majority of health promotion interventions world-wide have been based on models focusing on individual and interpersonal health behaviour and much less attention has been given to models or theories which attempt to understand change within groups, organizations and even the whole community (Oldenburg, Glanz, and French 1999, p. 503). South Africa has been no exception to this trend, as there seems to be poor emphasis on an environmental rather than personal approach to health promotion interventions (Coulson 2000, p. 1).

Multisectoral Approach to Health Promotion

In the WHO (2001, p. 5) report on health promotion strategy for the African region, the regional director mentioned that with HIV/AIDS pandemic in this region, the WHO recognised the need to involve all people in addressing the broad determinants of health. One of the strategies that was identified was to mobilize new players, the non-governmental and private institutions to join in the effort to achieve health for all in the 21st century and also in health development. One of the identified guiding principles in this WHO regional strategy was tapping in all sectors and creating partnerships between different sectors.

This WHO strategy suggests that for successful health promotion initiatives all sectors need to work together towards the same goal of promoting the health of their employees. These different sectors can be in the form of private corporate organization (the private sector), universities, which are semi-private, prisons and hospitals, either in the public sector or the private sector. This strategy also requires working with smaller institutions within the society in order to reach the people in different sectors. Wass (2000, p.174) believes that since society at large is made of smaller institutions and within these institutions people are exposed to healthy or unhealthy environments, operating at

institutional level can have a forceful impact on people's lives. The argument is that the people who are employees are members of the society; hence working with institutional policies in order to influence healthy public policies can be another approach to health promotion (Wass 2000, p.174).

Healthy public policies, which are one example of health promotion initiatives, focus on the larger society and are common in most countries. South Africa is one country which has implemented such policy in the form of Tobacco Legislation. Healthy public policies are viewed as an infrastructure for sustainable health promotion interventions (Stachenko 1994, p. 107). The criticism of this kind of intervention has been that society is too broad and hence it is difficult to monitor the outcomes of such interventions (Wass 2000, p.175). Working with smaller institutions within the broader society is therefore seen as an effective approach to health promotion initiatives.

The health sector is often excluded when exploring employee health promotion/wellness interventions as it is assumed that health workers can take care of their own health needs. Maben and Macleod-Clark (1995, p. 1160) have argued that since the hospital has workers (health professionals), patients and relatives, it can therefore provide a good setting for workplace health promotion. The WHO (1986, p. 3) also advocated that health services need to be reoriented so that they play a role in encouraging people to adopt healthy lifestyles and to make their living environment more health promoting. They therefore initiated the Health Promoting Hospital Initiative in 1988, based on the Ottawa Charter (WHO 1996, p. 2). The WHO Health promoting hospitals initiative means that health promotion in the hospital should address the needs of everybody associated with the hospital, including staff, patients, and the broader community.

According to the White Paper On Transformation of Health Services (RSA 1997, p.146), work related diseases include diseases related to (a) chemical agents, resulting for instance in skin problems, (b) biological agents, resulting for instance in Tuberculosis, (c) ergonomical hazards, resulting for instance in back pain, (d) psychological hazards, resulting for instance in stress and stress related diseases, and (e) physical agents, resulting for instance in noise induced deafness. Jeebhay and Jacobs (1999) also outline that the most common occupational diseases outside the mining industry are noise induced hearing loss, major depression, dermatitis, and tuberculosis. Except for the noise induced hearing loss, health workers are no exception to being affected or infected by these diseases. Hope, Keller. and O'Connor (1998, p. 440) argue that the nursing profession is a stressful one, with the major source of stress being the nature of the work itself, the role of the nurse, career aspects and organizational structures, and concern about infectious disease such as HIV/AIDS.

This evidence raises questions as to how much is being done to protect health workers in the hospital setting from being exposed to these risk factors. Runy (2000, p. 454) argues that nurses work long hours, are exposed to hazardous substances and believes that there is a need for a hospital risk management strategies. As much as this is true, the problem at this stage is that hospital risk management is mostly client-centred and is regarded as an extension of normal clinical responsibilities (Young 2001, p. 1). Risk management is seen as involving "the development of strategies to prevent patient injury, minimize financial loss and preserve agency asserts" (Marriner-Tomey, 1996, p.454).

In the private sector the legislation and the unions are putting pressure on the importance of minimizing accidents and disease hazards in the workplace (Wolfe, Parker, & Napier 1994, p.23).

One such legislation in South Africa is the OHS Act. This Act emphasizes that employers should identify work related hazards and risks in the workplace and to prevent exposure of employees to such risks. Different organizations have responded to this Act by putting some health promotion interventions in place regarding employee health, such as employee assistance programs (EAP), HIV/AIDS programs, and continuous employee surveillance (Woods cited in Huiskamp 2003, p.6). Some workplaces have, in addition to these programs, initiated smoking cessation programs, chronic disease management, weight control and physical fitness programs as part of their health promotion interventions. Woods argues that these health promotion activities perform a vital function in helping employees take care of their health in the midst of organizational change. It is, however, not clear whether organisational policies that focus on health promotion interventions do exist in these organizations as part of enhancing the health of employees and also to promote healthy environments. One of the challenges identified by the WHO (2001, p. 5) on the implementation of health promotion is the lack of health promotion policies and guidelines for the coordination of different methods and approaches.

Health programs are not a statutory requirement, but, according to the WHO (1988, p.8), occupational health services provide a focus for their implementation. Health promotion programs are based on humanitarian and economic value (WHO 1988, p. 12), and this is true for both the public and the private sector. It is therefore imperative to explore the health promoting activities in these sectors and to identify the existing health promotion programs and policies. This analysis will assist in identification of specific individual and/or organizational characteristics that can be utilized in health promotion policy development.

Health Promotion in Different Sectors in South Africa

According to Coulson (1999, p. 291), health promotion in South Africa is a multisectoral activity as in most other countries. The organizations involved include the government, non-government and private sectors. For South Africa, as part of the global market, health promotion is becoming more important. Chu et al. (2000, p. 155) argued that the concept of a health promoting workplace is becoming more important and relevant as more public and private institutions recognise that future access to the globalised marketplace can only be realised through healthy, qualified and motivated workplaces. For this reason, health promotion is gaining momentum worldwide (Huiskamp 2003, p. 56). In South Africa, the government is showing concern about the well being of working individuals. The dilemma at this stage is that there is not enough infrastructure in place as far as workplace health promotion is concerned. In her review of health promotion infrastructure, predominant approaches and the present capacity gaps, Coulson (1999, p. 289), focused on government institutions. The review revealed that, in South Africa, health promotion focus was on environments such as the schools. Strachan (2000, p.1) suggests that even though South Africa has tried to put such initiatives in place, this country has so far failed to evaluate these interventions and to publish the results of the process and progress of such interventions.

The WHO (2001, p. 6) has emphasized the importance of health promotion action in different sectors as, they argue, this will contribute towards the achievement of priority programs of the WHO's African region. The objectives of these priority programs include, among other things (a) prevention of communicable disease such as HIV/AIDS, tuberculosis and Malaria (b) prevention of non-communicable disease such as mental illnesses, cardiovascular diseases, diabetes mellitus, and cancer and (c) fostering lifestyles and conditions that are conducive to physical, social and emotional well being (WHO 2001, p. 7).

The impact of communicable diseases such as HIV/AIDS in the workplace calls for strategies that will improve the deteriorating health status of the workforce in all sectors. These strategies can be in the form of psychosocial support for those who are already infected or affected by the disease or prevention strategies for those who are not infected. The HIV/AIDS pandemic requires reform in policies and institutional arrangements such as an integrated approach combining the core interventions that include primary prevention and care and support of people living with HIV/AIDS (Tawfik & Kinoti 2001, p. 4). Health promotion interventions can therefore be implemented as one of the human resource development strategies in the fight against HIV/AIDS pandemic.

There is a need to redirect health promotion strategies so that there is a shift from workplace health promotion to health promoting workplaces or healthy workplaces. Workplace health promotion refers to health promotion activities in the workplace. This approach focuses only on certain areas or individuals within the workplace and tends to focus on a single illness or risk factor, whereas healthy workplaces or health promoting workplaces means that health promotion programs have to focus both on individual risk factors and the broader organizational and environmental issues, starting from policies to management attitudes (Chu et al. 2000, p.156).

PROBLEM STATEMENT

Workplace health promotion has been applauded as a holistic approach, which addresses both individual risks and the broader organizational and environmental issues (Chu et al. 2000, p. 155, Wilson, De Joy, Jorgenson, and Crump 1999, p. 360). Literature review reveals that in South Africa, little research has been conducted to review the process of health promotion interventions in the workplace and other settings (Strachan 2000, p.1).

Although health promotion interventions have been implemented in South Africa, such as healthy public policies and the Health Promoting Schools Project, a program of health promoting workplaces is yet to be reviewed (Coulson 1999, p.297). There is a lack of formal documentation on what is happening as far as health promotion is concerned and the existing policies are still draft policies (Coulson 1999, p.300). Reviewed literature indicates that to date the health promotion policy document still remains in a draft form. There is also no evidence of any evaluation studies conducted concurrently in public and private sectors, focusing on workplace health promotion. A report on the findings of the review of occupational health services in Department of Health facilities focused on the public sector (Vergotine 2003, p 1). Furthermore, reviewed literature shows that health promotion research in the health sector is focusing on the health promotion of patients rather than on the human resources. There is therefore a need for a comprehensive research study, which will explore health promotion programs in different sectors, and focus on employees' health as part of the human resource development plan.

The National Directorate of Health Promotion has advocated the settings approach to health promotion, but more attention has been paid to the health promoting schools projects and the health promoting workplaces initiative has not fully been initiated so far (Coulson 1999, p.297, Moodley 2003). For these changes to occur, guidelines applicable to the South African workplaces need to be developed. Therefore, evidence of workplace health promotion policies or programs in different sectors need to be explored, to assist in the development of health promotion guidelines for the workplace.

Literature review also reveals that little research has been done on wellness programs involving hospital employees (Pender 1987, p. 85). Personnel in hospital settings have a responsibility to care

for their clients. They have vast knowledge of health promoting activities and yet this knowledge is not often applied to their personal lifestyles. The majority of health promotion initiatives focus on the patients rather than on all the individuals in the hospital environment, including the staff (Pender 1987, p. 85).

There is therefore a need for a comprehensive study to explore health promotion programs and policies in all these work settings in order to develop policy guidelines for workplace health promotion, which will be applicable in all sectors.

PURPOSE OF THE STUDY

The purpose of the study was to develop policy guidelines for workplace health promotion based on an exploration of the current status of health promotion in South African workplaces.

OBJECTIVES OF THE STUDY

1. To describe the current situation in private and public organizations, in terms of a settings-based health promotion framework.
2. To develop policy guidelines to improve the functioning of workplaces as health promoting settings.
3. To evaluate the implementation of the guidelines in selected organizations.

RESEARCH QUESTIONS

Related to objective 1:

- 1.1 What characteristics do work settings have which have influence on health promotion activities?
- 1.2 What process is involved in the implementation of health promotion interventions?

1.3 What is the organisation doing to support health promotion interventions?

Related to objective 2:

2.1 Who should be involved in developing health promotion policy guidelines, and how should they be involved?

2.2 What should be included in the health promotion policy?

2.3 How should the health promotion policy be implemented?

2.4 How should the health promotion program be evaluated?

Related to objective 3:

3.1 How do the organisations implement policy guidelines?

3.2 Who is involved, and what process was followed to involve them?

3.3 Which aspects were successfully implemented and which were not?

3.4 What are the barriers during implementation?

3.5 What are the support factors?

3.6 What are the short-term outcomes?

SIGNIFICANCE OF THE STUDY

There has been a concern that in South Africa even though workplace health promotion is one of the health priorities, according to the governments five-year plan submitted by the National Directorate for Health Promotion (RSA 1997), very little has been done at this stage to implement it (Coulson 2000, p. 1). In the White Paper for the Transformation of Health Services in South Africa, the government pledges “to create and sustain work environments which will support and sustain

positive health outcomes through policies and programs” (RSA 1997), but some government owned institutions have still not implemented workplace health promotion strategies.

The results of this study can therefore be utilized to assess progress on the implementation of workplace health promotion programs and to identify barriers and impediments to the implementation of such programs. These results will be used to formulate guidelines to implement workplace health promotion policies in both the public and private sector, in order to bridge the gap between these two sectors. The findings can also serve as guidelines in policy formulation and in the implementation of health promoting hospitals in South Africa.

WORK SETTING BASED HEALTH PROMOTION FRAMEWORK

Owing to the lack of a relevant model or framework in the reviewed literature, a **work setting based health promotion framework** was developed, based on the literature, to address certain variables. The framework draws from four different theories, namely Antonovsky’s salutogenesis model (1983), Stufflebeam’s Context Input Process Product (CIPP) model of evaluation (1983), Berrien’s general systems theory (1968) and Nutbeam’s outcome model for health promotion programs (2000). The work setting based health promotion framework consists of four distinct variables, namely, the **salutogenic workplaces**, the **context**, the **process** and the **product**.

Substantive Concepts Underlying the Framework

Salutogenic workplaces

In this framework, the definition of a **salutogenic workplace** draws from Antonovsky’s (1983) Salutogenic Model (Antonovsky, 1996). In the salutogenesis model the emphasis is on the importance of a supportive environment in assisting the individual to cope with external stressors.

The argument is that the health of individuals depends on their ability to cope and the supports or resources they can turn to for help. The resources can be internal, such as self-esteem, or external, such as the local environment and cultural influences (Royal College of Midwives 2002, p.1). The focus in this framework is on the external environment and the available resources as a form of support for the individuals. Salutogenesis focuses on the promotion of well-being or health creation (Macdonald, McDermott, Woods, Brown & Sliwka, 2000, p.1; Cowley and Billings 1999, p. 994). Macdonald et al. (2000, p.3) have linked salutogenesis to resilience because of its health promoting approach. These authors have further asserted that the term 'salutogenesis' extends beyond the psychological focus to be the enhancement of environmental health.

This framework depicts a salutogenic workplace as the one that is health promotive and provides a physical working environment that is supportive to the health of the employees – the focus being on the individuals', and their psychological and physical environment. Salutogenic workplaces also need to provide resources to support the health promoting programs offered in the workplace. Effective health promoting workplaces provide appropriate resources to facilitate activities designed to improve well being and that a supportive environment is required to enhance the health promotion program in the workplace (Cowley & Billings 1999, p. 1001).

To define a salutogenic workplace further a definition of a health promoting workplace by The National Steering Committee for Health Promotion in the Workplace (1998, p.3) will be adapted, that is, a salutogenic workplace should provide educational, organizational and economic activities that are designed to improve the health of workers and therefore the community at large. Furthermore, these health-promoting programs in the workplace should be distinct and separate from

the responsibilities which employers have in the implementation of occupational health and safety measures in the workplace.

The context, the process, the product and the outcome

The next four variables, namely the **context**, the **process**, the **product** and the **outcome**, are based on Stufflebeam's CIPP model of evaluation (1983), Berrien's General Systems Theory (1968), Donabedian's Systems Theory (1968) and Nutbeam's outcomes model (2000). According to the CIPP model the evaluation of an organization should focus on four domains namely, the context, input, process, and product (Stufflebeam, 1983 p.122). According to Stufflebeam (1983) "the **context** evaluation is used to identify institutional context and its needs, the input evaluation is used to identify institutional needs and capabilities, **process** evaluation records and judges procedural events and activities and the **product** is aimed at describing and judging the outcomes and relating them to the objectives" (p129).

Berrien (1968) in his general systems theory argue that a system consists of inputs, which are seen as information introduced to the system, the components which interact in order to produce an output (p15), and the outputs, which are those energies, information, or products that components discharge from the system into the suprasystem. The workplace is viewed as a system with interdependent components that work together for the overall objective of a whole (Berrien, 1968 p.11). Berrien (1968 p.17) argued that the components of the system should interact among themselves in some way on stimuli they receive to produce an output. According to the general systems theory (Berrien 1968 p.17), components need not be homogeneous although homogeneity is not eliminated.

Donabedian (1969), on the other hand, views a system as composed of three components, namely, the **structure**, which consists of the inputs and organizational parameters; the **process**, which consists of content or throughput; and the **outcomes** which consists of end points or impact. Donabedian in this model proposes a causal linkage between the structure, process and outcome variables that can be modified by intervening variables or feedback to the system (Albrecht & Nelson 1993 p. 44).

Context

Stufflebeam (1983) views **context** evaluation as focusing on institutional context and identifying institutional needs (p.129). In this framework the context is viewed as a social context of an organization (Peltomaki et al. 2003, p. 116). This includes such characteristics as (1) **employee staff profile (demographic characteristics)** such as age, gender, racial/cultural background, job type, level of education, contract or full time employees; (2) **organizational characteristics** such as size, public/private sector, health promotion activities, medical aid, health promotion policies, type of industry, types of risks/hazards, infrastructure (availability of resources/facilities supporting health promotion); and (3) **stakeholders** comprised of any individual, groups or organizations who may influence the decision making within the organization. They are expected to provide support for health promotion programs. Such people will include employees, labour unions, occupational health practitioners and management.

Within this framework the context of workplace health promotion programs are examined in terms of what they are, and how they are offered. The existence of health promotion programs is explored through the identification of all **health promotion activities** offered in the workplace. The aim is to determine whether any health promotion programs or activities do exist in an organization.

Examples of such programs are (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) safety in the workplace (e) spirituality (f) weight control (g) nutrition and food (h) physical fitness (i) smoking/substance abuse cessation (j) stress management, (k) chronic disease management and others.

A **policy** is defined as a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace. This document will deal with such issues as smoking/substance abuse in the workplace. The policy should stipulate who is responsible for execution of all health promotion activities. Policies are expected to be accessible to all employees and managers and trade union members.

Infrastructure in this framework is understood as the presence of any facilities or resources that will facilitate the successful implementation of health promotion activities and /or programs. These include facilities for physical activity and exercise within the worksite, availability of low fat and low calorie food choices in canteens (Oldenburg et al. 2002 p.289), and financial support.

Process

Donabedian (1969) defines the process of a standard as “actions in implementing and monitoring the standard” (p.9). The process also deals with explaining the methods used to provide and carry out the procedure. Stufflebeam (1983) describes an objective of process evaluation as to record and judge procedural events and activities and hence to get an overview of how the program is operating (p. 133). The idea of conducting process evaluation is to gain more understanding of the phenomenon under study (Stufflebeam 1983, p.133).

A health promotion program is defined based on the definition by Wilson et al (1999), where it is defined as “formal, planned sessions that address any health related issue” (p. 360) In addition to this definition, these sessions must involve employees at all levels and be offered within the workplace setting.

One crucial variable to be included under the process in this framework is the assessment of whether the programs are **targeted** or **comprehensive** health promotion programs. A comprehensive workplace health program consists of three levels, namely, (a) awareness which involves educational opportunities that prepare an individual to change behaviour, (b) behaviour change which involves additional educational opportunities (c) a supportive environment is linked to behaviour change, in that if the behaviour change occurs in a supportive environment, that change is most likely to occur and be maintained (Schmitz, in Sol and Wilson 1989, p.9).

The variable health promotion program is again explored under the **process**. It is explored in terms of health promotion approaches, health promotion models and the health promotion objectives being used to execute these programs.

In assessing the health promotion approach, the existing health promotion activities are examined to see whether they are preventive in approach, that is, if the focus is mostly on the disease and the prevention of its occurrence (primary prevention), or slowing the existing illness (secondary prevention). Furthermore, it can be assessed whether the focus is on educating the employees about various diseases, that is, providing information and leaving the employees to make their choices, or on creating healthy environments for the employees, whereby the idea is to work with the surrounding communities in creating healthy environments. The health promotion approach will also

be assessed if it is linked to the settings approach, where the aim is to render a healthy working environment for the employees.

The other approach may be behavioural change approach, whereby the aim is to persuade employees to change their lifestyles or their health behaviour and to adopt healthy lifestyles, such as healthy eating or physical activity. This approach utilises information, marketing, and public policies. The empowerment approach is employee centred. The health promoter facilitates the implementation of programs thereby empowering employees to identify their health concerns.

Product

According to the CIPP model the **product** is the feedback about what is being achieved (Stufflebeam, 1983p.134). The feedback is intended to define outcomes from the stakeholders and to look at the effects of the program (Stufflebeam, 1983 p.134). In this framework, the product will be presented as the results of the study in the first phase and hence facilitate the formulation of guidelines, which will lead to the outcomes. The product will be influenced by the findings of the study, that is, the feedback from the stakeholders and also by the context. The product will also influence the outcomes because they will be based on formulated guidelines.

Outcome

The Nutbeam (2000) outcome model for health promotion programs discusses health promotion program outcomes. The major concepts in Nutbeam's model are health promotion actions, health promotion outcomes, intermediate outcomes and social and health outcomes. The health promotion **outcomes**, from which this framework draws, are divided into (a) ultimate/long term outcomes, (b) intermediate outcomes, and (c) short term outcomes

(<http://www.phs.ki.se/mpcourse/evaluationmodels.ppt>). According to Nutbeam (2000, p.30) the short-term outcomes are (a) health literacy, (b) social action/influence and (c) healthy public policies and organizational practice. This study framework will focus only on the short term outcomes of Nutbeam's model. These short term outcomes are (a) health literacy (b) social action and (c) organizational practice.

Health literacy focuses on such attributes of the employees as awareness about health promotion interventions; health promotion related knowledge, attitudes and beliefs; motivation to get involved in health promoting behaviours; behavioural intention, to change unhealthy behaviours; personal skills available to change unhealthy behaviours; and self efficacy, that is belief in self that one can change to healthy habits.

Social action and influence include such changes in employees as employee participation in health promotion activities; and employee opinion, that is, what they feel about the health promotion activities.

Healthy public policy and organizational practice involves changes that take place in the organization itself. These include policy statements on health promotion programs, legislation and regulations on how health promotion programs will be performed and resource allocation specifically for health promotion related activities.

Underlying Assumptions of the Framework

In the present study framework the workplace is viewed as a system with interdependent components that work together for the overall objective of a whole (Berrien 1968, p. 11). Berrien

(1968, p.17) argued that the components of the system should interact among themselves in some way on stimuli they received to produce an output. According to the general systems theory (Berrien 1968, p.17) components need not be homogeneous although homogeneity is not eliminated.

The underlying assumptions of the work-setting framework are that:

1. The **work environment** is perceived to be operating as a system with interrelated components, and the interaction of these components yields outputs and these outputs influence the outcomes.
2. The social **context** is very significant in determining employee change in health behaviour.
3. The process of health promotion programs in the workplace will closely interact with the social context. For example, the presence of managerial support and trade union support will result in the presence of health promotion programs and hence employee involvement.
4. The outcome of health promotion programs depends largely on employees' demographic characteristics rather than on organizational characteristics
5. Organizational characteristics, such as the organizational size and type, will influence the presence of health promotion programs.

Propositional Statements

A system is viewed as a collection of parts that relate to one another in a direct and consistent manner (Gharajedanghi & Ackoff 1984, in Colarelli 1998, p. 1045). The parts of the system are therefore generally assumed to influence one another in a coupled manner, and therefore the relationship among the parts and outcomes is assumed to be stable and consistent over time (Colarelli, 1998, p.1045). The relationship between the parts of the system suggests that the different variables in the system approach will influence each other and consequently the outcomes. Health

promotion interventions are expected to enhance employees' health and therefore increase productivity. In a system, such as an organization, the components are not like machinery whose functioning can be predicted. Human beings, who are also part of the system, can change their behaviour and therefore act unpredictably. Human beings may or may not change their behaviour owing to their social context or other extraneous/extrinsic context, and this behaviour change, or lack of it, will largely influence the outcomes of the health promotion programs.

There exists a relationship between an individual's social context or demographic characteristics and his/her health behaviour. Variables such as gender, age, race/ethnicity will largely determine whether an individual will change unhealthy habits or not, and hence affect the outcomes of the health promotion programs. From the sociological point of view, social class may be defined as a social relationship premised on people's structural location within the economy (Krieger et al.1997 in Sorensen, Emmons, Hunt, Barbeau, Goldman, Peterson, Stoddard, and Berman 2003, p.189). Social class will determine one's prospects in life, access to social and economic resources and exposures to life stressors (Sorensen et al., 2003, p.189). Individuals from different social classes and ethnic groups will seem to have different perceptions of health promotive behaviours owing to their different cultural backgrounds and the availability of resources. The individuals' willingness to get involved in health promotive activities and hence to change behaviour will be largely influenced by their social context.

Participation in health promotion activities is also influenced by other employee characteristics such as age, gender, level of education, and level of employment of the employee. Participants in such programs are likely to be younger, well educated, female, non-smokers and white collar workers (Harden, Peerman, Oliver, Mauthner, & Oakley, 1999, p.541, Peltomaki et al. 2003, p. 120).

Organizational characteristics would also have a large impact on the implementation and sustainability of the outcomes of a health promotion program. The basis for determining the **size** of an organization can be based on its attributes such as the number of employees or the annual revenues (Wilson et al., 1999, p.358). In this present study framework the number of employees determined the size of an organization. Large organizations had more than five hundred employees, medium sized organizations had between one hundred and five hundred employees, and small organizations had fewer than one hundred employees. Small and medium sized workplaces were expected to have higher rates of injury and ill health than larger workplaces, because of being disadvantaged by lack of infrastructure or human/financial resource barriers (Holman, Donovan, Corti, and Jalleh, 1998, p.330; Lusk, Kerr, Ronis, and Eakin, 1999, p. 541).

The **type** of an organization will also determine the outcomes of a health promotion program. Holman et al. (1998) also argue that workers in the public sector experience a higher prevalence of healthy workplace than their private sector counterparts (p.330). In South Africa, though, the circumstances are different, and the other way round, with the public sector (the health sector in this case) not having any formal health promotion programs in place (Strachan 2000, p.1). The type of organization can determine whether the workplace has seasonal contract workers, irregular workers changing teams, is in the formal or informal sector, or has mostly blue collar workers or white-collar workers (Peltomaki et al., 2003, p. 121). The assumption is that employees in contract, irregular settings, small industries, the informal sector, blue collar workers and persons in risk- related jobs will be less likely to participate in health promotion programs owing to lack of infrastructure and work-related policies.

The presence of **Medical Aid** benefits that support health promotion activities will highly influence employee participation in health promotion programs. Employees with no health insurance or where benefits are limited to non- health promotive activities will be less likely to be involved in any health promotive activities, even if these activities are work based. If the health promotion services are **outsourced** the situation may be worse, because employees may have to make use of their own time to get involved in health promotive behaviour. It should therefore be made clear to the employees whether there is someone on site who is responsible for the health promotion of the employee. The organization needs to have separate personnel dealing with occupational health and safety, health promotion and the employee assistance program. The size of an organization and lack of resources may largely contribute to the absence of these personnel and hence affect the implementation and outcomes of health promotion programs.

Accessibility of policies will facilitate information sharing amongst employees and address many queries that employees might have. Lack of accessibility to policies will affect the process and therefore the outcomes. Poor implementation of health promotion policies will discourage employees from engaging in health promotion programs (Oldenburg et al. 2002, p.289).

Different stakeholders in an organization, such as management, employees, labour unions and other partners will largely influence the needs and goals of an organization (Peltomaki et al. 2003).

Support of health promotion programs by management, labour unions and occupational health services is of significance for positive outcomes, as their support will ensure active employee participation in planning and execution of such programs, and therefore the feeling of program ownership. Availability of infrastructure is essential because employees will be more likely to

participate in health promotion activities if they are aware of the availability and convenience of infrastructure facilities.

Health promotion models and approaches used will largely determine the product or outcomes of health promotion programs. An empowerment approach is likely to yield positive and sustainable programs since the employees will be involved in promotion of their own health and hence develop self reliance. The settings approach to health promotion will be more effective because it will also include the work environment, but effective health promotion means providing appropriate resources to facilitate activities designed to improve well being (Naidoo & Willis 2000, p.337). This implies that supportive stakeholders and infrastructure are required to enhance the health promotion program in the workplace.

Relevant Studies

The findings of a study conducted by Wilson et al. (1999) revealed that the size of the worksite had a huge impact on worksite type and extent of worksite health promotion programs. According to these findings, even though one in four small worksites had offered some type of health promotion program, compared to 44% in large worksites, smaller worksites were less likely to offer programs such as nutrition and weight management (Wilson et. al., 1999, p.361). These findings were also similar to the study by Holman et al. (1998) which demonstrated that respondents from large worksites were more likely to have access to health promotion programs than those in small worksites (Holman et al. 1998, p.329).

Another study by Peltomaki et al. (2003) showed that the social context and work setting influenced employee participation in health promotion activities. The findings of this study showed that factors

that can be associated with the feasibility and sustainability of health promotion programs include demographic characteristics of the employee population, workplace characteristics and the type of work setting and the extraneous context, such as all operational partners, funding organizations and labour unions (Peltomaki et al. 2003, p.120). These authors have concluded that support from management, occupational health services and trade unions are essential for health promotion programs to be sustainable. Other researchers are in agreement with these findings, but suggest that the workplace should also provide support in terms of making available the relevant facilities and policies (Oldenburg et al., 2002, p.289; Holman et al., 1998, p.326).

Harden et al., (1999) conducted a study to identify and review the evaluation of effectiveness of health promotion programs in the workplace. They argued that health promotion programs need to include different levels of the context, that is, the individual and organizational level. This approach, they argue, will result in evaluation of outcomes or outputs at different levels and can play a role in sustaining behaviour change (Harden et al., 1999, p.543). The findings of the study showed that there is a relationship between outcomes at individual and organizational level. Changes at individual level are supported by changes at organizational level. For example, providing healthy food choices in the cafeteria will influence the willingness of employees to eat healthy foods (Harden et al., 1999, p.543).

Holman et al. (1998) have also concluded in their study that the approach or models being used in the execution of health promotion programs have implications for measurement of health promotion outcomes.

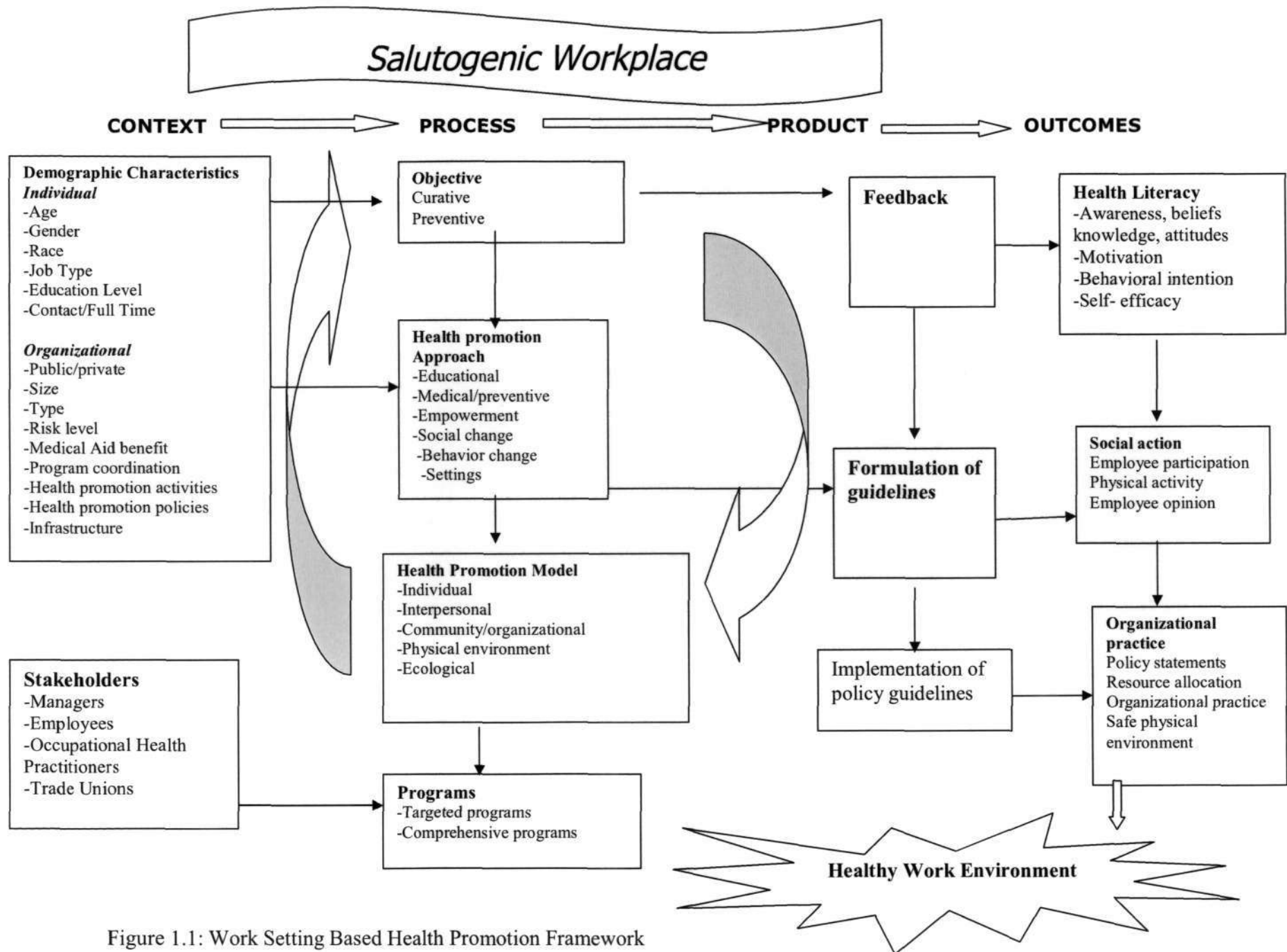


Figure 1.1: Work Setting Based Health Promotion Framework

OPERATIONAL DEFINITIONS

An employee: The definition of an employee in the OHS Act will be adopted for the purpose of this study. An employee is defined as “any person who is employed by or works for an employer and who receives and is entitled to receive any remuneration or who works under direction or supervision of an employer or any other person” (RSA 1993, p.1)

The Context includes such characteristics as (1) employee *demographic characteristics* such as age, gender, racial/cultural background, job type, level of education, contract or full time employees; (2) *organizational characteristics* such as size, public/private sector, health promotion activities, medical aid, health promotion policies, type of industry, types of risks/hazards, infrastructure (availability of resources/facilities supporting health promotion); and (3) *stakeholders* comprised of any individual, groups or organizations who may influence the decision making within the organization.

Health promoting workplace is one that actively promotes wellness through health promoting programs and addresses workers' health concerns.

Health promotion programs in this study were defined based on the definition of Wilson et al (1999), that is “formal, planned sessions that address any health related issue” (p. 360). The examples include worksite based programs such as (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) safety in the workplace (e) spirituality (f) weight control (g) nutrition and food (h) physical fitness (i) smoking/substance abuse cessation (j) stress management, (k) chronic disease management and others. This definition will also mean assessing whether the programs are targeted or comprehensive health promotion programs.

Health promotion refers to activities designed to improve or maintain the health status of an individual and his /her environment, with the focus on disease prevention. The term health promotion is used interchangeably with the terms “wellness” and “wellbeing”.

Infrastructure in this framework was understood as the presence of any facilities or resources that would facilitate the successful implementation of health promotion activities and /or programs. These included the availability of facilities for physical activity and exercise within the worksite, management support of health promotion programs, and financial support.

Occupational classifications Occupations are classified according to the classification by the Department of Labor (1998) in the Employment Equity Act. In this document occupations are classified under the following classifications,(a) Legislators, senior official and managers (b) Professionals (c) Technicians and associated professionals (d) Clerks (e) Service and sales workers (f) Skilled agricultural and fishery workers (g) Craft and related trade workers (h) Plant and machine operators and assemblers and (i) elementary (RSA 1998; Kell 2006)

Organisational size was to be determined by the present number of employees for example **large organizations** will be the ones with more than five hundred employees, **medium sized organizations** have between one hundred and five hundred employees, and **small organizations** have fewer than one hundred employees.

Organizational type in this study refers to the work sector (public/private/parastatal) and can imply whether the workplace has seasonal contract workers, irregular workers changing teams, working in

the formal or informal sector, type of employment, for example production, health, engineering, communications, and so on.

Parastatal organization. In this study, the Oxford dictionary's definition of a parastatal will be adopted. It is defined as a "Business Corporation closely associated with the State, which may be its only or principal shareholder, or have other means of control." (Editor, p.)

A Policy is defined as a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace.

Safe physical environment refers to an environment that is free of hazards or risks that could affect the person's health or safety.

Salutogenic workplace is depicted as one that is health promotive and provides a physical working environment that is supportive to the health of the employees. The focus is on the individual and the psychological and physical environment. A salutogenic workplace should provide educational, organizational and economic activities that are designed to improve the health of workers.

Workplace. The definition used in the OHS Act was adopted as "any premise or place where a person performs work in the course of his employment" (RSA 1993, p.1).

OUTLINE OF CHAPTERS

The study comprises seven chapters which are outlined as follows:

Chapter 1: This chapter presents the study background, problem statement, purpose of the study, study objectives and research questions, description of the work-setting based health promotion framework and operational definitions.

Chapter 2: In this chapter literature review is presented, including relevant health promotion models and theories.

Chapter 3: Research methodology used in the study is presented in this chapter. The discussion includes approaches used in each phase of the study. Data collection instruments are also described in detail. Data analysis techniques and ethical considerations are also discussed.

Chapter 4: This chapter presents the results of phase one for three cases and cross case analysis of all six cases.

Chapter 5: In this chapter discussion of case study results is presented.

Chapter 6: Phase 2 and 3 are presented in this chapter. Phase 2 describes the process involved in the development of policy guidelines, and phase 3 outlines the process that was followed in the implementation of the policy guidelines in the selected organizations.

Chapter 7: In this chapter the study summary, conclusions and recommendations are presented

CONCLUSION

The discussion in this chapter has revealed that in evaluating workplace based health promotion programs one needs to focus on the organization as a system with interdependent parts. Literature also shows that there is a significant link between the context, the process and the product and/or outcomes of health promotion programs. Relevant research and interventions implemented in other countries have focused mostly on these issues in the private sector. In South Africa there is still a

dire need for such studies and mostly for studies focusing on all work sectors, as workplaces. There are still no workplace based health promotion policy guidelines to help in the evaluation of such programs. A study determining how these programs are conducted and developing policy guidelines should be imperative for future implementation and evaluation of such programs.

CHAPTER 2

LITERATURE REVIEW

CONCEPTUALISATION OF HEALTH PROMOTION

The first World Health Organization (WHO) international conference on health promotion was held in Ottawa, Canada, in 1986. The outcome of this conference was the formulation of the Ottawa Charter for health promotion (WHO 1986, p.1). This conference was based on the progress made through the international Primary Health Care (PHC) conference, held in Alma Ata, 1978. The outcome of this PHC conference was the declaration of Alma Ata which contained the ten principles which were the blueprint for PHC. PHC was identified as a key to achieving an acceptable level of health for all the people of the world by the year 2000 (Wass 2000, p.10). This was later known as "*Health for all by the year 2000*" (HFA) (Wass 2000, p.10). In this declaration of Alma Ata one of the recommendations was that PHC should address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly (WHO 1978, p.1).

The goals and targets for HFA, as identified in Alma Ata, were to achieve an increase in life expectancy and in the quality of life for all, and also to implement measures to promote health. According to the WHO (1997, p.1), HFA focused on action to be taken to address the determinants of health and to promote health in all settings. Hence, the Ottawa Charter for health promotion set out the action required to achieve the HFA.

The concept of health promotion was defined in the Ottawa conference. Health promotion was defined as "the process of enabling people to increase control over, and to improve, their health"

(WHO 1986, p1). Since this conference, different authors in the health field and even outside the health field, such as in the field of psychology, have debated the meaning of the concept of health promotion\ There are many differing views on what health promotion is. The most prominent ones that can be identified are (a) those that are purely based on the original definition of health promotion as defined in the Ottawa conference; (b) the ones that view health promotion in relation to behavioural change; (c) health promotion as covering health protection and health education;(d) as related to primary health care and community health nursing (e) health promotion in the context of “marketing” and (f) health promotion in the context of empowerment.

In their concept analysis, Maben and Macleod –Clark (1995) proposed that health promotion be defined as “an attempt to improve the health status of an individual or community, and is also concerned with the prevention of diseases” (p. 1163). In this context, health promotion is viewed as attempts to improve the health of an individual or community and is concerned with prevention of disease. Health promotion is concerned with people and their well-being, but from their own perspective (Raeburn 1992, cited in King 1994, p. 209).

Authors such as Clark (1996, 10) and Flynn & Krothe, cited in Stanhope and Lancaster (1996 p.239), are of the opinion that health promotion is the first level of care that involves activities designed to improve or maintain health status, also that it should be considered as one of the tools for achieving primary health care (PHC), and that it focuses on disease prevention. This view is disputed by others, since they argue that, although health promotion is an important tool in primary prevention, which is the focus in primary health care delivery; these two concepts are different (Nutbeam 1986, p. 25; Pender 1987, p. 6; Whitelaw 1997, p. 60 & King 1994, p. 212). These authors

are in agreement that even though these terms are different they are complementary activities, which overlap in a variety of situations and circumstances.

Nutbeam (1986), cited in Dines and Cribb (1997, p. 25), distinguishes between the two concepts by first looking at their aims. For this author, disease prevention aims to conserve health and focuses on the selected individuals or groups, health promotion on the other hand, aims to enhance health and starts out with the whole population in the context of their every day lives. This differentiation is echoed by Dines and Cribb (1997, p.25) where they maintain that disease prevention is part of health promotion because if health is to be enhanced this must include its conservation, but they further argue that health promotion begins with people who are basically healthy and seeks the development of community and individual measures. Pender's (1987, p. 6) explanation of the two terms is that health promotion is not disease specific whereas disease/illness prevention is.

Other authors prefer to portray health promotion as an umbrella term, which includes any activity designed to foster health. These authors' understanding is that health promotion needs to be viewed as an umbrella under which any health service may find coverage (Tones, Tilford & Robinson et. al. 1990, p. 18; Duncan & Gold 1986, cited in King 1994, p.212). Denis et al. (1982), cited in Dines and Cribb (1997, p.), are also in agreement with this view, and further assert that health promotion includes all those activities that seek to improve the health status of an individual and the communities. This understanding of health promotion seems to be too broad. It draws attention to an argument raised by Maben and Macleod (1997, p. 1159), when they questioned whether health promotion could be equated to health promotion plus health education or whether these two terms can be used interchangeably.

Maben and Macleod (1997, p. 1160), argue that these two terms cannot be equated but are complementary, as health promotion should be equated to health education plus information giving, life skill teaching, self empowerment and promotion of health through social environment measures. Health education should be seen as an essential prerequisite, in the delivery of all health promotion programs (Huiskamp 2003, p. 56).

Health promotion and health education, even though they are not similar, go hand in hand but health promotion should also include other factors such as environmental, organizational and economic factors (Green 1987, cited in Norton 1998; Tones et al. 1990). These authors suggest that these factors are also very important in the successful implementation of health promotion programs. The significance of these factors is also supported by the Ottawa Charter components, that is, health promotion should mean, among other things, creating supportive environments, and building health policies (WHO 1986). Pender (1987, p.7) echoes this declaration and states that the health of individuals and families is affected markedly by the community, environment and the society in which they live. The approach in health promotion should therefore focus mainly on the environments where individuals live.

HEALTH PROMOTION, WELLNESS AND WELLBEING

The three concepts health promotion, wellness and wellbeing are sometimes used interchangeably in literature with regard to workplace health interventions. These concepts have, however, been conceptualised differently by professionals and practitioners in different fields. Health promotion, as conceptualised in the abovementioned literature review, aims to help people to change their lifestyle to move towards a state of optimal health. Wellness, on the other hand, has been defined as “a set of organised and systematic interventions, offered through corporations/worksites, managed care

organisations, and governmental/community agencies, whose primary purposes are to provide health education, identify modifiable health risks, and influence health behaviour” (Mulvihill 2003, p. 13).

Other authors have argued that in defining wellness, attributes such that it is based on individual choices about their own lives and priorities that determine their own lifestyles should be added (Arizona State University 2000, p1).

The concept of wellbeing has been defined in terms of physical, emotional, mental and social wellbeing which includes workplace alcohol use. There appears to be a link between physical and emotional wellbeing, with emotional distress from life events creating susceptibility to physical illnesses, such as cardiovascular disease (McAllister 2005, p.9). Wellbeing programs therefore need to focus on all these areas. For example, health interventions focusing on social and emotional support can contribute in reducing or preventing illness and reducing disease. Health promotion programs therefore need to be operationalised to indicate the level they are in or a combination of all these programs can be offered as comprehensive workplace health interventions.

HEALTH PROMOTION THEORIES AND MODELS

Different authors have classified the models and theories that are commonly used in health promotion to different, yet linked, classifications. The first classification of health promotion models classifies them according to their use in health promotion programs, namely:

- (a) Planning models, such as the PROCEDE- PRECEDE model (Green & Kreuter 1991),
- (b) Evaluation models such as Nutbeam’s outcome model for health promotion (Nutbeam 2000),
- and (c) Stages of change/Transtheoretical model (Prochaska & DiClemente 1983).

Table 2.1: Common models and theories used in health promotion (Adapted from National Institutes of Health, 1995, p. 3; National Centre for Chronic Disease Prevention and Promotion, 2003, p. 1)

Level	Theory/Model	Focus
Individual level	Health Belief Model	Person's perceptions of the threat of a health problem and the appraisal of recommended behaviour (s) for preventing or managing the problem.
	Stages of change (Transtheoretical model)	Individual's readiness to change or attempt to change toward healthy behaviour.
Interpersonal level	Social learning theory (Social cognitive theory)	Health behavioural change is a result of reciprocal relationships in which personal factors; environmental influences and attributes of behaviour interact. Self-efficacy is one of the important characteristics that determine behavioural change.
	Theory of reasoned action	For behaviours that are within the person's control, behavioural intentions predict actual behaviour. Intentions are determined by attitude towards the behaviour and beliefs regarding other people's support of the behaviour.
Community level/Organizational level	Community organization theories	Emphasize active participation and development of communities that can better evaluate and solve health social problems.
	Organizational change theory	Concerns processes and strategies for increasing the chances that healthy policies and programs will be adopted and maintained in formal organizations.

The second classification is based on the levels at which the models are utilized in health promotion interventions. The argument is that this classification can help the health promotion practitioner to identify potential points of intervention (National Centre for Chronic Disease Prevention and Health Promotion, 2003). National Institutes of Health (2003) refer to this approach as an Ecological perspective or levels of influence. The levels of focus are (a) Individual level, (b) Interpersonal level, and (c) Community level. What is notable in this classification is that the community and the organization are classified under the same models and therefore the assumption is that any model that is usable in community interventions can be used in the organizational interventions. This classification is summarized in table 2.1.

Individual Level Theories

Staging Theory (Prochaska & DiClemente (1983)

Prochaska and DiClemente (1983) developed a staged model (Stages of readiness to change model, Transtheoretical model). The Transtheoretical model specifies a series of independent variables, called the process of change (stages of change), and a series of intervening or outcome measures that have been labelled the stages.

These consist of 7 stages, namely:

1. Pre-contemplation stage: The individual has no intention to take action within the next 6 months. At this point, lifestyle issues are not high on an individual's "personal agenda" and he is not considering the benefits of lifestyle change. Moving ahead to the next stage appears to be dependent on (a) taking "ownership" of the problem, (b) increasing awareness of the negative aspects of the problem and (c) accurately evaluating one's ability and capacity to change.

2. Contemplation stage: an individual intends to take action within the next 6 months. He/she begins actively to consider the benefits of lifestyle change, and maybe even intends to take some action to change, but has not yet acted upon this intention.

3. Preparation/ Commitment stage: An individual is thinking about change, in the near future, is ready and keen to take action, has taken some behavioural steps in this direction and needs to set goals and priorities

4. Action stage: The individual implements the specific action plans or has changed overt behaviour for fewer than six months. The individual begins to engage in active attempts to change or modify some aspects of his life. He needs to acquire skills to use key strategies in order to change habitual patterns of behaviour and adopt a healthier lifestyle.

5. Maintenance stage: This stage involves the continuation of desirable actions. The individual has changed behaviour for more than six months. Even after six months of active attempts to make change, setbacks and reversals are common.

6. Relapse: Some people have added a stage of relapse where an individual can be involved in the behaviour again.

7. Termination stage/ Exit stage: Overt behaviour will never return, and there is complete confidence that the individual can cope without fear of relapse

The staging models can be applicable at both individual and organizational levels. The model can be used to match the stage of change of either an individual or target group with particular intervention strategies. This model has been widely used in the development of a variety of intervention programs, for example, programs aimed at quitting smoking, changing dietary

behaviours and increasing physical activity. This model has been used in conjunction with other theories, for example social learning and cognitive theories, in particular, self-efficacy.

Health Belief Model (Houchbaum, Kegels & Rosenstock, 1952)

The health belief model (HBM) was originally developed by researchers in the public health service to explain the use of preventive health services and has been since modified and used to explain health related behaviours (Raczynski & DiClemente 1999, p.28). The model focuses on the individual behaviour and avoidance of illness.

Propositions: The model suggests that for an individual to take action, he must decide that the behaviour creates a serious health problem, and that he is personally susceptible to its health harm and that moderating or stopping the behaviour will be beneficial (Gorin 1998, p.26).

There are two interpretations given for this model, that is (1) the desire to avoid illness or to get well (value) and (2) the belief that a specific action available to a person would prevent illness (expectation) (Glanz, Rimer & Lewis 2002, p.49).

The main components of this model include the following concepts:

1. **Perceived susceptibility:** one's belief regarding the chances of getting a condition,
2. **Perceived severity:** one's opinion of how serious a condition and its consequences are,
3. **Perceived benefits:** one's opinion of the efficacy of the advised action to reduce the risk or seriousness of impact,
4. **Perceived barriers:** one's opinions of the tangible and psychological costs of the advised action,

5. Cues of action: Strategies to activate one's "readiness", and

6. Self efficacy: Confidence in one's ability to take action.

(National institute of health (NIH) 1995; Raczynski & DiClemente 1999, p.28; Glanz, Rimer & Lewis 2002, p.49).

Goals:

The first intention of this model was to determine why other persons who are illness free take action to avoid illness whereas others fail to take protective action. Secondly, it aimed at predicting the conditions under which the people would engage in simple preventive behaviours (Gorin 1998, p.26)

Assumptions: The perceived barriers to undertaking the behaviour are considered most salient to health promotive efforts (Janz & Becker 1984, in Gorin 1998, p.26). The perceived susceptibility to and the perceived severity of harm are based on the individual's knowledge of the disease and its perceived outcomes. The combination of perceived susceptibility to and severity of harm provides the force for action, and the perception of high benefits and low barriers provides the course for action (Rosenstock, 1974, in Gorin 1998, p.26).

Interpersonal Level

Social Learning Theory/ Social Cognitive Theory (Bandura, 1969)

Social cognitive theory was first developed by Albert Bandura (1969). It was earlier known as social learning theory (Raczynski & DiClemente 1999, p 32). The theory reflects the approaches of

(a) stimulus response and (b) social cognitive theories.

The theory views behaviour in the context of environmental events and personal factors that influence it and in turn how behaviour is influenced by these factors (Raczynski & DiClemente 1999, p.32).

The three central concepts in this theory are behaviour, environment and person. In the context of health promotion, health promotion is analysed as it applies to individuals, families and groups.

The main assumption in this theory is that behaviour is determined by expectancies and incentives (Gorin 1998, p.28). The cornerstone of this model is the reciprocal determinism between cognition, behaviour and environment (Bandura 1986, p. 22 in Gorin 1998, p.29). Self efficacy is another core concept in the application of social cognitive theory in health promotion.

Propositions

Stimulus response theory is built on a belief that learning results from events (reinforcements or consequences of behaviour) that reduce physiologic drives (tension, anxiety) that then activate behaviour.

Self-efficacy is the conviction that one can execute the behaviour successfully.

Assumptions: The theory assumes that:

- (1) Behaviour is determined by expectancies and incentives.
- (2) The initiation and maintenance of behaviour change may be accomplished by providing feedback and rewards so that the positive behaviour becomes rewarding.

Most learning occurs through modelling (watching others). Individuals with high self efficacy are more confident of their capabilities to maintain behavioural change and will attempt to execute it more readily, with greater intensity, and with greater perseverance in response to initial failure than individuals with comparatively low self efficacy (Baer & Lichtenstein 1988, Devins 1992 in Gorin 1998, p. 29)

The social cognitive theory assumes that change takes place through the following changes:

- Promotion and motivation of persons toward changing target behaviour;
- Skills training so that individuals can acquire specific behavioural change skills;
- Development of support networks so that new behaviour can be maintained;
- Maintenance of the behaviour through reinforcement;
- Generalization to all levels of interaction from the family to the community (Lefebvre,

Lasater, Carleton & Peterson 1987 in Gorin 1998, p.30)

Theory of Reasoned Action (Ajzen and Fishbein (1980)).

This theory was developed by Ajzen and Fishbein (1980). The theory explains factors related to values and expectations to explain behaviour (Raczynski & DiClemente 1999, p. 25). The theory asserts that the most important determinant of behaviour is a person's behavioural intention, and that the determinants of an individual's behavioural intention are his attitude towards performing the behaviour and his subjective norm associated with the behaviour. The person who holds strong beliefs that positively valued outcomes will result from performing the behaviour will have a positive attitude towards the behaviour, while the person who holds strong beliefs that negatively valued outcomes will result from the behaviour will have a negative attitude towards the behaviour (Glanz, Rimer & Lewis 2002).

Concepts:

The concepts that are that common in this theory are (a) beliefs, which are verbalized opinions, (b) attitudes which refer to the judgment that the behaviour is good or bad and that a person is in favour of or against performing the behaviour, and (c) the intentions in determining action.

Propositions: this theory is a mathematical description of the relationship between the individual's beliefs, attitudes and his intentions.

Assumptions: The theory has the following assumptions:

Most volitional behaviour can be predicted by beliefs, attitudes and intentions. This assertion assumes that by changing the beliefs underlying the individual's attitudes or norms, changes in behavioural intentions, and subsequently in behaviour, can be induced.

A person's intention to perform or not perform behaviour is the immediate determinant of the action.

The person's intention is a function of another two determinants, namely (a) one's attitude towards the behaviour; and (b) the subjective norm, or the person's perception of the social pressures put on one to perform or not to perform the behaviour in question (Ajzen & Fishbein 1980, in Gorin 1998, p.27). This means that the individual will intend to perform the behaviour in question if he thinks that the significant others in his social circle deems it important for him to perform it. The external variables are also considered as being influential on the individual's beliefs. The individual controls the relationship between the intention to act and the behaviour. If a female maintains a positive attitude toward using birth control pills, is supported by the set

of family and community norms supporting the use of contraception, she will ultimately use them (Fishbein, Jaccard, Davidson, Ajzen & Loken 1980 cited in Gorin 1998, p.28).

Community Level Theories

The models that focus on community level sometimes overlap and can be combined.

Community level models are vital in designing health behaviour and environmental change initiatives to serve communities and targeted populations, not just individuals. It has been argued that promoting the wellbeing of collective communities requires that such communities or environments create structures and policies that support healthy lifestyles, and by reducing health hazards. This approach, however, requires an understanding of how social systems operate and how change occurs within and among systems (Glanz, Rimer & Lewis 2002, p. 275).

Community organization theories

In categorising community organisation, Rothmans (2001, p.28) argued that there are three distinct models of practice, namely:

a) Locality of development model (community development):

This model is process oriented and uses people in the community to identify and solve their own problems. Capacity building is used to help the community address its concerns. The focus in this model is group consensus and cooperation hence it is aimed at building group identity and a sense of community.

b) **Social planning:** This planning is task oriented and addresses substantive problem solving, with expert practitioners from outside the organisation providing technical assistance to benefit the community.

c) **Social Action:** It can be viewed as a combination of process and task oriented. The aim is to increase the problem solving ability of the community and to achieve concrete changes to redress social injustice that is identified by a disadvantaged or oppressed group.

Community organisation theories and models focus on five concepts, namely empowerment, critical consciousness, community capacity, issue selection, participation and relevance. These concepts are defined in Glanz et al. 2002, p. 288) as follows:

Empowerment: Social action process for people to gain mastery over their lives and the lives of their communities.

Critical consciousness: A consciousness based on reflection and action in making change,

Community capacity: Community characteristics affecting its ability to identify, mobilise, and address problems,

Issue selection: Identifying winnable and specific targets of change that unify and build community strength, and

Participation and relevance: Community organizing that “starts where the people are” and engages community members as equals.

Organizational change theory

Stage theory

The stage theory explains how organizations innovate new goals, programs, technologies, and ideas (Glanz, Rimer & Lewis 2002). This theory is based on the idea that organizations pass through a series of steps or stages as they change, but is not related to DiClemente's Stages of Change. By identifying these stages, strategies to promote the change can be matched with various points in the process of change.

Components

This model consists of the following stages:

1. **Sensing of unsatisfied demands on the system (awareness):** The system receives information indicating a potential problem or problem,
2. **Search for possible responses:** Elements in the system try to find alternative solutions,
3. **Evaluation of alternatives:** Various alternatives are compared,
4. **Decisions to adopt a course of action:** An alternative is chosen among the evaluated alternatives and a strategy is adopted,
5. **Initiation of action within the system:** Policy or directive is formulated, resources for beginning change are allocated,
6. **Implementing of change:** Innovation is implemented, reactions occur, and role changes occur, and
7. **Institutionalisation of change:** Policy or program becomes entrenched in the organization, new goals and values are internalised.

Assumptions

The assumption in this theory is that the series of steps or stages that organizations go through require a unique set of strategies if the innovation is to grow and mature. Furthermore, strategies that are effective at one stage may be misapplied at the next, and therefore the most effective strategies are contingent upon the organization's stage of change in adopting, implementing, and sustaining new approaches.

Organizational Development (OD) theory:

This theory grew out of the recognition that organizational structures and processes influence worker behaviour and motivation. Technologies and workplace norms can be foci for organizational development theory. It is concerned with identifying problems that impede organization's functions rather than introducing a specific type of change.

Main concepts:

In this theory the emphasis is on the organisation's designs, technology, norms, values and environment. The three main concepts in this theory are:

- a) **Organisational climate:** This is conceptualised as a mood or personality of an organisation. A definition of organisational climate is that it is "those characteristics that distinguish an organisation from other organisations and that influence the behaviour of people in the organization" (Gilmer 1966, p.23; Glanz et al. 2002). This concept is further defined as the manner in which the organisation is perceived by its members.

- b) **Organisational culture:** This concept is related to organisational climate but is based on shared “assumptions” which form slowly over time and is more stable and resistant to change.
- c) **Organisational capacity:** This capacity is influenced by both the organisational culture and climate. It is defined as “an optimum level of functioning within an organisation’s subsystem: production of services or products, maintenance of organisational operations, support from the social and political environments in which organisation operates, adaptation of organisational operations based on ever-changing environmental conditions, and management of these subsystems as a coherent whole” (Katz & Kahn, 1978, in Glanz et al, 2002, p 341).

Planning Models

PRECEDE PROCEDE Model

The PRECEDE PROCEDE model was developed in two phases with the first part of the model “PRECEDE” being developed in 1970 by Green and colleagues (Kreuter, Deeds and Patridge), the second part “PROCEED” was later developed to the framework in 1991 (Glanz et al. 2002 p.410). The PRECEDE PROCEDE model is a planning that has been widely used for planning health education and health promotion programs (Green & Kreuter 1991, p.22). One of the very important assumptions in this model is that change in health behaviour is voluntary in nature. According to Glanz, et al. 2002, p. 410), health professionals have been concerned that health education tended to focus on the implementation intervention rather than assessment. In addressing this concern, the first part of the model “PRECEDE”, is based on the premise that

health education should precede an intervention plan just as medical diagnosis precedes a treatment plan. This is the first step in planning the health promotion programs.

The planning process involves systematic planning which seeks to empower individuals with understanding, motivation, skills and active engagement in community affairs to improve their quality of life. PROCEED is based on the environmental factors which are viewed as the determinants of health and health behaviour (Glanz et al. 2002, p.411). The model consists of nine phases. The first five phases are diagnostic phases (PRECEDE), while the remaining four phases (PROCEED) are for implementation and evaluation.

Phase 1: Social diagnosis

This stage consists of assessing some of the general hopes, or problems of concern for the target population. These can be self-determined needs, wants, resources or barriers to them (Glanz & Rimer 1995, p.36; Green & Kreuter 1991, p.26).

Phase 2: Epidemiological diagnosis

This phase is for identification of goals or problems that may contribute to the social goals or problems noted in phase 1. The available data or information generated by appropriate investigations and epidemiological and medical methods is used and ranked into several health problems (Glanz & Rimer 1995, p.36, Green & Kreuter 1991, p.28).

Phase 3: Behavioural and environmental diagnosis

This phase includes diagnosis of specific behaviours and environmental factors that could be linked to the health problems chosen for the program to address. Environmental factors are those external to the individual, beyond his or her control, that can be modified to support the behaviour, health or quality of life of that person (Glanz & Rimer 1995, p. 36, Green & Kreuter 1991, p. 28).

Phase 4: Educational and organizational diagnosis

The educational and organizational diagnosis phase deals with the diagnosis of the predisposing, enabling and reinforcing conditions, which immediately affect the behaviour.

Predisposing factors include the person's knowledge, attitudes, beliefs, values and perceptions, that facilitate or hinder motivation for change. **Enabling factors** are the skills, resources or barriers that can help or hinder the desired behavioural and environmental changes. **Reinforcing factors** are rewards received and the feedback that a person receives from others following the behaviour (Glanz & Rimer 1995, p.37, Green & Kreuter 1991, p. 29).

Phase 5: Administrative and policy diagnosis

This phase is for the assessment of organizational and administrative capabilities and resources needed or available within the organization and the support or barriers existing in the organization or community (Glanz & Rimer 1995, p. 37, Green & Kreuter 1991, p. 29).

For the remaining four phases, phase 6, 7, 8 and 9, to take place, data from the PRECEDE phase should be in place (Glanz et al. 2002, p. 420). Once the program has been implemented (phase 6), evaluation (phases 7 to 9) can take place. Basically, phase 7 focuses on process evaluation, phase 8 is for impact evaluation and phase 9 for outcome evaluation (Glanz et al, 2002, Glanz & Rimer 1995, p.38; Green & Kreuter, 1991, p. 29).

Evaluation Models

Evaluation of health promotion programs remains a very important debate in health promotion. The WHO working group has argued that policy makers should support further research into the development of appropriate approaches to the evaluation of health promotion (Springett 2001, p.39). Evaluation of health promotion can be done in any health promotion intervention, whether it is worksite based or community based health promotion. What is essential, though, according to Raczynski and DiClimente (1999, p.57), is for the evaluator to be specific about the purpose of the evaluation, that is, what aspect of the health promotion intervention is being evaluated. The most commonly evaluated aspects of health promotion programs are the extent to which the planned activities of the project are being executed (process evaluation) and cost effectiveness or cost benefit of the program.

Bertera (1990) conducted a health promotion evaluation study to evaluate the impact of a comprehensive workplace health promotion program on absenteeism among fulltime employees, and hence its cost effectiveness. The findings of this study revealed that this health promotion program had some influence on lowering disability days and therefore provided favourable returns as an investment (Bertera 1990 p.1101). Smith (1988, p.66) is in agreement

with these findings and adds that evaluating worksite-based health promotion programs involves accurately measuring behavioural change associated with participation in designated health promotion activities, monetarizing behavioural changes, then comparing monetarised changes with the associated program cost. These results will make more meaning to management than purely looking at the outcomes of the program with no demonstration of cost benefit to the organisation.

Springett (2001, p.141) feels that evaluation on health promotion programs is different because it involves social intervention, engaging people in the process rather than targeting risk factors. Further, this author feels that health promotion interventions should not only be aimed at individual behavioural change but should also focus on the determinants of health. In their discussion on the determinants of health, Dahlgren and Whitehead (1991) believe that the wider influences on a person's ability to maintain health include their living and working conditions.

Nutbeam's Evaluation Model (2000)

Nutbeam (1998), cited in McMahon et al. (2002, p. 299), argues that evaluation of health promotion interventions is not necessarily best achieved by measurement of conventional long-term health outcomes, but may prove more useful by the employment of diverse methodologies, combining the advantages of qualitative and quantitative techniques. Nutbeam therefore proposes a model that evaluates health promotion outcomes resulting from a program in lieu of assessing intermediate and long-term health outcomes, such as lifestyle, morbidity and mortality (McMahon et al. 2002, p.299). Nutbeams health promotion evaluation model

(2000) specifically focuses on workplace health promotion interventions. This outcome model for health promotion (Nutbeam 2000) is used to measure the outcomes of a health promotion program.

It focuses on:

1. Changes to social health and social outcomes (long term);
2. Changes to health determinants - behavioural, economic, environmental changes (short term),
3. Health promotion impacts – changes to knowledge, motivation, capacity, social norms, public policy and organizational practice (short term).

O'Donnell's Employee Health Program Levels (2000)

O'Donnell (2000) suggested three levels that can be used to evaluate workplace employee health promotion programs. This author outlined these three levels as (a) awareness (b) lifestyle change and (c) supportive environment (O'Donnell 2000, p. 5).

(a) Awareness level

Organisations that are at this level have programs that aim to increase employee's awareness on the topic or program. Examples of awareness programs include newsletters, poster fliers, health fairs, educational classes, weekend retreats, and health screening without feedback or follow up. Although awareness health programs are cost effective, they have been criticised for being of no value to the employer and because they will rarely change participants' behaviour.

Lifestyle change level

The programs are aimed at setting lifestyle-related behaviour change. Such programs might include smoking cessation, exercising on a regular basis, successful stress management and healthy eating. For a successful lifestyle behaviour change programs, it is recommended that these programs be offered in conjunction with other programs such as awareness program, behaviour modification, social support, incentives and feedback opportunities. Lifestyle change programs have been prized for being of benefit to the employer in that they will result in improved health status and morale boost. One setback with these programs is that they will only benefit employees who are ready for change.

(c) Supportive environment level

The aim in these programs is to create an environment within the work setting that encourages a healthy lifestyle. Creating healthy environments includes changes in the physical setting, corporate policies, and corporate culture, implementing ongoing programs, and enhancing employee ownership.

Combining the three levels of programs has been recommended as it will provide both employer and employee benefits. The benefits include reduction in health care costs and absenteeism, enhancing organisational image, and stimulating improvements in productivity.

Ottawa Charter for Health Promotion

In the Ottawa conference, the meaning of health promotion actions was clearly delineated. The Charter for Health Promotion Model consists of the following five components:

(a) Building healthy public policy

Health promotion puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

(b) Creating a supportive environment

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way that society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

(c) Strengthening community actions

Health promotion works through concrete and effective community action at setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is empowerment of communities, their ownership and control of their own endeavours and destinies.

(d) Developing personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. It increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health.

(e) Reorienting Health Services

The role of the health sector must move increasingly in a health promoting direction, beyond its responsibility to provide clinical and curative services. Health services need to embrace an expanded mandate, which is sensitive, and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between health sector and broader social, political, economic and physical environment component. Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This reorientation must lead to a change of attitude and organization of health services, which focus on the total needs of the individual as a whole person.

DIFFERENT APPROACHES TO HEALTH PROMOTION

Contemporary health promotion has a few health promotion approaches that have been introduced to implement health promotion programs.

Medical/Preventative Model

This is perceived as a traditional approach in health promotion and remains the most popular (Naidoo & Wills 2000, p. 92). This approach focuses on disease, medical interventions and medical explanations of health (Ewles & Simnett 1995, p.). It is directed at improving decreasing physiological risk factors, such as high blood pressure (Act community care 2006).

These authors maintain that the medical/preventive approach promotes health through the following:

Preventing the initial occurrence of an illness (primary prevention),

Stopping or slowing existing illness (secondary prevention),

Reducing the re-occurrence and establishment of the chronic illness (tertiary prevention).

This approach has been criticised for its narrow concept of disease and because it ignores social/environmental dimensions, such as immunizations and screening (t & Simnet, 1995).

Educational Approach

According to Naidoo & Wills (2000), the educational approach aims at providing advice and information to the individuals so that they can make informed choices. In this approach, clients are given health education about the illness and it is up to them to decide on taking an action or not. It is widely used in giving health education in schools.

Social Change

This model is also known as the socio-environmental approach. It is a radical health promotion approach, which focuses on the socio-economic environment in determining health (Ewles & Simnett 1995). The assumption in this approach is that health is not just about prevention of disease and increasing longevity, but is also concerned with maximising well being (Naidoo and Wills 1998). This approach promotes health by addressing the broader social determinants of health as well as creating healthy environments

(<http://www.healthpromotion.act.gov.au/whatis/basics/approaches.htm>). This approach is therefore commonly used in actions focusing on creating healthy environments, working with the community to strengthen healthy environments and advocating public policy, since these are part of health promotion as identified in the Ottawa Charter.

Table 2.2: Approaches to health promotion (Adapted from Ewles & Simnett, 1995)

Approach	Aim	Health Promotion Activity	Important Values	Example: Smoking
Medical	Freedom from medically defined disease and disability	Promotion of medical intervention to prevent or ameliorate ill-health	Patient compliance with preventive medical procedures	Aim: freedom from lung disease, heart disease and other smoking related disorders. Activity: Encourage people to seek early detection and treatment of smoking-related disorders.
Behaviour Change (lifestyle change)	Individual behaviour conducive to freedom from disease	Attitude and behaviour change to encourage adoption of 'healthier' lifestyle	Healthy lifestyle as defined by health promoter	Aim: behaviour changes from smoking to non-smoking. Activity: persuasive education to prevent non-smokers from starting and persuade smokers to stop.
Educational	Individuals with knowledge and understanding enabling well informed decisions to be made and acted upon.	Information about the cause and effects of health- demoting effects of health – demoting factors. Exploration of values and attitudes. Development of skills required for healthy living.	Individual right of free choice. Health promoter's responsibility to identify educational content.	Aim: clients will have understanding of the effects of smoking on health. They will make a decision whether or not to smoke and act on that decision. Activity: giving information to clients about the effects of smoking. Helping them to explore their own values and attitudes and come to a decision. Helping them to learn how to stop smoking if they want to.
Client centred (Empowerment)	Working with the clients on the clients' own terms.	Working with health issues, choices and actions which clients identify. Empowering the client.	Client as equal. Client's right to set agenda. Self-empowerment of client.	Aim: anti- smoking issue is only considered if clients identify it as a concern. Activity: clients identify what, if anything, they want to know about it.
Societal change (socio-environmental approach)	Physical and social environment which enables choices of healthier lifestyle	Political/social action to change physical/social environment	Right and need to make environment health-enhancing	Aim: make smoking socially unacceptable, so it is easier not to smoke than to smoke. Activity: no smoking policy in public places. Cigarette sales less accessible, especially to children, promotion of non-smoking as a social norm. Banning tobacco advertising and sports sponsorship.

Behaviour Change/Lifestyle Approach

According to Naidoo and Wills (2000), this approach aims to persuade individuals and groups to change their health behaviour and adopt a healthy lifestyle. It is based on a belief that giving people knowledge and skills to adopt a healthy lifestyle will improve their health. It commonly focuses on an individual or population level and uses strategies such as health education, social marketing, self-help, self-care and public policies to support a healthy lifestyle. Stop smoking campaigns' are mostly based on this approach

(<http://www.healthpromotion.act.gov.au/whatis/basics/approaches.htm>). This approach has been criticized for assuming that unhealthy behaviour such as smoking is a freely chosen individual behaviour, thereby ignoring other social determinants such as social class, ethnicity and income.

Empowerment Approach

Naidoo and Wills (2000) refer to this approach as the one that assists people in identifying their health concerns and in developing skills to act upon these. The health educator acts as a facilitator (Ewles & Simnett 1995). This approach focuses on self and community development (Naidoo & Wills, 2000; Ewles & Simnett 1995).

Empowerment includes enabling people to recognise their strengths, abilities and personal power (Mason et al. 1991, in Rodwel 1996, p307). This approach will parallel the social change approach and settings approach in that it also emphasises the significance and availability of environmental resources in order for people to achieve health (Jones & Meleis

1993, p. 8). These authors argue that the process of empowerment incorporates environmental as well as individual change, through sharing of resources and collaboration. This means that the environment should be supportive and the attitude of management to employee participation in health programs should be positive, in order to enhance the process of empowerment (Hagquist & Starrin 1997, p 230). Empowerment in health promotion interventions increases people's ability to identify their health needs and take control of their health. The empowerment approach requires that the health promoter adopt a role of a facilitator and resource person. This makes this approach also complement the behaviour change approach.

This is a more appropriate approach in workplace health promotion because it attempts to involve the important components of health promotion namely, individual behaviour, the environment and resources, and increasing people's abilities.

Settings Approach to Health Promotion

After the Ottawa conference on health promotion, the fourth international conference on health promotion was held in Jakarta, in 1997. This conference resulted in the Jakarta declaration on leading health promotion to the 21st century (WHO 1997). What was significant about this conference was that for the first time, the health promotion conference was held in a developing country and that it was the first to involve the private sector in supporting health promotion. One of the elements that came out of this conference was that particular settings offer practical opportunities for the implementation of comprehensive strategies. These settings included mega cities, islands, cities, municipalities, local communities, markets, schools, the workplace and health care facilities (WHO 1997).

The settings approach to health promotion is hence based on the Jakarta declaration. Settings approach to health promotion means “practising health promotion in settings where people live and work, including home, school, workplace, hospitals, sporting and social setting” (Cullen 2003, p. 1). According to the WHO (1986), the workplace is a very important setting in achieving health promotion and health for all. WHO (1988) further argued that there is an interaction between the individual’s health and his work. This makes the work environment the most important setting for health promotion. The working environment may influence the individual either positively or negatively and this will affect the individual’s productivity at work since his mental or physical well being depends on his state of health (WHO 1988). For this reason it is imperative that workplaces establish a health institutional policy as the basis of institutional health promotion (Wass 2000, p. 175).

Chu et al. (2000) depict workplace as one of the most important settings affecting the physical, mental, economic and social well being of workers and the health of their families, communities and society.

Furthermore, these authors believe that the workplace offers an ideal setting and infrastructure to support the promotion of health of a large audience. Huiskamp, King and Hattingh (2002) are in agreement with this argument and have also asserted that health promotion in the workplace is an integral part of the modern and contemporary management of the workplace and occupational health and safety. These authors further argue that the workplace is seen as an effective setting for health promotion because a great number of people can be reached and this

working population can be in turn be role models to their families and friends. Health promotion in the workplace is therefore effective for economical and population reasons.

Chu et al. (2000) firmly believe that the concept of a health promoting workplace is becoming more significant and more relevant in the contemporary workplace, as more private and public organizations recognise that the success in an increasingly globalised marketplace can be realised with a healthy, qualified and motivated workforce. The latest approaches to health promotion in the workplace increasingly address both individual risk factors and organizational and environmental issues (Chu et al. 2000). This approach is better than earlier approaches, which focused mostly on individual wellness programs and ignored the organization as an environment wherein individuals interacted, and also proves to be in line with the Ottawa Charter strategies.

The National steering committee for health promotion in the workplace (1998) have defined workplace health promotion as “those educational, organizational and economic activities that are designed to improve the health of workers and therefore the community at large. This type of health promotion involves workers and management participating on a voluntary basis in the implementation of jointly agreed concepts. This committee further argues that health-promoting programs in the workplace are distinct and separate from the responsibilities which employers have in the implementation of proper occupational health and safety measures in the workplace.

Cowley and Billings (1999) elucidated that effective health promotion means providing appropriate resources to facilitate activities designed to improve well being. He implies that a supportive management is required to enhance the health promotion program in the workplace. Chu et al. (2000) are in agreement this with argument but they are perturbed by the fact that workplace health promotion activities have been dominated by wellness programs which focus largely on an individual.

Such interventions, these authors argue, focused on such interventions as health screening, stress management courses, nutritional foodstuff in canteens, exercise and back care programs and health information seminars. These authors believe that workplace health promotion should be reoriented and be more holistic in approach, to address both individual risk factors and the broader organizational environmental issues. This attitude is in accord with the Ottawa charter for health promotion strategies, which put an emphasis on reorienting health services. This reorientation should also, however, incorporate building healthy public policies. Occupational health and safety programs need to focus on the enhancement of health promotion strategies within the organization, particularly those that require policy change.

According to Schmitz, in Sol and Wilson (1989) a comprehensive workplace health program consists of three levels, namely, (a) awareness which involves educational opportunities that prepare an individual to change behaviour, (b) behaviour change, which involves additional educational opportunities (c) supportive environments are linked to behaviour change, in that if the behaviour change occurs in a supportive environment, that change is most likely to occur and be maintained.

Based on the settings approach, the hospital as an institution can also be considered as a workplace. Maben and Macleod-Clark (1987) argued that the hospital has workers, patients and relatives and therefore can be a good setting for health promotion. Health professionals are expected to act as role models for their clients in all aspects, including health promotion activities. Pender (1987) has raised an argument that the responsibility that health personnel assume for the care of others, their knowledge of health, is often not applied to their personal lifestyles. Pender believes that health promotion in hospitals, aimed at health care providers, can improve the role modelling capabilities of health professionals. Hope, Keller & O'Connor (1998) view the nurse professional as a key player in promoting change at a personal level, as role model, as a health promoter and as a professional carer.

Literature reveals that little research has been conducted on the impact of wellness programs on behaviours and lifestyle of hospital employees or on their viability as healthy role models for the patient population. The findings of the study conducted by Prendergast (1992), cited in Hope, Keller, and O'Connor (1998), revealed that public health nurses had healthier lifestyles than their hospital based counterparts. Stress in the nursing profession is widespread, with the workplace as a major stress source for nurses. This can be linked to the work itself, the role of the nurses, career prospects and organizational structures and concern about HIV/AIDS (Dionne, Proulx & Pepin 1993). Pender (1987) recommended that the focus of health promotion in the hospital setting should be on nutrition, weight control, stress management and fitness.

The findings of a study conducted by Hope et al. (1998) on the lifestyle practices of hospital nurses and the impact of specific interventions in the hospital environment reported that greater numbers of qualified nurses reported experiencing stress on a regular basis than student nurses. The study was conducted across 3 different sectors, namely, industrial, educational and hospital sectors, aimed at designing, implementing and evaluating health promotion initiatives in the workplace, and involved qualified nurses and student nurses. Dines and Cribb (1997) have raised a concern that nurses' intervention in the hospitals focuses on the individual and curative care. They further asserted that there is a need for reorientation of the hospital nursing philosophy, as outlined in the Ottawa Charter, to become more health promoting and to involve the patients and their families in health care. Furthermore, there has been a suggestion that nurses need to be educated on healthy lifestyles to promote their own health and to promote their function as exemplars so as to avoid loss of credibility as health promoters (Perish et al. 1991, cited in King 1994; Maben & Macleod 1997).

Salutogenic Approach to Health Promotion

The Salutogenic approach to health promotion is based on Antonovsky (1987)'s salutogenesis model. It is opposed to pathogenesis which assumes that health is promoted by identifying and preventing determinants of disease (Cowley & Billings 1999, p. 996). The assumption in this theory is that life experiences produce generalized resistance resources for coping with stressors without undue harm (Cowley & Billings 1999, p. 996, Strumpfer & Mlonzi 2003:30). According to Strumpfer & Mlonzi (2003, p. 30), frequent availability of relevant resources result in an individual developing a strong sense of coherence (SOC). Levenstein (1994:26)

further asserts that SOC will strengthen an individual's ability to cope with stress more effectively, thereby remaining healthy.

Macdonald (2001, p.1) has extended this concept of salutogenesis beyond the psychological focus to the environmental. The focus is therefore on health enhancing in the context of people's lives, their physical, emotional, economic and cultural environment (Macdonald, McDermott, Woods, Brown & Sliwka 2000, p1). Salutogenesis is currently the new approach to health promotion and has been used to achieve clinical effectiveness and to assess interventions designed to promote health (Cowley & Billings 1999, p.994). Different authors have had different views on what salutogenesis is about. Macdonald et al (200, p.1) have equated the salutogenic approach to the health promotion approach, while others have described it as health creation or promotion of well-being (Cowley & Billings 1999, p.994; Royal College of Midwives (2002, p3).

Salutogenesis seeks to look into health and how to promote it. Salutogenesis can therefore be used by all those concerned with health promotion, as a tool to assess health promotion needs (Royal College of Midwives 2002 p.3). This assessment can help one understand how people manage their health, and what resources they use to promote their health.

HEALTH PROMOTION IN THE SOUTH AFRICAN CONTEXT

The South African Health Promotion draft policy (1994) is based on the Alma Ata Declaration (WHO 1978) and the Ottawa Charter (WHO 1986) on health promotion and it uses these documents as a framework. Within this policy, health promotion is understood to be concerned

with helping people gain and maintain good health through promoting a combination of educational and environmental supports, which will influence people's actions and living conditions. According to this policy, the aims of health promotion are, among other things, to develop the health promotion capacity amongst all health workers and to facilitate and encourage health promotion research to ensure policies are based upon sound scientific practice.

One of the priority areas for developing health promotion in South Africa (RSA 1994, p. 12) is research on health promotion. It is recommended that a national health promotion database needs to be established in conjunction with the provinces and updated at regular intervals. The main areas that were identified for health promotion research were (a) baseline research, (b) appropriate needs assessment, (c) research to determine the feasibility of the program (d) research for program development; and (e) formative and summative evaluation.

The importance of creating a health promotive environment is emphasized in this health promotion draft policy and the creation of health promotive environments. Developing health promotion policies, legislation and guidelines are identified among the strategies necessary. In the White Paper on Transformation of the Health Service (RSA1997), it is outlined that the areas of principal activity for an effective health promotion and common strategy are the development of public policies and legislation, community action, and skills development supportive environments. This activity is based on the Ottawa Charter Strategies.

According to this White Paper (1997), the aim of health promotion is to improve the health of South Africans through creating social, political, economic and physical environments, which help the public to make healthy choices. The focus is on the environments, which are the main determinants of health.

One of the objectives that the Government planned to pursue in the implementation of health promotion was to develop a skilled cadre of health promoters (RSA 1997). According to Coulson (2000), there are presently very few training opportunities for South Africans in health promotion. This also means that in the nursing institutions, health promotion is not amongst the priority topics.

Workplaces, and health services as workplaces, are not yet reoriented to provide a health-promoting environment for patients, staff and communities. The only health promoting projects that have been initiated have been outside the health sector, for example the health promoting school project (Coulson 2000). This is in line with findings of the workshops conducted on a situational analysis of occupational health services at the provincial, regional and district level in South Africa (Vergotine 2003). One of the findings in this workshop was that there is little or no service provision at Regional and district level (Vergotine 2003).

In section 12 of the OHS Act it is stated that every employer should identify the work related hazards and risks in the workplace and prevent the exposure of employees to such hazards or to minimize exposure (RSA 1993). This Act further suggests that occupational hygiene programs, biological monitoring and medical surveillance should be carried out to minimize work-associated risks. What is observable in this Act is that even though health promotion for the

employees is not spelt out, its components are clearly stated., The health of the employees, risk biological monitoring, and risk management are all identified as some of the characteristics of a health promoting workplace. In section 1 of this Act an employee is defined as “any person who is employed by or works for an employer and who receives or is entitled to receive any remuneration or who works under the direction or supervision of an employer or any person” (RSA 1993, p. 1). This implies that workers in all work settings are covered by this Act, irrespective of the type of employment.

According to the Ottawa Charter, the health services need to be reoriented so that they play a role in supporting people to adopt healthy lifestyles and to make their living environment more health promoting (WHO 1986). The WHO (1996), in the Ljubljana Charter, has asserted that hospitals play a central role in the health care system since they practise modern medicine, conduct research and education, and can therefore influence professional practice in other institutions and social groups.

The model of a health promoting hospital in the South African context as discussed by Promtussananon (2003) has shown some positive outcomes even though it is still in the early stages. The setting was in the Limpopo province and involved three hospitals as cases and two control cases. The project involved conducting workshops and staff training of staff on a health promotion hospital program. The outcomes of the project have been among other things, flower gardens, office decoration, body weight check up, vegetable garden, salad bar party, prayer service, counselling and group education. Unfortunately this project has not demonstrated other aspects of healthy workplaces, such as physical fitness and employee

assistance program. This project was focused only on the hospital as workplace, and it is not clear if any guidelines were developed from the outcomes of the project.

EVALUATION OF HEALTH PROMOTION INTERVENTIONS

There has been a notable increase in the evaluation of evidence based health promotion interventions. According to Macdonald (1996), cited in McMahon, Keller, Helly and Duffy (2002), this arises from the renewed focus on quality assurance as well as the need for policy makers to allocate resources based on effectiveness, need and evidence.

The evaluation of health promotion interventions can focus on the impact on the image of an organization, financial impact and impact on the quality of care (Kernaghan & Giloth 1988). WHO (1998) recommends their own principles in evaluating health promotion. These include participation by all involved, the use of multiple methods drawing different disciplines, enhancement of capacity of individuals, communities, organizations and governments and appropriateness, in that they accommodate the complex nature of health promoting interventions. Nutbeam (2002) believes that the success of health promotion can be measured by evaluating the outcome hierarchies which distinguish between (a) changes to health and social outcomes (long term), (b) changes to health determinants – behavioural, economic, environmental (medium term) and (c) health promotion impacts – changes to knowledge, motivation, capacity, social norms, public policy, organizational practice (short term).

CONCLUSION

From the reviewed literature it is evident that health promotion is a recent field of study, but it is impressive that a number of developments have been initiated. The most notable of these is the introduction of the settings approach to health promotion. Sadly in South Africa though, not much has been done to implement health promotion as one of the strategies to overcome the scourge of the multiple diseases with which the country is faced. The consequence is that there is not much literature or formulated policies on worksite based health promotion intervention, and hence their evaluation.

CHAPTER 3

METHODOLOGY

INTRODUCTION

This was a multiple case study, which consisted of multiphases, using a different methodology for each phase. The first phase of the study was exploratory in nature and the relevant concepts on the workplace health promotion were explored in different work settings. Phase two will focus on policy guidelines development, using a Delphi technique. The third and final phase will be the implementation of policy guidelines. These phases and the relevant methodology will be discussed in more detail.

PHASE 1: CURRENT SITUATION WITH REGARD TO HEALTH PROMOTION

Research Design

A case study design was chosen for this phase because, according to Yin (2003, p. 97), the case study design allows the investigator an opportunity to use many different sources of evidence. Case studies are used by researchers in order to explore in depth a program, an event, an activity, a process or one or more individuals, but families, groups, institutions and other social units may also be the focus (Creswell 2003, p.15; Polit & Hungler 1999, p.250). Yin (2003, p. 3) argues some researchers believe that case studies are appropriate only for the exploratory phase of an investigation but he maintains that case studies can also be utilized in the explanatory and causal inquiry.

Tellis (1997 (a), p.1) classified case studies into exploratory, explanatory and descriptive in nature. Case studies aim to answer specific research questions such as “what”, “why”, “who”,

“how” and “where” (Mariano, in Munhall & Oiler 2000, p. 311). Yin (2003, p. 6) suggests that exploratory case studies aim to answer the questions “what” and “how”, therefore, research questions that seem to answer the question “what” should be considered to be exploratory in nature. In the first phase of this study the main question was “*What* characteristics do work settings have which have influence on health promotion activities?” The first phase of this study was therefore an exploratory case study.

Case study research strategy, with multiple case study designs, was used in this phase. Multiple cases were identified so as to obtain data from different sources of evidence. Yin (2003) argues that using multiple sources of evidence strengthens case study findings, as findings become more convincing and accurate if based on several different sources of information. This phase involved exploration of the context. The existence of health promotion policies, health promotion programs and other related activities in the identified workplaces were explored. After data analysis in phase 1, the findings that emerged were used in the next phase of the study (phase 2), which is aimed at development of health promotion policy guidelines.

According to Burns and Grove (1995, p. 255) a case study is likely to use both qualitative and quantitative elements. Qualitative measures were therefore combined with the quantitative approach in the first phase. In addition to the qualitative methods used, quantitative methods were used to gather descriptive information about the characteristics of an organization and its health promotion activities. The researcher believed that using quantitative methods would result in qualitative findings being understood in a broader context, an argument supported by Polit and Hungler (1999, p. 266).

Case protocol

This section of the study outlines the case protocol which was used to guide the first phase of the study. According to Yin (2003), the case protocol has to include (a) an overview of the case study project, (b) project objectives, (c) data collection procedures, and (d) guide for the report (Yin 2003, p. 69, Yin 1994, p. 64).

The presence of the case study protocol is another way to increase the reliability of the case study and is a requirement in the multiple case study design (Yin 2003). This case study protocol was used to guide the study and is based on the first phase of the study. The protocol was designed as follows:

The first part of the protocol focused on the overview of this case study project, and research activities are briefly discussed in this section. The second part of the protocol focuses on the project objectives. In the third part of the protocol the researcher discusses data collection procedures and access to sites. The research question and the conceptual framework are also discussed in this part of the protocol.

An overview of the case study project

Unit of Analysis

The unit of analysis is a critical factor in the case study (Tellis 1997 (a), p.2). The case has to be defined in terms of the unit of analysis. A case in this study was a workplace or an organization, with all its embedded health promotion activities. There were multiple cases with several units of analysis, embedded in each case, namely staff profile, the characteristics of an

organization, health promotion activities offered by the organization, health promotion models, objectives of health promotion activities and stakeholders.

Sampling

Yin (1994 cited in Tellis 1997 (b)), argued that case studies do not need to have a minimum number of cases or to select cases randomly, but that researchers need to be called upon to work with the situation that presents itself in each case.

According to Feagin, Orum and Sjoberg (1991 cited in Tellis 1997 (a)) case studies are multi-perspectival analyses and require the researcher to consider not just the voice and perspective of actors but also of the relevant groups of actors and the interaction between them. These authors argue that this inclusion makes the case study method give voice to the powerless and voiceless.

In order to involve as many actors as possible and to acquire as much data as possible about the state of health promotion interventions in the organisations, the researcher utilized multiple sites and different participants within these sites. The involvement of multiple sites also ensured a larger, more diverse, and more representative sample. It has been argued that case study designs do allow such flexibility during data collection (Polit & Hungler 1999, p. 155).

Different sampling methods were used since the researcher had to sample the cases and also the participants. These sampling methods are discussed separately below.

Sampling of cases

Sampling of cases was done differently in each sector as the researcher could not find a sampling frame with all sectors listed. The researcher had planned to select all nine cases purposively, using “Kwa-Zulu Natal Top Business Portfolio” (Dhasia- Ventura 2004), as a sampling frame. This publication provides the portfolio of selected Kwa Zulu Natal Top businesses. Organizations are classified under different groupings such as public service, education, manufacturing, business, communications and information technology, hospitality and tourism, transport and, lastly construction and mining. The publication provides information on these organizations such as the nature of business (what kind of product is manufactured), number of employees, the year it was established, annual turnover and physical address. This type of sampling frame, it was anticipated, would make it easy for the researcher to select cases that were typical of the cases in question.

The selection of organizations was based on its size (the number of employees) and proximity to the researcher. The researcher used the size of an organization as one of the selection criteria because the size was identified as a significant attribute according to the propositional statements of the conceptual framework. The researcher required small, medium and large organizations under each classification. Some organizations identified through this sample frame were not keen to participate in this study. The researcher had to identify other organizations, which had similar attributes to the organizations that were initially identified, outside the sampling frame.

Stake (1995) asserted that cases that are selected should be easy and willing subjects. Stake's argument is based on the fact that a good instrumental case does not have to defend its typicality. In this study, the researcher was looking for specific cases with identified characteristics, and therefore cases were identified based on their typicality and willingness to participate.

The nine selected cases were also selected to represent three groupings, namely 1) the private sector, 2) the parastatals and 3) the health sector. Within these three groupings, the organizations had to be further divided according to their sizes that is, small, medium and large organizations. The reason for selecting cases with these characteristics was based on the propositional statements of the study, that is, the characteristics of an organization will have some influence on the health promotion programs. Also, as it was mentioned earlier on, the South African workplace is divided into the public and the private sectors. The health services fall under either public or private sector.

The only public sector organizations identified to participate in the study were those that fall under the health sector. These organizations unfortunately did not participate in the study owing to the delay related to study approval and other organizational logistics. Since the parastatal organizations are managed by both the Government and the private sector, the researcher felt that it would be ideal to include them in the study.

Private sector:

In the private sector, non- probability purposive sampling was used to sample cases. This sampling method involves conscious selection of by researcher of certain subjects or elements to include in the study (Burns & Grove 2001, p. 376). All three cases in this sector were sampled using the “KwaZulu Natal Top Business Portfolio” (Dhasia- Ventura 2004), as a sampling frame. The researcher ensured that the chosen organizations did not manufacture similar products in order to widen the range of the sample.

- **Case 1-** This was a manufacturing organization which had 1200 employees. Based on the definition of organizational size, this case was classified as a large organization.
- **Case 3 –**This was a food blending company which had a total of about 200 employees. It was therefore classified as a medium sized organization.
- **Case 3-** This was a heavy engineering company working with heavy iron materials. In total there were about 100 employees. It was therefore classified as a medium sized organization.

Parastatal:

In this category, the researcher realized that there were very few organizations that represented such parastatals. The researcher first used the researcher used “KwaZulu Natal Top Business Portfolio” (Dhasia- Ventura 2004), as a sampling frame but could only find one parastatal in this publication. This organization was purposively sampled based on its size and proximity to the researcher. Thereafter the researcher used snowball sampling, until there were two identified cases.

Eventually, the sampled cases comprised two large cases. The reason for this selection was that the organizations which were initially identified as a small and medium sized parastatals had branches in other provinces, with managerial staff and labour unions representatives being based in other provinces outside KwaZulu Natal. After discussions with the companies' management, the researcher was convinced that including such organizations with take long as they would not be easily accessible to the researcher.

- **Case 4-** This was a very heavy engineering, mechanical organization with about 1400 employees. It was classified as a large organization.
- **Case 5 –** This was an academic institution which had about 1400 employees. It was also classified as a large organization.

Health sector

Sampling in the health sector was conducted differently, as the names of hospitals did not appear in the KwaZulu Natal Top Business Portfolio, which was used as a sampling frame. Stratified random sampling was the method used. The researcher used a list of all hospitals in Kwa Zulu Natal, Ethekwini health district, taken from the hospital year book (Alex White Holdings 2005/6). These institutions were divided into Public sector, private sector and Public/Private sector strata. One hospital was randomly selected from each of these strata.

In this category, organizational classification was not according to the size of an organization but the inclusion criterion was the different sectors that these organizations belonged to, namely private, public or public/private sector classification.

- **Case 6** –This was a health care organization with about 480 employees. In this study it represented a medium sized organization in the private sector.

Sampling of respondents

To sample the *employees*, the researcher had initially identified stratified random sampling as a method to be used. The employee population in each organization was to be divided into different strata, based on different occupations. The aim of this method of sampling was to enhance representativeness of respondents at all levels (Polit & Hungler, 1999). The researcher aimed to divide employees into homogeneous groups, using different strata of occupations, and from these groupings respondents were to be selected randomly. Owing to the uniqueness of each organization, the groupings had to be altered slightly to suit each organization, but the researcher ensured representativeness of the sample. The method used for sampling is discussed under each case.

Management was sampled using theoretical sampling. The investigator started with a few eligible study participants (Polit & Hungler 1999, p.281), usually the risk managers or the human resources manager (whichever was applicable in the organization). The other managers were included as the investigator was referred to them or if she needed more information. This continued until there was saturation of data and no new information could be obtained.

To sample the *occupational health practitioners*, purposive sampling was the method of choice. This method was preferred because there are very few individuals in this category in each organization. The sample included occupational health practitioners and medical

practitioners where possible. These were identified because they were regarded as typical of the required participants (Seaman 1987, p.244).

For the *labour organizations*, participants were selected using convenience sampling. Shop stewards of different labour unions in each organization were identified through human resources or the organization’s contact person. The shop stewards on duty during that day were approached and if they were willing to participate they were interviewed. The researcher had to ensure that there was equal representation of each labour organization.

Sample size

The total number of participants in this phase was 258. The specific participants are outlined in table 3.1 below. Specific sampling methods are discussed under each relevant case.

Table 3.1: Summary of sample size

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Total
Employees	39	38	31	44	39	30	221
Managers	2	2	1	2	1	1	9
OHP	1	2	-	1	2	-	6
Labour unions	5	-	5	11	-	1	22
Total	47	42	37	58	42	32	258

Project objectives

The main objective to be achieved in this phase of the study was objective number one, namely, “to describe the current situation in the private and public organizations in terms of settings-based health promotion framework”.

Data Collection Procedures

Owing to the sample size of the participants, which ranged between 1 and 5, other than the employees, the researcher had to collect qualitative data from all participants, using the interview guide. There were three types of interview guides, namely, interview guide for 1) managers 2) labour organizations and 3) OHP. All instruments had an attachment where terms such as policy, health promotion, health promotion programs, health promoting workplace and safe physical environment, were defined.

Employee questionnaires were distributed to different organizations on different days.

Participants who were employees were asked to complete the questionnaires themselves. The employee questionnaires were available in both English and isiZulu. Two Zulu speaking people were asked to translate the questionnaire into isiZulu and the translated questionnaires were given to a third person to review the Zulu version of the questionnaires. The researcher then accepted the questionnaire which most reflected the original meaning of the questions, based on the reviewer's comments and also from the researcher's understanding as she also speaks isiZulu. Employees who required assistance with completion of the questionnaire were assisted by the researcher. The researcher had individual interviews with occupational health practitioners and managers. Individual interviews or focus groups were conducted with selected members of labour organizations, depending on the number of participants.

The whole data collection process was first discussed with management who would indicate when data could be collected. The data collection process therefore differed from one

organization to the other. For this reason, detailed data collection process is discussed under each specific case.

Data collection instruments

There were four different data collection instruments prepared for different participants (appendix 1).

The items in data collection instrument used for these participants differed because the assumption was that there would be information which was to be uniquely obtained from each of these groups. The instruments consisted of questionnaires developed for employees (instrument 1); different interview schedules specifically designed for labour unions (instrument 2), management (instrument 3), and occupational health practitioners (instrument 4).

Instrument 1

Instrument 1 was a questionnaire designed to collect quantitative data from employees. This was a 20 item instrument, which was divided into sections A and B. The instrument was designed using both the conceptual framework and research questions. **Section A** had 8 items (A1 to A8), focusing on the context, and specifically on staff profile. Items A1 to A6 were on staff profile (demographic data), that is, the age, gender, race (sometimes removed) level of education, level of employment, occupation (optional) and period of employment. Response to the question on occupation was made “optional” as some respondents were uncomfortable with responding to such questions for fear of being easily identified by management. Item A7 asked about health status (presence of chronic condition), as this was another factor which was

believed to have some influence on involvement in health promotion programs. Item A8 was based on the organizational characteristics, that is, respondent's membership in a medical aid scheme.

Section B focused on both the context and the process. This section consisted of both closed-ended and open-ended questions. The questions were asked and respondents were asked to explain their answers in some instances. Items B1 to B4 asked about organizational characteristics, such as existence of the health policy, health promotion programs and/activities and involvement of respondents in health promotion programs.

Items B5 and B6 obtained data about the process of health promotion programs, that is, program objectives and approach.

Item B6 had 7 items in which a Likert scale was used where respondents were asked to respond to statements on health promotion activities in the workplace, availability of infrastructure and the willingness of employees to get involved in such activities.

Instrument 2

All the interview guides were designed so that the first section of the interview obtained information on the context, that is, the characteristics of the organization and the second section of the interview explored health promotion programs and activities, policies and the process involved in executing these programs.

Instrument 2 was used to collect qualitative data from the trade union representatives. This instrument consisted of two sections A and B. In **section A**, items A1 to A8 obtained information on the focus group participants or the individual being interviewed. From the focus group the researcher only obtained information about the racial background of participants, their positions in the union, their health status and their membership of a medical aid scheme and also their involvement in a health promotion program.

In **section B** the instrument had 6 structured questions, items B1 to B6, which the researcher used to explore and to understand the health promotion context and process in the workplace. Participants were asked about organizational characteristics such as the existence of health promotion policies (B1) and programs (B2). In this part the researcher also explored the activities involved, the model used and whether these programs were targeted or comprehensive, the approach being used and the objectives of the program. Participants were also asked about their involvement in health promotion programs (B3). Participants were asked about the importance of the health promotion program to the unions and had to rate their response on the Likert scale (B4). The responses were to be explored further through probing. Question B6 wanted participants to talk about the health promotion approach and objectives used in the workplace. Participants were asked to identify statements which described their health promotion programs and these were discussed further with participants to determine the approach, model and objectives. The last question (B7) consisted of 7 statements similar to the ones in the Likert scale in instrument 1. Participants were asked to explain their responses through further discussion.

Instrument 3

Instrument 3 was used to collect qualitative data from the managers. **Section A** of this instrument had 4 items and obtained demographic data such as age, level of employment, occupation (optional) and period of employment in the organization. The options given were similar to the ones in instrument 1. **Section B** consisted of 13 structured questions. In section B the researcher explored the context and the process of health promotion programs in the workplace.

The managers were asked about the context using questions on the following topics:

B1: Is the workplace public or private?, B2: the size of the organization, B3: Risk level, B4: existence of health promotion policy, B5: health promotion programs or activities, B6, 8, 9: existing infrastructure in the form of management or organizational support, B7: company medical aid scheme, etc, B10: occupational health program coordination, B11: health promotion model used, B12: and health promotion program objectives and approach used. The last question (B13) was similar to the Likert scale in instrument 1, except for the last question B6.7 where managers were asked to respond to the statement “*It is my duty as an employer to put health promotion programs in place*”.

Instrument 4

This instrument was used to obtain qualitative data from occupational health practitioners through individual interviews. The instrument was divided into sections A and B. In **section A** Items A1 to A4 asked about demographic data of the participants. These were age, level of

employment, occupation (optional) and period of employment in the organization, respectively.

The options given as responses were also similar to those in instrument 1.

In **section B** the participant was asked about the context and the process of health promotion programs. There were 13 structured questions where the interviewer had to probe to obtain more information from the interviewee. Item B1 to item B7 required information on the organizational characteristics, such as the size of an organization, medical aid benefits for employees, whether occupational services were outsourced or part of the organization.

Participants were asked about their awareness of the existence of a health promotion policy and health promotion programs. Participants were asked further questions regarding the program, what it entailed and about the objectives of the program and its approach. Questions on organizational support were also asked to obtain information about the infrastructure.

In item B12 the interviewer asked again about the program activities, to determine the exact programs in place. The participant was asked to identify existing programs from the list provided. Participants could choose more than one program but had to describe the identified programs further. The last item, item B13 required participants to identify program objectives and the approach used, by choosing statements from a list provided.

Quality of instruments

The instruments were developed by the researcher and therefore required to be tested for validity and reliability.

Validity

For instrument quality, content validity was tested (Table 3.2). Content validity is concerned with the sampling adequacy of items for the construct that is being measured (Polit & Hungler 1999). Content validity ensures the representativeness of the questions being asked on the topic. This validity was ensured through instrument validity.

Reliability

The reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to be measuring, in terms of consistency and accuracy (Polit & Hungler 1999, p 411). Reliability of an instrument can be expressed as a form of correlation co-efficient with a 1.00 indicating perfect reliability and 0.00 indicating no reliability (Burns & Grove, 2001, p 396). These authors have further argued that for a newly developed instrument a reliability of 0.70 is considered acceptable. This argument was also supported by Terreblanche and Durkheim (1999), when they stated that any value between 0.70 and 0.75 is considered reliable or internally consistent.

To ensure reliability of an instrument in this study the researcher measured internal consistency of the instrument, using coefficient Alpha (Cronbach's alpha). The employee questionnaire was made up of 20 items, 8 of which addressed demographic variables. The 12 remaining items addressed employees' awareness of health promotion policies and programs in their workplace. These items comprised an alpha coefficient of 0.73.

Table 3.2: Content validity of the instrument

Theoretical Framework	Research question	Item in questionnaire	Instrument Number
Context			
Staff profile			
Age	1.1	A2	1
Gender	1.1	A1	1
Job type	1.1	A 4,5	1
Educational level	1.1	A3	1
Organizational characteristics			
Public/Private	1.1		3,4
Type Public/Private	1.1	B1	3,4
Size	1.1	B2	3,4
Risk level	1.1	B3	3
Medical aid benefit	1.1	A8	1
		A8	2
		B7	3
		B3,B4	4
Program coordination	1.1	B10	3
		B5	4
Health promotion activities/program	1.1	B2, B3, B4, B6.1, B6.4, B6.6	1
		B2,B5, B6.1, B6.4, B6.6	2
		B5, B11, B6.1, B6.4, B6.6	3
		B7,B12	4
Health promotion policies	1.1	B1, B6.3	1
		B1, B6.3	2
		B4, B6.3	3
		B6	4
Infrastructure (resources)	1.3.	B6.5	1
		B6.5	2
		B6,B8,B9, B6.5	3
		B12	4
Process			
Programs targeted/comprehensive	1.2	B2, B5	1
		B2, B6	2
		B5,B12,	3
		B7,B8,B11	4
Health promotion approach	1,2	B5	1
		B6	2
		B12	3
		B9, B10, B13	4
Health promotion model	1.2	B2	1
		B11	3
		B8	4
Program objectives	1.2	B13	4
		B5	1
		B6	2
		B12	3
		B9	4

Another measure used to ensure instrument reliability was the provision of definition of terms as an attachment to the questionnaires and interview guide so that all participants had a similar understanding of the concepts being explored. Concepts such as health promotion, safe physical environment, policy, health promotion programs and health promoting workplace were defined for all participants.

Data were collected across the full range of appropriate settings, at different times, from different respondents. This is another acceptable way of ensuring instrument reliability (Miles & Huberman 1994, p. 278).

Trustworthiness and credibility

For qualitative data interviews, the researcher used focus group methods and individual interviews. Both qualitative and quantitative data instruments had open-ended and semi-structured questions. This ensured trustworthiness and credibility of data obtained.

Quality of research design

Yin (2003, p. 34) suggested four tests that are relevant to establish the quality of empirical research, such as case studies. These are (a) construct validity (b) internal validity (c) external validity and (d) reliability. To enhance the quality of the research design and of the study as a whole, the researcher used these tests for both the study and the instruments (table 3.3).

Validity

Validity refers to the degree to which an instrument or the study measures what it is supposed to be measuring. To ensure the quality of the study, construct validity, internal validity and external validity were used.

Construct validity

Tellis (1997 (b)) has argued that case study is known as triangulated research strategy. As such, triangulation was largely used in this study to enhance its quality and validity. Construct validity was verified by using multiple sources of evidence. The multiple sources of evidence were ensured through **triangulation**, which refers to the use of multiple methods or perspectives to collect or interpret data (Polit & Hungler 1999, p 717). *Data triangulation* was ensured through the use of multiple cases from different sectors, and data was collected from participants at different levels of employment and categories within the organization. These different categories of participants were employers, managers, occupational health practitioners and labour unions. To ensure *triangulation of methods*, both qualitative and quantitative approaches were used during data collection. At the end of phase one, key informants were asked to review draft case study report (Yin, 2003, p 34). This was another way of ensuring the validity of data obtained.

Internal validity

Burns and Grove (2001) describe internal validity as “the extent to which the effects detected in the study are a true reflection of reality rather than the result of extraneous variables” (p 228). Two specific tactics that have been identified by Yin (2003,p 36) to achieve internal

validity of the case study are (a) pattern matching and (b) explanation building. Yin has indicated that that internal validity is a concern for causal or exploratory study but can also be relevant in descriptive case studies, as long as specific variables are defined prior to data collection (p. 116). Internal validity in this study was ensured through pattern matching, which was done through cross case analysis. Campbell (1975) cited in Tellis (1997 (b)) described pattern matching as a situation where several pieces of information from the same case may be related to some theoretical proposition.

Table 3.3: Quality of case study design and instruments (adapted from Yin, 2003: 34)

Case study		
Test	Case study tactic	Phase
Construct validity	<ul style="list-style-type: none"> • Use of multiple sources of evidence (Triangulation) • Key informants review draft case study 	Data collection
Internal validity	<ul style="list-style-type: none"> • Pattern matching 	Data analysis
External validity	<ul style="list-style-type: none"> • Use of replication logic 	Research design/data analysis
Reliability	<ul style="list-style-type: none"> • Use of case protocol 	Data collection
Data collection instruments		
Test	Instrument tactic	Phase
Content validity	<ul style="list-style-type: none"> • Aligning content to framework and objectives 	Instrument development
Construct validity	<ul style="list-style-type: none"> • Triangulation of methods 	Data collection
Reliability	<ul style="list-style-type: none"> • Internal consistency • Definition of terms • Triangulation 	Data collection

External validity

External validity of the case study means establishing the domain to which the study's findings can be generalized. Although it has been argued that qualitative studies, especially case studies, cannot be generalized, Yin (2003, p 37) has argued that case studies rely on analytical

generalization. According to Yin, analytical generalization does not mean trying to select a representative case or set of cases but means that an analyst should try to generalize the findings to theory. In this study one of the analytic strategies being used is pattern matching. This strategy has been described by Audet and d'Amboise (2001, p 13) as comparing and contrasting organizations that were predicted to be similar (literal replication) or different (theoretical replication).

Reliability

In their definition of the reliability of a study, Miles and Huberman (1994:278) outlined that reliability ensures that the process of the study is consistent, reasonably stable over time and across researchers and methods. Reliability of the case study seeks to demonstrate that the operation of a study can be repeated with same the results (Yin, 2003). In this study, reliability was achieved through the use of case study protocol during data collection. The objective was to ensure that if a later investigator followed the same procedures as described by an earlier investigator, and conducted the same case study all over again, the later investigator should arrive at the same findings and conclusions (Yin, 2003, p 35). The case study protocol guided the data collection process and the selection research questions asked. The whole procedure that was followed during data collection process was documented.

Guide for the Report

In discussing the results the researcher is guided by the theoretical framework and the research questions.

The first part of the framework to be discussed is the **context**. The context comprises data on 1) demographic characteristics and 2) stakeholders of an organization. The demographic characteristics of an organization present such information as the *staff profile* and *organizational characteristics*. *Staff profile* includes information such as *age* of employees, *gender*, *job type* and *level of education*. *Organizational characteristics* included data on the *size* of an organization, *type* of organization i.e. whether an organization is classified as public, private sector or parastatal, *risk level*, presence of *medical aid benefits*, and *occupational health program* coordination, existence of *health promotion policies and activities* and lastly the availability of *infrastructure*.

Information on demographic characteristics of an organization was obtained from all the participants with employees providing information on staff profile and managers and OHP providing information on organizational characteristics. All participants were asked questions relating to existence of health promotion activities and policies. Stakeholders had already been identified as management, employees, labour unions and OHP in an organization.

The **process** is discussed next and this part of the framework focuses on the different health promotion programs offered in each organization. This section is very descriptive and provides results on: whether the organization has any policy (ies) addressing employee wellness programs 2) Is there any health promotion/wellness program(s) in this organization. 3) How are these programs offered 4) What are the objectives of these program(s). 5) What approach and model are used to deliver the program(s). 6) If the organization does not have any health

promotion or wellness programs in place, what are other health promotion interventions are in place to address employee health issues.

These questions are answered through both qualitative data obtained from the OHP, management and trade union representatives, and quantitative data from employees.

Data Analysis

Data Analysis was also multiphase, and coupled with data collection. The data collection process occurred simultaneously with data analysis. As soon as data was obtained from the first case in phase one, data analysis commenced. Data from each case was analysed separately and the researcher moved to the next case until all data was analysed.

For the quantitative data, a computer based statistic software package (SPSS) was used to analyse data. All data was entered into this computer program and coded into different variables. Only descriptive statistics were used in analysis and presentation of this data. According to Antonius (2003) descriptive statistics aim at “describing a situation by summarizing information in a way that highlights the important numerical features of the data” (p 34). The analysed data was presented in frequency tables and graphs.

For qualitative data analysis, the researcher used the N Vivo computer package.

Interpretational analysis was used where the researcher found constructs, themes and patterns. Data was segmented to meaningful units. The segments were coded and sorted into categories.

Relationship among categories was then established. Cross case analysis for all findings was done and presented in matrices. Pattern matching was performed from the emerging data.

PHASE 2: DEVELOPMENT OF POLICY GUIDELINES

Research Design

In this phase, consensus method, using the Delphi technique, was used. The consensus method aims to determine the extent to which experts or lay people agree about a given issue (Jones & Hunter 1995, p.376). A Delphi technique as one of the three consensus methods has been chosen for this study. The Delphi technique involves questioning a panel of experts who are asked to complete a series of questionnaires focusing on their opinions and judgements concerning a particular topic (Jones & Hunter, 1995, p 378; Polit & Hungler 1999, p.208). This process continues until consensus is reached (Polit & Hungler 1999, p.700).

The Delphi method aims to obtain the most reliable consensus of opinion from a group of experts, or appropriately experienced individuals, without bringing the individuals together in a meeting (Rowe & Wright 1999, p. 353). Since the researcher was aiming to involve experts from various parts of the country and abroad, the Delphi technique was appropriate, as this method has been suggested as advantageous in situations where input is needed from more individuals than can effectively meet face-to face, over distance and time (Linstone & Turrof 1975)

The researcher used a computer-based Delphi technique. This method has been applauded as having more advantages than a paper and pencil based method. One advantage for using a

computer based Delphi technique is that whilst in the paper and pencil Delphi every contribution first goes to the coordinator of the exercise and then is integrated into a single summary provided to all participants, in a computer-based program this is not necessary (Turoff & Hiltz 1995, p. 61). Another advantage identified by these authors is that communication in computer based Delphi is faster and less costly, and participants who are geographically distanced can be included. The first round of Delphi was conducted over the period of one month, to allow participants enough time to respond. According to Murphy et al (1998) two or more rating rounds are likely to result in some convergence of individual judgements.

Sampling

Identification of participants

The researcher searched for experts in the field of health promotion/wellness, occupational health and policy development from different databases, sectors, academic institutions, and industries. A list of potential participants was developed based on the identified names, and participants were purposively selected. The criteria for involving the participants in the study were that they should be interested in and knowledgeable about the topic. Participants had to be involved in the identified fields, either in conducting research (must have published some work on the topic), teaching or being actively employed in that field at the time of the study.

Sample size

Fifteen participants from different backgrounds were identified to participate in the study. According to Rowe and Wright (1999, p.354), the sample size varies, and depends on the

research topic. Murphy et al (1998) suggested that in order to maximise areas of agreement, the group should be homogeneous, and to identify areas of uncertainty, a heterogeneous group is appropriate. In this group the participants will comprise individuals involved in promoting health in different settings.

Delphi Round 1

Data collection methods and instruments

Identified participants were contacted by e-mail. A covering letter explaining the objectives of the Delphi and conditions of participation was included in the e-mail. Participants were asked to respond and indicate their intentions to participate in the Delphi study or if they did not respond by given date the researcher would assume that they were not interested. In order to ensure that the identified participants received their e-mails, the e-mail message was set on automatic response such that a message was sent to the researcher once the recipient had opened and read the message. Identified participants were also given an option to sign a consent form and fax it back to the researcher if they could not e-mail back. Once the participant had responded and indicated an intention to participate, a formulated questionnaire was e-mailed with a covering letter, giving instructions and deadlines to the participants.

The data collection instrument (Instrument 5) was an questionnaire that was formulated based on a reactive Delphi approach, whereby respondents were asked to respond to previously prepared information that addressed topics of concern (appendix 1). The information was based on the results of the first phase of the study, the research questions and the conceptual framework.

The instrument comprised mixed questions with both closed ended and open ended questions. This type of questions would allow for open ended responses by experts (Burns & Grove 2005, p. 407). The questionnaire had five sections in which participants were requested to indicate their agreement or disagreement and to comment on the given statements. **Section 1** focused on health promotion policies in the workplace. Participants were asked to give their views on the idea of having health promotion policies in the workplace. In this section participants were also asked if they felt that the type and size of organizations were important in determining the contents of such a policy. In **Section 2** participants were asked to comment on issues relating to employee involvement and awareness of workplace health promotion programs and related policies. In **Section 3** participants were asked to provide their views on what needed to be included in health promotion policies and programs. **Section 4** requested participants' input on the view that health promotion programs should be designed based on the context, that is, employee characteristics and organizational characteristics. **Section 5** explored health promotion models and approaches that were recommended for workplace health promotion programs.

Data Analysis

As soon as the researcher received responses from participants, data was screened and data synthesis was performed. From the obtained data, the researcher searched for categories and patterns that emerged from all responses. A standard correlation analysis approach was used during analysis. By using this method, the researcher determined if there were subgroups or patterns of agreement or disagreement that existed across different issues or judgements made in the Delphi exercise. The researcher then determined if these patterns were common among

different professionals and different sectors. Data analysis was based on research questions and new categories that emerged were also included.

Delphi Round 2

Round two was the final round of the Delphi. Study results from phase 1 and Round one of the Delphi were utilized to develop policy guidelines. The aim in this round was to feedback to the participants, allow participants to validate results from round one, indicate their level of agreement or disagreement and rerank their initial scores. Participants were also expected to comment on and authenticate the developed policy guidelines.

Data collection methods and instrument

Participants in the first round of the Delphi were again contacted by e-mail. A covering letter explained the objectives of Round two of the Delphi and conditions of participation.

Participants were asked to indicate their intentions to participate in the Delphi study and informed that if they did not respond by the given date the researcher would assume that they were not interested. In this Round again, the e-mail message was set such that a message was sent to the researcher once the recipient had opened and read the message. Once the participant had responded and indicated an intention to participate, a formulated questionnaire was e-mailed with a covering letter giving instructions and deadlines to the participants.

The data collection instrument (instrument 6) comprised two sections, namely section A and B (appendix 1). **Section A** focused on the Round 1 Delphi findings. In this section participants were presented the summary of findings from Round 1. These findings were grouped under

themes such as (a) health promotion policy, (b) employee awareness of health promotion programs, (c) type of health promotion programs and (d) the context. Participants were requested to indicate their agreement or disagreement with the presented findings and re-rank their responses should they wish to do so.

Section B focused mainly on the developed guidelines. Participants were again asked to comment on the different sections of the guidelines, namely, (a) Choosing employee health promotion/wellness program, (b) key policy elements, (c) policy implementation plan, and (d) policy evaluation. Participants were again requested to indicate their agreement or disagreement with information given under these sections of the guidelines.

Credibility

Participants were from different settings and from different parts of the country, even from abroad. This would enhance the credibility of and widespread acceptance of the guidelines.

Data analysis

Obtained data was analysed for the degree of agreement or disagreement in participants' responses. Data was again summarised, identifying categories and the obtained findings were used to finalise the developed guidelines. Any major disagreements were resolved through consultation with the existing literature or concerned participants to reach consensus.

Research Ethics

Letters of consent were written to individuals requesting their participation in the Delphi study. In these letters participants were informed that their participation was voluntary and they could withdraw at any stage of the study. Participants were also informed that the information they gave to the researcher would be kept in confidentiality. Participants were assured that their identity would remain confidential. Participants were then asked either to sign consent forms if they agreed to participate in the study or to indicate their interest by responding to the researcher.

PHASE 3: IMPLEMENTATION OF POLICY GUIDELINES

During this phase, the researcher observed policy guidelines being implemented. Two cases, one a parastatal and one from the private sector were selected from the six cases for implementation of policy guidelines. Guidelines for use by managers in the development of health promotion policy were implemented in these organizations, with the researcher as an observer.

Owing to time constraints, the policy guidelines were implemented for two months and evaluation was carried out for short term outcomes.

Research Design

In this phase, the researcher conducted implementation analysis, which is part of evaluation research. Implementation research design aims at answering the questions “what is happening?”, “what is expected or desired?” and “what, if any, were the barriers to

implementing the program successfully?”, during the implementation of social programs (Polit & Hungler 1999, p 203; Werner 2004, p. 1). Polit and Hungler (1999, p. 203) argued that implementation analysis can be used primarily to describe a program so that it can be replicated by others. This method was therefore considered suitable for this study as the policy guidelines are aimed for use by any other organizations.

According to Polit and Hungler (1999, p.203), an implementation analysis typically involves an in-depth examination of the operation of the program, often involving both qualitative and quantitative data. The process of implementation will be observed and documented.

Participants

The population was all organizations that have participated in phase one of the study. The researcher purposively selected two organizations, cases 2 and 4 to participate in the implementation phase. The reason for purposively selecting these cases was to have different types of organizations and also different sizes to ensure reliability of the results. Also, the selected cases were willing to participate.

Participants in these two cases were also selected purposively. The criteria of involving these participants in the sample was that participants should have been involved in the initial phase of the study, and should be involved either as implementers or as recipients of the service.

Data Collection and Instrument

The guidelines were presented to management and there was a discussion on the implementation and the deadlines. It was also explained that the researcher would be there during policy development as an observer during the whole process and could provide necessary support where necessary.

The researcher used different data collection methods to gather all the necessary data. Bernard (1994) advocated involving an array of data collection methods including observation, natural conversations, checklists and unobtrusive methods. The study utilized loosely structured observational methods using the process of participant observation, natural conversation and checklists.

During the implementation period the researcher spent one day per week in the research site observing how the managers implemented the policy guidelines. All observed activities during the implementation of policy guidelines were documented using field notes (instrument 7) and checklist (instrument 8).

The researcher also used unstructured interviews with different participants in the organization to listen to the views of those under study, and copious field notes were taken. Participants included all relevant stakeholders. During the policy development process, the researcher also observed if the policy guidelines were adhered to. The research used an approach described by Polit and Hungler (1999, p. 368) as single positioning, whereby the researcher sat in management team meetings and listened to progress on policy development and listened to

input from all the stakeholders involved. The researcher's observations were guided by research questions. These research questions related to the following:

- **The process of policy development**
 - How were the policy guidelines implemented during policy development?
 - Which aspects were successfully implemented and which ones were not?
 - What are the support factors?
 - What are the barriers?
 - What are the short term outcomes?

- **The participants**
 - Who is involved and how were they identified?

The researcher used a check list to guide observations and made field notes during data collection. Both these instruments were developed based on the research questions and the outcome component of the conceptual framework. The first instrument, used for field notes, assisted the researcher in observing and collecting data on who was involved in policy development, the policy components, barriers and support factors. Researcher also used the back page of this instrument to note any other observations and informal conversations with participants.

The second instrument, a checklist guided the researcher in observing the managers' adherence to the guidelines flow chart during implementation and if the short term outcomes, namely (a)

health literacy (b) social action and (c) organizational practice were being addressed in policy development.

Data quality

To ensure data quality, the researcher used triangulation of data collection methods. The participants were given feedback on the recorded data so that they could give their input.

Data analysis

Data was analysed using descriptive data analysis methods. The editing style of data analysis was used whereby the researcher searched for meaningful segments (Crabtree & Miller 1992, p.21). The meaningful segments had to relate to the research questions. These segments were sorted and organised into categories. The researcher categorised data into patterns relating to the research questions and used direct quotations where applicable. Deductive analysis was followed during this process. This process involves analysing data according to an existing framework (Patton 2003, p. 375). Data was then organised under the research questions with relevant categories emanating from the analysed data.

Stake (1995, p.74) has advocated direct data interpretation in case study research, and this method was used in this phase. This process involves looking at a single instance and drawing meaning from it. The researcher established patterns and data from the two cases (cases 2 and 4) which were then displayed in matrices showing relationship and differences between the cases.

ETHICAL CONSIDERATIONS

Permission was sought with the University of Kwa Zulu-Natal's ethics committee to conduct the study. Permission letters were also sent to identified organizations. Permission was also sought with the Department of Health to conduct research in the health care organizations that were under the Department of Health (appendix 2). Letters of consent were written for individuals and organization representatives explaining the conditions of participation in the study.

These letters explained that participation was voluntary and they could withdraw at any stage of the study. Participants were also informed that the information they gave to the researcher would be kept in confidentiality and that refusal to participate in the study would not interfere with the employees' work in any way. Organizations were also assured that the identity of each organization would remain confidential. It was also explained to all organizations that at the end of the study, two organisations would be selected for implementation of the guidelines, and that participation in the second phase of study was also voluntary. Participants were then asked to sign consent forms if they agreed to participate in the study.

CONCLUSION

In this chapter the research methodology for all three phases of the study has been discussed. Phase one of the study utilized the case study method. The Delphi technique and the consensus method were used in the second phase, and implementation research in the third phase. The researcher also discussed how the quality of the research and instruments utilised was ensured.

CHAPTER 4

RESULTS, CROSS CASE ANALYSIS AND DISCUSSION (PHASE 1)

INTRODUCTION

In this section the results of case studies will be reported. Only 3 cases, cases 1, 4 and 6, will be discussed in detail. Each of the 3 cases is discussed individually, using the conceptual framework to guide the discussion. The results of all 6 cases are presented in cross case analysis, using matrices.

METHODOLOGY

The researcher had anticipated collecting data from nine (9) cases in the Durban and surrounding areas, but in the end, only six organizations ended up participating. The problem identified was the lack of communication between organisational structures which resulted in the researcher being sent back and forth. In some organizations, the researcher had to submit the research protocol more than two times as it was lost somewhere in the system. This delay resulted in a lot of discouragement on the part of the researcher as negotiating entry to some organisations took more than six months. The researcher had to abandon two research sites owing to poor response from management, and other organizations had to be approached.

Some organisations, though, responded very well to the research, and negotiations for entry only lasted for a few days, and data collection was very easily conducted. The researcher had also planned to have more than one **manager** participating in the study, but in most cases, only one manager participated in the study. The risk or human resource managers, who were generally the starting point for the researcher, often did not refer the researcher to any other

management staff, which she had not anticipated. Other managers were reportedly too busy to sit for interviews, rather than not willing to participate in the study.

For **trade union** representatives, focus groups were presented in some cases but in other cases individual interviews were conducted because there were only a few participants. In most cases there were not more than three (3) unions operating. This resulted in fewer than three trade union representatives per case.

Occupational health services were not offered in some cases and therefore OHPs could not participate. In cases where there were occupational health services, only one occupational health practitioner, the nurse, could participate. The feeling from the occupational health centre management was that since the doctors spent only a maximum of three hours in the organization, the occupational health nurses had more reliable information. Also, the doctors could not be interviewed between 7am and 10am when they were busy with patients and if they were to spend a few more minutes on site, to be interviewed, the organization had to pay for that extra time.

During the quantitative data collection process it was noted that some respondents were not comfortable with providing information of their "race". This question was therefore not asked in some cases. The only cases where respondents were asked to provide this information were in cases 2, 3 and 4.

RESULTS OF CASE 1: LARGE PRODUCTION COMPANY (PRIVATE SECTOR)

METHODOLOGY

Sampling

The researcher contacted the organization's reception desk to identify the risk manager or human resources manager, and to confirm the organization's address. A letter was sent to the human resources manager, requesting permission to conduct the study in the company. The human resources manager recommended that the suitable contact person in this case would be the occupational health manager. The occupational health **manager** agreed to be the first person to be interviewed. The occupational health manager also identified the human resources manager as another person who could be interviewed. There were two **occupational health practitioners**, with one employed full time and the other one employed part time. The researcher used purposive sampling to select the one who was employed full time as the suitable participant. The assumption in using this selection criterion was that since she had been with this organization longer, she would have more insight with regard to the organizational policies. The organization had a part-time occupational health doctor, who was on site between 7am and 10am. He could unfortunately not be interviewed, owing to the reasons indicated earlier on.

The human resources manager assisted the researcher to secure appointments with the **trade union** representatives (shop stewards). It was not possible for the researcher to meet with all union representatives at the same time as they worked shifts, including night shift. The human resources manager assisted the researcher by providing the names of shop stewards for

different labour organizations. Convenience sampling was used, as the researcher approached any shop steward who was available on the day to participate in the study. The researcher visited the organization on two separate days. Though there were three labour organizations in total, a total of five shop stewards participated in the study.

To sample **employees**, the researcher had planned to use stratified random sampling, but this was not feasible as the organization could not provide the researcher with confidential employee information such as company numbers. The researcher had to use convenience sampling, whereby employees availed themselves to complete questionnaires. The researcher visited the organisation on separate days and at different times and approached employees in different venues to ensure representativeness of the sample.

Data Collection Process

Appointments were made with different participants to conduct individual interviews. The researcher first explained the process, the participant then had to sign a consent form if he/ she agreed to participate. Structured questions from the interview guide were asked and responses were noted down by the interviewer. Participants were also asked to fill in other parts of the interview guide such as the personal details (excluding the name) in order to facilitate the process.

For quantitative data, questionnaires were left in the health centre for employees to complete whilst waiting to be seen by the OHP. Some questionnaires were distributed with assistance from the HR manager whereby questionnaires were left in different departments and

employees were approached during their tea time and lunch time to complete the questionnaires. A notice was also put up in the company's notice board for employees to participate in the study. Boxes labelled "completed questionnaires – health promotion research" and "consent forms – health promotion research" were left at all these points for the participants to drop their completed questionnaires and consent forms. The researcher collected completed questionnaires weekly over a period of three weeks.

CONTEXT

Case description

This case was a large production company with branches nationwide. The organization had a total of 7000 employees in the whole organization but the researcher had chosen the Durban site because of its accessibility. The Durban site had 1100 permanent employees in total; hence the company was classified as a large organization. The organization had a mixture of male and female employees, with male employees being in the majority. Only the permanent employees were included in the study as the contract workers were not permanently part of the company. Services that were outsourced, such as the security and cleaning, were not included in the study. The site had an occupational health centre, three labour unions and an occupational health manager who was responsible for the occupational health centre.

Staff Profile

The researcher had aimed for about 110 respondents (10%) but only 39 (3.5%) of the employees participated in the study.

Age

Of 39 respondents, the majority (31%) were between the ages 31 to 40 years of age. No respondents were below the age 20 years (Table 4.1).

Table 4.1: Age of the participants in case 1

Age of participants	Frequency	Percent (%)
20-30 years	9	23%
31-40 years	12	31%
41- 50 years	8	20%
Above 50 years	10	26%
Total	39	100%

Gender

Thirty two (82%) of the participants were males while only 7 (18%) were female.

Table 4.2: Gender of the participants in case 1

Gender of Participants	Frequency	Percent (%)
Male	32	82
Female	7	18
Total	39	100

Job types

Of 39 respondents, 23 (59%) were in non-management positions, while only 5 (9%) were in management positions. None of the respondents occupied senior management positions; while of 5 respondents who were in management positions, only 2 (5%) were in medium

management position. Ten respondents (26%) identified their levels as “other” but did not specify these levels. One respondent (3%) did not respond to this question (Table 4.3).

Table 4.3: Level of employment in case 1

Levels of employment	Frequency	Percent (%)
Medium management level	2	5%
Lower management level	3	8%
Non-management position	23	6%
Other	10	26%
Total	38	100%

Thirty two out of 39 respondents responded to the question on level of employment. Respondents categorized themselves under 19 types of occupations. The majority of respondents (15.6%) were laboratory analysts. The rest of the participants were evenly distributed amongst other occupations, ranging between 1 (3%) and 3 (9%) employees in each occupation (Table 4.4).

Table 4.4: Job types in case 1

Classification of Occupations	Frequency	Percent (%)
Technicians and associated professionals		
Technical Assistant	3	9.4
Laboratory analyst	5	15.6
Stock Prep. Technician	1	3.1
Production planner	1	3.1
Project buyer	1	3.1
Production Planner	1	3.1
Clerks		
Administrator	2	6.3
IT administrator	1	3.1
Project administrator	1	3.1
Payroll administrator	2	6.3
Time administrator	2	6.3
Craft and related trade workers		
Artisan	2	6.3
Rigger	1	3.1
Professionals		
Engineer Inspector	1	3.1
Project Engineer	1	3.1
Chemical Engineer	1	3.1
Others		
Machine operator (<i>Plant and machine operators and assemblers</i>)	2	6.3
General assist. / laborer (<i>Elementary</i>)	3	9.4
Line training	1	3.1
Total	32	100

Period of employment

Thirty eight respondents responded to this question. A majority of 20 respondents (53%) had been employed by this organization for more than 10 years. Other respondents had been employed for a period ranging between 3 (8%) and 9(24%) years (Table 4.5).

Table 4.5: Period of employment in case 1

Period of employment	Frequency	Percent (%)
less than 1 year	6	16%
1-5 years	9	24%
6-10 years	3	8%
more than 10 years	20	52%
Total	38	100%

Educational level

All respondents had received formal education, with 23 respondents (59%) having completed tertiary education. Six respondents (15%) had completed junior secondary education only. The other 10 respondents (26%) had completed senior secondary education (table 4.6).

Table 4.6: Highest level of education in case 1

Highest level of education	Frequency	Percent (%)
Junior secondary education	6	15%
Senior secondary education	10	26%
Tertiary education	23	59%
Total	39	100%

Organizational Characteristics

This section of the questionnaire was aimed at obtaining data on specific attributes of an organization. Respondents were asked about such attributes as the size of the organization,

based on the number of employees, organizational type, that is, if the organization was classified under private, parastatal or the public sector. The researcher also asked questions relating to the occupational health services, whether they were outsourced or part of the organization, employee medical aid benefits and health promotion programs. This information was obtained through both qualitative and quantitative methods. All four categories of respondents were asked questions relating to this section.

Organizational type

Both managers and the occupational health practitioner classified the organization as a private sector.

Organizational size

The managers were asked about the number of employees the organization had in order to determine the size of an organization. In this case both managers indicated that there were between 1000 and 1100 employees. The managers did not have the exact numbers because employees were resigning or dying which made it difficult to give the exact number.

Risk level and type

Both managers classified this case as a medium risk organization. The feeling was that since the employees worked with different chemicals and machinery, there were risks involved but compared to other companies such as engineering companies, this company was a high risk.

"We, as an organization do have risks that our employees are exposed to, but I cannot really say they are life threatening. I can say we are a medium risk organization".

"Yes our employees are exposed to some risk because they work with machinery, different equipments, electrical currency and humidity. This can however not be classified as high risk, I would rather call it medium risk".

Medical Aid benefit

All five **trade union** representatives who were interviewed were all members of a medical aid.

The **managers** indicated that the majority of employees in this case were medical aid members. The company provided medical aid to all full time employees but individuals could decide on a suitable one from an available list. The medical aid also provided for health promotion services, such as mammography and PAP smear. Employees who were not on medical aid had to be seen by the occupational health practitioner at the clinic for all primary care needs. These were mainly contract workers and workers who chose not to belong to any medical aid scheme.

"Yes our employees are covered by medical aid benefits. They have managed care option which provides for screening tests such as mammography, PAP smear and DEXA. They are also allowed to go for one medical per year".

"Employees who are not on medical aid are allowed to go for some primary care in the occupational health clinic".

From the **employee** quantitative data, out of 39 respondents, the majority, 33 (85%), indicated that they were members of a medical aid scheme, while only 6 (15%) were non- members.

All respondents who were non-members were asked to explain why they were not members. This question was asked in order to determine various reasons resulting in employees' not becoming members of company medical aid. Of the 6 respondents, 4 (67%) were not members of a medical aid scheme because they were not full time staff and therefore could not enjoy company benefits. The other remaining respondents gave reasons that "*it was too expensive*" and that they were "*not a medical aid scheme member yet*" which could mean that this respondent was still waiting for approval.

Health status

Respondents were asked if they were suffering from any chronic medical condition, and of 39 respondents 38 (97%) responded.. Out of 38 respondents 24 (63%) were not suffering for any chronic medical condition, while the remaining 14 (37%) were suffering from some form of chronic illness.

Occupational health program coordination

The occupational health services in this case were part of the organization. The organization had an occupational health centre and they employed various occupational health practitioners. The occupational health manager was operating in the whole group but the organization also had occupational medical practitioners (OMP) visiting the site regularly.

Health promotion policy existence

All respondents were asked about their awareness of health promotion policies in their workplace. There were different views on the existence of health promotion policies. Some respondents denied any knowledge of workplace health promotion policies in their workplace while others agreed that there were health promotion policies in existence. The respondents who had any knowledge of health promotion policies being in place had different, yet complementary views on what these health promotion policies entailed.

The analyzed qualitative data from the **trade union** representatives had the following categories describing on the existence of health promotion policies;

Online policy

For some shop stewards the health information that the organization displayed for their employees on the intranet was regarded as the company policy on health promotion:

"Yes we do have various health programs that the company has on the intranet, in that way the company is educating employees about health".

Policies for specific health programs

The majority of the interviewed shop stewards felt that the organization had a very good policy that dealt with HIV/AIDS for all the affected employees.

“I am aware of the HIV/AIDS policy that the company has. It helps employees who are infected with the HIV virus. Anyone who is employed by the company can go for testing and get treatment”

“Yes the company has introduced a policy on HIV/AIDS, and also another on Alcoholism and drugs. As employees we can make use of this service.”

Some shop stewards were aware of more than the HIV/AIDS policy, but also the policy which focused of employees with drug and/or alcohol abuse problem.

“I know that the company has a policy that allows employees who are alcoholics to go for rehabilitation. I am not sure how it works”.

Occupational health and safety act

The other view was that the OHS Act, which is the Government act, is another way that the company tries to reinforce promotion of employee health.

“The only policy I know of which looks after employee health in this company is the occupational health and safety act. This is to make sure that all employees are healthy”.

No awareness of policy

Some respondents were not aware of any existence of a policy focusing on health promotion in this workplace.

“No, I will be lying to you, I do not know of any such policy in this place. I am not aware, maybe it's there but I do not know it”.

Data from the **managers** demonstrated that the two managers had different yet complementary understanding on the existence of health promotion policies. The following were the categories that emanated from the analyzed data:

Occupational Health and safety Act

The managers felt that the policies they had in this organization were based on the OHS Act which provides for protection of employees:

“The health and safety of our employees is paramount. Health promotion is actively managed and reviewed in this organization. The policies we have are backed by this belief”.

When interviewed, the **occupational health practitioner** felt that the company had a whole range of health policies that focused on the employees' health. It could not be established though, whether these were written policies or just policies that existed. The following category emanated from this data.

Programs for specific health programs

There was a variety of policies in existence. There was a policy focusing on each specific program at a time. The organization did not have an umbrella health promotion policy but different policies focusing on different issues:

"Yes, we have a variety of policies in this organization. If I can mention some of them, they include OHS policy, HIV/AIDS policy, EAP policy, occupational health policy and environmental policy....These are in place to ensure that our employees stay healthy".

The **employees** were also asked about their awareness of the existence of this policy. From the quantitative data obtained from the employees, it emerged that the difference between the employees who were aware of the health promotion policy and those who were not aware of such policy was not very significant. Out of the 39 respondents, 23 (59%) were aware of the existing health promotion policy, while 16 (41%) were not aware of the existence of such a policy.

Only 13 (56%) of the 23 respondents who were aware of the policy responded to the next question where they had to explain what the policy entailed. The remaining 10 respondents (44%) could not explain the details of this health promotion policy. Eight out of 13 respondents (62%) explained that the policy was on HIV/AIDS awareness. Other policies, as mentioned by other respondents in the qualitative data were given, such as the policy on fitness program (31%) and the OHS policy (23%). (Table 4.7)

Table 4.7: Employees' explanation of health promotion policy in case 1

Explanation of the health policy	Frequency	Percent (%)
HIV/AIDS awareness program	4	31%
Health and safety policy	2	15%
HIV/AIDS awareness & fitness program	4	31%
Familiar with ART	1	8%
NOSA & OSH Act	1	8%
Annual medical check-up	1	8%
Total	13	100%

Health promotion programs (activities)

The **trade union** representatives were asked if they were aware of any health promotion programs in their workplace. This question was aimed at identifying any health promotion activities that might be taking place in this workplace. The participants were asked to explain these health promotion activities if they were aware of any. From this data four categories emerged:

HIV/AIDS related programs

It emerged that there was an HIV/AIDS awareness program which was aimed at raising employee awareness on HIV/AIDS related issues:

“We have an HIV/AIDS assistance program. It helps employees who are affected by the virus. People get tested and they can then get ARVs, but also they get counselling from the peer counsellors”.

“Yes, there is an HIV/AIDS awareness program. I am not sure how it really works, but I know it’s there and that people can go there if they want to know their status”.

Physical fitness program

There was a fitness gym which was designed for employees to go and use it during working times.

“I know there is a fitness gym in this workplace. I have never been there myself but I know it’s there. We can use it whenever we want to, any employee can go, so they say”.

“I have heard about the gym, I have seen it there at the clinic. But, hey I am always too tired to get there myself”

Rehabilitation program

Other respondents highlighted that there was a program aimed at employees with alcohol and drug abuse problems. The company provided rehabilitation program through an external organization. This rehabilitation program was for employees who wanted to stop drinking alcohol, or if the employee was having a problem in coping with his/her work due to alcohol and drugs.

“Yes, we have a program which sends people with drinking problem for rehabilitation. Also people with a drug problem can go for rehabilitation. The company helps them until they are better, but they are treated outside, not at this clinic”.

No health promotion programs

The other view was that there was no health promotion program at all. The available health programs were not health promotive in nature.

“Based on the way health promotion is defined here, I cannot think of any health promotion program in this place. We go to the clinic when we are ill, but health promotion, no”.

Data from **managers** revealed that there was a variety of health promotion programs that existed in this workplace. According to the managers the organization offered a range of health promotion activities which, when combined, formed an employee wellness program. The following categories emerged:

Disease preventive programs

The organization offers an annual medical examination and medical surveillance, for early identification of health problems, including lifestyle diseases:

“The company offers risk based medical surveillance for occupational health risks which is supported by active promotion of health. All our employees have to go for an annual medical exam, to determine any health problems that might have developed. Part of this medical examination is aimed at identifying lifestyle diseases which the employees might present with”.

EAP program

Employees are also offered employee assistance program (EAP), for employees with a range of other problems:

“We as a company do not only care for the physical illness of employees we also have an EAP program, and a social worker attends to employees with social problems, offering even counselling to them”.

Physical fitness program

There was a fitness gym which could be utilized by employees, within their workplace:

“....the company has invested on biokineticist and a fitness gym, it helps employees to keep fit and de-stress”.

The **occupational health practitioner** seemed to share similar views with both the managers and the labour unions on the existence of the health promotion programs. The following categories emerged from the analyzed data:

Disease preventive programs

According to the occupational health practitioner, the company conducts medical surveillance for early identification of illnesses, as part of a health promotion program:

“We conduct medical surveillance for all our employees. This is done as part of the early identification of diseases, including occupational health diseases”

HIV/AIDS related program

The HIV/AIDS program was also identified as one of the programs that the company has for its employees.

“One program that comes to mind is our HIV/AIDS program. The company is trying to ensure that employees stay healthy even after being diagnosed with HIV. We provide them with ARV, but they need to come for VCT, to be involved in the program...”

Health education program

The occupational health practitioner explained these health programs as the regular health education sessions that are directed towards employees. The topics range from purely health issues to occupational health and safety issues:

“Well, we conduct health education on a regular basis. Different topics are discussed ranging from health issues to safety issues. I can say it is part of health promotion”.

Quantitative data on the existing health promotion programs was also obtained from **employees**. This data yielded similar but somehow interesting results, as explained below. Employees were furthermore asked about their involvement in these health promotion activities. The analyzed data revealed that some health promotion activities were in place in this workplace.

When respondents were asked about their awareness of the existing health program, (51%) of 39 respondents said they were aware of the programs and the remaining 19 (49%) said they were not aware of any health promotion programs in this workplace.

The 20 respondents who indicated they were aware of health promotion programs, 14 (70%) responded to the question on description of the health promotion programs, while (30%) did

not. Of the 14 respondents, 5 (35%) described health promotion activities as those related to HIV/AIDS programs. Of these 5 respondents, 2 (14%) described these programs as a combination of HIV/AIDS, TB and Cholesterol programs. The other 3 respondents (21%) described health promotion activities as fitness programs (21%). For some respondents health promotion activities were the cholesterol program and the implementation of OHS Act (2%) respectively. The remaining respondents described these health promotion activities simply as personal protective equipment (PPE) that is supplied by the organization (1%) and education which is given at the clinic (1%).

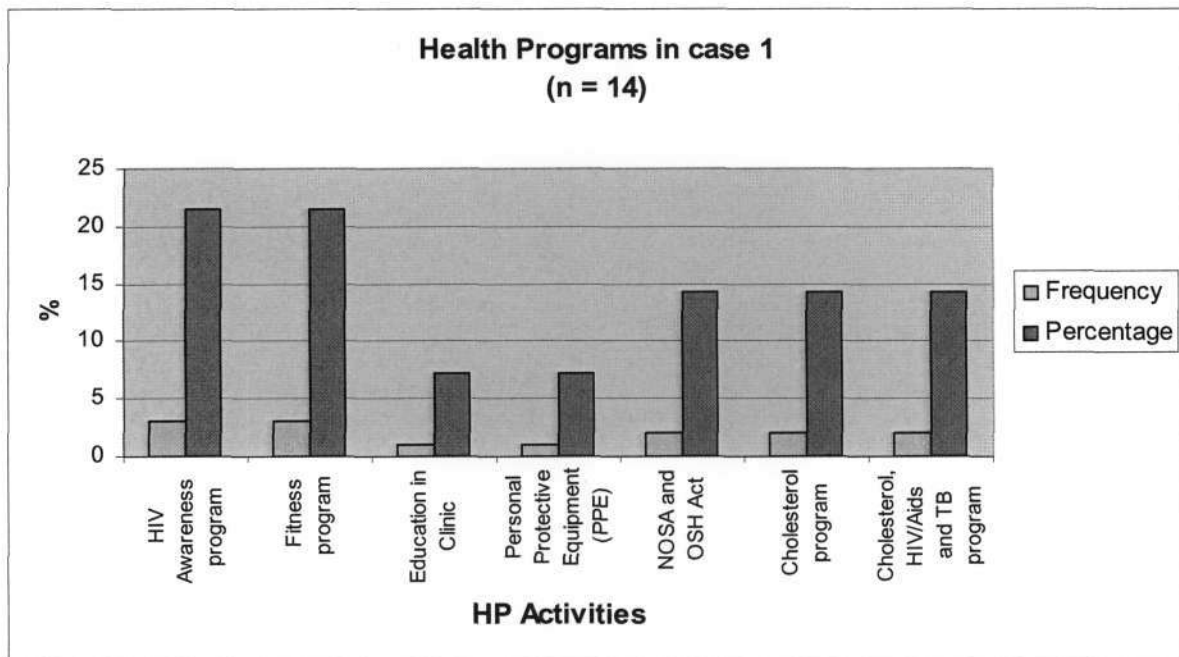


Figure 4.1: Health Promotion programs in case 1

To ensure that all respondents identified the existing health promotion programs which they might have left out in the previous questions, the researcher provided them with a list of possible health promotion programs, and were asked the question “*Do you have the following programs in this workplace?*”. The instruction was to choose more than one option.

All the five (100%) participating **trade union representatives** identified HIV/AIDS as an existing promotion program while only 2 (40%) respondents identified EAP. Majority of respondents, 4 (80%), knew about the physical fitness program while only 1 (20%) respondent identified nutrition and lifestyle management as one of the existing programs.

The data obtained from **managers** was slightly different from the one given by employees in that they added Women's health program, Weight control programs and chronic disease management but they did not identify stress management as one of the programs.

The **occupational health practitioner** also identified similar programs to those identified by management except for the women's health program, but she also did not identify stress management as one of the programs offered.

From the employees' quantitative data, 35 out of 39 respondents (90%) responded to this question. The majority of respondents, 26 (74%), identified HIV/AIDS as a health promotion program that existed in this workplace, 23 (66%) identified physical fitness, whereas only 14 respondents (40%), and 2 respondents (6%), identified stress management and EAP respectively. (Figure 4.2)

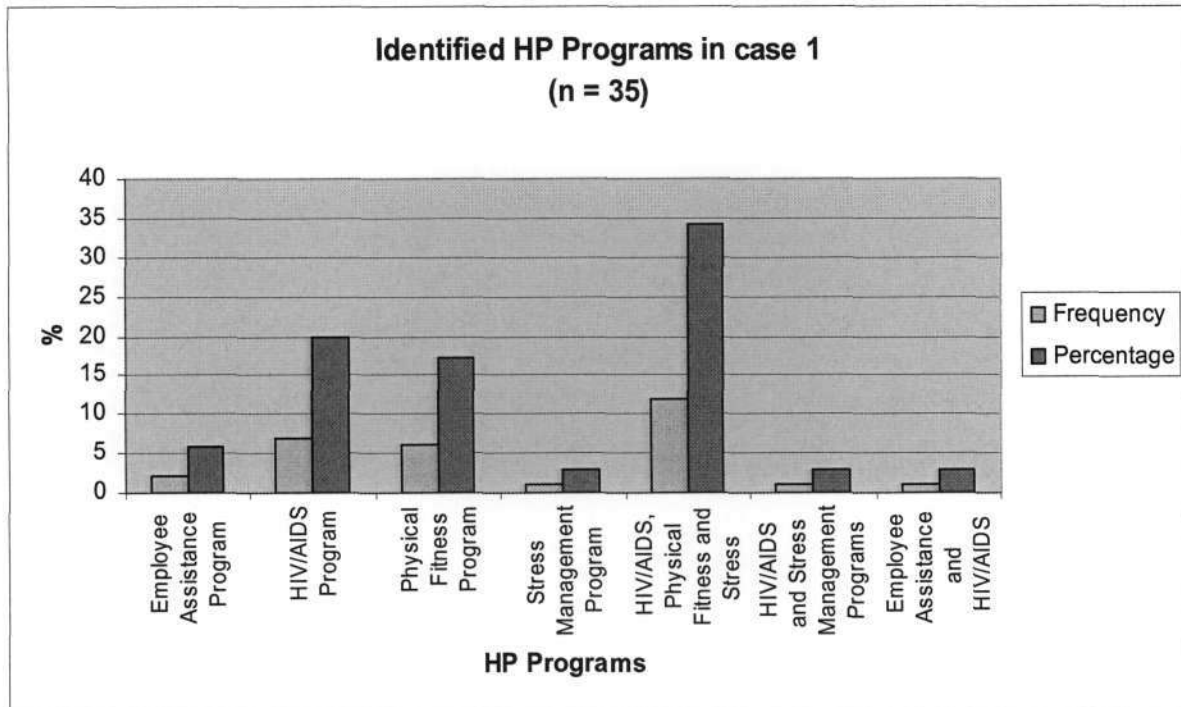


Figure 4.2: Identified health promotion programs in case 1

Involvement in health promotion programs

The trade union representatives and the employees were asked if they were involved in any of the health promotion programs. Analyzed qualitative data from the **trade union** representatives showed that of the five trade union representatives, only one responded that he was involved in health promotion programs, while four responded that they were not involved in any health promotion programs. The respondent who answered that he was involved in a health promotion program was asked to describe the program he was involved in. The answer was that he was involved with the HIV/AIDS program:

“As a shop steward I also get involved in peer counselling for HIV/AIDS. We assist in the counselling of our members who wish to become part of the program.”

When asked about the reasons for their non-participation in health promotion programs, trade union representatives responses ranged from “non-availability” of these programs to “lack of time”. Four categories emerged from this data:

Non-availability of programs

The respondents indicated that they were not involved in health promotion programs because such programs were not there and that if they were available they would maybe consider involving themselves:

“...the reason why I am not involving myself is because these programs are not there. I then see no need to participate. Maybe if it was something that we have, maybe I will be part of it, really.”

Lack of awareness

For some respondents the reason for their non involvement in health promotion programs was that they were not aware of such programs. They did not deny the existence of the program but they were just not aware of its existence:

“I am really not aware of any program of that kind in this place. I do not say we do not have it, it's just that I do not know about it, it might be there, you know”.

Lack of time

Some respondents were keen to get involved in health promotion programs but their problem was that they were too busy at work and did not have time to get involved in any other activities:

"I just wish I had enough time to get involved in any other activity here at work such as the gym, but I get so busy by the time I get free, it's time to go home."

"It's a good idea, I just do not have time; I wish I had time to do all these things. You have no idea how we get so busy here."

No need to participate

For some respondents, participation in health promotion programs was mostly for people who already had health problems. Participation was not viewed as a prevention of ill health but as prevention of complications:

"For now, I just feel that I am still very young, and do not have health problems. I do not see the need to participate for now, maybe later...ha ha ha."

From the analyzed **employees'** quantitative data, it emerged that out of the 39 respondents, only 3 (8%) responded they were involved in a health promotion program, while the remaining 36 respondents (92%), said they were not involved in any of the health promotion programs.

The three employees who were involved in health promotion programs indicated that they were involved in “*aids awareness program*” “*fitness program*” and “*first aid program*” respectively.

Also in the quantitative data from employees, respondents who said they were not involved in any health promotion activities were asked to explain they were not involved in these activities. Of 36 “no” respondents, only 22 (63%) responded to the question asking why they were not involved in health promotion programs while 14 (37%) did not respond to the question. Five respondents (23%) responded that they “*do not have time*”, while the other 5 respondents (23%) responded that they “*do not know or are unaware of these health promotion programs*”. Other reasons given for non-involvement in health promotion programs were that respondents “*do not have any health promotion programs in the workplace (9%)*, or they were “*working shifts and there is stress after that (5%)* or simply that they were “*not interested (14%)*”.

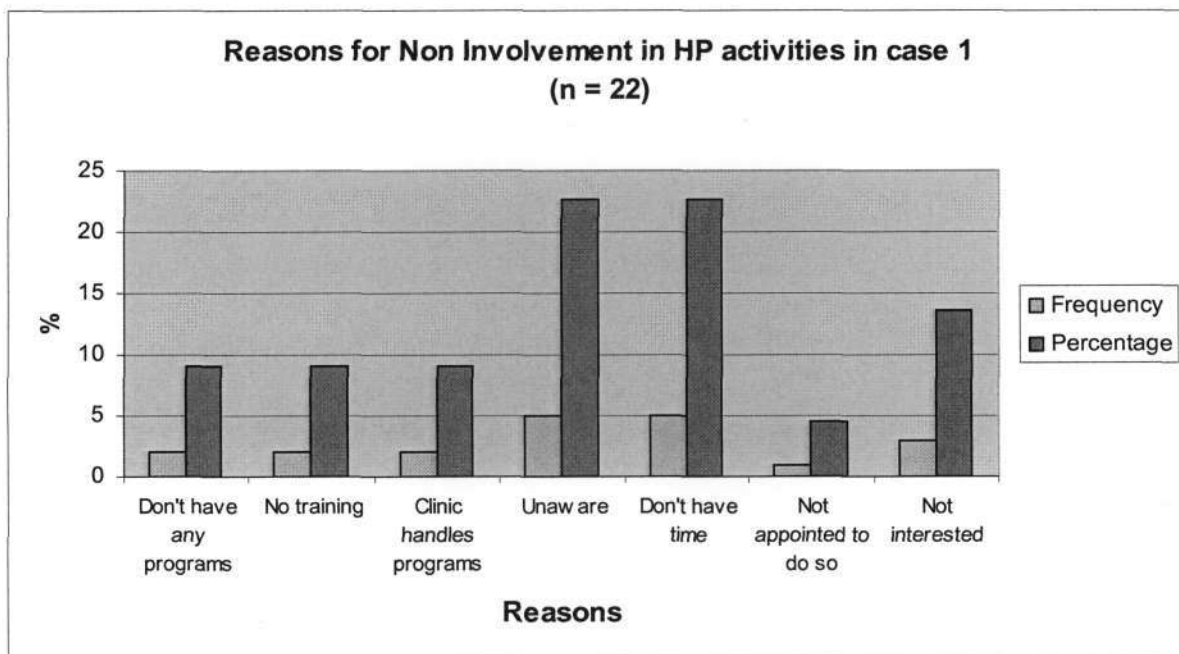


Figure 4.3: Reasons for non – involvement in HP activities in case 1

Importance of health promotion programs

Only the trade union representatives were asked to comment on how important they thought health promotion programs are, as a union. From this data it was apparent that all union representatives thought that health promotion programs were important. Four of 5 participating union representatives felt that health promotion programs were “*very important*”, while the fifth participant said that it was “*important*”. In explaining the reasons why they felt health promotion in the workplace was important, the trade union representatives gave various responses, but all in all they felt that such programs benefited both the employer and the employee. The following are some excerpts from them:

“Healthy members are valuable to his/her the union, as they are valuable to the company, the family and the community.”

“If we have this program, there will be control on dust, heat, and noise in this place and our members will be happy.”

“This program helps to encourage employees to look after their health and well being.”

“It will benefit the employee to stay healthy.”

“It prevents temporary and permanent disability, such as hearing loss. Dwindling health of employees is a concern for both employers and us as a union. Employees must be helped to stop abuse of alcohol and drugs and to prevent HIV and other diseases like Diabetes.”

Availability of Infrastructure

This question was asked for both the managers and employees. Infrastructure was asked about in terms of financial and human resource, but also in terms of building structures and organizational or management support.

Management answered that they provided all the necessary support to their employees in terms of health promotion and health related programs.

“The health and safety of our employees is paramount....management will provide adequate resources to promote their health. We offer subsidized meals in the canteen; we offer medical aid, which includes access to the Momentum Multiply program. To assist employees not on medical Aid, there is also some primary care in our occupational health clinics, which pays for VCT, ART, and these are all managed within the company clinics.”

Both managers “*agreed*” to the statements “*there are enough resources for health promotion programs*” and “*it is my duty as an employer to put health promotion programs in place*”. One manager “*strongly agreed*” to the statement health promotion activities are relevant for employees”, while the other one “*agreed*” to this statement.

From the **employees’** data, there were 37 out of 39 respondents (95%).From the data it emerged that 15 (41%) respondents “*agreed*” that resources were available while 10 respondents “*disagreed*”.

Table 4.8: Employees response to availability of health promotion program resources in case 1

Response	Frequency	Percent (%)
strongly disagree	1	3%
disagree	10	27%
undecided	9	24%
agree	15	41%
strongly agree	2	5%
Total	37	100%

Process

Program structure (Targeted/comprehensive)

According to the occupational health practitioner this organization had one comprehensive health promotion program.

“Our health promotion program is very comprehensive in that we have many health programs that ensure that our employees stay healthy. We do not target one problem at a time. We have a comprehensive wellness program which has components such as an exercise clinic, a diabetes and hypertension clinic, physical fitness and so on.”

Health promotion program approach

The respondents identified different approaches that the organization uses in their implementation of health programs. The qualitative data from the **trade union** representatives had the following categories emanating:

Disease prevention approach

Some trade union representatives believed that the organization used an approach whereby the focus was on keeping employees healthy so that they could be more productive:

“The company aims at bettering the health of their employees so that they can stay healthy.”

“The company wants to keep the workforce healthy, as you know that a healthy workforce is a productive workforce.”

Educational approach

For other trade union representatives, the approach was more educational in that the organization was educating employees in order to increase their disease awareness:

“The company is using an aids awareness program to give education, so that we, the employees, can be aware of this disease as it is a global problem. If we get education we will be aware.”

The managers also identified similar approaches to the trade union members and had one additional approach. The identified prevention approach was clearly at all three levels of prevention:

Disease prevention approach

The identified disease prevention approach included a lot of health programs which ensured that the onset of the disease is prevented and that the organization ensures that there is early detection of occupational illnesses through risk assessment and medical surveillance:

“We have an ongoing health risk assessment which is conducted by our hygienist; we also have direct observation and monitoring of employees with chronic disease. Our employees are also referred to a

psychologist where necessary. There is active case finding and management that we do during our medical surveillance."

"We conduct annual medical checkups to ensure that our employees stay healthy."

Educational approach

Employees are educated on different health issues to increase their awareness. This approach is also used to encourage behavioural change amongst employees.

"We hold regular meetings where employees get educated on a variety of issues such as humidity, medical aid issues, and so on."

"Employees get educated on issues relating to health including lifestyle."

Behavioural change approach

It also emerged that the organization is focusing on issues pertaining to lifestyle changes to maintain or promote a healthy lifestyle:

"Employees get educated on issues relating to health including lifestyle changes. There is an involvement of biokineticist in exercise therapy, since the organization has a fitness centre or the gym."

"Employees can make use of the gym; this helps them with weight loss, which is good for their health."

The **occupational health practitioner** also outlined that the organization used all levels of disease prevention as their approach and they also focused on behavioural change and creating healthy workplaces.

“Our approach is very comprehensive in that we run a wellness program for employees who are not ill, we have a clinic for employees with chronic illnesses, we also run a bio kinetic rehabilitation .We educate our employees on the importance of staying healthy which of course requires behaviour change. Through our health and safety programs we try and ensure that our employees stay healthy at all times.”

According to **employees** different approaches to health promotion programs are being used in this organization. Out of 39 respondents, 29(74%) responded to this question. The majority of 23 (79%) respondents said that the health promotion approach in this workplace was to educate employees on targeted issues. The other 14(48%) respondents said the approach was to change the behaviour of employees. Twelve (41%) respondents felt that the approach was to empower the employees while only 8 (28%) employees said the approach was to prevent the occurrence of occupational illnesses. Only 2 (7%) said the approach was to change the work environment and to cure occupational health illnesses, respectively (table 4.9).

Health promotion program model

There was no specific question that asked respondents about the model used to execute health promotion programs. The researcher was hoping that this information would emanate in the discussion of health programs, with all respondents. In this organization, the explanation of health promotion programs by different respondents showed that the organization aimed at

providing skills training to employees so that individuals could acquire specific behavioural change skills. There was no specific model in place but the respondent had the following to say:

“We educate our employees on the importance of staying healthy which of course requires behaviour change. Through our safety programs we try and ensure that our employees stay healthy at all times”.

Table 4.9: Employees’ views on approach to health interventions in case 1

Approach to health interventions	Frequency	Percent (%)
Educating employees on targeted health issues	4	14%
Prevention of occupational illnesses	2	7%
Empowering employees in the workplace	1	3%
Educating employees & curing occupational illnesses	1	3%
Preventing & curing occupational illnesses	1	3%
Educating, empowering and changing employees’ behaviours	10	36%
Educating and changing employees’ behaviours	4	14%
Educating and prevention of occupational illnesses	4	14%
Prevention of occupational illnesses & creation of healthy work environment	1	3%
Empower employees & healthy working environment	1	3%
Total	29	100%

Health promotion program objectives

This question was also answered through the question asking about the aims of the program.

This question addresses the approach and objectives of the program. According to the trade union representatives, there were two aims of the health promotion programs, namely, prevention of occupational health disease and increasing awareness on diseases such as HIV/AIDS.

“The company wants to keep the workforce healthy, as you know that a healthy workforce is a productive workforce.”

“The company is using the aids awareness program to give education, so that we, the employees can be aware of this disease as it is a global problem. If we get education we will be aware”

The managers also identified education and disease prevention as the aim that the organization has in providing their health programs. The managers felt that the organization needed to increase the employees’ awareness of diseases and further made sure that these were managed where possible.

The occupational health practitioner also identified educating employees on targeted health issues, and preventing occupational health illnesses, as the two objectives of the organizations’ health promotion program.

From the **employees’** quantitative data, 24 out of 39 respondents (62%) responded to this question. Twelve (50%) respondents identified the objectives of health promotion programs in

their workplace as aiming “to educate employees on health related issues”, 9 (37%) respondents identified the objectives of health promotion programs as aiming “to promote the health of employees/to prevent diseases”, the remaining 6 (25%) respondents identified the objective as “to promote a safe working environment.”

Employees’ views on their workplace health promotion program

All 39 (100%) respondents responded to the statement “*This workplace is a health promoting workplace.*” . The majority of 23 (59%) respondents *agreed* with the statement, while only 6 (16%) *disagreed*. On responding to the statement “*this workplace is a safe physical environment*” 22 (56%) *agreed* while only 6 (15%) *disagreed*, 5(13%) respondents were *undecided*.

Thirty six (92%) of 39 respondents responded to the statement “*policies focusing on health promotion are in place in this workplace*”. Of these 36 respondents, 16 (44%) *agreed* with this statement whereas 12 (33%) were *undecided*. Thirty seven respondents responded to the statement “*We need more health promotion programs in this workplace.*” 24 (65%) of these *agreed* with this statement, 10 (27%) *strongly agreed*, while 3 (8%) were *undecided*. Thirty six (92%) respondents responded to the statement “*health promotion activities are relevant for employees*”. Sixteen (41%) of these respondents *agreed* with this statement, while 8 (21%) *strongly agreed*, only 1(3%) respondent *strongly disagreed*. The last statement “*it is the duty of my employer to put health promotion programs in place*”, had a 100% response. All respondents agreed to this statement, with 24 (63%) responding that they *agreed* to the statement and 14 (37%) *strongly agreed* (Table 4.10).

Table 4.10: Employees' response to the statement regarding health promotion, safety, policies and need for health promotion programs in their workplace in case 1

Response	Frequency	Percent (%)
This workplace is a health promoting environment		
strongly disagree	4	10%
disagree	6	16%
undecided	4	10%
agree	23	59%
strongly agree	2	5%
Total	39	100%
This workplace is a safe physical environment		
Strongly disagree	3	8%
disagree	6	15%
undecided	5	13%
agree	22	56%
strongly agree	3	8%
Total	39	100%
Policies focusing on health promotion are in place in this workplace		
strongly disagree	1	3%
disagree	5	14%
undecided	12	33%
agree	16	44%
strongly agree	2	6%
Total	36	100%
We need more health promotion programs in this workplace		
undecided	3	8%
agree	24	65%
strongly agree	10	27%
Total	37	100%
Health promotion activities are relevant for employees		
strongly disagree	1	3%
disagree	6	17%
undecided	5	14%
agree	16	44%
strongly agree	8	22%
Total	36	100%
It is the duty of my employer to put health promotion programs in place		
agree	24	63%
strongly agree	14	37%
Total	38	100%

RESULTS OF CASE 4: LARGE ENGINEERING COMPANY (PARASTATAL)

METHODOLOGY

Sampling

The researcher contacted the organizations secretary to identify the human resource manager. A letter was sent to the centre manager to request permission to conduct the study, since the human resources manager was reporting to the business manager. The business manager was identified as the person who was to coordinate the process of this research project. After a few meetings with the business manager, the researcher was introduced to management and the research proposal was presented to them so that they could be familiar with what was to be done during data collection. The two union officials were also in the meeting and they promised to assist the researcher by conveying the message to their members.

The first person to be included in the **management** sample was the business manager, as he was the one responsible for the risk section. In order to obtain more information, the researcher also included the human resources manager.

There were two **labour unions** in this organization. The two trade union officials who were at the meeting were purposively selected to participate and they agreed to organize other union shop stewards, and coordinators, for the focus group interviews. Each trade union representative was asked to organize 6 to 10 representatives to participate in the focus group interview. These were selected randomly, using convenience sampling. If they were available, and interested in participating they were automatically included in the sample.

There was one **occupational health practitioner** on site and she was purposively selected. The visiting occupational medical practitioner was only on site between 7am and 9am. She would have to be paid for any additional time she spent on site. She was therefore excluded from the sample.

Owing to the organization's rules, the researcher could not have access to employee records for stratified random sampling, as initially planned. To sample **employees** the researcher had to use convenience sampling. The union representatives informed their members about the research that was to take place, they were asked to participate but were informed that participation was voluntary. Employees were given details about when data would be collected and the venues that would be utilized by the researcher. They then came to the data collection venue if they wanted to participate.

Data collection process

For collection of qualitative data, the researcher started with the **occupational health practitioner**. An appointment was made to meet with the occupational health practitioner at the clinic. After explaining the conditions of participation in the study, an interview was conducted using the interview guide. The interview lasted for about 45 minutes and all the information was recorded on a tape recorder and the researcher jotted additional notes on the interview guide that was used.

The two **managers** were the next to be interviewed. Managers were interviewed on separate days as the researcher had to make separate appointments with them. Each interview lasted for

about 45 minutes. The researcher interviewed the managers using an interview guide. All the information was recorded on a voice recorder and additional notes were taken during the interview.

The **trade union representatives** were interviewed on separate days. This organization had a union official on site, for each union. These union officials organized themselves and other union representatives for the focus group interview. The first focus group was held in the union offices on site. There were 6 participants, 3 white, 1 Indian and 2 African participants. The researcher started by explaining the conditions of participation in the study, to which they all agreed, and signed consent forms. The researcher started the interview which lasted for about 1 hour 15 minutes. Questions were guided by the prepared interview guide and responses were recorded on a voice recorder and the interviewer also took notes.

The second focus group interview with other union representatives followed a week later. The data collection procedure was similar to that of the first focus group except that the interview was conducted outside the workplace, as the union shop stewards and other representatives were having a meeting in town, which is where the interview was conducted.

Quantitative data from employees was collected over a period of two weeks. All employees in this organization, except for upper level management, were members of either of the two unions. Each union organized a separate day for data collection from their members. The researcher was offered a room with chairs and tables in the plant and employees who wanted to come and participate in the study were released by their supervisors. Not more than 10

respondents were allowed in the room at a time, so that the researcher could monitor the completion of questionnaires. For each group of respondents the researcher started by explaining the conditions of research. The researcher offered those who were interested pens to sign consent forms and to start completing questionnaires. The researcher had to assist some respondents who could not complete their questionnaires because of illiteracy. Respondents were given a choice of isiZulu or English questionnaires. The process went on until there were no more employees who were willing to participate.

Context

Case description

Case 4 was a large Durban-based engineering company, which specialized in heavy machinery. The organization also had branches in other provinces either than Kwa Zulu Natal. This organization was classified as a large organization as it had more than 1000 employees in its Durban branch only. The Durban site was the only site included in the study due to its accessibility to the researcher. This site had a mixture of male and female employees with male employees being in the majority. The organization employed permanent full time employees, and contract full time employees. There were also students who were employed for their learnerships and practical work. Only full time permanent employees were involved in the study because the other employees, such as contract workers, not directly employed by the organization under study.

Staff Profile

The researcher had aimed for a sample of 110 respondents but ended up with 44 (40%) respondents.

Age

Of 44 respondents, the majority of 20 (45%) respondents were between the ages 20 and 30 years, while only 3 (7%) respondents were above 50 years of age (figure 4.4)

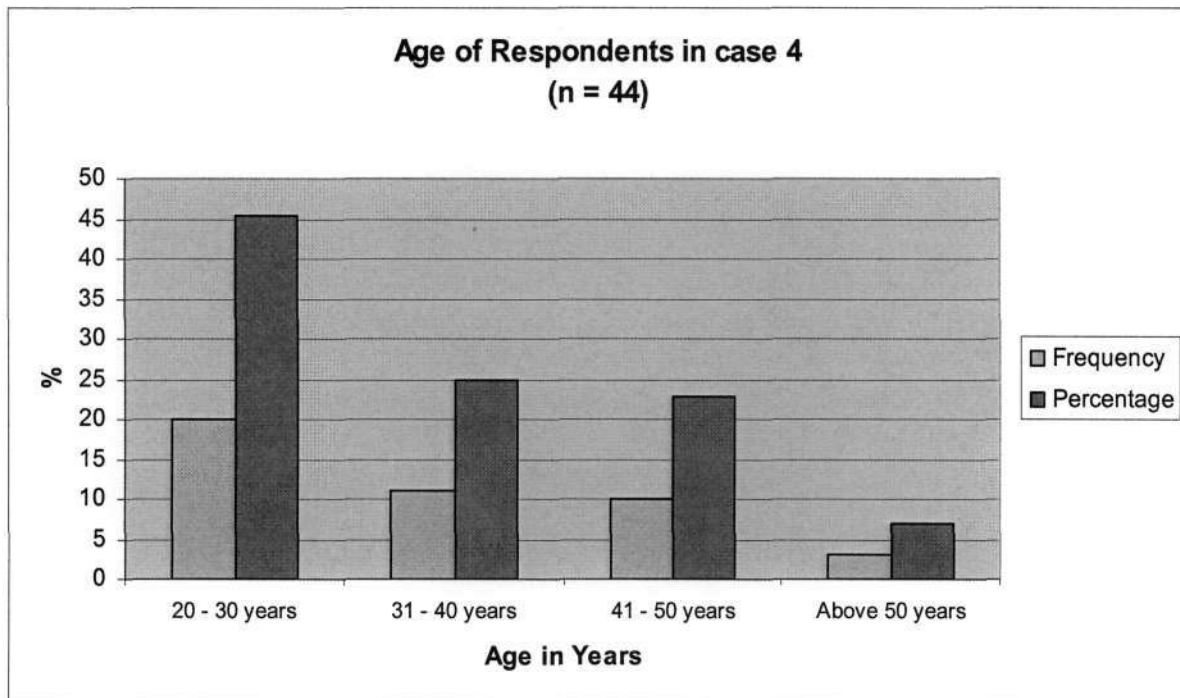


Figure 4.4: Age of respondents in case 4

Gender

Thirty seven of the 44 respondents (84%) were female, while only 7 (16%) were male.

Race

Forty one of the 44 respondents (93%) responded to this question. Of the 41 respondents, the majority, 30 (74%) were African, while only 1 (2%) was coloured. The remainder of the participants were of White or Asian origin, 12% respectively (table 4.11).

Table 4.11: Race of participants in case 4

Race of respondents	Frequency	Percent (%)
Coloured	1	2%
African	30	74%
Whites	5	12%
Asian	5	12%
Total	41	100%

Job types

Forty two (96%) respondents responded to this question. Of these 42 respondents, 20 (48%) were in non-management positions, while only 8 (19%) were in management positions. The remaining 14 (33%) respondents indicated their level of employment as “other” but did not explain these levels of employment (table 4.12).

Only 29 of the 44 respondents (65%) responded to the question on occupations. Occupations were categorized into “Elementary”, “Technicians & associated professionals”, “Craft & related trade workers”, “Legislators, senior officials and managers” and “others”. The category

of elementary employees in this organization comprised general assistants, technicians and associated professionals were technicians and electricians, while craft & related trade workers comprised artisans, fitters, turners, trade hands and grinders. Fifteen (52%) respondents were in the category of craft and related trade workers, while six respondents (21%) were in management positions. One respondent (3%) was classified as “other” as this respondent did not clearly state his/her occupation, but just wrote “coordinator” (table 4.12).

Table 4.12: Job types in case 4

Job Types		Frequency	Percent (%)
Level of employment	Medium management level	1	2%
	Lower management level	7	17%
	Non-management position	20	48%
	Other	14	33%
Total		42	
Occupations	Elementary	3	10%
	Technicians & associated professionals	4	14%
	Craft & related trade workers	15	52%
	Legislators, senior officials and managers	6	21%
	Others	1	3%
	Total	29	100%

Job status

A total of 23 out of 44 respondents (52%) responded to this question. Of the 23 respondents, 20 (87%) were employed permanently while the remaining 3 (13%) were employed as contract workers.

Period of employment

All 44 respondents responded to this question. Fifty percent of the respondents (22) had been employed in this organization for a period between 1 and 5 years. Fifteen (34%) had been employed for more than 10 years in this organization. Only 1 (2%) respondent had been employed for less than a year, while 6 (14%) had been employed for a period between 6 and 10 years.

Educational level

All 44 respondents responded to this question. Analyzed data revealed that 17 (39%) of respondents had attained senior secondary education while only 2 (4%) had no formal education. Fourteen (32%) respondents had completed tertiary education (table 4.13).

Table 4.13: Highest level of education in case 4

Level of education	Frequency	Percent (%)
no formal education	2	4%
Primary education	7	16%
Junior secondary education	4	9%
Senior secondary education	17	39%
Tertiary education	14	32%
Total	44	100%

Organizational Characteristics

All four categories of respondents were asked questions relating to this section.

Organizational type

Both managers and the occupational health practitioner classified the organization as a parastatal because it was owned by the government but also had private stakeholders.

Organizational size

In this case both managers indicated that there were between 1000 and 1100 employees.

Risk level and type

Both managers classified this case as a high risk organization. The reason for classifying this organization as a high risk one was because it is an engineering company and this, according to these managers, resulted in employees being involved in various work related risks.

“It is a high risk environment, because it is an engineering company. People have to lift machines (ergonomics) causing back problems, welding causes occupational disease due to dust, chest or lung problems are caused by chemicals and we use a lot of paint” (M1).

“It is a high risk organization –health related risks because it is an engineering company. We have quite a number of risks in this organization because some of them drive hysters and it can cause fatalities. There are chemicals being used, people can sustain back injuries because they do a lot of lifting” (M2)

Medical Aid benefit

In total only two **trade union** representatives (one from each focus group) were not members of medical aid. The other 8 participants were members of the company medical aid. The reasons for not being members were given as the system was not working for them.

“Because I was paying too much money, R500, but when I go to the doctor, I am told I have no money, and my medical aid ran out easily” (FG 1).

“The problem is that the medical aid offered by the company is not accepted in the clinics we use. I end up having a problem not getting medication in the pharmacies too. I am now using my wife’s medical Aid” (FG 2).

Other participants indicated that the majority of employees were on medical scheme of their choice. The company offered a wide range of medical aid schemes where employees could select one which was suitable for them.

“There are different types of plans within the organization. It’s your choice which one you want to belong to, maybe his was a different one but almost everyone is a member” (FG 1).

“It depends on which plan you are because with some plans, you can see the doctor as much as you want but others are not like that” (FG 1).

Both **managers** indicated that employees in this case had to choose a plan of medical aid that suited them best. There was a list available from which they could choose one scheme. The

Company provided medical aid to all full time employees. Employees who were not on medical aid were attended to at the PHC clinic. Health promotion was not covered by medical aid.

“We do have medical aid covering most of the diseases but not on health promotion issues. We have Lifestyle management program whereby the company pays for HIV related expenses. Primary health care related issues are seen by our occupational health sister or the doctor at the clinic” (M1).

From the **employee** quantitative data, 43 out of 44 respondents (98%) responded to this question. 43 respondents, 23 (54%) were members of a medical aid scheme while the remaining 20 (46%) respondents were non-members. All 20 (100%) respondents who were not members of a medical aid scheme responded to the question on the reason for not being members. Twelve (60%) respondents indicated that they were not members because they were not permanently employed in this organization. The remaining 8 (40%) gave varying reasons for their non membership. These reasons included “it is too expensive (15%) and “I am still going to join.”

Table 4.14: Reasons for non membership to medical aid scheme

Reasons for non-membership	Frequency	Percent (%)
It is too expensive to contribute	3	15%
I don't know about medical aid benefit	1	5%
Not on permanent staff	12	60%
Belong to Private Medical Aid	1	5%
Still going to join medical aid	2	10%
Don't need Medical Aid	1	5%
Total	20	100%

Health Status

All 44 respondents (100%) responded to this question. Of 44 respondents, 32 (73%) did not suffer from any chronic illness, while the remaining 12 (27%) suffered from some form of chronic illness.

Occupational health program coordination

The occupational health services in this case were part of the organization. There were two occupational health nurses who were employed by the organization and were based in the occupational health centre. The occupational medical practitioner was employed on a locum basis and visited the occupational health centre Monday to Friday between 7am and 9am.

Health promotion policy existence

There were differing views on the existence of health promotion policies. The view held by management and occupational health practitioner differed from the views of labour unions and their members (the employees). All participants agreed that the organization had a policy on HIV/AIDS.

Qualitative data from the trade union representatives showed that the policy was there but a bit fragmented. The following categories emerged from this data:

Policies for specific health programs

Some participants indicated that the policy was there but focused mostly on HIV/AIDS related issues:

"There is something that deals with HIV or AIDS but I am not sure how exactly it operates" (FG 1).

"Yaaa ...People are always told that they need to go and test for HIV, so yes it's there" (FG1).

Occupational health and safety act

For other participants the existing health promotion policy was guided by the OHS Act. It was not a stand alone policy:

"We are guided by the OHSACT –which is a policy in itself. Apart from that, we have an HIV policy" (FG 2)

No awareness of policy

Other participants were not aware of any existing policy on health promotion in this workplace:

"I do not think all of us are aware of that policy. They come and give awareness on HIV every now and then, but they do not really discuss the policy as such" (FG 1).

"I do not know of any policy in this work of mine. I suppose a policy should be known by everyone in a particular workplace. I personally have never heard of any such policy or even seen it" (FG 2).

Qualitative data from the **managers** showed that a health promotion policy was in place.

According to the managers the organization had a very clear policy which was based on the existing Governments OHS Act. This policy addresses all wellness issues, but specifically HIV/AIDS related issues.

"The Occupational health and safety policy that has been developed by the company is based on the OHS act. We need to provide a safe environment for the employees. We have audits with regard to safety issues" (M 1).

"Yes, we have a wellness policy which addresses HIV/AIDS. There is a document which is used for induction which covers health related issues. There is also EAP which addresses social problems, alcohol abuse, stress and depression" (M2).

From the **occupational health practitioner's** data it emerged that this organization had a policy on HIV/AIDS and also a policy on rehabilitation. The rehabilitation policy was for employees who abuse alcohol and/or drugs.

"Yes there are policies. One is for HIV and the other is for rehabilitation. They are mostly run by HR. With the rehabilitation policy, if a person is an alcoholic they are referred through EAP. From here, they are then referred to the centres where they are detoxified and rehabilitated. This is initially done with the employee paying for all the expenses. After 6 months this is paid back if the employee abstains from taking alcohol. The employee gets back his leave days and money spent on the program. EAP falls under this company."

From the employees quantitative data all 44 respondents (100%) responded to this question. Twenty four (55%) of these 44 respondents were aware of a health promotion policy in this workplace while 20 (45%) were not aware of such a policy. Twenty one of the 24 respondents responded to the question on explaining the policy. In explaining the policy, 11 (53%) respondents explained it as an HIV/AIDS awareness program, 5 (24%) explained it as an

occupational health and safety policy. Other respondents gave explanation such as First aid policy and annual medical check up (9%), respectively (table 4.15).

Table 4.15: Explanation of policy in case 4

Explanation of policy	Frequency	Percent (%)
First aid policy	2	9%
HIV/AIDS awareness program	11	53%
Back training / fitness training	1	5%
Health and safety policy (OHS act)	5	24%
Annual / general medical check-up	2	9%
Total	21	100%

Health promotion programs (activities)

From the qualitative data of the **trade union** representatives it emerged that there were health promotion programs in this workplace, but they lacked coordination. Two categories emerged from this data.

Targeted once off programs

The participants felt that even though the programs were in place there would always be a once-off program which targeted one problem at a time. Sometimes there would be posters just addressing that specific program:

“Yes there are programs; we had a health day here where they checked our BP, weight and eyes. But it was only for that one day, and it was the first time they did it this year” (FG 1).

"Also, we have posters like these (pointing on the wall) where they tell us about good nutrition to raise awareness on healthy eating" (FG 1).

"Once a year we have celebrations when we talk about HIV, that is during the end of the year when it is AID day. But that is only once a year. We get addressed on HIV issues on that day." (FG 2).

"Sometimes we get health education when we are just in the queue but not as a planned session. I'll tell you one thing; this issue of health programs is not well addressed. If you come to me and say you will give me an apple, you must eat it now because you have given it to me now. They should organize this properly and say ok at such and such a time we will sit and discuss this, it will be effective. If you just see me while I am in the queue and you tell me this type of food has vitamins and this one does not have, immediately when I walk out that door I will forget what you told me" (FG 2).

HIV/AIDS related programs

It also emerged that there were HIV/AIDS programs offered by the company, based on the OHS act:

"It's not at all like the planned sessions; it just happens that we start talking about AIDS especially when we talk about the company's health and safety act" (FG 2).

"Safety and health issues are also discussed now and then. That is related to the OHS act. Such discussions about the issues related to HIV will come up now and then when we discuss the act. That's the HIV management program that the company has" (FG 2).

Uncoordinated health promotion programs

The other view was that the existing health promotion programs were not well coordinated, they just happened, which results in employees not being aware of them:

“Let me say this, my feeling is that we do have programs but the people who are involved in this are not doing it properly. They do not do it. We have AIDS training, there are documents, and there was a plan on who will cater for what. But the way I see it, the coordinating committee is just dead, it’s not there”

“The company had a plan to send people for HIV counselling and what have you, but those things have not been done until today. There was training on AIDS awareness which was organized. I did not hear about it before, but only a few people went there, some were even turned back. It was never revived. The program is not well coordinated”.

Data from **managers** revealed that there was a variety of health promotion programs that existed in this workplace. The existing programs were addressing employee’s health in a holistic approach in that they addressed the physical and the social problems of an employee. The health programs were also targeting occupational risks in order to prevent disease. The following categories emerged from this data:

Disease preventive programs

The organization aimed at preventing diseases through a primary health care clinic situated on site, and conducting risk assessment:

“We have the medical surveillance programs to identify the nature of risk and deal with it as early as possible. Periodical tests are conducted based on the nature of the risk, such as lung function tests for employees working in dust areas” (M 1).

“There is a primary health care clinic on site where employees can go for any health related issue” (M 2).

Programs for specific health programs

The organization offered other programs that were specific problems such as HIV/AIDS and other social programs. These were in the form of EAP and HIV/AIDS programs that the company offered:

“The company employs a social worker who works on EAP, and provides counselling for employees. There is also a continuous HIV/AIDS program which is working very well, where employees are provided with VCT and treatment for HIV related diseases.”

The **occupational health practitioner** also identified the HIV/AIDS program as the existing health promotion program. Another program was the DOTS program for employees with Tuberculosis.

“Besides the EAP program, the other program is the HIV/AIDS lifestyle management program. In this program, the company takes full responsibility for the HIV positive employee. They pay for everything, VCT, ARV, Blood tests. The employee does not pay anything. It does not matter even if you are on medical or not. The family members also do get benefits .We also have a TB DOTS program for

employees with TB. They come to the clinic for monitoring and we do weighing and they get their treatment.”

For employees’ quantitative data on the existing health promotion programs, 42 out of 44 respondents (96%) responded to this question. Of these 42 respondents, 25 (60%) were not aware of any health promotion programs in this workplace, while 16 (36%) were aware of such programs. Of the 16 respondents, 7(44%) described the program as HIV/AIDS awareness program, 2 (13%) described the program as medical check-ups and blood pressure checks respectively (table 4.16).

Table 4.16: Employee description of health promotion programs in case 4 (n=16)

Description of health promotion program	Frequency	Percent (%)
HIV awareness program	7	44%
Health and safety working environment	1	6%
Back training, HIV program, safety & stress management	1	6%
Training / talks about health program	1	6%
Cholesterol, HIV/AIDS & TB programs	1	6%
Eating in the workshops forbidden	1	6%
Participate in medical checks-up	2	13%
Blood Pressure, TB and AIDS	2	13%
Total	16	100%

When respondents were asked to identify the existing health program in their workplace from the provided list, similar programs were identified, but there were some additional ones (table 4.17).

From the **trade union** representatives' data it emerged that several programs were in place but some of these programs were not health promotive in nature, and some of them were not very active at this stage.

The first program that was identified was EAP. There were slightly differing views on the functioning of this program from the two focus groups. One group felt that the program was operating well but the problem is that it was not preventive in nature; it focused on solving the problems that were already there. For the other group, the feeling was that the program structure was there but they were not convinced that it was doing what it was supposed to be doing:

"We do have EAP. It's not purely health though, but it has to do with social problems, such as financial problems. They also help you if you have family problems and they affect your work. Basically, you can go there with any problem and they can assist you wherever they can, or give you advice on where to go. The thing is, you have to go there only when you have a problem, not to prevent it."

"About EAP, all I can say is that we do have a structure but I am not sure if it is happening. I would like to know what it's doing. Its only people who want to stop alcohol or drug abuse or have family problems that go there".

Participants in both groups identified the HIV /AIDS –Lifestyle management program as an existing program.

“They can assist you in that, say you work here and you have HIV virus, you can get your assistance with ARVs, but not your family members, only you. They have a budget for employees with HIV. They will do anything to assist you but unfortunately, not your family members, only you”.

With regard to **physical fitness program**, there appeared to be no formal fitness program, but employees were involved in a variety of activities to keep themselves fit.

“We do not have such a program but we make it up because we work very hard here. Also, some of us jog when we come to work to keep fit.”

“We do not have anything like a gym, but some of us are playing for a soccer team, the girls are playing in the netball team to keep ourselves fit.”

On **nutrition and lifestyle program**, it emerged that the organization did not have a separate program that focused on nutrition but this was addressed in the HIV lifestyle management program:

“We do not have a separate program for that, but it is covered in the HIV program, when they talk to employees about nutrition, it's part of the HIV program”.

Chronic disease management was identified as part of the primary health care services offered at the clinic:

“The sister at the clinic makes sure that you take your TB treatment at the clinic and finish it. Also, people like me, with hypertension, can go to the clinic for a check-up”.

“People with chronic diseases go to the clinic for testing their blood laves and collect medicines. Some people collect their medicines outside the clinic”

It also emerged from the data that the organization offered counselling services through the social worker. The participants did not think of this service as stress management though.

The data from the **managers** showed that the managers identified programs similar to those identified by the trade union representatives. The difference was that the managers did not identify fitness programs but identified the stress management program as one of the programs which is offered to the executive members of the organization.

The occupational health nurse also identified similar programs as identified by the previous participants. According to the occupational health nurse though, the counselling services offered by the social worker form part of the stress management for employees.

With regard to the women’s health program some issues were raised by the occupational health nurse and the trade union representatives. According to the trade union representatives, women’s needs are not catered for and they have to go outside the workplace if they need help with their health related problems.

“Women’s health program– no, because they have to go to outside this place to see doctors. Sometimes this creates problems with their supervisors. They are not catered for properly for their specific problems”

The OHP also identified this problem, but she attributed it to the fact that this organization used to have mostly male employees and there was no need for programs pertaining to women’s health. According to the OHP there are such programs as family planning programs in the pipeline.

In identifying the existing health promotion programs from the given options, 42 respondents (96%) responded to the question. Of the 38 respondents, all 38 (91%) identified HIV/AIDS program as an existing program in this workplace, 25 (60%) identified the EAP, and only 1 (2%) identified the weight control program (table 4.17).

Table 4.17: Health programs identified by employees in case 4. (n=42)

Identified programs	Frequency	Percent (%)
Employee assistance program	1	2%
HIV/AIDS program	7	17%
Physical fitness program	2	5%
HIV/AIDS program, physical fitness & stress management program	4	10%
HIV/AIDS program & weight control program	1	2%
HIV/ AIDS program & stress management program	2	5%
Employees assistance & HIV/AIDS program	24	57%
weight control program & chronic disease management	1	2%
Total	42	100%

Involvement in health promotion programs

From the trade union representatives' data it emerged that there was very limited or no involvement in health promotion programs. There was, however, an indication that if relevant health promotion programs were in place, there would be participation or involvement. The following categories on involvement in health promotion program emerged:

Limited involvement

"Yes, some of us went to the health day. To tell you the truth, other than that and involvement in HIV committees, not really"

"Yes, some. I am involved in a soccer team here at work. We only play when necessary though. Ah, yes there is also a netball team for girls but it also plays once, if there are tournaments. All sports are open for everyone but some people are just lazy".

Lack of time and resources

Some participants felt that the type of work that they were doing did not give them enough time to get involved in these, but they might also get involved if the programs were in place.

"We do not have enough time to go there because of the work we do. If they were available we would go, but we do not have such things as the fitness centre here".

In the quantitative data from **employees** 43 out of 44 respondents (98%) responded to this question. Of these 43 respondents, 37 (86%) were not involved in any of the health promotion

programs. The other 6 (14%) respondents were involved in some of the health promotion programs.

Of the 6 respondents who were involved in health promotion programs, only 4 (67%) could identify the programs they were involved in. Two out of 4 respondents (50%) were involved in health and safety programs, while the remaining 2 (50%) respondents were involved in sports activities.

Importance of health promotion programs

All the trade union representatives felt that health promotion programs in the workplace were “*very important*”. The reasons given for this response were that having healthy employees will benefit both the employees and the organization:

“Yes, the organization needs healthy employees to increase production. We say so because if employees are not healthy, it can affect production negatively.”

“HP is very important for us and our members. We believe that employees should have regular checkups, so that they can stay healthy. For example if you are working in a place with chemicals, they affect your lungs, also if you are in a noisy area you must have your ears tested early so that they can pick up hearing loss”.

Availability of Infrastructure

According to both managers the company provided support to their employees in terms of health related programs. This support was provided in the form of on-site clinic and training on

health related issues. The clinic was identified as one of the measures taken by the company to provide primary care for employees not on a medical aid scheme.

“There is an on-site clinic for all primary health care needs. People are sent to hospitals for treatment if they develop occupational illnesses”.

“We provide training on HIV/AIDS for our employees. In this manner we increase their awareness and therefore prevent occurrence of the disease. They are also trained on safety issues, on how to render their workplace a safe working environment”

Both managers agreed that there are enough resources for health promotion programs in this company financially, and in term of management support and space. They also agreed that it was the organization’s duty as an employer to put health promotion programs in place.

From the **employees’** data, all 44 respondents (100%) responded to this question. Seventeen (39%) agreed to the statement *“There are enough resources for health promotion programs in this workplace”*, while 5 (11%) respondents said they strongly agreed with the statement. Eight (18%) said they disagreed, while 10 (23%) said they were undecided on this statement (table 4.18).

Table 4.18: Employees’ views on the availability of health promotion resources in case 4 (n=44)

Response	Frequency	Percent (%)
strongly disagree	4	9%
disagree	8	18%
undecided	10	23%
agree	17	39%
strongly agree	5	11%
Total	44	100%

Process

Program structure (Targeted/comprehensive)

The occupational health practitioner responded that this organization tried to target a number of issues but they tended to target one problematic issue at a time.

"In our approach we try and focus on a lot of issues. Firstly on the environment, we have ISO 9000, ISO 14000, to ensure a healthy and safe environment. We provide Medical surveillance, this helps in prevention of conditions such as hearing loss and we educate them about ergonomics. We talk to people about that and prevention of back injury and hearing loss. Also on prevention we have Hep B, but we try to target those conditions that we know our employees are at risk of contracting. Nutrition and lifestyle is the one program targeting HIV/AIDS issues".

Health promotion program approach

The respondents identified different approaches that the organization uses in their implementation of health programs.

Qualitative data emanating from both **trade union** representatives focus groups showed that health promotion programs in this organization focused on people who were already ill and therefore used the programs. Two categories emanated from this data:

Educational approach

Participants felt that employees did get educated but this was mostly on HIV related issues, and also on safety issues.

“People get educated on safety days on how to make our workplace safe. There is also peer counselling which is on HIV for some employees”.

Disease prevention approach

According to the union representatives, health programs only assisted people when they were sick, attempting to show down the progress of the disease:

“They do not aim to prevent them (the diseases), they wait until you develop such problem as dermatitis and then they send you for treatment. People are sent to hospital when they get ill” (FG 1).

“It is people orientated. They look at specific health conditions which is already there. The sick people get their treatment when they are ill”.(FG 2)

The **managers** also identified similar approaches to the trade union members. They outlined that employees are educated on HIV related issues, but they felt that the approach was that of primary prevention. One manager also identified the occupational health and safety program as another way used by the organization to create healthy working environment.

The **occupational health practitioner** also outlined that the organization used various approaches in dealing with health issues. These included the focus on the environment (healthy workplace approach), education approach, preventive approach, and behavioural change approach. She admitted that the organization had not reached the empowerment stage in their approach and were also struggling with the behavioural approach.

“In our approach we try to focus on a lot of issues. Firstly on the environment, we have ISO 9000, ISO 14000, to ensure the healthy and safe environment. We provide Medical surveillance, this helps in prevention of conditions such as hearing loss and we educate them about ergonomics. We talk to people

about that and prevention of back injury and hearing loss .Also on prevention we have Hep B, we target those conditions that we know our employees are at risk of contracting”

“Our program is curative in that we issue TB treatment through our DOTs program. We monitor them. We issue their TB treatment and weigh them and we liaise with DCC for treatment and any other identified problems. They supply us with treatment. Also employees with chronic illness are managed here at the clinic”.

“We have tackled the behaviour change it’s a difficult one but we have done a KAP study to determine attitude”

According to **employees** different approaches to health promotion programs are being used in this organization table 4.19).

Table 4.19: Employees’ views on the aims of health promotion programs in case 4

Health promotion approach	Frequency	Percent (%)
Educating employees on targeted health issues	4	13%
Educating employees & curing occupational illnesses	1	3%
Educating, empowering and changing employees’ behaviours	3	9%
Educating employees and empowering employees in the workplace	4	13%
Educating and changing employees’ behaviours	3	9%
Educating and prevention of occupational illnesses	7	22%
Prevention of occupational illnesses	4	13%
Prevent & curing occupational illnesses	1	3%
Prevent occupational illnesses & change employees’ behaviours	1	3%
Changing employees’ behaviours and curing occupational illness	3	9%
Empower employees & healthy working environment	1	3%
Total	32	100%

Of 44 respondents, 32 (73%) responded to this question. Of these 22 (69%) said that the health promotion programs in this workplace were aimed at educating employees on targeted issues, 13 (41%) said the programs were aimed at prevention of occupational illnesses, while 10 (31%) felt that these programs were aimed at changing employee behaviour. 8 (25%) respondents said the programs were aimed at empowering employees while 5 (16%) said the programs aimed at curing occupational illnesses as they occur. Only 1 (3%) respondent answered that the programs were aimed at changing the work environment to be healthy (Table 4.19).

Health promotion program model

In this organization, the explanation of health promotion programs by different respondents showed that the organization aimed at providing skills training to employees so that individuals could acquire specific behavioural change skills. No model was identified as guiding the health promotion programs.

Health promotion program objectives

According to the **trade union** representatives, there were two aims in the health promotion programs, namely, prevention of occupational health disease and providing peer counselling for employees on HIV/AIDS.

The **managers** also identified education and disease prevention as the main aim that the organization has in provision of their health programs.

The occupational health practitioner also identified program objectives as related to the organization's HIV/AIDS program:

*"These are not written down but I know that our program has the following objectives:
To ensure that employees are kept at work; To reduce financial strain for employees and their families;
we are avoiding absenteeism due to HIV related illnesses and financial strain on their medical aid.
If you are on med aid, you can get benefits when you retire, but if not on medical aid, when you retire
your benefits are taken away. If your family members are not covered in your med aid then your family
members are not covered in this program should they become infected with HIV".*

From the employees' quantitative data, 32 out of 44 respondents (73%) responded to this question. Twenty two (69%) respondents identified the objectives of health promotion programs in their workplace as aiming "to educate employees on health related issues", 13 (41%) respondents identified the objectives of health promotion programs as aiming "to promote the health of employees/to prevent diseases", 10 (31%) respondents identified objective as "to change employee behaviour". Only 1 (3%) respondents identified the objective as "changing work environment to be a healthy one"

Employees' views on their workplace health promotion program

All 44 respondents (100%) responded to the statement "*This workplace is a health promoting workplace*". Twenty two (50%) of these 44 respondents agreed with the statement, while 8 (18%) *strongly disagreed*. On responding to the statement "*this workplace is a safe physical environment*" 43 (98%) responded, 18 (42%) of these *agreed* with the statement while 8 (19%) *strongly disagreed*. All 44 respondents responded to the statement "*policies focusing on health promotion are in place in this workplace*".

Table 4.20: Employees' response to the statement about health promotion programs and policies, and safety in their workplace in case 4

Response	Frequency	Percent (%)
This workplace is a health promoting environment		
strongly disagree	8	18%
Disagree	7	16%
Undecided	4	9%
Agree	22	50%
strongly agree	3	7%
Total	44	100%
This workplace is a safe physical environment		
strongly disagree	8	18%
Disagree	3	6%
Undecided	9	21%
Agree	18	41%
strongly agree	5	11%
Total	43	
Policies focusing on health promotion are in place in this workplace		
strongly disagree	10	23%
Disagree	7	16%
Undecided	7	16%
Agree	16	36%
strongly agree	4	9%
Total	44	100%
We need more health promotion programs in this workplace		
strongly disagree	3	7%
Disagree	2	5%
Undecided	1	2%
Agree	15	34%
strongly agree	23	52%
Total	44	100%
Health promotion activities are relevant for employees		
strongly disagree	3	7%
Disagree	2	5%
Undecided	7	17%
Agree	15	36%
strongly agree	15	36%
Total	42	100%
It is the duty of my employer to put health promotion programs in place		
strongly disagree	1	2%
Disagree	2	5%
Undecided	3	7%
Agree	12	29%
strongly agree	25	60%
Total	42	100%

Of these 44 respondents, 16 (36%) *agreed* with this statement while 10 (23%), 7 (16%) disagreed and an equal number of respondents (16%) were undecided. All participants responded to the statement “*We need more health promotion programs in this workplace*”, 23 (52%) of these strongly *agreed* with this statement, 15 (34%) *agreed*, while only 1 (2%) was *undecided*. Three (7%) respondents strongly disagreed.

Forty two (96%) respondents responded to the statement “*health promotion activities are relevant for employees*”. An equal number of respondents, 15 each (36%) *agreed* and strongly *agreed* with this statement, while only 2 (5%) disagreed and 3 (7%) strongly disagreed, 7 (17%) were undecided. The last statement “it is the duty of my employer to put health promotion programs in place”, had a 100% response. The majority of respondents *agreed* to this statement, with 12 (29%) responding that they *agreed* to the statement and 25 (60%) *strongly agreed* (Table 4.20).

RESULTS OF CASE 6: MEDIUM HEALTH CARE ORGANIZATION (PRIVATE SECTOR)

METHODOLOGY

Sampling

The researcher held a meeting with the senior manager in this organization, who then granted permission to be interviewed and for the organization to participate in the study. The researcher identified this manager as the right person to participate in the study as she was the first contact and was the person dealing with employee issues in the organization. She was therefore identified as a person who was knowledgeable about the organization and its policies.

The employee representative in the consultative forum was identified with the assistance of the manager, and was willing to participate in the study. The manager asked her personal assistant to supply the researcher with a list of all the units in this hospital so that employees could be approached for participation. The researcher then visited all the units and convenience sampling was used to sample respondents. Employees were approached and asked if they were willing to participate in the study. If they agreed they were then included in the sample. Students were not included in the sample as they were not hospital employees and could not comment on the policies in place. They were also on leave at the time when data was collected.

Data collection process

Ten departments or units were identified, including the administration unit and such places as the pharmacy and the outpatient section, with the help of the manager's personal assistant. Other places such as the specialised clinics (orthopaedic clinics, eye clinics etc.) were left out of the data collection process as they were privately owned and did not fall under the control of the hospital.

Five questionnaires were left in each unit, ensuring that different categories of employees were represented. The cleaning staff could not be included again, because they were not employed by the hospital as their services were outsourced. Employees were left to complete the questionnaire and these were collected after some time on the same day. This was done on different days and weeks so as to ensure that most employees had a chance to participate.

It was very unfortunate that employees in the intensive care units and operating theatres were willing to participate but were always too busy to complete the questionnaires and therefore did not participate.

Context

Case description

Case 6 was a health care organisation situated in Durban. In this study, it was classified as a private sector organisation sector. The employees in this organisation were grouped into nursing, administrative, pharmacy and maintenance employees. There were about 480 employees, six (6) managers, one (1) occupational health practitioners and one (1) person involved in the employee consultative forum (representing the labour unions in this case). These were the only people who were employed by the hospital; other employees working in this organisation were either employed as contract or as locum workers. Such employees were excluded from the study as they were not employed by the hospital under study.

Staff profile

The researcher had aimed that 48 employees (10%) would participate in the study but unfortunately only 30 employees (6%) returned their questionnaires. The results discussed in this section will therefore provide demographic data for these respondents.

Age

Of 30 participants who participated in the study, none (0%) was below the age 20years, 9 (30%) were between the ages 20 to 30 years, 12 (40%) were between the ages 31 to 40 years, 5

(17%) were between 41 to 50 years and 4(13%) of the respondents were above 50 years of age.

Figure 4.5, below shows the distribution of ages of the participants in case 6

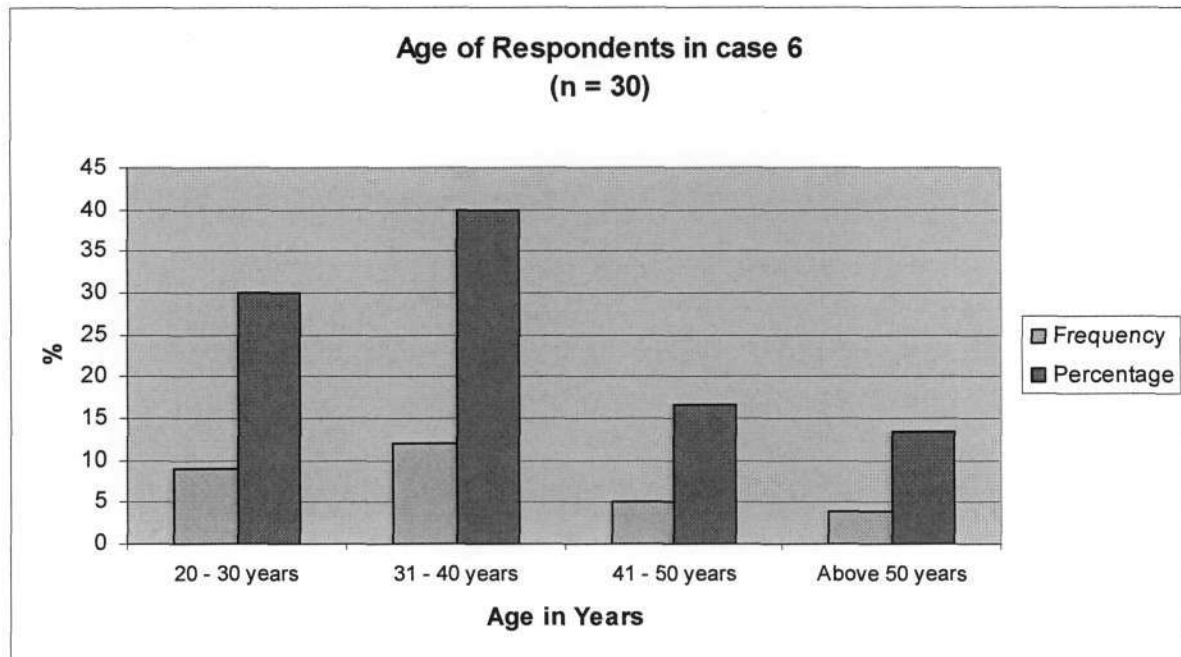


Figure 4.5: age distribution of participants in case 6

Gender

Of the 30 participants, 28 (93%) were female while only 2 participants were male.

Job Types

Twenty nine of 30 respondents (97%) responded to the question on level of employment. The majority of the respondents (62%) were in non- management positions, while only 2 (7%) respondents were in senior management. Most respondents expressed their discomfort in answering this question, as they felt that they could be easily identified through their occupations. This question was therefore made optional, in order to reassure respondents of

confidentiality. Twenty five out of 30 respondents (83%) responded to this question on their occupation.

The occupations of the respondents in this organization were classified into professionals, clerks and managers. The “professionals” category in this organization comprised jobs such as nurses, engineers and pharmacists. Of the 25 respondents, 16 (64%) were in the professionals category. The “clerks” category comprised jobs such as ward secretaries, personal assistants, admissions clerks and receptionists. Seven respondents (28%) were in this category whilst only 2 (8%) respondents were in the “managers” category (Table 4.21).

Table 4.21: Job types in case 6

	Job Types	Frequency	%
Level of employment	Senior management level	2	7%
	Medium management level	4	14%
	Lower management level	3	10%
	Non-management position	18	62%
	Other	2	6.9%
	Total	29	100%
Occupations	Professionals	16	64%
	Clerks	7	28%
	Legislators, senior officials and managers	2	8%
	Total	25	100%

Educational level

Twenty nine out of 30 respondents (90%) responded to this question. In this organization the majority of employees were highly educated, with 26 out of 29 respondents (87%) having

completed tertiary education level. The remaining 3 (10%) employees had attained senior secondary education.

Organizational characteristics

Organizational size

According to the manager, this case had 480 employees. In this study, an organization with this number of employees was classified as a medium sized organization.

Organizational type

This organization was classified as a private organization as it did not depend solely on the government for its day to day functioning.

Risk level and type

The managers felt that this organization does have health hazards, but should be classified as a low risk organization. The risks identified in this organization were health related in that they were mostly disease transmission.

"Our employees work mostly with very ill clients. They are exposed to such risks as HIV/AIDS transmission, TB transmission and working with cytotoxic drugs. I will classify these as low risk because we do have protocols for risk reduction in place".

Occupational health programs

Occupational health programs were outsourced, as the outside company provided care to the sick members of staff.

Medical Aid

According to both the manager and the representative of the consultative forum this organization had medical aid benefits for its employees. Employees were allowed to use their medical benefits for any illness as per medical aid guidelines.

From the employees' quantitative data, all 30 respondents (100%) responded to this question. Of 30 respondents, 29 (97%) agreed that they belonged to a medical aid scheme and only 1 respondent (3%) did not belong to the medical aid scheme. The reason given by this respondent for not belonging to any medical aid scheme was that he/she was "*no medical aid scheme yet*". This response was ambiguous as it was not clear what the response meant, whether it meant that this respondent had registered for one medical aid scheme but not been approved yet or maybe had not found a suitable one.

Health status

All 30 respondents (100%) responded to this question. Of 30 respondents, the majority of 26 respondents (87%) did not suffer from any chronic illness while the remaining 4 (13%) suffered from some chronic illness.

Health Promotion Policies

There were differing views on whether health promotion policies existed in this workplace or not. The representative of a consultative forum maintained that there was no such policy in this workplace:

“There is no health promotion policy as such. Health is promoted on an informal basis here.”

According to the manager in this workplace, such policy existed and it was explained as follows:

“We do have such policies. These are such policies as the one on HIV/AIDS peer educators, as well as a policy on a wellness program”.

The data obtained from the **employees** demonstrated that the majority of employees were aware of health promotion policies in this workplace. All respondents (100%) responded to this question. Of the 30 respondents interviewed, 19 (63%) agreed that they were aware of such a policy but 11 (37%) respondents were not aware of this policy.

When employees were asked to explain the health promotion policies, it emerged that they were referring to some health promotion program. It was therefore not clear if there were written policies on these programs or not. Of 19 respondents who had responded that they were aware of the policies, 17 (90%) responded to this question. Of these 17 respondents, 12 (71%) explained these policies as those related to HIV/AIDS programs. Six (35%) respondents explained these policies as a combination of HIV/AIDS awareness program and Back training, HIV program, safety & stress management. The other remaining participants explained these policies to be those on health and safety, empowerment of employees, back training and fitness (6%) respectively (table 4.22).

Table 4.22: Employees' explanation of health promotion policy in case 6

Explanation of the policy	Frequency	Percent (%)
Fight against the spread of HIV/AIDS/ HIV/AIDS Policy	1	6%
Empowerment of hospital employees	1	6%
HIV counselling course, diabetics talks & back training	1	6%
HIV/AIDS awareness program	4	24%
Back training ,HIV program, safety & stress management	6	35%
Back training / fitness training	1	6%
Protocols policies	2	12%
Health and safety policy	1	6%
Total	17	100%

Using a Likert scale employees were asked to respond to the statement *“policies focusing on health promotion are in place in this workplace”*

Twenty eight of 30 respondents responded to this question. Fourteen (50%) of these respondents agreed with this statement with 9 (32%) responding that they agreed with this statement and 5 (25%) strongly agreed. Only 12 (43%) respondents disagreed with this statement (table 5.23).

Table 4.23: Employees' response to the statement “Policies focusing on health promotion are in place in this workplace”, in case 6

Responses	Frequency	Percent (%)
disagree	12	43%
undecided	2	7%
agree	9	32%
strongly agree	5	18%
Total	28	100%

Existence of health promotion programs

Among the qualitative data, there were some discrepancies in the answers given. According to the manager these programs were in place and employees could get involved in them. The following quote depicts the manager's response:

"Yes there are health promotion programs in this workplace; these are wellness programs and also HIV/AIDS programs that our employees can get involved in"

The representative of the consultative forum denied any existence of a health promotion program in this workplace.

"As far as I know there are no health promotion programs in this workplace"

The quantitative data from employees also showed mixed responses to this question, with some employees saying that there were health promotion programs and others saying there were no such programs in this workplace.

All 30 respondents responded to this question. Twenty one of these 30 respondents (70%) agreed that there were health promotion programs in their workplace, while 9 (30%) responded that there were no health promotion programs in their workplace.

The respondents had varying explanations of what these health promotion programs entailed.

The **manager** described these as the wellness programs and the HIV/AIDS programs which the organization has put in place.

Of the 21 respondents who had answered “yes” to the question on the existence of health promotion programs, only 12 (57%) responded to this question on explaining these programs. Seven of these 12 respondents (60%) described these health promotion programs as those related to HIV/AIDS programs. Other health promotion programs such as back training, safety & stress management were identified by 43% of the respondents. The following table (table 4.24) depicts the description of health promotion programs as outlined by employees in case 6.

Table 4.24: Employees’ description of health promotion programs in case 6

Description of health promotion programs	Frequency	Percent (%)
Training on neuro	1	8%
Helpline for HIV	1	8%
HIV/AIDS & weight-loss program	1	8%
Back training, HIV program, safety & stress management	5	43%
HIV awareness program	2	17%
ARV's support program & Needle stick post exposure program	1	8%
Health beauty program and back care program	1	8%
Total	12	100%

In order to verify that that the information on the existence of health promotion programs was exhaustive, the researcher included the question where the respondents had to identify the existing programs in their workplaces from a provided list. This included programs such as *Employee Assistance Program (EAP), HIV/AIDS Program, Physical Fitness Program, Stress Management Program, Smoking Cessation Program, Women’s health program, Weight Control Program, Nutrition and Lifestyle program, Chronic Disease Management*, and the option of “Other” was given, where the respondents had to explain the program mentioned.

The **consultative forum representative** identified the “HIV/AIDS program” as one of the programs offered in this organization.

According to the **manager** this organization offered an HIV/AIDS program and Stress management. She added that weight control and nutrition and lifestyle management were also part of their health promotion programs.

In the quantitative data, the **employees** identified similar programs to those identified by the manager but also EAP as one of the programs offered. All 30 respondents responded to this question. Of 30 respondents, 30 (100%) responded to this question. Twenty six of 28 respondents (93%) identified HIV/AIDS program as one of the health promotion programs offered in this organization. Stress management program was added to the HIV/AIDS program by 4 (20%) respondents. The other 3 employees (15%) added EAP to the HIV/AIDS program. One can therefore conclude that the programs that are offered in this organization are HIV/AIDS program, a stress management program and EAP (Figure 4.6).

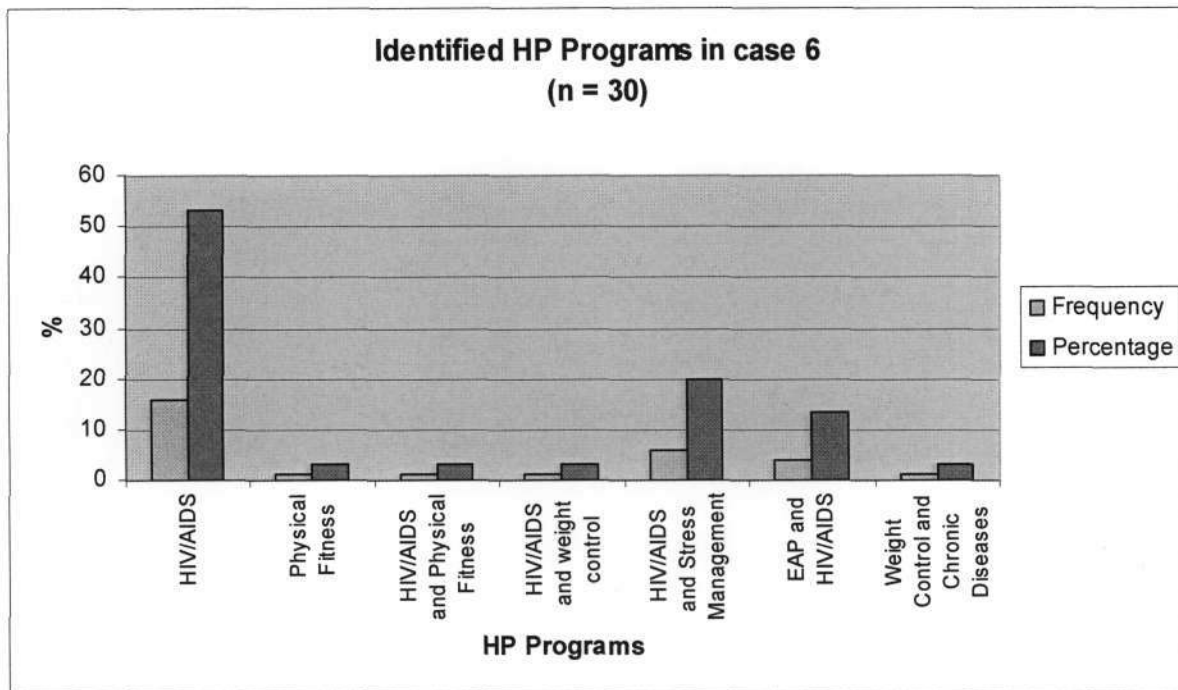


Figure 4.6: Identified health promotion programs in case 6

Employee involvement in health promotion programs

All 30 respondents (100%) responded to this question. Twenty five out of 30 (83%) respondents said they were not involved in any of the health promotion programs, while only 5 (17%) agreed that they were involved in health promotion programs.

Of the 5 respondents who were involved in health promotion programs, 2 (40%) respondents were involved in back training and safety. The other 3 employees were involved in post trauma counselling, aids awareness and sugar/ cholesterol programs (20%) respectively.

Reasons for non-involvement

Respondents who were not involved in health promotion programs gave various reasons for not being involved in health promotion programs. Sixteen out of 21 respondents (76%) responded to this question. Some respondents were not involved in these programs because they did not have time or were not interested (31%) respectively. The other respondents were not involved because they were either not aware of the program or because they thought the organization did not have any of these programs (13%) (figure 4.7).

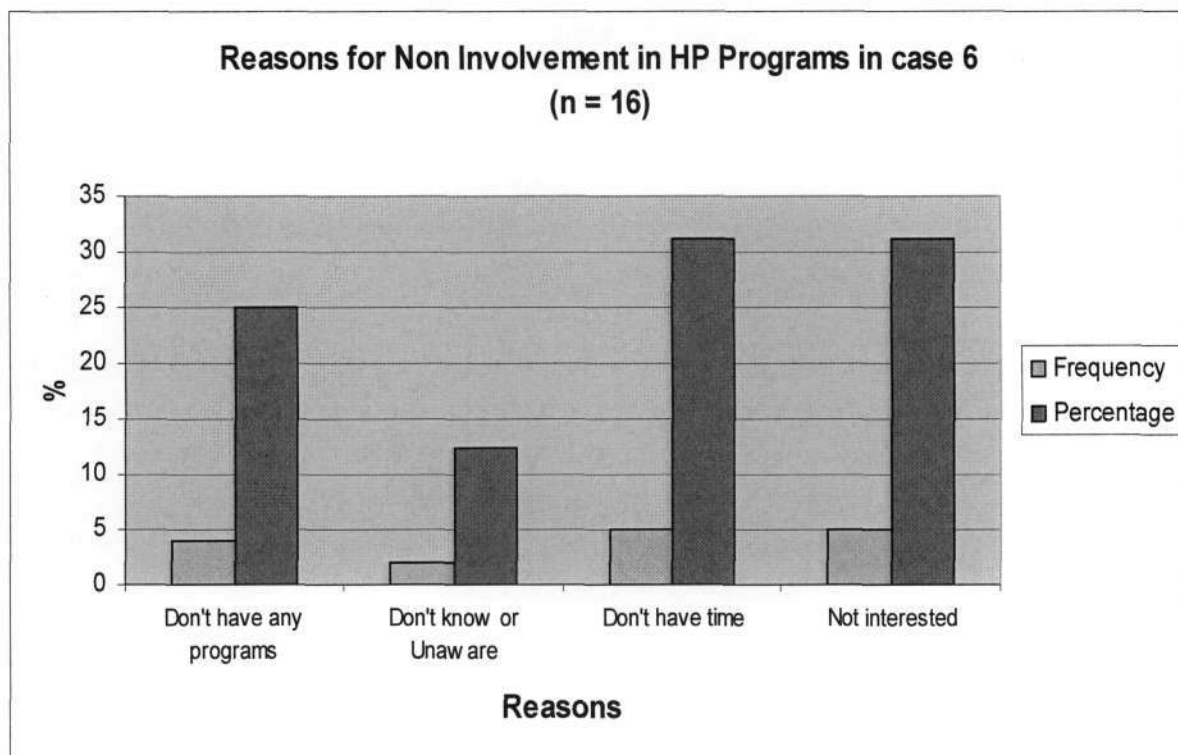


Figure 4.7: reasons for non – involvement in health promotion programs

Importance of health promotion programs

The representative of the consultative forum outlined that health promotion in this workplace was “important”. The reason given was that staff should be kept healthy for their benefit and again for the organization’s benefit:

“Staff should be kept healthy at all times because healthy staff have increased productivity and another thing is that staff will feel appreciated and valued if the organization provides such services for them”.

Availability of Infrastructure

When asked about the support offered by the organization in terms of health promotion programs, the manager responded that the organization is offering the support in terms of the programs offered as mentioned.

The manager ‘*strongly agreed*’ to the statement that there were “*enough resources for health promotion programs in this workplace*”

From the **employees’** data, 29 out of 30 (97%) respondents responded to the statement “*there are enough resources for health promotion programs in this workplace*”. Of these 29 respondents, 16 (55%) respondents had a positive response, with 14 (48%) saying they “*strongly agreed*” and 2 (7%) saying they “*agree*”. Only 3 (10%) respondents “*disagreed*” with the statement, while 10 respondents (35%) were “*undecided*”.

Table 4.25: Employees response to the statement on availability of health promotion program resources in case 6

Response	Frequency	Percent (%)
disagree	3	10%
undecided	10	35%
agree	14	48%
strongly agree	2	7%
Total	29	100%

Process

Program structure (Targeted/comprehensive)

The program structure could not be determined in this organization as the OHP did not participate in the study.

Health promotion program Approach

In this organisation the OHP did not participate in the study and there is therefore no specific data on the approach and aims of the organizational health promotion programs. According to the qualitative data obtained from the manager and the representative of the consultative forum, the approach used is an educational one because employees are educated on HIV related issues.

The explanation given by the representative of the consultative forum was that employees get educated in order to empower them on HIV/AIDS related issues.

“Education on HIV/AIDS is given, therefore empowering employees to be aware of the dangers at work and home”

According to the representative of the consultative forum, regular updates given to employees also contribute to employee education on health issues. The explanation given was that,

“Back awareness is also stressed with regular updates being given”.

The **manager** felt that their health promotion programs aimed at all these options but mostly education, empowerment and changing work environment.

“Educating employees on targeted health issues, empowering employees in the workplace and changing the work environment to be healthy”.

The only explanation provided by the manager on program aims was related to employee training:

“We ensure that our employees receive regular training on the above mentioned programs”

The **employees** gave different yet complementary opinions on the approach of health promotion interventions in this workplace. Of 30 participants, 25 (83%) responded to this question. Fifteen of these 25 respondents (60%), which was the majority, said that the approach used in the execution of the health promotion programs was to educate the employees on targeted health issues. Another 13 (52%) respondents said that in addition to the health promotion programs aiming to educate employees they also aim at changing employees’

behaviours. Only 3 (12%) respondents said that health promotion programs aimed at preventing occupational illnesses.

Table 4.26: Employees' views on the aims of health promotion programs

Aims of HP programs	Frequency	Percent (%)
Educating employees on targeted health issues	6	24%
Empowering employees in the workplace	1	4%
Changing the work environment to be healthy	1	4%
Educating employees & curing occupational illnesses	1	4%
Prevent & curing occupational illnesses	1	4%
Changing the work environment & employees behaviours	2	8%
Prevent occupational illnesses & change employees' behaviours	1	4%
Educating, empowering and changing employees' behaviours	5	20%
Educating employees and empowering employees in the workplace	1	4%
Educating and changing employees behaviours	1	4%
Changing employees behaviours and curing occupational illness	4	16%
Educating about and prevention of occupational illnesses	1	4%
Total	25	100%

Explanations given by employees on their identified aims of these programs confirmed that programs were mostly intended to educate employees on targeted issues. Only 12 (40%) respondents responded to this question. Eight of these respondents (66%) identified workplace training on targeted issues such as “HIV/AIDS workshops and quality programs” and “attending empowerment training” as some of the explanations for the aims of health promotion program. The remaining respondents explained the objectives as promoting healthy environment and the prevention of back injuries, (17%) respectively (figure 4.8).

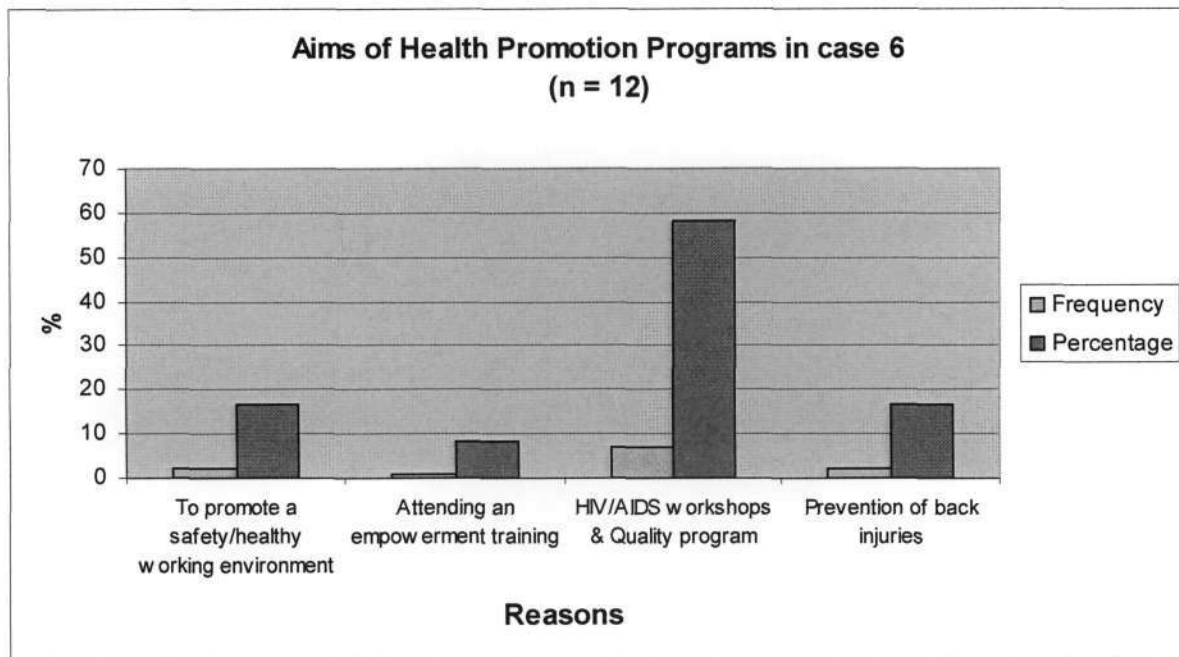


Figure 4.8: Aims of health promotion programs in case 6

Health promotion program model

In this organization, the explanation of health promotion programs by different respondents showed that the organization aimed at providing skills training to employees so that individuals could acquire specific behavioural change skills. This explanation was however not linked to any health promotion model. This view came from the data of both the manager and the representative of the consultative forum:

Health promotion program objectives

The **employees** gave different yet complementary opinions on the aims/objectives of health promotion interventions in this workplace. This question was also answered through the

question asking about the aims of the program. This question on the aims of the program was also addressing the approach and objectives of the program.

Employees' views on their workplace health promotion program

Of 30 respondents, 28 (93%) responded to the statement "*This workplace is a health promoting environment*". Twelve (43%) of these respondents agreed with the statement and 6 (21%) strongly agreed, while 8 (29%) disagreed. Only 2 (7%) respondents disagreed with this statement. To the statement "*This workplace is a safe physical environment*" 29 (97%) responded. Of the 29 respondents, 19 (65%) agreed with the statement and 6 (21%) strongly agreed, while 4 (14%) disagreed.

On the statement "Policies focusing on health promotion are in place in this workplace", there were 28 respondents. Of 28 (93%) respondents, 12 (43%) disagreed with the statement, while 9 (32%) agreed, and 2 (7%) were undecided. On the statement "*We need more health promotion programs in this workplace*", there were 29 (97%) respondents. Of 29 respondents, 15 (52%) agreed with the statement, while 3 (10%) disagreed, and 6 (21%) were undecided.

Table 4.27: Employees' response to the statement about health promotion programs, policies and safety in their workplace" in case 6

Response	Frequency	Percent (%)
This workplace is a health promoting environment		
disagree	8	29%
undecided	2	7%
agree	12	43%
strongly agree	6	21%
Total	n=28	100%
This workplace is a safe physical environment		
disagree	4	14%
agree	19	65%
strongly agree	6	21%
Total	n=29	100%
Policies focusing on health promotion are in place in this workplace		
disagree	12	43%
undecided	2	7%
agree	9	32%
strongly agree	5	18%
Total	n=28	100%
We need more health promotion programs in this workplace		
disagree	3	10%
undecided	6	21%
agree	15	52%
strongly agree	5	17%
Total	n=29	100%
Health promotion activities are relevant for employees		
disagree	1	3%
undecided	3	10%
agree	19	66%
strongly agree	6	21%
Total	n=29	100%
It is the duty of my employer to put health promotion programs in place		
disagree	4	14%
undecided	4	14%
agree	8	27%
strongly agree	13	45%
Total	n=29	100%

There were 29 respondents who responded to the statement “*Health promotion activities are relevant for employees*”, 19 (66%) of these agreed with the statement, while only 1 (3%) disagreed, and 3 (10%) were undecided. Twenty nine respondents (97%) responded to the statement “*It is the duty of my employer to put health promotion programs in place*”. Of the 29 respondents 13 (43%) strongly agreed to the statement, while 4 (14%) disagreed to the statement (table 4.27).

SUMMARY: CROSS CASE ANALYSIS

INTRODUCTION

This section of the study presents cross case analysis of all six cases. The variables to be explored in cross case analysis are the context and the process. In discussing the context, employees’ awareness of health promotion policy and programs will be explored in relation to staff profile. Employees’ involvement will also be explored in relation to the staff profile. Participant awareness and involvement in health promotion programs is also discussed in relation to organizational characteristics such as the organizational type, size and risk level. The concept of awareness is also discussed. The discussion also includes infrastructure as viewed by stakeholders.

The discussion of the process variable will focus on health promotion program approaches and models used in different cases, in relation to staff profile and organizational characteristics. Cases are presented in matrices to explore similarities and differences in all cases in different categories, namely the private sector, the health sector and the parastatal.

Sampling of employee participants

Due to organizational rules and confidentiality of employee records, the researcher could not use stratified random sampling as intended. In all six cases the researcher therefore used convenience or volunteer sampling whereby employees were recruited via organisational notices (Polit & Beck 2004, p. 305) sent by management and unions. Employees then availed themselves to complete the research questionnaire.

Summary of the staff profile

Age of participants

Table (4.28) below shows that of all 6 cases, the majority of respondents in the employee category were in the age group 20 to 30 years, with case 2 having 21 (55%). 20 (46%) respondents in this age group. Also in case 5, which has more professional employees from the othershad, 13 (33%) respondents were in the age group “above 50years” compared to case 2 where only 1 (3%) respondent was in that age group.

The age group 31 to 40 years was more or less equally represented in all 6 cases, ranging from 9 to 13 respondents. Only case three had one respondent who was in the age group “below 20 years” (table 4.28).

Table 4.28: Cross case analysis on age of participants

		Case 1 (LPR)	Case 2 (MPR)	Case 3 (SPR)	Case 4 (LPS)	Case 5 (LPS)	Case 6 (MPHS)	Total
Below 20 years	Frequency	0	0	1	0	0	0	1
	(%)	0%	0%	3%	0%	0%	0%	0%
20-30 years	Frequency	9	21	9	20	5	9	73
	(%)	23%	55%	29%	46%	13%	30%	33%
31-40 years	Frequency	12	13	9	11	11	12	68
	(%)	30.8%	34.2%	29.0%	25.0%	28.2%	40.0%	31%
41- 50 years	Frequency	8	3	6	10	10	5	42
	(%)	20.5%	7.9%	19.4%	22.7%	25.6%	16.7%	19%
Above 50 years	Frequency	10	1	6	3	13	4	37
	(%)	25.6%	2.6%	19.4%	6.8%	33.3%	13.3%	17%
Total		39	38	31	44	39	30	221
Percent		18%	17%	14%	20%	18%	13%	100%

- *LPR – Large private organization
- *MPR – Medium private organization
- *SPR – Small private organization
- *LPS – Large parastatal organization
- *MPHS – Medium private health sector

Gender of Participants

The majority of participants were male. Male participants constituted 61% of the sample, and female only 39%. The only organizations that had more female employees were cases 5 (30%) and case 6 (32%).

Table 4.29: Gender of the participants in all 6 cases

		Case 1	Case 2	Case 3	Case 4	Case 5	Case 6	Total
Male		32	24	27	37	13	2	n=135
	%	14%	11%	13%	17%	6%	1%	61%
Female		7(8%)	14(16%)	4(5%)	7(8%)	26 (30%)	28(33%)	n=86
	%	3%	6%	2%	3%	12%	13%	39%
Total (N)		n=39	n=38	n=31	n=44	n=39	n=30	N= 221
Total %		18%	17%	14%	20%	18%	14%	100%

Educational level

Case 2 had a majority of 16% participants who had no formal education. The majority of participants with tertiary education qualification were in cases 4 and 5, with 80% and 90% respectively.

Table 4.30: Highest level of education in all 6 cases

Level of education	Case 1 n=39 18%	Case 2 n=38 17%	Case 3 n=31 14%	Case 4 n=44 20%	Case 5 n=39 18%	Case 6 n=29 13%	N=220 100.0%
No formal education	0	0	5	2	0	0	7
	0%	0%	16%	5%	0%	0%	3%
Primary education	0	2	8	7	0	0	17
	0%	5%	26%	16%	0%	0%	8%
Junior secondary education	6	1	4	4	0	0	15
	15%	3%	13%	9%	0%	0%	7%
Senior secondary education	10	20	6	17	8	3	64
	26%	53%	19%	39%	21%	10%	29%
Tertiary education	23	15	8	14	31	26	117
	59%	40%	26%	32%	80%	90%	53%

Summary of organizational characteristics

Risk level

Only cases 3 and 4 were classified as high-risk organizations. Cases 2, 5 and 6 were classified management as low risk organization while case 1 was classified as a low risk organization.

Medical aid benefits

In all cases but case 2, medical aid benefits options were available to all employees, whereas in case 2, medical aid benefits were only available to permanent staff.

Policy existence

In all cases, except for case 3, **management** agreed that they had health promotion policies.

Four out of 5 cases defined their policies as Occupational health and safety (OHS) policy. Of the 5 cases that had policies, only case 6 did not have OHS policy. Cases 2, 4 and 6 had HIV/AIDS policies and case 5 had a hearing conservation policy.

Employees in all cases were aware of policies relating to health promotion, but in case 3, only 10% of employees were aware of these policies, whereas in case 2, 73% of employees were aware of the policy. In 4 cases, cases 1, 4, 5 and 6, the policy was mainly defined as HIV/AIDS and OHS policies. In case 2 the policy was defined as only OHS policy.

The **labour unions** in case 1 and 4 also defined the policy as HIV/AIDS, but some of them in these two cases said they were not aware of the policy. In cases 3 and 6, the unions said they were not aware of the policies.

Table 4.31: Summary of the organizational characteristics

		Case 1 Production (LPR)	Case 2 Manufacturing (MPR)	Case 3 Engineering (SPR)	Case 4 Engineering (LPS)	Case 5 Academic (LPS)	Case 6 Health (MPHS)
Type		Private	Private	Private	Parastatal	Parastatal	Health -Private
Size		Large	Medium	Small	Large	Large	Medium
Risk level		Medium	Low	High	High	Low	Low
Medical aid benefits		Yes (Optional)	Yes (permanent staff)	Yes (optional)	Yes (optional)	Yes (optional)	Yes (optional)
Program coordination		Part of organization	Partially Outsourced	None	Part of organization	Part of organization	Outsourced
Policy existence (Managers)		OHS ACT	OHS ACT HIV/AIDS	None	OHS ACT HIV/AIDS	OHS policy Hearing conservation	HIV/AIDS
Policy awareness (Employee)	Y	23 (59%) n=39	27 (73%) n=37	3 (10%) n=31	24 (55%) n=44	11(28%) n=39	19 (63%) n=30
	N	16 (41%)	10 (27%)	28 (90%)	20 (45%)	28(72%)	11 (37%)
Policy explanation		HIV/AIDS Health & Safety Fitness Program	Health & safety	None	HIV/AIDS OHS policy Medical surveillance	HIV/AIDS Health & safety	HIV/AIDS Back training Health & Safety
Policy existence (unions)		Online HIV/AIDS Drug & Alcohol OHS ACT No awareness	_____	None	Yes - Fragmented HIV/AIDS OHS ACT No awareness	_____	No policy
Policy existence (OHP)		Health & safety HIV/AIDS EAP	Health policy HIV/AIDS	_____	Drug & alcohol rehab.	HIV/AIDS	_____
Program awareness (Employee)	Y	(51%)	14	5	(40%)	9	(70%)
	N	(49%)	22	26	(60%)	30	9(30%)
Program awareness (Unions)		HIV/AIDS related Physical fitness program Rehabilitation program No program	-	None	Health days Health education HIV/AIDS EAP		NO
Involvement	Yes	3 (8%)	5	0	6 (14%)	1	5 (17%)
	No	35 (92%)	32	31	37 (86%)	38	25 (83%)
Importance of programs		Very important	_____	Very important	Very important	_____	Important
Availability of infrastructure (Management)		Supportive information Resources	Resources (budget) PHC clinic	Supportive information	Supportive information Resources PHC clinic	Busy with program PHC clinic	Supportive information
Availability of infrastructure (employee)		15(41%) Agreed 10	5 11	3 11	17(39%) agreed 8	9 8	14 (48%) agreed 3

Program awareness

In case 6 the majority, 70% of **employees**, were aware of health promotion programs. These were followed by 51% of employees in case 1, who were also aware of the programs. Only 5% of employees in case 3 and 9% in case 5 were aware of the health promotion programs.

Labour unions in case 3 and 6 were not aware of any health promotion programs in their workplace.

Table 4.32 shows that all six cases had some health promotion activities that were taking place. In all cases, health programs identified by different stakeholders, within the same organization, differed significantly. For example in case 1, the OHP identified 3 programs, namely, HIV/AIDS, EAP, physical fitness and health education. Management also identified 4 programs, did not identify health education but added medical surveillance instead. The trade union in this case identified similar programs but added drug and alcohol rehabilitation. The employees identified health programs too but did not identify drug and alcohol rehabilitation and medical surveillance but added disease management. In case 2, the programs identified by the 3 participating stakeholders differed completely. A high percentage of employees, in all cases, felt that there were just no programs in place (table 4.33).

Table 4.32: Health promotion programs in all 6 cases

HP activities	OHP	Employees	Management	Labour unions
Case 1	HIV/AIDS, Health education, EAP, Physical fitness	EAP (9%), HIV/AIDS (24%), Physical fitness (9%), Disease management (6%) Health education (3%) No programs (58%) (n=33)	HIV/AIDS, Medical surveillance, EAP, Physical fitness	HIV/AIDS Physical fitness Drug & alcohol rehab No programs
Case 2	News letters, Information brochures, HIV/AIDS	Health & safety (31%) Health screening (3%) No programs (63%) (n=35)	Medical surveillance	_____
Case 3	-	IV/AIDS (7%), Health & safety (3%) No programs (87%) (n=30)	Drug & alcohol rehab	No programs
Case 4	EAP, IV/AIDS, TB/DOTS	HIV/AIDS (27%), Health & safety (2%) Stress management (2%) Disease management (5%) Health screening (5%) Health education (5%) No programs (61%) (n=41)	Medical surveillance, HIV/AIDS, Drug & alcohol rehab	Health days Health education HIV/AIDS EAP
Case 5	HIV/AIDS, Physical fitness	HIV/AIDS (8%), Health & safety (8%) Physical fitness (3%), Health education (5%) No programs (77%) (n=39)	Hearing conservation, HIV/AIDS	_____
Case 6	_____	HIV/AIDS (62%), Health & safety (3%) Weight control (2%) Back care (31%) Stress management (24%) No program (31%) (n=29)	HIV/AIDS, Wellness	No programs

Table 4.33 shows that when employees were given a list of programs to choose from, the identified programs changed considerably. For example, in table 4.31, 27% of employees identified an HIV/AIDS program, but in table 4.32, 88% of employees identified this program as one of the programs in their workplace.

An HIV/AIDS program was common in all cases, whereas programs such as smoking cessation, weight control programs and women's health were not offered in any of the cases. Case 3 had the fewer (only two) programs offered. Physical fitness programs were offered in 5 out of 6 cases except in case 3. Of the 4 cases that had physical fitness program, only case 1 had a formal physical fitness program with a biokineticist on site, while in other sites the fitness programs were informal programs. For example, in case 4, the employees engaged in soccer and netball playing occasionally, while in case 5 there was an unsupervised gym within the work premises.

Table 4.33: Health promotion programs identified by employees in all six cases

	Case 1 (LPR) n=35	Case 2 (MPR) n=36	Case 3 (SPR) n=30	Case 4 (LPS) n=43	Case 5 (LPS) n=36	Case 6 (MPHS) n=30
HIV/AIDS	26 (74%)	2 (6%)	5 (17%)	38 (88%)	23 (36%)	26 (87%)
EAP	3 (9%)	14 (42%)	7 (24%)	25 (58%)	4 (6%)	4 (13%)
Physical fitness	23 (66%)	3 (8%)	0	6 (25%)	9 (25%)	2 (7%)
Stress management	14 (40%)	5 (14%)	0	6 (6%)	8 (6%)	6 (20%)
Smoking cessation	0	1 (3%)	0	0	0	0
Women's health	0	0	0	0	0	0
Weight control	0	0	0	0	0	2 (7%)
Chronic disease management	0	2 (6%)	0	0	0	1 (3%)
No programs	0	14 (39%)	12 (41%)	3 (7%)	9 (19%)	2 (7%)

Table 4.34 shows that awareness of health programs differed within employees at different levels, in different cases. Employees in non-management positions seemed to be more aware of the health promotion activities.

Table 4.34: Awareness of health promotion activities by employees at different employment levels

		Case 1 n=38	Case 2 n=36	Case 3 n=29	Case 4 n=40	Case 5 n=39	Case 6 n=29
Senior management	*	-	-	0		0	2 (7%)
		-	-	1(3%)		1(3%)	0
Medium management	*	0	1(3%)	-	0	3(8%)	3 (10%)
		2 (5%)	1(3%)	-	1(3%)	6(15%)	1 (3%)
Lower Management	*	2 (5%)	4(11%)	1(3%)	3(8%)	2(5%)	1 (3%)
		1 (3%)	2(6%)	2(7%)	4(10%)	4(10%)	2 (7%)
Non-management	*	15 (40%)	5(14%)	4(14%)	7(18%)	3(8%)	12 (41%)
		8 (21%)	17(47%)	19(66%)	12(30%)	14(36%)	6 (21%)
Other	*	2 (5%)	4(11%)	0	6(15%)	1(3%)	2 (7%)
		8 (21%)	2(6%)	2(7%)	7(18%)	5(13%)	0

Rows marked with * indicates awareness of health promotion programs

INVOLVEMENT IN HEALTH PROMOTION PROGRAMS

When participants were asked about their involvement in health promotion programs, it appeared that only a very low percentage of employees, if any, were involved in such activities. For example, only 17% in case 6 and 8% in case 1 were involved in health promotion activities, whilst in case 3 none of the employees was involved.

Table 4.35 below shows that involvement in health promotion programs varied with age of participants. Employees between the ages 20 and 40 years were mostly involved in health promotion activities.

Table 4.35: Employee involvement in health promotion programs age in all cases

Case No.	Age						Total
	Involved?	Below 20 years	20-30 years	31-40 years	41-50 years	Above 50 years	
Case 1	Yes	0	0	2 (67%)	1 (33%)	0	3 (8%)
	No	0	9 (25%)	10 (29%)	6 (17%)	10 (29%)	35 (92%)
Case 2	Yes	0	4 ((80%)	0	0	1 (20%)	5 (14%)
	No	0	17 (53%)	13 (41%)	2 (6%)	0	32 86%
Case 3	Yes	0	0	0	0	0	0
	No	1 (4%)	9 (36%)	9 (36%)	6 (24%)	0	25 (100%)
Case 4	Yes	0	3 (50%)	1 (17%)	2 (33%)	0	6 (14%)
	No	0	16 (43%)	10 (27%)	8 (22%)	3 (8%)	37 (86%)
Case 5	Yes	0	0	0	1 (100%)	0	1 (3%)
	No	0	5 (13%)	11 (29%)	9 (24%)	13 (34%)	38 (97%)
Case 6	Yes	0	1 (20%)	3 (60%)	1 (20%)	0	5 (17%)
	No		8 (32%)	9 (36%)	4 (16%)	4 (16%)	25 (83%)

The racial background of participants was determined only in cases 2 and 4. Table 4.36 below shows that the majority of participants who responded to this question or who even participated in the study were of African origin, with 29 (83%) in case 2 and 15 (58%) in case 4. In total Africans constituted 72% of the sample (44 out of 61 participants). The table therefore shows that the majority of 26 (74%) African participants were not participating in any health promotion activities and similarly in case 4, the majority of (15) 58% were not participating in health promotion activities. The table shows that the coloured participants formed 6% of the population in case 2 and 4% in case 4. In case 2 both participants did not participate in the health programs while in case 4 the 1 and only participant did participate. The Asian

participants formed 13% of the population and of these 6% participated in health programs in case 2, while in case 4 only 4% participated. With white participants only, there was only one in case 2 and the same participant participated in health programs. In case 4 the majority of 4 out of 5 participants participated in health programs

Table 4.36: Involvement in health promotion activities by race

	Case 2 n=35		Case 4 n=26		Total
Involved	Yes	No	Yes	No	N=61
African	3(9%)	26(74%)	0	15 (58%)	44(72%)
Asian	1(3%)	2(6%)	1(4%)	4(15%)	8(13%)
Colored	0	2(6%)	1(4%)	0	3(5%)
White	1(3%)	0	1(4%)	4(15%)	6(10%)
Total	5(14%)	30(86%)	3(12%)	23(88%)	61(100%)

Table 4.36 below, shows involvement of participants in health promotion programs, in relation to their educational levels. In cases where there were employees no formal education (cases 3 and 4) and where there were employees who had their highest educational level as primary education (cases 2,3 and 4), none of these participants were involved in health promotion activities. There was some involvement in employees who had tertiary education, though it was not the majority of these employees.

Table 4.37: Involvement in health promotion programs by educational level

	Case 1 (n=38)		Case 2 (n=37)		Case 3 (n=31)		Case 4 (n=43)		Case 5 (n=39)		Case 6 (n=29)	
Involvement	Yes	no	Yes	no	Yes	no	Yes	no	Yes	no	Yes	no
No formal education						5 (16%)		2 (5%)				
Primary education				2 (5%)		8 (26%)		6 (14%)				
Junior secondary		5 (13%)		1 (3%)		4 (13%)	1 (2%)	3 (7%)				
Senior secondary		10 (26%)	1 (3%)	18 (48%)		6 (19%)	5 (12%)	12 (28%)		8 (21%)		3 (11%)
Tertiary	3 (8%)	20 (53%)	4 (11%)	11 (30%)		8 (26%)		14 (32%)	1 (3%)	30 (76%)	5 (17%)	21 (72%)

AWARENESS IN RELATION TO INVOLVEMENT IN HEALTH PROMOTION PROGRAMS

The table 3.8 below shows that the majority of participants in non-management levels were not aware of the health promotion policies and programs and hence were not involved in such programs. The majority of participants who were in management positions were aware of health promotion policies and programs but were not involved in these programs (table 4.38).

Table 4.38: Involvement and awareness on program in different levels of employment

Case s	Management		Policy awareness		Involvement	
	Level	Number	Yes	No	Yes	No
1 (n = 38)	Medium	2	1 (3%)	1 (3%)	0	2 (5%)
	Lower	3	2 (5%)	1 (3%)	1 (3%)	2 (5%)
	Non Management	33	19 (50%)	14 (36%)	2 (5%)	31 (82%)
2 (n = 37)	Medium	2	2 (5%)	0	1 (3%)	1 (3%)
	Lower	6	6 (16%)	0	2 (5%)	4 (11%)
	Non Management	29	19 (52%)	10 (27%)	2 (5%)	27 (73%)
3 (n = 29)	Senior	1	0	1 (3%)	0	1 (3%)
	Lower	3	1 (3%)	2 (7%)	0	3 (10%)
	Non Management	25	2 (7%)	23 (80%)	0	25 (87%)
4 (n = 42)	Medium	1	0	1 (2%)	0	1 (2%)
	Lower	7	4 (10%)	3 (7%)	1 (2%)	6 (14%)
	Non Management	34	19 (45%)	15 (36%)	6(14%)	28 (67%)
5 (n = 39)	Senior	1	0	1 (3%)	0	1 (3%)
	Medium	9	6 (15%)	3 (8%)	0	9 (23%)
	Lower	6	2 (5%)	4 (10%)	1 (3%)	5 (13%)
	Non Management	23	3 (8%)	20 (51%)	0	23 (58%)
	Senior	2	2 (7%)	0	1 (3%)	1 (3%)
6 (n = 30)	Medium	4	2 (7%)	2 (7%)	1 (3%)	3 (10%)
	Lower	3	3 (10%)	0	0	3 (10%)
	Non Management	18	9 (30%)	9 (30%)	3(10%)	15 (50%)

Employee attitude to health promotion programs

Employees in all 6 cases showed a positive attitude when asked if they needed health promotion programs in their workplaces. In case 1, the majority of 95% were in agreement with this statement, It was however noted that in case 6 on 69% of respondents were in agreement with this statement.

Table 4.39: Employees response to the statement “We need more health promotion programs in this workplace”

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Strongly disagree	-	2 (6%)	-	3 (7%)	1 (3%)	-
Disagree		2 (6%)		2 (5%)	1 (3%)	3(10%)
Undecided	3(8%)	1(3%)	4(14%)	1 (2%)	2(5%)	6(21%)
Agree	24 (65%)	10(26%)	14(50%)	15 (34%)	18(45%)	15(52%)
Strongly agree	10(27%)	21(55%)	10(36%)	23 (52%)	17(44%)	5(17%)
TOTAL	37	36	28	44	39	29

PROCESS OF HEALTH PROMOTION PROGRAMS

Table 4.40 below shows the summary of different structures, approaches, models, and objectives that were used in different cases to implement health promotion programs.

In cases 3 and 6 there were no OHPs and therefore information about the health promotion programs could not be obtained. The information on the process is therefore based on 4 cases, namely, case 1, 2, 4 and 5.

All 4 cases used the preventive and educational approaches. Case 1, 2 and 4 utilized the behavioural change approach in addition, while case 5 also focused on slowing down the

existing illness. In case 4 it was indicated that the organization was also trying to make the workplace a healthy one.

There were no distinct models that any of the cases used in the implementation of their programs.

Table 4.40: Cross case analysis of the process of health promotion

	Case 1 (LPR)	Case 2 (MPR)	Case 4 (LPS)	Case 5 (LPS)
Structure	Comprehensive	Comprehensive	Targeted	Targeted
Approach	-Prevention -Educational -Behavioural change	-Prevention -Educational -Behaviour change	-Prevention -Educational -Healthy workplace -Behaviour change	-Prevention -Educational -Slowing down of existing illness
Model	No model	No model	No model	No model
Objectives	-Prevention of occupational disease -Increasing awareness	To assist employees to assume responsibility for their own health	Prevention of disease complication	To prevent diseases before they occur

CONCLUSION

The findings from all the 6 cases of the study showed that there were some similarities in the provision of health programs in the participating workplaces, irrespective of their type. There was however some differences based on organizational size whereby larger organizations tended to offer more health promotion programs compared to smaller organizations.

Employees were expecting their workplaces to offer more health promotion programs as they felt that it was necessary to have such programs in their workplaces.

CHAPTER 5

DISCUSSION OF CASE STUDY RESULTS

INTRODUCTION

In the previous chapters, the background to the problem, the purpose of the study and the conceptual framework that was guiding the study were discussed (chapter 1). Chapter 2 presented the literature review and in chapter 3, research methodology was described in detail. In chapter 4 the results of the case studies were presented and summarized in the form of cross-case analysis.

In this chapter the results of the case studies are discussed in relation to the existing literature. The discussion of results will be guided by both the research questions and the conceptual framework. In the first phase of the study the purpose was to explore the current status of planning and implementation of workplace health promotion programs in the public and the private sector, in order to develop policy guidelines, which would be tested through limited implementation. The following research questions had to be answered:

1. What characteristics do work settings have which influence health promotion activities?
2. What process is involved in the implementation of health promotion interventions?
3. What is the organisation doing to support health promotion interventions?

In discussing the characteristics of the workplace, the discussion will be based on the health promotion activities.

CHARACTERISTICS OF THE WORKPLACE SETTING

In trying to answer the research question on the characteristics of the work setting, the study explored different characteristics of the context, namely employee characteristics/staff profile, workplace characteristics and stakeholders' involvement. The context was explored in relation to health promotion policies and programs. The study aimed to find out if these characteristics had any influence on health promotion activities in these work settings. The following discussion is based on the findings around these characteristics of the context.

Staff profile

Age

In all six cases the majority of respondents in the employee category were in the age group 20 to 30 years. Case 2 had 21 (55%) employees in this age group, which was to be expected in a heavy engineering company which involves a lot of physical work compared to professional work. Similarly in case 4, which is also a heavy engineering organization, 20 (46%) respondents fell into this age group. In case 5, which had more professional employees, 13 (33%) respondents were in the age group "above 50 years" compared to case 2 where only 1 (3%) respondent was in that age group.

The age group 31 to 40 years was more or less equally represented in all 6 cases, with case 4 having the lowest percentage in this age category (25%) and case 6 having the highest percentage of 40% (Table 4.28). Only case 3 had one respondent who was in the age group "below 20 years", which could be attributed to the fact that this organization is fairly new and this employee was young and still doing his internship or in-service.

Level of employment

According to the reviewed literature, the level of involvement in workplace health promotion programs is higher in young and white collar workers (Lusk, et al., 1999; Peltomaki, et al. (2003). Similarly, findings of this study showed that involvement in health promotion program was higher in both the young employees (20-30years) and also in the middle age group (31-40years) than in the older age group. According to the findings of Peltomaki et al. (2003), the blue colour workers and persons in risk related jobs may be less likely to participate in workplace health promotion. My findings supported that of Peltomaki et al. (2003) and Lusk et al (1999) in that the level of involvement was very poor in the high risk organizations such as case 3.

Educational level

There was, however, not a discernible difference in levels of employee involvement in workplace health promotion (WHP) according to level of education. For instance, case 5 and case 6, which both had employees with a high level of education, had 3% and 17% of employees respectively involved in WHP, compared to organizations with more employees with less education (case 2 with 14% involvement and case 4 with 14%).

Race and educational level

The majority of African employees who participated in this study were not involved in any of the health promotion programs. This finding is inconclusive because the race of participants was not determined in all cases, as this variable was made optional because of participants' reluctance to give such information. The data about racial background was therefore obtained

from participants in only 2 out of 6 cases, namely case 2 (private, medium) and case 4 (private large engineering organization).

In the two cases where such information was available, the majority of employees who participated in the study were of African origin (72%) with 5% of the participants being coloured, 13% of Asian origin and 10% white (Table 4.35).

In terms of involvement in health promotion programs, based on educational level, the findings clearly showed that employees with no formal education, or those who had primary education as their highest education level, were not involved in any of the health promotion program. These findings and the ones on race were in line with the findings of the previous studies by Lusk et al. (1999) and Peltomaki et al. (2003), mentioned above.

These findings support the assumption of this study that certain demographic characteristics of the employee such as age, racial/cultural background, job type, level of education will have influence on the individual's participation in the health programs.

Organizational Characteristics

Medical aid

There appeared to be some difference in the availability of medical aid benefit amongst cases or organizations of different sizes, and in different sectors. In medium size cases, medical aid was limited to permanent staff. This finding was expected in small to medium size companies but surprisingly, the small case did have medical aid available as an option for all employees.

The results therefore did not show any relationship between involvement in WHP and the availability of medical aid schemes for employees.

Program coordination

As expected, the findings of this study showed that small organizations did not have occupational health services on site. Both medium size cases in the study had occupational health services either fully or partially outsourced. All large cases in the study had their occupational health services as part of the organization. In all these large organizations, only the occupational health nurse was employed full time by the organizations, while the occupational health medical practitioners were employed on a locum basis.

These findings agree with the findings of the study conducted by Bradshaw and Fishwick (2001) in the United Kingdom where 14% of the surveyed SMEs employed the services of a part-time occupational health physician, 11% employed a part-time occupational health nurse. Literature also shows that in South Africa the situation is the same. According to Ryan (1998) the models used in the provision of occupational health services in South Africa follow the same pattern, where medium and large organizations tend to have an occupational health nurse on site and an occupational medical practitioner on a part-time basis. Ryan further argues that smaller organizations usually identify a local general practitioner, often without any qualification in occupational health, to deal with their injuries on duty and to conduct pre-employment examinations at the doctor's rooms. The latter was not true in the findings of this study because employees had to depend on the nearest hospital for their health related needs and injuries.

There was no evidence that employment of the fulltime occupational health nurse had any positive influence on employee involvement in health promotion programs. For example, in case 1 there was more than 1 occupational health nurse on site and a group occupational health medical practitioner, but only 8% of employees were involved in health promotion programs. On the contrary, in case 6 where occupational health programs were outsourced, 17% of employees were involved in health programs.

Organizational size

As predicted by literature, large size worksites such as case 1 were more likely to have a wide range of health promotion activities (Collins, 1991; Holman, et al., 1998; Lusk, et al 1999 & Morrow, 2003). It was interesting, however, that there was not marked influence in terms of the organizational size and employee involvement in WHP. In all cases, irrespective of their size and type, there was very low involvement in WHP, with small organizations having no involvement at all. In comparing the low involvement among the cases, the private health sector organization had better involvement (17%), followed by a medium sized private and a large parastatal (14%),each. It was of note that in case 1, where there were more resources and more programs than in any other organization, and where 51% of employees were aware of the program, involvement was only 8%.

There is a variety of reasons to which this low level of involvement in WHP in case 1 could be attributed. One reason could be the fact that some employees in this organization were shift workers. The findings of the study by Peltomaki et al., (2003), predicted that seasonal workers and employees who work shifts are less likely to participate in WHP. It was not determined in

this study, however whether the employees who were not involved in WHP were shift workers or not. Only 5% of the employees in this case verbalized that they were “*working shifts and there is stress after that*”. Another study that supports this finding of participation was that of Luski et al. 1999, which found that a common barrier to participation in WHP, regardless of the risk status, was a lack of time.

Policy awareness

Case 2 (73%) and case 6 (63%) had the highest percentage of employees who were aware of health promotion policies. Ironically the highest number of employees who were aware of health promotion policy and programs did not mean the highest percentage of employee involvement in health promotion activities. For instance, in case 2 where 73% of employees were aware of the policy and 39% were aware of health promotion programs, only 8% were involved in any health promotion activities.

As expected, case 3, which had the lowest percentage of employees who were aware of the health promotion policy (10%), had the highest number of employees who were not aware of health programs (84%), and no employees were involved in health promotion programs in this organization. This finding was in line with the study’s assumption that poor implementation of health promotion policies will discourage employees from engaging in health promotion programs (Oldenburg, Sallis, Harris & Owen, 2002).

The finding on employee policy awareness contradicted that of a previous study (Hunt et al., 2000) in which smaller worksites were associated with a higher level of employee awareness

of health promotion programs and employee participation in such activities. The possible explanation that for this finding is that, employees were not aware of the programs because they were non-existent. This explanation is not true for case 1 where the programs were in place, but employees were just not aware of them. Hunt et al's finding could be true for case 6 where there was the highest number of employees who were aware of health promotion programs. This finding could also be attributed to the fact that case 6 was a health sector where employees were expected to have high health literacy.

It was however surprising that in an academic institution which had a high number of literate employee; the percentage of employees who were aware of health promotion programs was 23%, which was the second lowest. It would be expected that the higher the level of education, the more aware the employees would be of health programs.

The majority of medium level managers who were aware of both the policy and health programs were not involved in the existing health promotion programs (table 4.37). This was a significant finding since it demonstrated that increasing the level of program awareness of employees at lower level should increase their involvement in such programs, however, the same could not be true for middle to high management positions. Managers would have been made aware of these health policies only through their involvement in decision making and not because of direct involvement

It should be mentioned however, that even though all cases indicated that they had formal health promotion policies, none of these organizations had a policy that met the definition of

the policy as defined in this study. In cases 1, 2 and 4, the managers, when asked to show the researcher the policy, pointed at the OHS policy documents, which had a section referring to health requirements for their employees. There seemed to be a misunderstanding about what a health promotion policy was and hence reference was always made to national occupational health and safety policies.

This was expected in the private sector as literature has indicated that the legislation and the unions are putting pressure on the private sector to minimize accidents and disease hazards in the workplace (Wolfe, Parker & Napier, 1994). One such piece of legislation in South Africa is the OHS Act (Act 85 of 1993) (RSA, 1993). This Act emphasizes that employers should identify work related hazards and risks in the workplace, and prevent exposure of employees to such risks.

The assumption in the framework of this study has been that **organizational characteristics** such as size, public/private sector, health promotion activities, provision of medical aid, health promotion policies, type of industry, types of risks/hazards, and infrastructure (availability of resources/facilities supporting health promotion) influence health promotion programs. The findings have shown that larger organizations have more health promotion programs and on site occupational health services, but that the issue of a health promotion policy was generally not well understood across all types of organizations.

PROCESS INVOLVED IN IMPLEMENTING HEALTH PROMOTION

INTERVENTIONS

The results on the process of health promotion interventions are based on 4 cases that had OHP. In cases 3 and 6 this data could not be obtained because there were no OHPs to provide this data. An interesting finding was that cases 1 and 2, which were both private organizations, the OHPs said they used a comprehensive structure in the execution of their health promotion programs, while OHPs in cases 4 and 5, which were parastatal organizations, said they utilized targeted structures. Literature defines a comprehensive program structure as the one that includes a well-planned, well funded program, with long range objectives and wide participation (Collins 1999). The OHPs defined comprehensiveness of the program as one that targeted a wide range of health programs at a time.

Literature had predicted that comprehensive health approaches to health promotion would have a strong emphasis on organizational and psychological factors (Aust & Ducki 2004, p. 259). In cases 1 and 2, their approach to health promotion programs focused on changing the behaviour of their employees, which deals with motivation - a psychological factor. Surprisingly, case 4 which used the targeted structure, used both behavioural change and also strove to create a healthy working environment. Aust and Ducki (2004, p. 259) also predicted that a comprehensive program would affect workers' health and increase their participation, but in both cases 1 and 2 participation in health programs was lower compared to the other two cases that were using targeted approaches.

Both the comprehensive and targeted programs had clear objectives but, according to the OHPs in all 4 cases, these objectives were not written down as a document. This finding was a concern because this meant that the objectives could be adjusted by anyone, at any stage, without informing other stakeholders. Not having well documented objectives for the program also implied that it would be difficult to evaluate the program for its outcome and impact.

The finding on the health promotion approach could not be confirmed by other participants such as employees since they were not directly asked about the health promotion approaches in their workplaces. When describing the aims of their workplace health promotion programs, however, the majority of respondents (36%) in case 1 responded that the focus was on educating and changing employee behaviour (table 4.9), in case 4 the respondents (22%) described the programs as educating and preventing illnesses (table 4.19) and in case 6 the majority described the programs as focusing on educating employees on targeted issues (table 4.26). From this finding it could therefore not be concluded that the programs were comprehensive based on the definition of comprehensive health programs in the literature.

All 4 organizations with OHPs used preventive and organizational approaches in implementing their programs. These approaches involved the use of education and use of posters to disseminate health related information and hence increase knowledge. Cases 1, 4 and 5 added that they were also trying to slow down the disease before it occurred. What was common in these three cases was that they had occupational health services on site as part of the organization, and they were all large organizations. This finding was positive as it

demonstrated that large organizations provide more programs than smaller and medium organizations (Ippolito et al. 1999).

In none of these 4 cases was there evidence of a specific health promotion model being used. In case 4 the focus was on the individual and the environment while in the other 3 cases the focus was mainly on the individual rather than the environment. None of the cases focused on the organizational approach to health promotion. This was not surprising, since most cases did not even have a policy on health promotion program. It was assumed that a model would have been based on an existing policy.

Organizational Support

It was a cause for concern that 14% employees in case 1 gave reason for non-participation in WHP as “not interested”. This group of employees did not seem to see any benefit in health WHP for themselves or for the company. According to Morrow (2003), employee involvement can sometimes be increased if employers provide additional rewards for participation, such as flexible credits toward the cost of benefits if an employee meets certain criteria, such as attending health education class or pledges to engage in healthy behaviours.

There was no evidence that employees were involved in planning the existing health promotion programs in any of the workplaces. In their study, Peltomaki et al. (2003) found that active participation of workers in planning and execution of WHP programs would tend to counteract paternalism that tends to clash with the autonomy of the individual or worker collective. This argument was true for case 2 where there was very low employee participation in WHP

programs (14%). The labour unions in this organization were very sceptical of any discussion of health promotion programs and even refused to participate in the study as they felt that the researcher was part of a management “conspiracy”. Aust and Ducki (2004) have suggested a comprehensive approach in rendering health promotion programs, whereby employees participate in the process of identifying their health problems as well as developing suggestion for improvement. This approach, they argue, would increase the sense of ownership and self-efficacy amongst the employees.

All occupational health and safety officers or occupational health and safety practitioners who were responsible for healthy and safety issues in all studied organizations, described the health policy, as focusing almost exclusively on the OHS Act. Though the OHS Act is meant for both health and safety, the findings of this study showed that most emphasis was on the **safety** part of the Act. This was also apparent with the employee participants putting an emphasis on safety issues such as personal protective equipment (PPE). This finding was expected because the **health** programs are not a statutory requirement, but are offered on employer discretion.

Wilson et al.(1999) argued that the incidence of specific persons being responsible for health promotion or health and safety increased significantly with worksite size. The larger the organization, the more people are responsible for health and safety. This might involve a team of occupational health services such as the occupational health nurse, occupational hygienist, occupational medical practitioner, employee wellness program manager, and health and safety manager. This situation is very rare and will only be practicable in very large organizations, but it would ensure that every aspect of employee well being was given some attention.

Uncoordinated WHP programs was one of the findings in this study in that none of the cases studied had a wellness practitioner assigned to coordinate health/wellness programs. As one trade union member was quoted in the focus group discussions in case 4 “...*the program is not well coordinated*”. In case 1 there was a biokineticist who was responsible for the physical fitness of employees, however, this did not increase employee participation in health programs, since there was no team effort with specific goals. All cases, except for case 3, had HIV/AIDS prevention programs in place, but these were programs which were exclusively for the prevention and management of HIV/AIDS, and excluded employees with other health needs. The finding demonstrated that the participating organizations had resources that were available for the wellbeing of employees, but that such resources were used exclusively for HIV/AIDS program at present, owing to the priorities of the country.

The findings in this study indicated that there were resources that were in place in organizations that could be used to enhance health promotion activities but they were either under utilized or the organization was not aware of such opportunities. For instance, in cases 1 and 2, employees were computer literate and mentioned internet based policies (case 1). Employers in these cases could capitalize on this resource by utilizing the computers to advertise their health programs and hence increase employee awareness. Cases 1, 4, 5 and 6 had staff canteens but these did not have a healthy menu. These canteens could be utilized to the company's advantage to sell healthy meals appropriate for employees' needs. This was a similar finding to that of Bradshaw et al. (2001) in a study conducted in SMEs where 32% of the organizations had staff canteens but only 14% of these prompted healthy eating.

As predicted in the framework assumptions, stakeholders, such as management and the labour unions provided support for health promotion programs. Support for health promotion programs was in the form of space (cases 2, 4, 5), supportive information (cases 1, 3, 4, 6), and finance (cases 1 and 2). It was also encouraging that in some cases management was in the process of planning health programs but needed support from outside consultants (cases 2, 4 and 5).

The labour unions in cases 1 and 4 felt that health promotion programs were very important and, as predicted in the study assumption, in these two large cases there were more health promotion programs but there was not much employee awareness. Contrary cases were also found, such as case 3 in which there was much support for health programs from the labour unions, but the organization did not have any health programs in place. Employees in all 6 cases also felt very strongly that health promotion programs were important for them and that they needed more health promotion programs in their workplaces. This was a positive finding as it guaranteed a positive environment for implementing health promotion programs in future.

CONCLUSION

The strengths found amongst the six cases studied were that:

- The studied worksites all had some health promotion/wellness activities in place. These activities were not well organized in the form of policies but they were in place, and could provide a good starting point for implementing wellness programs in these workplaces.

- The management in all the studied organizations was very enthusiastic about setting up wellness programs in their workplaces, to such an extent that they were requesting that their organizations be used for a pilot study if there was such a program. This enthusiasm showed that there was a lot of managerial support for employee wellness programs.
- A majority of employees felt that health programs were very important to have in the workplace and that they needed them in their workplaces.

In conclusion, the health promotion policies developed will have to build on these strengths and address the study limitations if they are to be appropriate and effective in promoting salutogenic or health promoting workplaces.

CHAPTER 6

DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES (PHASES 2 AND 3)

INTRODUCTION

The findings of phase one of this study indicated that in South African workplaces, progress in the areas of workplace health/safety and employee wellness has been achieved independently of each other. The recommendation is a synergic approach that uses the worksite as an axis to promote employee health, safety and wellbeing across the work life. A holistic approach to employee and safety programs will increase productivity and enhance employee well being. An employee wellness policy should be a comprehensive one which advocates employee total well being but also benefits all worksite stakeholders.

In this phase of the study, the aim was to develop policy guidelines to assist managers in any South African workplace to develop their employee wellness policies. In this section the process of the development of these policy guidelines is discussed.

PHASE 2: DEVELOPMENT OF POLICY GUIDELINES

METHODS

A qualitative design was used in this phase. The Delphi technique was selected as one of the consensus methods as the aim was to determine the extent to which experts agreed about workplace health promotion policy. A panel of experts were asked to complete questionnaires during two rounds of the Delphi.

DELPHI ROUND 1

The aim of this round was to obtain opinions, consensus and comments from a group of experts. The researcher developed initial questionnaires based on the findings in the first phase of the study.

METHODOLOGY

The questionnaire focused on five broad issues, namely: (1) The importance and components of health promotion policy document (2) Stakeholder involvement and increasing employee awareness during policy development (3) Type of health programs that could be addressed in the health promotion policy (4) The role of the context during policy development, and (5) Relevant health promotion approaches and models.

Participants

In this round of Delphi, 15 experts in the field of occupational health and health promotion were identified. Letters requesting their participation the study were sent via e-mail. Of the 15 experts approached, 12 indicated interest in participation in the study but only seven experts returned their questionnaires. There were therefore seven participants in total (table 6.1).

Table 6.1: Panel of experts

Expert No.	Gender	Field of practice	Country
1	M	Academic –health promotion	New Zealand
2	F	Academic and practitioner -Health promotion	United States
3	F	Academic – Health promotion	South Africa
4	F	Academic -Health promotion and occupational health	South Africa
5	F	Academic and practitioner -Occupational health	South Africa
6	M	Occupational health and Risk manager	South Africa
7	F	Group occupational health manager	South Africa

RESULTS

The results are discussed based on the broad issues that that were covered in the questionnaire. Participants were requested to respond within two weeks of receiving the questionnaire. Data was analyzed as soon as the response was received from participants. Responses with fewer than 4 participants in agreement were considered as disagreements and had to be further clarified with participants in the next round.

HEALTH PROMOTION POLICY

Respondents were asked to comment on the importance of health promotion policy, its development, as well as what needs to be included in such a policy. From this data it emerged that a health promotion policy was seen as a vital document for provision of effective occupational health and safety services in an organization. Health promotion policy document could however differ from one organization to another depending on employee and organizational need.

Need For a Health Promotion Policy

All participants agreed that there was a need for health promotion policies in the workplace.

Table 6.2: Need for health promotion policy

Expert	Need for HP policy	Reasons
1	A	Well being, accident reduction
2	A	Cost effectiveness, increase productivity
3	A	Wellness, comprehensive health and safety program
4	A	Decreased absenteeism, increased productivity, cost reduction, wellness
5	A	Improved productivity, well being, accident reduction
6	A	Employee well being, improved productivity
7	A	Decreased absenteeism, cost effectiveness, well being

*A indicates agree

*D indicates disagree

The existence of health promotion policies, it was argued, would benefit both the organization and its employees. Having a comprehensive health promotion policy was identified as one way of enhancing an occupational health and safety policy, improving employee wellbeing and hence increasing productivity. The following reasons for having health promotion policies were cited:

Improved employee wellbeing

The belief was that organizations need to focus on the wellbeing of employees, physically and emotionally. By so doing they will keep their employees healthier and happy.

“As an organization we need to focus on the wellbeing of our employees. This does not mean only the physical wellbeing since there are many emotional issues that employees are faced

with these days, such as HIV/AIDS, that affect employees. A healthy employee is a happy and productive employee.”

Increased productivity

Generally, all respondents felt that employee wellbeing was crucial for production because if employees were healthy, they would be more productive, which in turn would benefit both the company and employees:

“Increased health and wellness leads to greater productivity, a happier workforce and less sickness/absenteeism, fewer accidents.”

“If employees are not happy and healthy, they cannot be productive.”

Cost effectiveness

Health promotion programs were also identified by the respondents as a means through which organizations can save money. Having unhealthy employees could result in increased absenteeism also low production. Prevention of illnesses through health promotion was seen as cheaper than curing the disease once it has occurred:

“It is cheaper to provide preventive services than to treat actual health problems once they occur”.

“Health promotion activities will decrease absenteeism rate”

Comprehensive occupational health and safety programs

Some respondents felt that having one comprehensive health and safety policy could enhance the implementation of wellness programs and the OHS Act. The feeling was that implementing individual programs such as occupational health, safety, and HIV/AIDS was not working well. The suggestion was that one person should coordinate a comprehensive occupational health and safety program:

“Currently the government has implemented the employee wellness program (EWP) which is widely implemented, but the EWP does not cover all relevant areas of health promotion. It needs to improve comprehensive health and safety program and not segmented programs e.g. occupational health and safety, healthy workplace, HIV/AIDS, etc.”

“My suggestion will be to have on e individual that will manage or coordinate the occupational health and safety program. We keep on hearing about health and safety, but when you get closer you can see that it’s only safety that is being addressed. Such a policy should be comprehensive, to address all issues related to occupational health and safety’.

Definition of a Health Promotion or Wellness Policy

All but one respondent agreed with the definition that health promotion policy should be defined as *“a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”*

and that *“This document should furthermore stipulate exactly who is responsible for the execution of all health promotion activities in the organization”*.

Organizational Size

Five out of seven respondents agreed that the size of an organization should not be used to determine whether the organization has or does not have a health promotion policy. Basically the feeling was that every organization needs to have a health promotion or wellness policy irrespective of its size. The participants however added that the developed policy should demonstrate that the policy is driven by a wide range of factors such as:

The needs of employees and the organization

“If the intention of the policy is to ensure employee wellbeing, then organizational size should not matter. The policy should rather be guided by the type of issues that the organization and its employees face, for example obesity, because of lifestyle issues”.

“I don’t believe that size should have any bearing on the fact that all organizations, size aside, should strive to implement health education and health promotion programmes”.

Organizational commitment to employee health and welfare

“There must be clear commitment to health policy, organizational reforms, equal rights and determination between workers and managers, behaving as a model employer, with notable commitment to health and welfare of workers and investment in health”

The experts who disagreed with this statement (5 and 7 in table 6.1) felt that the difference in policies developed for different sizes of organizations should be as follows:

Table 6.3: Structure of health promotion policy

	Small organization	Medium sized organization	Large organizations
Focus	Wellness, Health promotion	Wellness, Health promotion through health risk assessment	Wellness, Health promotion through health risk assessment
Content	Health risk assessment, Medical surveillance, Health education, Substance abuse, and HIV/AIDS programs	Health risk assessment, Medical surveillance, Health education, Substance abuse, and HIV/AIDS programs	Health risk assessment, Medical surveillance, Medical aid fund benefits, Wellness, Health education, Substance abuse, HIV/AIDS, programs and DSUI EAP
Structure	Through external agencies on a 3-4 monthly basis	Internal and external agencies, in an annual program, Addressing different work groups on a monthly basis	Internal permanent practitioners

Content of the Policy

There was agreement from all participants that the policy firstly needs to be based on employee needs. The content of the policy also needs to demonstrate that the documentation came into being through negotiation between all the stakeholders. The focus should be employee wellbeing, but most importantly every organization must show its commitment to employee wellbeing.

“Included in this document would be attention to the health and well-being of employees.

A visible and negotiated health policy agenda - based on workers' and the organization's needs assessment. Visible health benefits linked to workers' contracts i.e. health check-ups, health awareness-raising programmes, healthy canteens etc".

"The policy must demonstrate the organizational commitment to employee health and safety. This must be demonstrated by the organizations' pledge on how they will keep their employees healthy. How the policy was developed, such as information on employee involvement might also be important so that whoever reads the policy can see that the organization involved the employees in the process".

In addition to these suggestions, two respondents (4 and 5 in table 6.1) had some specific issues needed to be addressed by the policy and these were as follows:

- The organizational mission and values
- Model to be used
- Message from the CEO
- Health promotion procedure or approach to be followed, for example audits, planning, budgets, evaluation, and so on.
- Any relevant legislation on which the policy is based
- Health benefits

EMPLOYEE AWARENESS OF HEALTH PROMOTION PROGRAMS

Respondents were asked to comment on how to increase employee awareness of the health promotion programs in their workplaces. Literature and previous studies have shown that

involving employees in policy development and continuous awareness creation were constructive ways of increasing employee awareness.

There was agreement on the provided awareness strategies that could be used in different sized or sector organizations. Any 4 or more agreements were interpreted as agreement. These findings can be summarized as in table 6.4.

Large and medium sized organizations

Information via the Internet, information booklets and posters were the most preferred methods for medium and large sized organizations in all sectors, with the majority of respondents choosing this method. In the parastatal and the health sector payslips were the least preferred strategy. In the private sector, however, weekly meetings were also least preferred in large private organizations. One respondent explained the reason for disliking meetings as follows:

“Weekly meetings in large and medium organizations can be impractical and disruptive”

Small organizations

In small organizations across all sectors, posters and weekly meetings seemed to be the most preferred strategies for creating awareness. There was also agreement that payslips information was an effective method in private and health organizations. The internet was the least preferred method in all small organizations.

Table 6.4: Awareness strategies for health promotion programs

Size	Private	Parastatal	Health
Large	Internet 1,2,3,4,5,6,7 Information booklets 1,3,4,5,6,7 Weekly meetings 1,5 Posters 1,2,4,5,6 Pay slip information 1,3,4,6	Internet 1,2,4,5,6,7 Information booklets 1,5,6,7 Weekly meetings 1,5 Posters 1,2,4,5,6 Pay slip information 1,4,6	Internet 1,2,3,4,5,6,7 Information booklets 1,3,4,5,6,7 Weekly meetings 1,3,4,5 Posters 1,2,3,5,6 Pay slip information 1,4,6
Medium	Internet 1,3,4,5,6 Information booklets 1,3,4,5,6,7 Weekly meetings 1,2,4,5,6,7 Posters 1,3,4,5,6,7 Pay slip information 1,3,4,6	Internet 1,4,5,6 Information booklets 1,4,5,6,7 Weekly meetings 1,2,5,6,7 Posters 1,4,5,7 Pay slip information 1,4	Internet 1,3,5,6,7 Information booklets 1,3,5,6,7 Weekly meetings 1,2,3,5,6,7 Posters 1,3,4,5,7 Pay slip information 1,3,4
Small	Internet 1,4,5 Information booklets 1,4,5,7 Weekly meetings 1,2,5,6 Posters 1,3,4,5,6,7 Pay slip information 1,3,4,6,7	Internet 1,5,7 Information booklets 1,5,7 Weekly meetings 1,2,5,6 Posters 1,4,5,6,7 Pay slip information 1,4,6	Internet 1,5,7 Information booklets 1,3,5,7 Weekly meetings 1,2,5,6 Posters 1,3,4,6,7 Pay slip information 1,3,4,6

Additional suggestions

Other methods that were suggested were one on one discussion with occupational health practitioners during induction, and annual medical check-ups. Health days involving family members were another suggestion for increasing employee awareness.

TYPE OF HEALTH PROMOTION PROGRAMS

On identifying factors that should be taken into account when designing health promotion programs, respondents were mainly in agreement that factors such as employee needs, demographics, organizational needs and availability of resources need to be taken into account when designing health programs and policies.

Table 6.5: Factors to be considered when designing HP program

Expert	Employee needs	Employee demographics	Organizational needs	Availability of resources
1	A	D	A	A
2	A	A	D	A
3	A	A	A	A
4	A	A	A	A
5	A	A	A	A
6	A	A	D	A
7	A	A	A	A

*A indicates agree

*D indicates disagree

This general agreement was based on the idea that all these factors are interdependent and play an important role in program development. For example, if resources are not available, programs identified by employees' needs may not materialize. The respondents had the following to say:

"These factors all contribute to a successful program. For example if employee needs are not considered they will not see the need to get involved in the program. Also, if there are not enough and relevant resources the program can not be sustained".

“Employee lifestyle is influenced by both the needs and demographics to a certain degree. Therefore, should be considered. Availability of resources will also determine the type and number of programs.”

THE CONTEXT

All but one respondent agreed that employee characteristics (the context) should play a vital role in the development of organizational health policy and programs. The responses demonstrated largely that employee characteristics, such as age and gender, should have more influence on the policy development than the educational level of employees (table 6.6).

Age

There was agreement for organizations with employees in the age group 20-30 years; health programs should include physical activity (6/7), education on safe sex (5/7) and awareness of substance abuse (4/7). For organizations with employees in the age group 31-50 years, there was agreement should that there has to be stress management programs (5/7). Participants also agreed that programs such as retirement planning (4/7) and disease prevention (4/7) should be offered for employees who are 50 years old and more.

“Simple but effective programs should be offered that do not involve any reading materials and exercise program can be utilized in videos”

Table 6.6: Employee characteristics useful for planning HP programs

Employee	E 1 Agree	E 2 Agree	E 3 Disagree	E 4 Agree	E 5 Agree	E 6 Agree	E 7 Agree
AGE							
20-30yrs	Physical activity, mental health drugs awareness, safe sex	Substance abuse, safe sex, nutrition, exercise, stress management	physical activities, sexuality, reproductive health	Physical activity, accident prevention, Stress management, substance abuse	Healthy living- diet, exercise, sexuality	Physical activity, nutrition, sexuality	Healthy lifestyle, prevention of substance abuse stress management
31-50yrs	Stress management	Stress reduction, nutrition and weight management	Same as	disease prevention, physical activity, stress management, nutrition	Prevention of chronic illnesses, retirement financial planning, stress management	Physical activity, nutrition	Healthy lifestyle, stress management
Above 50yrs	Retirement planning, disease prevention	age specific annual exams, stress management, nutrition	Routine check up, screening, psychological health	Physical activity, stress management	Chronic disease prevention, retirement financial planning, stress management	Chronic disease prevention, physical activity, nutrition	Chronic disease prevention, retirement planning, exercise, nutrition
EDUCATION	Not relevant	Not relevant	Not relevant	Not relevant	Not relevant		
None						Exercise programs	Basic personal hygiene, nutrition,
Primary						Same as above	Same as above
Secondary						Healthy living, physical activity	Physical activity, positive living
Tertiary						Healthy living	Booklets, internet sites on health issues
GENDER		Same for male and female			Same for male and female		
Male	Men's health issues		Substance abuse, safe sex	Any relevant health topics		Men's health issues	Sexual health, substance abuse
Female	Women's health		Women's health, child care	Women's health		Women's health	Sexual health, women's health

Employees with tertiary education were perceived to be more educable as they could engage in any type of information or program, including internet based programs and other reading materials.

Education

Participants were in agreement that (5/7) educational level of employees should not determine the type of health programs that are offered in the workplace, but what should be considered is the technique used to deliver the programs.

Other respondents' views on this issue differed as they felt that employee educational level should be used in designing health promotion policy and programs:

For employees with no education the suggestion was to have:

Gender

There was agreement that be women health programs for women employees (5/7) focusing on such issues as prevention of breast and uterine cancers, contraception and others. There did not seem to be any agreement as to whether male employees required any specific programs.

These respondents suggested that male employees could be involved in any ordinary health promotion activities. The following were the suggestions for male employees:

- Programs have to be the same for male and female employees (2/7)
- Men's health (2/7)
- Safe sex and substance abuse (2/7)
- Any relevant health topic (1/7)

Organizational characteristics

Organizational characteristics such as risk level were not perceived to be vital in policy development on its own, as it was considered that these should be viewed in conjunction with employee characteristics.

For some respondents policy had to be the same irrespective of the context. These respondents however, suggested that health programs should be determined by employee characteristics.

“I disagreed because policy should be broad and guide for implementation. As mentioned above, policy should be the same. The implementation of activities and intervention should differ”.

Stakeholder involvement

All respondents were in agreement that stakeholder involvement was essential in policy development but suggested that different stakeholders could be involved at different levels. Table 6.7 provides information on these levels of involvement as identified in the gathered data:

Table 6.7: Stakeholder involvement in policy development

Group	Role in policy			
	Develop policy	Select program	Implement	Monitor or evaluate
Occupational health practitioners	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7	1,2,3,4,5,6,7
Labour unions representatives	1,3,5,6	4,5,6,7	5,6,7	3,5,6
Employees	1,2,3,4,5	1,2,3,4,5,6,7	1,2,3,4,6,7	1,2,3,4,6,7
Management	1,2,3,4,5,6,7	5,6,7	5,7	2,3,4,5,6,7

HEALTH PROMOTION MODELS AND APPROACHES

Respondents had differing views on the models and approaches that could be relevant in guiding health promotion programs in the workplace.

Models

There was evident agreement on the types of models to be used to guide the planning of health promotion programs and policies. Health belief model was the most preferred model (7/7).

Table 6.8: Models for workplace health promotion planning

Model	E1	E2	E3	E4	E5	E6	E7	Total
Health belief	A	A	A	A		A	A	7
Stages of change		A	A	A	A	A	A	6
Social learning theory		A	A				A	3
Theory of reasoned action		A	A		A			3
Community organization theory	A						A	2
Organizational change theory	A		A	A			A	4
Other :								
Proceed-precede	A		A	A				3

The participants agreed that the following models were relevant, in order of their preference:

Health belief model (7/7)

Some of the reasons given for choosing this model were that “*it focuses on the individual’s attitude and behaviour*”, “*It is useful for behaviour change*” and “*It will allow employees to take initiative for their health*”.

Stages of change (6/7)

This model was chosen for the following reasons: “*provides steps for implementing change*” and “*will provide for implementation of relevant programs.*”

Organizational change theory (4/7)

This theory was the least popular but some respondents identified it as they felt that it “*focuses on organization for all change process.*”

Approaches

There was much agreement in selecting the approaches to be used in the provision of health promotion in workplaces. The two approaches that were mostly preferred by participants were the behavioural change and healthy work environment approaches (6/7), respectively.

The least preferred approach was the curative approach (2/7).

Table 6.9: Approaches to guide workplace health promotion programs

Approach	E1	E2	E3	E4	E5	E6	E7	Total
Educational		A	A			A	A	4
Preventive		A	A	A			A	4
Behavioural change		A	A	A	A	A	A	6
Empowering	A	A	A		A		A	5
Curative		A					A	2
Healthy working environment	A	A	A	A	A		A	6

DISCUSSION

The first round of the Delphi study aimed to establish the degree of agreement or disagreement amongst the experts in the fields of occupational health and health promotion. The questions directed towards these experts were meant to explore the research questions:

1. Who should be involved in developing health promotion policy guidelines, and how should they be involved?
2. What should be included in the health promotion policy?
3. How should the health promotion policy be implemented?

The first question tried to establish the experts' views on having the workplace health promotion policy before asking them more questions regarding the policy development.

Responses to the statement "*Do you agree that organizations in general, irrespective of their size and type need to have health promotion policies focusing on the wellbeing of their employees?*" showed that all participants agreed that a workplace health promotion policy was an important document that all workplaces of all sizes need to have. All participants, irrespective of their location, and field of speciality, agreed on this statement. Again on the reasons for this policy being essential, all participants cited "improved employee wellbeing" as the most vital rationale for an organization to have this policy document. As predicted in literature (Leopold, 2004), employee wellness and increased productivity were the main reasons cited for having a health promotion policy (table 6.2).

In addition, what was apparent from the data, however, was that the experts in the field of occupational health mainly mentioned organization benefits such as increased productivity and health care cost reduction as the reasons for having a health promotion policy, whereas those experts in the field of health promotion mainly focused on individual health benefits such as employee health and safety. This finding was expected because occupational health practitioners are concerned with employee health but they also need to ensure that

implemented health programs have a positive impact on the organization in some ways. In this study this finding was very prevalent among the occupational health practitioners in management positions.

On the question of "*who should be involved in developing health promotion policy*", it was evident from the findings that all participants were in agreement that all stakeholders need to be involved in the process of policy development to some extent. When specifically asked about the different phases of policy development in which stakeholders need to participate, there appeared to be some disagreement, but all participants agreed that occupational health practitioners need to be involved in every step of policy development (table 6.7). This was a general finding among all participants, and not only participants in the field of occupational health, as expected. Participants from countries outside South Africa did not agree that trade union representatives should be involved in any phases of policy development, compared to the majority of their South African counterparts. This finding was expected, because the South African labour system is different from other countries, and the participants from outside South Africa were from a health promotion background.

Also of note was that participants in the academic field did not agree that labour unions should be involved in program selection and implementation but involved only in program planning and monitoring or evaluation. On the contrary, experts who were non-academic, and in the field of occupational health, all agreed that trade union representatives should play a role in program planning or development and selection. This finding, it was understood, was based on the fact that experts in the field of occupational health had an understanding of the important

role that the labour unions play in influencing decisions taken by their members (employees) and that labour unions are viewed as employee representatives. This understanding was also confirmed by the finding that the majority of participants in all fields agreed that employees should participate mainly in the program selection and implementation phases. The assumption was that in the planning phase employees will be represented by their labour unions and can actively participate in selecting the programs through surveys, and will participate in implementation through their involvement in health programs.

On the question of what should be included in the health promotion policy, the assumption in this study was that the type of health promotion policy and programs offered would differ depending on organizational size. Participants were in agreement that all organizations irrespective of size and type should have a health promotion policy. The participants furthermore indicated that other factors, including organizational size, would determine the content of the policy.

There was not much agreement on what needed to be included in the policy. Some participants did not seem to have understood this question very well, which might have been the cause of disagreement. It was, however, noted that some participants in the occupational health field, though in the minority, clearly outlined that the workplace health promotion policy needed to have the following considerations/ sections; (1) The focus of the policy, (2) the contents, and (3) the structure of the policy. These have been summarized in table 6.3. This broken down and summarized report of policy, had to be sent to the participants again in the second round of Delphi, to obtain their clarity and agreement or disagreement, for confirmation.

There was however agreement that policy content should be based on factors such as employee needs and that policy content should demonstrate that it was developed in consultation with employee consultation (employee involvement). According to the National Institute for Occupational Safety and Health (NIOSH) organization of work model, other work contexts such as aging workforce (employee characteristics), task attributes and organizational context, have an impact on employee work and safety (Sauter, et al. 2002). These factors should therefore be considered when developing a workplace health promotion policy. Participants identified such factors as employee characteristics and work context, such as the nature of work, as factors that should be considered when planning a health workplace health promotion policy.

Interestingly, some participants in the academic field pointed out that the policy should demonstrate the model or approach guiding the policy. The occupational health practitioners on the other hand mentioned that the legislation guiding the policy and the benefits to the company need to be reflected in the policy. These two findings showed that for if these experts could work together in the policy development the results would be a policy which uses both the relevant legislation and health promotion models as a policy framework. During the policy development process policy makers should therefore merge the two components in shaping the health promotion policy document.

Other recommendations were that the policy should be comprehensive and include both health and safety programs. This finding was also supported by NIOSH representatives (2006) where

they agreed to the use of a comprehensive policy that would address comprehensive health and safety programs rather than selective programs.

CONCLUSION

The participants in this round of the Delphi agreed on a majority of statements, such as the need for a workplace health promotion policy, who should be involved in policy development and some aspects of the policy contents. There were however some disagreements and other factors that still needed some clarification.

DELPHI ROUND 2

The aim of the second round of the Delphi was to give feedback to the participants and to allow them an opportunity to reformulate their responses. This feedback was also accompanied by another questionnaire which had been reformulated based on the results of the first round. The results of the first round were used to develop the draft policy guidelines. In round 2 of the Delphi this draft document of policy guidelines was sent to the participants to comment on it.

Participants

In this round of Delphi the questionnaires were sent to the seven experts who had participated in the first round of the Delphi. Letters requesting their further participation in the study were sent via e-mail. Of the seven experts that were approached, five responded. There were therefore five participants in total (table 6.10).

Table 6.10: Panel of experts

Expert No.	Gender	Field of practice	Country
1	M	Academic –health promotion	New Zealand
2	F	Academic and practitioner- health promotion	United States
3	F	Academic – Health promotion	South Africa
4	F	Academic -Health promotion and occupational health	South Africa
6	M	Occupational health and Risk manager	South Africa

Data Collection and Instruments

Participants were asked to respond to the reformulated questions, and summarised findings, by indicating their agreement or disagreement with the given statements. Participants were also given a choice of reranking their previous responses if they wanted to.

The instrument was formulated based on the findings of the previous round of the Delphi. The instrument had two sections,, section A and section B. Section A focused on the findings in the previous round of the Delphi, while section B focused on the policy guidelines. Participants were given a draft copy of policy guidelines and were asked to comment on them, by showing their agreement or disagreement with what was included in the document.

There were four subsections in section A, namely:

1. Health promotion policy
2. Employee awareness of health promotion programs
3. Types of health promotion programs, and
4. The context

In section B participants were asked to comment on the following four subsections of the policy guidelines:

1. Choosing employee health promotion/wellness program- This section aimed to answer the questions “Who should be involved in developing health promotion policy?” and “What health promotion programs should be addressed in the policy?”
2. Key policy elements – this section was to answer the question “What should be included in the health promotion policy guidelines?”
3. Policy implementation plan – “ How should the health promotion policy be implemented?” and
4. Policy evaluation – This section aimed to answer the question “How should the health promotion program be evaluated?”

RESULTS

In this second round of Delphi, section A of the instrument focused on five broad themes that were the focus in the first round. The aim in this round was to focus on the areas where there was disagreement and give feedback on response where there was agreement. These themes were (1) health promotion policy, (2) strategies for increasing employee awareness of health promotion programs, (3) health promotion programs, (4) the role of the context during policy development, and (5) relevant approaches and models. Section B of the instrument asked participants to indicate their agreement or disagreement with the following sections of the policy guidelines (1) Choosing employee health promotion/wellness programs, (2) Key policy elements, (3) Policy implementation plan and (4) Policy evaluation.

SECTION A

HEALTH PROMOTION POLICY

Respondents were requested to indicate their agreement or disagreement with the feedback given on the need for a workplace health promotion policy and the reasons for having such a policy. All 5 respondents agreed with the given statement and that the reasons for having such a policy would result in improved employee wellbeing, increased productivity, cost effectiveness and comprehensive occupational health and safety programs.

Definition of a Health Promotion or Wellness Policy

All 5 respondents agreed with the definition of the health promotion policy *“a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”* and that this document should furthermore stipulate exactly who is responsible for execution of all health promotion activities in the organization.

Organizational Size

All 5 respondents agreed with the given statement that the size of an organization should not be used to determine the focus of the health promotion policy but that every organization needed to have a health promotion or wellness policy irrespective of its size through the content of the policy would depend on the needs of employees and the organization.

Content of the Policy

All 5 respondents agreed with the statement that the content of the policy needs to demonstrate that the documentation came into being through negotiation among all the stakeholders and that the focus should be employee wellbeing.

EMPLOYEE AWARENESS OF HEALTH PROMOTION PROGRAMS

There was some disagreement on the rating of the awareness strategies that could be used in different sized or different sector organizations. Two out of five respondents agreed with the given strategies but disagreed with the ratings given to them. One respondent disagreed with the strategies altogether and maintained that these strategies could only be used in health education and not in health promotion, the remaining two participant agreed with the strategies and rating. The researcher contacted the three respondents who were in disagreement, and also referred to the literature (O'Donnell 2004; Cottrell, Girvan & McKenzie 2006, p.8) which stated that both health promotion and health education programs can make use of these awareness strategies. A decision was then taken to use these strategies in any size organisation and in any order, depending on what is feasible for the organisation.

TYPE OF HEALTH PROMOTION PROGRAMS

On identifying factors that should be taken into account when designing health promotion programs, respondents were all in agreement that these factors such as employee needs, demographics, organizational needs and the availability of resources need to be taken into account when designing health programs and policies.

TYPE OF HEALTH PROMOTION PROGRAMS

All 5 respondents agreed on the factors that should be considered when designing health promotion programs, namely, employee needs, employee demographics, organisational needs and availability of resources.

THE CONTEXT

All respondents but one agreed with the statement that the context (employee characteristics) should play a role in development of health promotion policy and programs). The respondent who was in disagreement with the statement suggested that other characteristics such as work characteristics (risk, hazard, shift work, chemicals, stress) should also be considered, in addition to employee characteristics, when designing workplace health policies.

SECTION B

Respondents were requested to comment and validate the developed policy guidelines by indicating their agreement or disagreement with the given sections of the guidelines.

CHOOSING EMPLOYEE HEALTH PROMOTION/WELLNESS PROGRAM

Health Programs to be included in the Policy

All participants agreed with the suggested programs except for two respondents who disagreed with spirituality (2, 6) and one disagreed with prevention for targeted specific groups (2).

Table 6.11: health promotion program to be included in policy

Health promotion program	1	2	3	4	6
Employee assistance program (EAP)	A	A	A	A	A
Spiritual exercise e.g. prayer meetings	A	D	A	A	D
Weight control	A	A	A	A	A
Healthy diet/Nutrition	A	A	A	A	A
Physical fitness	A	A	A	A	A
Control of smoking/substance abuse	A	A	A	A	A
Stress management	A	A	A	A	A
Chronic disease management	A	A	A	A	A
Prevention targeted, at specific groups e.g. young employees, older employees	A	D	A	A	A

Decision on Programs to Include

There was agreement on some of the factors on which decisions need to be based.

Table 6.12: Deciding on programs to include

Decision based on:	1	2	3	4	6
Employee needs	A	A	A	A	A
Organizational needs	A	D	A	A	A
Employee demographics	A	A	A	A	A
Availability of resources	A	A	A	A	A
Country's health priorities	D	D	A	A	D

Three out of five respondents (1, 2, 5) disagreed that the country's health priorities should be considered in deciding on the health programs that need to be offered.

Stakeholder Involvement

All 5 respondents agreed that all stakeholders need to be involved in all levels of policy development.

KEY POLICY ELEMENTS

Four of the 5 respondents agreed with the suggested key policy elements. One respondent disagreed with the inclusion of organisational philosophy and stakeholder involvement, but no explanation was given for this disagreement.

POLICY IMPLEMENTATION PLAN

All 5 respondents agreed with the suggested policy implementation plan.

POLICY EVALUATION

All respondents agreed that the health promotion policy document needed to be monitored and evaluated at regular intervals.

Evaluation focus

On the focus areas for evaluation all respondents agreed on the majority but one respondent disagreed on evaluating health literacy and another respondent disagreed with evaluation of organisational practice.

DEVELOPMENT OF POLICY GUIDELINES

The data obtained from rounds 1 of the Delphi were used to develop the policy guidelines for health promotion in the workplace. The draft document of the policy guidelines was developed based on the results of phase 1 and round 1 Delphi. This draft document was sent together with the round 2 Delphi questionnaire to the participants to comment on it.

Since there was much agreement on the content of the draft document, the results of round 2 Delphi and relevant literature were used to refine the policy guidelines document.

In developing the policy guidelines, the researcher used the results of phase 1 of the study, results of rounds 1 and 2 of the Delphi and relevant literature. The guidelines address such aspects as 1) the significance for health promotion policy in the workplace, 2) key policy elements, 3) choosing health promotion programs to be addressed in the policy, and 4) implementation of the policy guidelines. The developed policy guidelines were augmented by an algorithm which would be used in conjunction with the guidelines during policy development. Both these documents are presented in appendix 4.

The quality of the developed policy guidelines was further enhanced during policy development in phase 3. Participants were asked to evaluate the policy guidelines and provide their feedback on how they had experienced using the guidelines. Further adjustments were made on the guidelines based on the feedback of the participants in phase 3.

CONCLUSION

The participants in this round of the Delphi agreed on the majority of statements.

Disagreements were very minimal and therefore no need not to explore further. There was also more agreement on the structure and content of the developed policy guideline. The guidelines were hence refined accordingly.

PHASE 3: POLICY GUIDELINES IMPLEMENTATION

INTRODUCTION

The objective of this phase was to describe the implementation of the policy guidelines in selected organizations. The researcher spent an extended period in the worksite to conduct observation of the guidelines implementation.

SAMPLING

During phase one, the researcher had indicated to all six participating organizations that they might be requested to participate in phase 3, the implementation phase. Two organizations, cases 2 and 4, had initially indicated their willingness to participate in the implementation phase. In preparing for the implementation phase the researcher approached the six organizations that had participated in the first phase of the study to determine their interest in participating in the implementation phase.

The four cases that had not indicated their interest in participation were contacted first, and the other two, the large parastatal and the medium private organization, last. The organizations that did not participate in the implementation phase cited the following reasons for their non-participation:

- **Case 1 (large private organization)** - The management of this organization felt that they were already implementing parts of the health promotion program. They appreciated the present study in assisting them to evaluate their health programs, but felt that they already had health policies in place. For these managers the occupational health and

safety policy that the organization had was meant to address the employees' health issues.

- **Case 3** (small private organization) – For the management of this organization, the study was a good idea, but they felt that their organization was not at the stage where they were ready to implement any health promotion policy. Their reason was that the organization considered itself to be too small to implement such policy as they did not even have an occupational health nurse and their health related services were outsourced. According to management, the company handling their employee health needs should formulate such policies.
- **Case 5** (large parastatal organization) – This organization was already in an advanced stage in the process of formulating their health policy, which was only on HIV/AIDS policy. They welcomed inputs from the researcher during their policy implementation. The researcher already had another large parastatal in the sample, and in case 5, the labour unions had not participated in phase 1 of the study. The researcher therefore had to choose another large parastatal case in which all stakeholders had participated.
- **Case 6** (medium health sector) – In this organization the managers indicated that for an organization such as theirs, the health of employees is important to them, but their employees are well aware of health promotion issues. Also the health promotion/ occupational health services are outsourced which made it difficult for them as an organization to develop a formal health promotion policy.

Therefore, cases 2 and 4 were the two organizations that participated in the implementation phase.

This finding highlighted the gate keeping role of management during the research process. It is not clear if other stakeholders had any say in decision making regarding the organisation's participation in research. Managers are normally expected to decide which party they should act for, the company or the stakeholders, and this may create ethical problems in decision making (Urpilainen & Takala 1996). The assumption was that management would protect the company against unwanted or unnecessary external interventions. Company management however, besides gaining profit, has a duty to work for the wellbeing of their employees and to take care of the environment in which they operate. Employers therefore need to involve employees in decision making regarding their health. If all stakeholders were to participate in decision making, organisation could be transparent and present a more detailed report on who was involved in deciding whether to participate or not to participate in research relating to employee issues. Having management as gate keepers could be relevant in other types of research, such as that focusing on organisational structure or behaviour or evaluation of management programs.

OBSERVATIONS OF POLICY GUIDELINES IMPLEMENTATION

The researcher visited both organizations, case 2 and case 4, to describe how the process of guidelines implementation was to be conducted. This section of the study describes the implementation of the policy guidelines in selected organizations. The findings on the collected data are discussed based on the following research questions:

- How do managers implement policy guidelines?
- Who was involved and what process was followed to involve them?
- What aspects were successfully implemented and which were not?
- What were the barriers during implementation?
- What were the support factors?
- What were the short term outcomes?

Case 2

Case definition

This case was a medium sized private company. It is a fairly new organization, almost 10 years old, with only one site in KwaZulu Natal. The organization had a total of about 200 employees. The organization had a mixture of permanently employed and contract employees, male and female employees, with male employees being in the majority. The site had an occupational health centre, which was shared among the three organizations within the premises. There was a locum occupational health doctor and an occupational health nurse, employed full time by a company,. The company had one newly formed trade union with two shop stewards.

On the management side, there was an operations director who had a risk manager reporting to him. The safety, health, environment and quality (SHEQ) officer, who was responsible for health related issues, reported to the risk manager. The researcher therefore had to work with both the risk manager and the SHEQ officer.

Data collection process

A shortened and simplified version of the study findings was presented to the managers for comment. There was much concurrence with the findings and the researcher was informed that since they had participated in the first phase of the study, the organization had realised that changes had to be executed in the health promotion programs. They updated on changes that had transpired in this organization in the past year, since phase one of the study was conducted.

These changes included:

- The appointment of a new fulltime occupational health nurse
- The introduction of new health programs, such as an HIV/AIDS Program
- A plan by the health and safety team to implement a comprehensive program that addresses employee health and safety issues equally.

The researcher then reiterated the objectives of the study and that the aim was to work with the organization in implementing the health promotion policy, using the developed policy guidelines. The managers were pleased and willing to develop their policy, with the researcher as an observer. The researcher was invited to attend weekly health and safety team meetings.

The researcher worked with this organization from the 9th October 2006 until the 6th December 2006. The data collection technique was through observation. The observed behaviour and process were documented using copious field notes, informal interviews and a checklist. The researcher met different stakeholders who were involved in policy development and attended

the policy development meetings to observe the process being followed. Sometimes the researcher had informal conversations with other stakeholders to confirm the observations.

Implementation of policy guidelines

The process of policy development involved the arrangement of meetings with stakeholders, brainstorming in subsequent meetings, e-mail discussion, consultation with other larger organizations, outside consultants and sometimes with the researcher herself, to clarify some aspects of the policy being developed. The researcher held a total of 5 weekly meetings with the stakeholders in this organization.

Since this organization was already in the process of reorganizing the health and safety policies, the managers were very much involved in the process and showed a lot of commitment. The following categories were observed during the implementation process:

Planning

During the first meeting the participants were given a copy of the policy guidelines document, the long document and the algorithm (appendix 4). All participants were asked to study the documents and draft their ideas on the proposed health promotion policy, based on the documents. Planning for the next meeting was done with all participants being given a portion of the policy to report on at the next meeting for example reporting on the idea of what needs to comprise the purpose, contents, and other sections as defined in the guidelines, in the new policy document. Participants were also requested to look at the policy guidelines and determine if they were relevant to this organization and if they would be applicable in the

present policy development process. The first meeting was therefore viewed as a planning meeting in which participants would plan the policy implementation.

The process of policy development was well coordinated in this workplace with all activities planned. The planning involved such logistics as who would be involved in the process, when the meetings would be held, what would be included in the draft policy, and how will the present policy be affected by the one being developed. Owing to the time constraints, not all guidelines steps could be implemented but the committee had a plan on how every step would be implemented. Timelines were set on what needed to be completed by when and by whom. The plan for policy development was as follows:

- The committee decided to formulate a diagram depicting
- the proposed policy in brief with the policy statement, objectives, targeted programs, benefits and evaluation method. The idea was to present this diagram to the senior management for their approval;
- The committee had to come up with fund-raising strategies to support the implementation of proposed health programs so as to convince senior management that these programs would not require lots of money,
- To set realistic goals and evaluation techniques;
- To set up a health promotion program which would be spread over the whole year, with a theme for every month focusing on a specific health topic such as breast cancer, TB, HIV/AIDS and so on. Health calendars influenced by the national health calendar would be displayed in strategic places as part of health promotion awareness;

- The proposed policy should depict the company's commitment to employees' health and safety and to environmental health,
- There was a plan to have a total of 5 meetings with the first three meetings aiming to draw up a proposal for the policy, the 4th meeting for ratification of the policy by senior management and the fifth meeting to finalise the policy document.

According to the plan, every committee member needed to understand his/her role and to try and meet the deadlines.

Role allocation

During the policy implementation process, all participants were clearly informed of their roles in the process. This would make things easy for the participants. For example the OHN was asked to work out the list of possible health programs to be targeted in the policy, the risk manager was asked to start working on the introduction section of the policy. Someone was asked to take minutes during the meetings, other participants were asked to search for relevant information, call other organizations and attend relevant workshops. Clarifying the roles of every participant, made it easier to supply feedback in the subsequent meetings and to avoid confusion.

Relevance of the policy guidelines

In one of the earlier meetings the participants reported that on reading the policy guidelines document they had realised it was relevant for policy development exercise in their workplace. It was, however, pointed out that the problem was that there was an already existing health and safety policy which was in line with the government's OSH Act. The feeling amongst

participants was that they would have to substitute the new policy for the existing policy to avoid having a number of confusing policies. After much brainstorming, it was decided that the document would be referred to as *“Employee well-being policy”*. The idea was that this will be a comprehensive document which would be supported by the organization’s health and safety policy. The participants felt that such a policy would create a positive wellbeing culture based upon prevention, by integrating occupational health and safety with general wellness promotion programs such as physical activity and control of substance abuse. One participant even indicated that:

“Well-being will mean that an employee is healthy physically, emotionally, and mentally, which will have an impact on how our employees practice their work safely. Healthy employees will be more safety conscious as they will work with clear minds.”

During the implementation process the participants always brought their copies of policy guidelines algorithm and would always refer to the step being discussed in the meeting. Feedback was frequently given to the researcher on the usefulness of each step. A comment that came from one of the participants was that having the algorithm was very helpful for quick reference:

“I am so glad you compiled this shorter version of the document which provides quick reference and page numbers. We are such busy people and cannot sit and read the long document. If we need to read further we know exactly where to look. The guidelines are easy to follow and very simple”.

The guidelines were therefore described as relevant in guiding policy development in this workplace.

Identification of relevant health programs

In the subsequent meetings the participants brainstormed about the health promotion programs to be targeted in the policy. There was agreement that individual health programs would fall under the comprehensive well-being program. The idea was to use a staggered approach in the implementation of such programs as the budget would not allow implementation in one phase. The OHP presented her ideas, based on a workshop of HIV/AIDS peer educators. She proposed that the company adopt the idea of having HIV/AIDS peer educators. After some brainstorming the committee liked the idea but the concern was that these educators would focus on one program, which is HIV/AIDS. At the end the committee suggested other relevant name for these employees who had to be trained to provide support to other employees on health and safety related issues.

There was more brain storming during which programs were targeted with reference to the example given in the policy guidelines document and the ones that already existed in this workplace. Finally, the following wellness promotion programs were identified as those to be added to the existing safety programs:

EAP – The plan was to document how this program worked and its objectives. The participants indicated that this program already existed but was not well documented.

Tuberculosis prevention and treatment- The committee had a plan to implement this program continuously, including the DOTS program, and dealing with stigma

Peer educators – There was a plan to train some employees to provide support to their peers

Weight control- The plan was to revamp the already existing weight control program with more awareness and restructuring.

Involvement of different stakeholders

The main committee involved in the health promotion development policy involved 3 managers. These were the risk manager, SHEQ officer and the OHP (occupational health practitioner). These 3 participants were involved in this committee for the following reasons:

- They were already members of a health and safety committee in this workplace,
- In the first phase of the study people in the same positions had participated,
- They had already been selected in the organisation to start working on the health policy.

These three participants were only the core committee members who had to draft the policy document but had to report back to the senior management and to other employees on the policy development process.

According to these participants, the organisation aimed to involve the employees once a drafted policy was finished. The reason for this lack of employee participation in the planning process was that the organisation had initially planned to have the trade union representatives participating in this phase of policy development as employee representatives, but they were not willing to participate as they said they had other issues to deal with. The researcher's attempts to talk to the shop stewards were also futile. The management were, however, not deterred as they were planning to have other employees participate in the next phase of policy development, in the form of a survey, whereby employees would be asked to provide their

input on the developed draft policy. The other participant in the development of this policy was the occupational health doctor who was not physically present at the meetings but was consulted on a regular basis for his input.

Implemented aspects of policy guidelines

The committee's decision was to have a very concise policy document which would be user friendly for all stakeholders. The draft therefore consisted of the following sections:

- **A policy statement** which expressed the philosophy of the organization and its commitment to employee health and safety, and commitment to comply with the OHS Act,
- **The purpose of the policy.** This section comprised policy objectives and benefits to the organization and its employees,
- **Involvement of stakeholders.** This is where the policy described the inclusiveness of the policy and how all stakeholders were involved, and at what phase of the policy development process they were involved
- **Health promotion programs and evaluation.** This section was more detailed and outlined which programs would be addressed in the policy. Each program was briefly described, and the health promotion approach to be followed to implement the program. The evaluation strategy, that is when the project would be evaluated, for example every 6 or 12 months, was also briefly stated.

In their planning, the committee clearly specified who would be responsible for every aspect of policy implementation and how it would be implemented. For example it was specified which services would be outsourced and which ones would be offered on worksite. The other aspect of planning was working out a draft budget for these services. The policy structure was therefore well implemented as the planning was properly done on paper and presented to management.

The committee was still not sure how certain aspects of the policy would be implemented, for example, creating awareness among employees. There was still no agreement as to which strategy would be more effective to use in communicating this policy to the employees. One member felt that notice boards and posters could be used while other members other methods such as payslips and intranet should be used. This aspect was still to be discussed at length. The committee also tackled the issue of creating a supportive environment, that is, how the organization would support the health promotion programs. It was, however, clear that support could be offered in terms of structural and human resources, as long as it did not take much of the employees' time, because production was more important. Financial resources were still a sensitive topic as the financial director was not keen to release any funds specifically for health promotion activities.

All committee members agreed on that dealing with behavioural change in employees would take a long time to achieve as they felt change in behaviour was an individual decision. They however indicated willingness to use methods such as role models to encourage behaviour change more, especially in implementing HIV/AIDS and substance abuse programs. The plan

was to conduct evaluation of this policy after a year and determine if it had worked and implement changes or adjustments where possible.

Barriers during implementation

The planning for policy development process in this organisation seemed on observation to be going well. There were, however, some barriers that were observed to stall the process. The following factors were identified as such barriers:

Non-participation of some stakeholders

During the planning phase of policy development only middle managers were involved, with senior managers allowed to give their input. The employees were not involved in this phase, and the shop stewards were also not involved in this very essential phase of policy development. During informal conversation and observations, it was found that some employees were eager to participate in the policy development process but since it was not in the committee's plans, this could not happen. This non-participation of other stakeholders in the planning phase resulted in decision making being delayed, as the committee had to consult with the other stakeholders before taking a decision.

Timing of the policy development process

The policy development process was initiated during the months of October and November, and since this was towards the end of the year, the managers were concentrating mostly on the production process before the year-end shut down. The committee members were therefore interrupted in meetings as they had to attend other meetings relating to production issues.

Lack of financial support

Bad timing also meant that the company had already worked out the budget for the following year, which affected the allocation of financial support for the health promotion programs. The managers could not confirm if there would be financial support for health promotion programs but could only say that they would do whatever was in their power to ensure implementation of these programs. There was therefore no commitment from management for provision of financial support.

Support factors

The support factors in this organization had always been observed even during the first phase of the study. The identified support factors were:

Positive stakeholder attitude

The managers in this organisation demonstrated a lot of commitment to working on this policy. The managers expressed their enthusiasm about making this process a success. The following are quotes from some of the managers:

“We are taking this (policy development process) very seriously and would like to try implementing a comprehensive health and safety policy as recommended, since we already have a safety program in place”.

“We need to start moving as soon as possible. We need to start by training about 5 peer educators. We need to find someone who can conduct this training for us, but in the long run we will need to have our program running”.

The stakeholder attitude toward policy development was therefore very positive, which would facilitate the process.

Timing

When the researcher arrived at this workplace to initiate the process of policy development, the managers were already in the process of reviewing their health policy. The policy guidelines were therefore welcomed by managers to provide some guidance on how to develop a relevant policy, which was also research based. The process was made easier by the fact that there was already an existing policy which had to be reviewed. This was better than starting on a new policy.

Short-term outcomes

The only short-term outcome that could be observed was organisational practice. The other two outcomes, namely health literacy and social action could not be observed, since they focused on such factors as employees' actions and attitudes. The fact that employees did not participate in the planning phase made it difficult for the researcher to obtain any data on employee opinion, intentions and attitudes. Regarding organizational practice, the following observations were made:

Policy statement

During the first phase of the study it was reported that this organization had a health and safety policy but this policy, it appeared in the third phase, did not have a very clear policy statement. The organization therefore reported that after the first phase of the study, it was decided by

managers that they needed to revisit their existing policy to work on some aspects of the policy such as the policy statement.

Resource allocation

The management in this organisation had decided to allocate more resources for health promotion. An example was deciding on sending five employees for training in health and well-being, to provide support to other employees. Initially management was a bit wary of this idea since they felt it was going to affect the production process, but after discussions they realised that there would be organizational benefits too. Although the organisation did not commit financial resources, they were not against the idea and were willing to source other funds to assist in this regard. Other company resources could also be used for such activities as training, awareness campaigns and skills development.

Organisational practices

The organisation was already taking an initiative in reorienting its work environment to be a health promoting worksite. Such initiatives included:

- The appointment of a new fulltime occupational health nurse,
- The introduction of new health programs such as an HIV/AIDS Program,
- Appointing a health and safety team to implement a comprehensive program that addresses employee health and safety issues equally.

The managers' attitude towards health promotion activities was a very positive one.

Case 4

Case description

Case 4 was a large Durban-based parastatal organization, which specialized in heavy machinery. During phase 1 of the study, the organizational structure was such that there were several units that were headed by managers. The occupational health centre was under the engineering unit. This meant that the occupational health nurse reported to the plant engineer, who was the unit manager. The unit manager, in turn, reported to the business manager. There was an EAP manager who reported to the HR manager. This meant that the OHP and EAP manager worked in different units.

When the researcher returned for phase 3 of the study, there had been some changes in the structure and new staff members had come on board. The changes were as follows:

- The previous plant engineer who had participated in phase 1 of the study had left the organization,
- The OHP now was under the risk management unit,
- A new risk manager had just joined the organisation,
- The EAP program was now managed by a new social worker who reported to the risk manager,
- The previous HR manager who had participated in phase 1 of the study had left the organization.

These changes meant that the OHP and the EAP manager reported to the same person, the risk manager..

This organisation had a very strong structure of two labour unions, with fully employed union representatives on site.

Data collection process

The researcher made an appointment to meet with the risk manager, the social worker, labour union representatives and the OHP, to discuss with them the findings of phase 1 of the study. The aim of this first meeting was to give feedback to the participants but also to give the risk manager and other new managers some background understanding of the study.

A shortened and simplified version of the study findings was prepared for the presentation. On arrival at the worksite, the researcher was informed that the risk manager could not attend the meeting and had asked the OHP to report back to him. The researcher presented the findings and there was much concurrence with the findings. The researcher then outlined the plan for the third phase of the study, that is, working with the stakeholders in implementing the health promotion policy, using the developed policy guidelines. The participants were more than willing to participate and informed the researcher that the organisation was in the process of restructuring the organizational health unit and programs. The next meeting for these company representatives was scheduled for the following week. The participants were asked to look at the copies of policy guidelines to familiarise themselves so that they could analyse them to see if they could use the guidelines and report on this at their subsequent meetings. The researcher was allowed attend these planning meetings and observe the implementation of guidelines. A total of four weekly meetings were attended between 31st October and 29th November 2006. The researcher also had some informal conversation with some stakeholders.

Implementation of policy guidelines

In the four meetings that the researcher attended, the social worker and the risk manager each attended one meeting, where the risk manager left before the meeting was finished, the labour union representatives attended two meetings, whereas the OHP attended all four meetings. The researcher ended up interviewing the OHP at the last meeting where other stakeholders did not attend.

In the meetings where the researcher was observing, the following categories emerged from the data were observed during implementation process:

Lack of team work

There was not much team work in planning for policy development that could be observed during the meetings. In the subsequent meetings only the OHP brought a draft document which she said she worked on in consultation with the company's social worker and one labour union representative.

In this draft document, the discussion was around the EAP and HIV/AIDS programs. The document proposed who should coordinate these programs, what the program objectives should be and who would be targeted. The policies were directed towards improvement on the existing policies. These would be called 'HIV/AIDS policy' and 'the EAP policy'. The OHP was to coordinate the HIV/AIDS aspect and the social worker was to coordinate the EAP aspect. They would both report to the risk manager. This plan could not be taken any further because the risk manager, who was not in the meeting, still had to read comments on it and then forward it to senior management for approval.

Conflict during planning process

The planning process in this organisation was complicated because it involved planning for restructuring of the whole health unit and not only the development of the health policy. The agenda of the first meeting was therefore a very long one, where stakeholders had to decide on what would happen to the occupational health unit. Before the policy guidelines could even be looked at, there was a heated dialogue as the manager presented his proposal that the occupational health services, which were previously part of the organization were to be outsourced. The labour unions and the OHP did not like the idea. The planning process for the policy development was therefore interrupted by other discussions related to the restructuring of the occupational health services. The observation was that the stakeholders could not start implementing the policy guidelines before they had negotiated and agreed on restructuring the agenda.

Relevance of policy guidelines

The OHP and the union representatives were very willing to give feedback on the developed guidelines in their policy development. From the informal conversations with these participants it emerged that:

The union representatives felt that the guidelines were very relevant and could be used in policy development but the problem was that there were so many disagreements between managers and the employees, which could delay the policy development process.

“On reading the guidelines I felt that they could really apply in this workplace. I just hope we can resolve this matter and start working on the policy because this (policy) is what we need.”

The OHP felt that the policy development process had to go on since the company will need it any way, irrespective of where the occupational health service was placed.

“For me, these guidelines are what we need to help us develop our health policy. We are in the process of reviewing our EAP and HIV policies. The idea is to merge all employee health related programs. Does it really matter where the occupational health services are placed? All I know is that we need these policies in this organization.”

The risk manager could not comment on the relevance of the guidelines since he had not had enough time to read the whole document and felt that he needed more time to do it.

Involvement of stakeholders

In this organization the participants who had initially been identified to participate in the study were the ones who had participated in the first phase of the study or people who had been substituted for the previous participants. This involved the OHP, two labour union representatives, risk manager, who was responsible for the health unit, and the social worker, because she had joined the health unit and was responsible for EAP. Observation on stakeholder involvement showed the following categories:

Inconsistent participation

Not all stakeholders were consistently involved in policy development. Only the OHP and the labour unions were committed to developing the policy. Other stakeholders did not even show interest in the policy development process

Employee non-participation

During the policy development process, there was no mention that employees would be involved. The only time employees would participate would be during implementation, when they would participate in health programs.

Role clarification

The committee was not formally nominated and there was therefore no role clarification. Participants did not know what was expected of them and therefore attended only if they were available. Those who attended the meeting sometimes came unprepared as there was no minute taking to show responsibilities had been given to participants in previous meetings.

Implemented aspects of policy guidelines

Owing to other unforeseen situations, such as discussions around occupational health service outsourcing, only a minor aspect of policy guidelines were implemented. There could also be no forward planning on other aspects of the policy guidelines since there were other bottle necks relating to the restructuring process and the non-involvement of managers. The only aspects of the policy guidelines that could be successfully implemented were the first three steps.

The participants were all in agreement that it was imperative for this organisation to review its wellness policy. As in the first phase, the unnecessary participants felt that this organization had some health related policies which could be classified as health promotion policies. After reading from the policy guidelines document, the participants realised that the policy was not comprehensive and decided to have a comprehensive wellness policy with other policies included. The safety policy was to be addressed differently as the safety aspect was handled by a different manager. The policy structure was worked out roughly but there was no model identified to guide the policy, only the approach, which was mostly preventive, was identified as the preferred one.

Barriers during implementation

A number of barriers were identified during the implementation process. The barriers were related to a number of factors namely:

Organizational structure

The organizational structure in this organisation was complicated as the occupational health nurse had to report to different managers who had no background in the field of health. This made it difficult for these managers to see employee health as their priority. The following excerpt from one participant demonstrates this barrier:

"Other disciplines in this workplace do not understand how occupational health nurses function. I find it so frustrating that an occupational health nurse has to report to an engineer

or a risk manager. These people cannot even provide support or evaluate health programs.

How is this relevant?"

The above quote shows the frustration with regard to implementation of health program as the person who is expected to approve or support these programs is said to have other priorities. This comment was confirmed by the risk manager's response when asked to give his opinion on the guidelines implementation:

"I understand how important these programs are for other people, but right now I am faced with other issues relating to safety and audits. Now I have to deal with restructuring the occupational health, so the sister will have to deal with this for now."

The other barrier which could be associated with the organisational structure was the lack of decision making for people who were more willing to participate in the policy development. This resulted in delay and the subsequent failure of implementing the whole process.

The timing of the study

At the time when this phase of the study was conducted, the organization was in a process to restructure their health program. Consequently there was a lot of tension which disrupted the policy development process. Another problem was that the implementation process occurred towards the end of the year and participants were exhausted and stressed.

Personal relations

There appeared to be a lot of tension between the participants. This tension was observed to emanate from work related issues. Some participants were very unhappy with what was happening in the organisation, that is, the changes, and one was quoted saying:

“This whole thing is causing me a lot of stress. We are supposed to be working together here but other people have their own agendas.”

Staff turnover

The resignation of the two managers who had worked with the researcher before was an important barrier since the researcher had to start explaining the research to the new participants. This process slowed down the implementation process. The engineering manager had been gone for about six months and had not yet been replaced, so other managers felt they were doing other people's work.

Support factors

Despite the barriers there were still some supporting factors that were identified during observation. These were as follows:

Commitment from other participants

It was observed that some participants such as the OHP and the labour unions, were strongly committed to make this policy work. These participants worked very hard to develop the draft document which had to be approved by senior management at a later stage.

Labour organizations

The presence of both labour organisation representatives to support policy development gave assurance that there would be employee support for policy development.

DISCUSSION

The guidelines implementation phase was conducted in two organizations, namely a medium sized private organization (case 2) and a large parastatal (case 4). From this implementation process it emerged that there were vast differences and only a few similarities in the manner in which these guidelines were implemented. In this section the comparison between the two cases is explored.

From the reasons cited by the non-participating organisations, became clear that workplaces were becoming more aware of the need for workplace employee health related policies. The workplaces were however faced with major challenges regarding the structure that such policies needed to take. The comments from case 3 that the organisation was too small to have a health promotion policy, and from case 6 that their employees were aware of their health needs, demonstrated this observation. Some organizations which had already started working on their policies were still debating such aspects as which health promotion intervention had to be outsourced, who to consult and which employees to target. These challenges were also apparent during the implementation process in the participating organisations.

On observing how the policy guidelines were implemented, it emerged that there were vast differences in the approach used in policy development and that this process was largely

influenced by such factors as organizational size, type and internal structures. The parastatal therefore only managed to implement a few steps of policy guidelines while the private organization succeeded in formulating a draft policy within a given space of time.

Guidelines implementation process

It was observed that in both organizations there was much willingness to develop the health/wellness policy but only from some participants, while others were not very enthusiastic. In case 2 for example, the labour union representatives were not willing to participate in the process. This observation was not surprising since the labour unions in this organization also did not participate in the first phase of the study. In case 4, on the other hand, the labour organisations were very enthusiastic about the policy development process, while the management representatives were not. This lack of enthusiasm amongst management was attributed to organisational changes relating to management staff turnover.

The organisational *structure* had much influence on how the guidelines were implemented. For example, in case 2 the middle managers were the ones involved in policy development committee and were expected to liaise with senior level management on the process and also for policy approval. In the parastatal organisation, however, the participants in policy development committee were not at the decision making level, and only one participant was at management level. This structure resulted in the policy development process being very slow. Participants had to report to other managers who would then report to senior level managers. Also, the committee at case 4 could not promptly take decisions during the process.

The *size* difference in these two organisations is another factor that tremendously influenced policy development process. In the medium sized organization, decisions could be made promptly because senior managers, such as company directors, were constantly on site and could easily decide on whether to adopt policy contents or not. In the large organisation, however, the hierarchical structure was more complicated and the draft policy had to go through various levels of management before it could be adopted. The senior managers, such as company directors, were not on site but at the head office in another province. The draft document therefore had to be sent through to them for approval before the next step could be taken.

It could not, however, be observed if the type of organisation had any influence on the policy development process. Literature had predicted that the private sector, owing to the pressure being exerted by the legislation and the trade unions, would be more involved in putting health promotion interventions in place (Woods, cited in Huiskamp, 2003). In case 2, the labour unions were not involved in the policy development but the management was determined to put the policy in place whereas in case 4, where labour unions were involved, the manager was concerned with issues other than health interventions. It was however not clear whether the difference was because of organisational type or other factors.

One other important observation was that in both organisations the existing health interventions were still focusing on individual health issues rather than organisational factors as defined by Chu et. al (2000). In case 2, however, the draft policy indicated that there was a move towards developing a more comprehensive health and safety policy that aimed to make

the workplace a healthy one. In case 4, however, the draft policy did not introduce much change and remained focusing on individual health factors, such as alcohol and drug abuse.

Stakeholder involvement

In terms of stakeholder involvement in policy development, these two organizations used different approaches. Hunt et.al. (2000) advocated stakeholder involvement in policy development, through effective communication amongst those involved. In both these organisations there was a noticeable lack of communication amongst some of the stakeholders. In case 4, the manager participating in policy development planning process did not effectively communicate with other participants or commit to the planning process, and this behaviour resulted in major delays and conflict. In case 2 on the other hand, the labour unions were not willing to have any discussions regarding policy development, and this behaviour resulted in non-representation of employees in the policy planning process.

In both cases the assumption was that all employees were members of labour unions, which was not necessarily true. In case 2, for example, only two thirds of employees were members of a labour union. In this institution there was, however, a plan in place, for involving employees in the subsequent stages of policy (program selection). It was not clear in case 4 when they were planning to involve employees and at what stage. According to O'Donnell (2000), involvement of senior management in health policy development would largely influence the possibility of creating healthy supportive work environment. On the contrary, relevant studies have shown that while top management support is necessary, it is often not a sufficient condition for ensuring success in putting health promotion intervention in place

(Linnan, Weiner, Graham & Emmons 2004). O'Donnell (2000, p7) describes creating a supportive environment as a process which involves corporate policies, corporate culture, and changes in the physical environment. Observation in the study showed that working with middle managers and trying to create a policy that aimed to create a supportive work environment was difficult in both cases as these managers found it difficult to make final decisions on certain issues, such as deciding on rewards for healthy behaviour, and incentives. Even in case 2, where committed middle managers were involved, they could not explicitly commit to every aspect of creating supportive work environments, as they still had to confirm with senior management.

Aspects of policy guidelines implemented

It was observed that goal setting during health policy implementation had a major impact on facilitating policy implementation process. In case 2, where policy developments were planned and coordinated, there was much progress on guidelines implementation. It was however noted that, as well as, lack of goal setting as in case 4, other external factors could have an undesirable impact on policy development process. External factors, such as disputes between management and employees, restructuring, and imminent retrenchments, that may affect policy development, need to be addressed before the policy development process can continue. Policy development in case 4 could not go further than drafting policy structure because in order to implement other aspects of policy development there had to be cooperation from all stakeholders. In case 2, even though not all aspects of policy development could be tackled, the committee could draw a plan of action as to how these unattended issues will be dealt with in future meetings.

Short-term outcomes

The researcher had planned to determine short term outcomes such as health literacy, social action and organisational practice, as suggested by Nutbeam (2000). Owing to non-participation of employees during this phase, only organisational practice could be observed because health literacy and social action depended on employee involvement. The researcher had also planned to interview employees who were involved in the planning process, and find out their intentions, motivation, knowledge and attitudes and since the employees were not involved in the planning process, observing such outcomes as health literacy and social action could not be achieved.

In their discussion of process evaluation, the WHO (1998) suggests the following principles for evaluating health promotion interventions:

- Participation by all involved
- Use of multiple methods, drawing from different disciplines
- Enhancement of capacity of individuals

Similarly, Nutbeam (2000) argued that evaluation of health promotion interventions is not achieved only through evaluating long-term outcomes but can be based on short term outcomes. Even evaluating short-term outcomes, however, can prove difficult to achieve.

Observing for short-term outcomes in this phase included aspects from both Nutbeam's and the WHO's evaluation models. The observations revealed that the only two short outcomes that were achieved in case two were that the policy development process drew from different disciplines, which was in line with the WHO's model, but there was little participation from

all stakeholders. As such this process could not enhance the capacity of all individuals, especially since it omitted employee participation.

This omission was in contradiction of the findings in phase two of the study where the experts in the fields of health promotion and occupational health had recommended employee participation in the planning phase of policy development. Similarly, in case 4, the involvement of different disciplines was implemented but not fully, as the employees were not involved. Another short term outcome that was observed in case 2 was that of organisational practice. In this organisation some elements of organisational practice, as suggested by Nutbeam (2000) were addressed. These included the policy statements that were revised and some resources allocation. In case 4, however, organisational practice could not be observed at any stage.

Comparing the findings in this phase of the study with previous studies, it was interesting to see that there were similarities and differences from a study conducted in the Republic of Ireland by the Department of Health and children, which aimed at evaluating outcomes of existing workplace health programs (McMahon, Keller, Helly & Duffy, 2002). The finding of this study showed that the barriers to the success of such programs included lack of management commitment, an uncoordinated approach in SMEs and lack of expertise. In this present study, the uncoordinated approach was noted in the larger organisation, whereas in the SME there was notable program coordination. Both organisations, however lacked, expertise that would contribute to the policy development. Even though the large organisation had

expertise in the field of HR, there was lack of management commitment, which resulted in the non-involvement of experts.

During the implementation process, the stakeholders involved in the policy development process in both organisations felt that the policy guidelines were very relevant for policy formulation and were easy to follow. The only barrier was that the guidelines could not be implemented over a 2 month period as developing a policy required consultation with other stakeholders and needed company resources to be used in policy development. This was a positive finding in that the long written document of policy guidelines could be used in conjunction with the algorithm for company executives to refer during policy development. The aim of developing the algorithm was to provide quick reference during meetings and to use the long document for confirmation and if clarification was required.

During the policy development process it became clear that for some organizations there might be barriers to policy development that needed to be identified prior to the policy development process. Supporting factors also needed to be identified as they would play a role in guiding the policy development process. This finding therefore led to the development of the policy guideline implementation chart which could be used to identify these factors.

Table 6.13: Summary of guidelines implementation process

	Case 2	Case 4
Size	Medium	Large
Type	Private	Parastatal
Guidelines implementation	<p>Coordinated planning meetings</p> <p>Role allocation</p> <p>Relevance of the policy guidelines- Policy to be referred to as "Employee well-being policy".</p> <p><i>"The guideline are easy to follow and very simple".</i></p> <p>Identification of relevant health programs:</p> <p>EAP</p> <p>TB prevention and treatment</p> <p>Peer educators</p> <p>Weight control</p>	<p>Lack of team work</p> <p>Conflict during planning process</p> <p>Relevance of policy guidelines: <i>"On reading the guidelines I felt that they really apply in this workplace."</i></p> <p><i>"For me, these guidelines are what we need to help us develop our health policy."</i></p>
Stakeholder involvement	<p>OHP</p> <p>Risk manager</p> <p>SHEQ officer</p> <p>Employees</p>	<p>OHP</p> <p>Risk manager</p> <p>Labour unions</p>
Aspects implemented	<p>A policy statement</p> <p>The purpose of the policy</p> <p>Involvement of stakeholders</p> <p>Health promotion programs and evaluation</p>	<p>Review of health policy</p> <p>Policy structure-approach</p>
Barriers	<p>Non-participation of other stakeholders</p> <p>Timing of the policy development process</p> <p>Lack of financial support</p>	<p>Organizational structural</p> <p><i>"An occupational health nurse has to report to an engineer or a risk manager".</i></p> <p>Negative attitude from some stakeholders</p> <p><i>"right now I am faced with other issues relating to safety and audits"</i></p> <p>The timing of the study</p> <p>Personal relations</p> <p>Staff turnover</p>
Support	<p>Positive stakeholder attitude</p> <p><i>"We are taking this (policy development process) very seriously"</i></p> <p><i>"We need to start moving as soon as possible"</i></p> <p>Existing health and safety policy</p>	<p>Commitment from other participants</p> <p>Labour organizations</p>
Short term outcomes	<p>Policy statement</p> <p>Resource allocation</p> <p>Organisational practices</p>	None

THE POLICY GUIDELINES IMPLEMENTATION TOOL

An implementation tool that would assist organizations to implement policy guidelines was developed based on the observation during this stage. There are factors that have to be identified that might influence the policy development process either positively or negatively. These factors have been classified into four areas namely (a) *situational factors*, which are more or less transient, impermanent or idiosyncratic conditions that have an impact on policy, (b) *structural factors*, which are the relatively unchanging elements of the society and polity, (c) *cultural factors*, which are the value commitments of groups within communities or the society as a whole, and (d) *environmental factors*, which are events, structures and values that exist outside the boundaries of a political system but which influence the decisions within it (Leichter 1979, cited in Walt, 1994, p. 30). These factors can be used in organizations during policy development to determine barriers and/or supporting factors that might influence policy development in the workplace.

The developed tool (appendix 4) suggests that stakeholders need to conduct self assessment and identify barriers and support factors that might strengthen or hinder the policy development process. The more support factors identified, the more successful the process will be. Should the organization identify barriers, it is advisable to remove the barriers first before proceeding with the policy development process..

CONCLUSION

During this phase of the study the aim was to observe policy guidelines being implemented. Observations from the two cases indicated that, there were notable differences between the

guidelines implementation process, while similarities were very minimal. The major finding in this phase was that the policy implementation process was better coordinated in the medium-sized private organization than in the large parastatal organization. It was not clear however whether these differences could be linked to organizational or individual/employee factors. What was very distinct though was that the organizational size, structure and dynamics could have a major impact on how a policy was implemented.

CHAPTER 7

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter presents a summary of the study, conclusions and the recommendations that can be drawn from it. The discussion is guided by the study objectives and the framework, the work setting based health promotion framework.

The summary includes a brief presentation of methodology and findings for each of the three major objectives of the study, that is:

1. The current situation in the private and parastatal organizations in terms of a settings-based health promotion framework;
2. The development of policy guidelines;
3. The implementation of the guidelines in selected organizations.

The findings of the study are expected to be used by policymakers, practitioners in the field of occupational health and health promotion, other professionals and research funders. Yin (2003) recommends that for reports on such studies, it is important to outline implications for action. The discussion will therefore outline implications of the study findings for workplaces, policy makers and researchers in South Africa and recommendations.

SUMMARY OF FINDINGS

The purpose of the study was to develop policy guidelines for workplace health promotion, based on an exploration of the current status. The first phase of the three-phased study aimed to explore the current status of planning and implementation of workplace health promotion

programs in South African workplaces, and to develop relevant policy guidelines. South African workplaces are classified under sectors such as private, public and parastatals. The public sector which comprises government institutions, did not participate in the study, which left the study focusing on private sector institutions and the parastatals. Four private sector institutions participated in the study, one of which was further classified as a health sector; while two parastatal institutions participated. In the private sector institutions, were a large, a medium and a small sized organization, while the health institution was medium sized. In the parastatals two large institutions participated.

Phase 1: The Current Situation of Health Promotion in the Workplace

A case study approach was used to analyse the current situation of health promotion in the workplace. Particularly, for this phase of the study the aim was to determine whether the participating workplaces were health promoting environments, or salutogenic, in nature.

In operationalising these concepts a **health promoting workplace** was defined as one that actively promotes wellness through health promoting programs, and addresses workers' health concerns. A **salutogenic workplace** was depicted as one that is health promotive and provides a physical working environment that is supportive to the health of the employees – the focus being on the individual, the psychological and physical environment (Kitchener, 2003). A salutogenic workplace was understood to provide educational, organizational and economic activities designed to improve the health of workers.

Health promotion programs in this study, was defined based on Wilson's (1999, p.360) definition that is "formal, planned sessions that address any health related issue." The examples included such programs as (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) safety in the workplace (e) spirituality (f) weight control (g) nutrition and food (h) physical fitness (i) smoking/substance abuse cessation (j) stress management, (k) chronic disease management and others.

In summarising the findings on the current situation of employee health promotion programs in this study one can base the findings on three levels of programs as described by O'Donnell (2000). According to O'Donnell (2000) organisational settings could be categorised for their health promotion programs at the following levels: (a) Level I – awareness (b) level II – lifestyle change and (c) level III – supportive environments. Data from the studied organisations showed that all organisations, except one small private organisation which had no health programs at all, reached the awareness level, at which only posters, newsletters, meetings and health days were offered.

The study showed that none of the participating organizations emerged as entirely salutogenic workplaces. Organizations that offered employee health promotion/wellness programs mainly focused on individual health and none of them was found to provide comprehensive holistic programs that aimed at providing healthy work environments.

The study did show, however, that organisations in both sectors were currently attempting to put some health programs in place. This finding was viewed as positive since it gives a starting point for new health promotion policy initiatives. It was also found that health programs in the studied work settings, were not well coordinated, and had no documented objectives.

Undocumented program purpose and objectives, it was anticipated, would result in poor program monitoring and evaluation, which are important tools for measuring program success or malfunction.

The Context and the Process of Workplace Health Promotion

Phase one of the study focused on the context and the process of workplace health promotion.

The **context** included such characteristics as *demographic characteristics* (staff profile and organisational characteristics) and *stakeholders*. The **process** looked into *program structure, the health promotion approach, a health promotion model* and *program objectives*.

Demographic characteristics and the workplace health promotion

Staff profile

Based on the findings of previous studies (Harden et al. 1999, p.541; Peltomaki et al. 2003, p.120), and the conceptual framework guiding the study, employee characteristics were expected to have a significant influence on employee involvement in health programs.

Participants in such programs were expected to be younger, well educated, female, non-smokers and white collar workers (Harden 1999, p.541; Peltomaki et al. 2003, p.120). The findings of the study however showed that employee characteristics such as educational level had no discernible influence on their involvement in health promotion programs. The only

characteristics that seemed to show difference in involvement was the age of employees. What emerged from the study findings was that involvement in health promotion programs was higher in both the young employees (20-30 years) and also in the middle age group (31-40 years) than in the older age group.

Differences in employee awareness on existing health promotion programs were found by job type. Employees in non-management job levels were not aware of any health promotion policies and programs and were hence not involved in such programs, whereas the majority of participants in medium and lower management positions were aware of health policies and programs. Nevertheless, neither of the two groups was involved in workplace health promotion activities and/or programs.

An unanticipated but important finding emerged during the focus group discussions that employees in lower levels of employment engaged in physical activities in a different way, such as joining a football club in their workplaces or outside their work environment, compared to joining a physical fitness program.

Organisational characteristics

The expectation based on the study framework was that **organizational characteristics** such as organizational size and type, health promotion activities, existence of health promotion policies, and infrastructure (availability of resources/facilities supporting health promotion) would have a large influence on the existence of health promotion programs and employee involvement in these programs. Smaller organizations were expected to have poor or no health

promotion programs while organizations in the private sector were expected to have more structured health promotion programs with employees on contracts, in irregular settings, small industries, the informal sector, and persons in risk related jobs less likely to participate in health promotion programs owing to lack of infrastructure and work related policies.

As expected, the findings of the present study have shown that larger organizations had more health promotion programs and provided these on site provided through their occupational health services. These findings were in line with the findings of previous studies which revealed that the size of the worksite had a huge impact on the type and extent of worksite health promotion programs. For instance, the study by Holman et al., (1998:329) showed that employees from large worksites were more likely to have access to health promotion programs than those in small worksites. Smaller worksites were less likely to offer programs such as nutrition and weight management (Wilson, De Joy, Jorgenson and Crump 1999:361). Similar findings were apparent in the current study. The findings of the present study have however demonstrated that the presence of these programs did not have a significant influence in increasing employee participation.

Furthermore, even though all workplaces indicated that they had formal health promotion policies, none of these organizations had a policy that met the definition of the policy as defined in this study, that is “a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”. As such, when asked to describe the policy, participants pointed at the OHS

Act or their health and safety policy, which had a section referring to health requirements for their employees.

Infrastructure in this framework was understood as the presence of any facilities or resources that facilitate the successful implementation of health promotion activities and /or programs.

The study findings demonstrated that there was strong verbal support of health promotion programs by all stakeholders, however there was not much commitment from management in terms of financial resources. Employees were also not involved in the process of planning and execution of such programs, which resulted in their lack of feeling of program ownership.

Stakeholders

The **stakeholders** comprised any individual, groups or organizations that might influence decision making within the organization. The examples were employees, labour unions, occupational health practitioners and management. Different stakeholders in an organization, such as management, employees, labour unions and other partners were expected to influence strongly the needs and goals of an organization (Peltomaki et al., 2003). Health promotion activities were, however, largely influenced by management and occupational health practitioners, while labour unions and other employees were not fully involved in such processes as workplace health policy development.

Phase 2: Development of Policy Guidelines

The consensus method, using a two round Delphi technique, was used in this phase. The Delphi technique involves questioning a panel of experts who are asked to complete a series of

questionnaires focusing on their opinions and judgements concerning a particular topic (Jones & Hunter 1995, p.378; Polit & Hungler 1999, p.208). This process continues until consensus is reached (Polit & Hungler 1999, p.700). This technique was used in this study.

There was a very strong concurrence between the findings from the experts and literature in terms of what needs to be included in health promotion policy guidelines. The key elements for a health promotion policy document were (1) **Organizational philosophy** which should reflect the organization's standing or vision on the health of employees, and also how importantly the organizations view their employees. South African workplaces are now competing in the global market and need to take pride in what they do differently from other countries in caring for their asserts, including human capital. The idea for taking care of employee wellbeing shows that employers are compassionate and understanding, and if this appears in the organizational philosophy it will improve the company's competitive edge. (2) **Stakeholder involvement** –it was recommended that the policy should demonstrate how, and at what level stakeholders were involved in the process of policy development . Amongst other things, employee involvement in the planning process will enhance the possibility of greater positive health behaviour change (Hunt et al. 2000, p. 223). (3) **Programs to be included in the policy** – the suggestion was that organisations need not necessarily provide all these health promotion programs or activities, but intensive engagement of all stakeholders will assist in deciding which of these programs are necessary in a particular organization. The idea was that deciding on which programs to have will depend on factors such as employee needs, organizational needs, employee demographics and availability of resources.

These suggestions by experts implied that organisations need to have a comprehensive policy with the recommended sections, namely (a) purpose (b) scope (c) definitions and abbreviations (d) responsibility (e) contents and (f) legal requirements. However, in addition to these sections the above components, as recommended by the experts, should be part of the policy.

Phase 3: Implementation of Policy Guidelines

In this phase of the study the aim was to observe how the developed policy guidelines were implemented in developing health promotion policy. Nutbeam (1998) argued that during health promotion evaluation, different perspectives should be reflected, including the population who are to benefit, health promotion practitioners, managers and academics. According to Nutbeam, the evaluation needs to focus on whether the program is participatory and addresses priorities identified by different stakeholders. Owing to non-participation of employees and labour union representatives in both the participating organisations in this phase, the only short term outcome that could be observed was that of organisational practice.

What was perceptible from the findings was that the observed organisations based their reactions on the findings and recommendations of the first phase of the study. From the study findings it emerged that the first phase of the study had resulted in the participating workplaces becoming more aware of the need for workplace employee health related policies. This was a positive finding because it based on the findings of the first phase of the study the participating organisations had decided to start developing their employee health programs that would be more coordinated and documented. No expertise however, was available inside these

organisations to develop such policies. The policy guidelines were therefore received with much enthusiasm.

During the policy development process it emerged that different strategies were used. This process was largely influenced by such factors as organizational size, type and internal structures. In the medium sized organization, decisions could be made promptly because senior managers, such as company directors, were constantly on site and could easily decide on whether to adopt policy contents or not. In the large organisation, however the hierarchical structure was much more complicated and the draft policy had to go through various levels of management before it could be adopted. In the private sector organisation, the health and safety program was more structured and organised compared to the parastatal organisation.

One other important observation though was that in both participating organisations the existing health interventions were still focusing on individual health issues rather than organisational factors as defined by Chu et. al. (2000). This finding was a matter of concern, but a good starting point, since having some health initiatives in place was showing some commitment.

The organisational *structure* had much influence on how the guidelines were implemented. For example, organisations where middle managers used a more hands-on approach the policy development process was observed to be quicker than in an organisation where the policy development task was assigned to non-managers.

Stakeholder involvement

Hunt et.al. (2000) advocated stakeholder involvement in policy development, through effective communication amongst those involved. In both the participating organisations there was a noticeable lack of communication amongst some of the stakeholders. For example, management did not communicate with employees or labour unions, which resulted in non-representation of employees in the policy planning process.

Short term outcomes

Comparing the findings in this phase of the study with previous studies, it was interesting that there were some similarities and differences from the study conducted in the Republic of Ireland conducted by the Department of Health and children, which aimed at evaluating outcomes of existing workplace health programs (McMahon 2002). The finding of this study showed that the barriers in program success included lack of management commitment, uncoordinated approach in SMEs and lack of expertise. In this present study, the uncoordinated approach was noted in the larger organisation, whereas in the SME there was notable program coordination. Both organisations however lacked expertise who would contribute to the policy development. Even though the large organisation had expertise in the field of HR, there was lack of management commitment, which resulted in non-involvement of experts.

CONCLUSIONS

The major findings to be drawn from the study had implications for the South African workplaces. These implications are discussed in this conclusion section which is guided by the study objectives.

Phase 1: The Current Situation of the Workplace Health Promotion Programs

One major finding in this phase was that the participating workplaces had no formal health promotion policies, but some had health and safety policies. Since organisations had no documented health promotion policies, they had no standardized definition for their workplace health promotion programs. Health promotion programs were understood to mean a wide range of things such as “health and safety programs”, “first aid”, “information booklets” and /or “medical surveillance”.

This finding could be an indication that workplace health promotion and related policies are conceptualised differently within South African workplaces. During the first and the third phase of the study it emerged that the concepts health promotion; wellness and wellbeing were used interchangeably to refer to any health related program. This finding was linked to that these terms are used as such in the existing literature. This anomaly could result in both health practitioners and lay stakeholders having different perceptions of what health programs should be addressing. Workplace health promotion programs are linked to perceptions regarding health intervention hence any confusion regarding health promotion intervention conceptualization can be reflected in discourse regarding such programs. This finding demonstrates a need for South African workplaces and policy makers to concur on their definition health promotion programs and on the terminology to be used in defining these programs. Such an initiative will be useful in putting workplace health promotion programs and policies in place. This ambiguity in the use of the concept of health promotion if not addressed, could result in duplication of programs and therefore wastage of resources.

Related to this finding was an observation that workplaces had three major categories of programs addressing employee health promotion. These were firstly *employee wellness* which included physical fitness; secondly, *disease prevention* which was done mainly on an individual level and also included health education, and lastly, *EAP*, focuseing on substance abuse and related rehabilitation programs. Literature has shown that workplaces outside South Africa traditionally used this approach but that there has been a paradigm shift towards comprehensive health management services, including fitness centres, health screening, risk appraisal, educational activities, behaviour change programs and high risk interventions in other countries (Mulvihill 2003, p.14).

In South African workplaces there appears to have been a similar shift from offering separate programs such as occupational health and safety, EAP, physical fitness and disease management, towards a much broader paradigm of employee wellbeing culture. These programs are however seldom articulated as a comprehensive approach. Rather, workplaces list all these programs as being different entities. Such a shift would be a positive one if the providers of such intervention were aware of such a shift and offered program support in terms of redirecting organisational goals and coordinating program implementation. South African workplaces therefore need to be sensitized of this paradigm shift and work towards redirecting their health interventions towards comprehensive employee wellbeing programs.

For more comprehensive employee health interventions, policy makers and workplaces need to have a common understanding on how they operationalize workplace health interventions. For example, a comprehensive employee wellbeing program could incorporate wellness in the

higher order, which integrates other domains of health such as physical, psychological, social, spiritual and environmental wellbeing.

The finding on non-existence of health promotion programs could also be linked to the OHS Act, which is regarded as one umbrella legislation that addresses employee health and safety issues. The OHS Act does not explicitly prescribe that workplaces should have a health promotion policy. Under the health section of this legislation, however, the Act prescribes a wide range of regulations supporting the Act such as “Noise induced hearing loss regulations” and “Hazardous chemical substances regulations” (LexisNexis 2006, p. 58). These regulations deal with such issues as medical surveillance, protective personal equipment (PPE), biological monitoring and First Aid in the workplace. For most employers, these health programs were essential health programs as they were prescribed by law. A health program such as Safety in the workplace is one component of the recommended workplace health promotion program; however it is not the only program that can be offered.

Health promotion programs, on the other hand, are not a statutory requirement but are meant to be provided by employers only as a form of good practice. One such program is the HIV/AIDS in the Workplace program which is based on the Department of Labour’s Employment Equity Act (Act No. 55 of 1998). Some workplaces offer such a program or have developed an HIV/AIDS policy, based on this document, known as “Code of good practice on key aspects of HIV/AIDS and employment”. This document provides guidelines for employers, employees and trade unions on how to manage HIV/AIDS within the workplace. The majority of workplaces that participated in the study had developed this program since HIV/AIDS

management was one of the country's health priorities at this stage. But should workplace health promotion programs be based on the country's priorities or employee or organisational priorities? The stakeholders need to decide what will determine their health programs and try to balance the company's needs with those of employees.

This absence of health promotion programs could also have been an indication that in South African workplaces the implementation of the OHS Act was still not well balanced, as the major focus was on the safety component, with the health component being somewhat neglected. Health and safety representatives receive regular training on the OHS Act. It is not clear however, how balanced these training sessions are in terms of safety and health components. Lack of balance in these two components during training can lead to implementers of the Act being biased towards one component, safety in this case. Employee safety and health components of the Act should be juxtaposed in all aspects of the Act's implementation as they both are significant aspects in employee and organisational functioning. The lack of clear differentiation between the two components of the Act could result in employers having varying perceptions of what is expected of them by the Act.

Section 8 (1) of the existing Act outlines the general duties of employers to their employees as "Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees" (RSA 1993, p.1). This part of the Act could be interpreted in many ways, such as providing whatever means are reasonable to avoid health and safety risks or avoiding health risks that may arise during exposure to an unsafe environment.

Organizations may therefore argue that whatever health programs they offer are the best they can provide for their employees or that they will only avoid health risks that may arise during employment or because of the type of work that an employee performs. This part of the Act is however prescriptive and uses the word “shall” and not “may” and should be very explicit. The legislation does not oblige employers to have a written health and safety policy, but section 7 (1) (a) and (b) outlines that “The chief inspector may direct any employer in writing; any category of employers by notice in the Gazette, to prepare a written policy concerning the protection of the health and safety of his employees at work, including a description of his organization and the arrangements for carrying out and reviewing that policy”. It is therefore up to the employers to decide to offer health promotion programs or disease preventive programs or even to have a health and safety policy. It could therefore be interpreted that having health promotion programs is not a statutory requirement, whereas safety programs are prescribed in the Act.

In addition, the Act prescribes that the employers, as their additional duties, shall “establish an occupational health service for workers as prescribed”. Amongst the prescribed duties of the occupational health service is to “establish a medical surveillance program for the benefit of workers as prescribed” (Section 26 (1) (h)) and “provide for safety-related medical examinations and tests for workers as prescribed” (Section 26 (1) (i)). The Act therefore does not prescribe that the occupational health services need to provide health promotion services for the employees. Employers may therefore perceive this approach as allowing them to use their discretion whether to develop employee health programs and policies or not. They could

however, interpret the Act as providing a framework for the provision of healthy and safe workplaces for their employees.

The interviewed stakeholders strongly linked the OHS Act to the health promotion programs in their workplaces; it is however not clear if the OHS Act was developed with the aim to address health promotion in workplaces. The Act however demonstrates a strong safety focus.

Nowhere in the Act is it stated explicitly that employers need to provide health promotion programs. The employers however refer to the OHS Act as the only government document aimed at addressing employee health issues. It also emerged from the study findings that all interviewed stakeholders and experts regarded workplace health promotion initiatives as a vital tool to enhance employee health.

It would be helpful if the government can support workplace health promotion interventions.

This government support can be in the form of a health promotion policy document which will be linked to the OHS Act. The policy guidelines developed in this study can then be a vital tool for use by managers in the development of their workplace health promotion policy document.

The policy guidelines will be useful as they are flexible and can be used in any workplace.

Another recommendation will be a comprehensible differentiation between workplace health programs and safety programs for budget purposes and also for monitoring of such programs.

The question however is who needs to take responsibility or an initiative to develop workplace health promotion policies? The existing OHS Act can be used as the government's holistic framework that can be used to guide employee health and safety programs in the workplace.

The government can make use of existing Act to improve work setting health promotion programs. Organizations will then be required to take an initiative and implement the OHS Act through aligning it to organizational goals, a vision statement and other existing policies such as the organization's business ethics and social responsibility practice. More structured and policy based health programs would allow employers to monitor program success and /or failure and to calculate the cost effectiveness of such programs every financial year, as part of the company's occupational health and safety program.

Most companies take pride in committing themselves to social responsibility, and best practice in ethical manufacture and supply of goods they sell (Dimitriades 2006). Employers need also to show their commitment to their employees' health and environment and the environments they operate in, by developing relevant policies and implementing them and not by mere verbal support of such programs. Although organizations are viewed as open systems on their own (Draft 2001), they need to be linked to their external environment they operate in. Businesses cannot operate in isolation and offering social responsibility programs for both their employees and their surrounding environment the organization demonstrates that they care about their employees and their environment. Developing health promoting workplaces can be part of such programs with community-business partnership focus.

The legislation can be linked to more explicit standards to be used by employers on how these two components could be individually monitored and evaluated. Furthermore, organisations can implement a comprehensive health and safety programs that would address health and

safety issues equally. One way of implementing such programs would be to employ a health and safety coordinator who is qualified in both health and safety. Presently some workplaces have Safety, health and environmental (SHE) managers/officers who coordinate health and safety programs. The present qualification, a diploma in safety management, does not equally address occupational health and safety issues because its focus is mostly on safety and risk management issues.

Training institutions may introduce relevant qualifications whereby the candidates will be trained on occupational health and safety modules, equally. These courses should be offered as additional skills for people already in the field or as a basic qualification for new candidates. Such an initiative could be cost effective and prevent fragmented program structure such as having, for example, an EAP manager, Occupational health manager and a Safety manager. One manager could coordinate these three areas and have responsible people reporting to him/her on relevant issues. Such a structure could function in large organisations, whereby it would be a unit/department on its own. In SME's however, the same idea can be applied in the business structure through outsourcing, or other similar interventions.

The finding that none of the studied organizations emerged as entirely salutogenic workplaces, but have some health promotion activities in place, is an indication that some organisations have taken an initiative to provide health programs for their employees. Some organizations that offered employee health promotion/wellness programs however focused mainly on individual health and none of them was found to provide comprehensive holistic programs that aimed at providing healthy work environments. Previous studies have shown that there are

huge savings associated with comprehensive health promotion programs in the workplace (Bartera 1990, p.1104). The findings of these studies have demonstrated that health promotion programs are good investments while helping to improve indicators of health among blue collar workers (Bartera 1990, p.1104).

This finding, viewed in conjunction with another major finding that the presence of health promotion programs in large worksites did not have a significant influence in increasing employee participation, could be an indication that the approach used in the provision of workplace health promotion programs needs to be reviewed. The findings of the present study showed that all the studied organisations were still using educational and medical/preventive approaches in the provision of health programs. Also, the level of these programs was classified as being at the awareness level which meant that they had not reached a supportive environment level.

If organisations aim to change the employees' behaviour the approach should therefore be to change the attitude of the whole organisation in order to influence the employees' attitudes.

The assumption in Ajzen & Fishbein's Theory of Reasoned Action (1980) is that the individual will intend to perform the behaviour in question if he thinks that the significant others in his social circle deem it important for him to perform it. The assumption in this theory is that external variables are considered as being influential on the individual's beliefs.

Having employers that are committed to creating healthy work environments could be one way of motivating employees to change their attitudes towards involving themselves in healthy

behaviours. Managers who do not view health promotion programs as an important aspect of the organisational culture could influence employees not to participate in health programs. As much as the Theory of Reasoned Action is used at an individual level, starting by changing a few individual attitudes could be useful in influencing the majority of employee community.

COSATU (2002), South Africa's largest trade union, in their draft model policy on HIV/AIDS, have proposed that shop stewards should be allowed to attend health related educational sessions. This opportunity could be used to engage health and safety representatives and shop stewards in discussions relating to employee health programs in general. Shop stewards and labour unions could act as role models hence encouraging other employees to take care of their own health.

Trade unions such as COSATU can also contribute to influencing employees' attitudes and the industry as a whole towards changing their lifestyle and engaging in health promotive activities and related programs. At this stage there is no evidence that trade unions such as COSATU have acted as stewards for workplace health promotion. Even though the trade union has addressed crucial employee health issues, looking at their priorities over the years (<http://www.cosatu.org.za/books.html>), it is apparent that the union has not gone beyond negotiating for social issues and others such as living wages and an HIV/AIDS policy.

Employees need not be coerced to participate in workplace health promotion programs but, as a starting point, they need to be provided with information that will assist them to make informed decisions regarding their health. One finding in this study was that managers did not

do much to disseminate information on health promotion programs to their subordinates. In order to create health promoting workplaces, managers need to facilitate and monitor the implementation of health promotion activities and programs in the workplace. It has been argued that promoting the wellbeing of collective communities requires that such communities or environments create structures and policies that support healthy lifestyles and reduce health hazards (Glanz et al. 2002, p. 275). Health promotion theories focusing on community organisation suggest that communities need to identify and solve their own problems. Capacity building is used, to help the community address its concerns. The focus in this model is group consensus and cooperation aimed at building group identity and a sense of community. The findings of the present study showed that the structure of existing health interventions in the participating organisations were targeted and focused on individual health issues rather than organisational or environmental factors. This individual approach discourages the functioning of organisations as environments or communities with shared goals. If organisations can start viewing themselves as communities with a shared vision and goals in terms of production, targets, including employee health, they may develop group identity.

Allowing the worker population to develop group identity could result in employees being able to relate the organisational goals and their common needs. This approach should result in organisational empowerment and working towards common goals. Rothman (2001) suggested that one of the three distinct models of practice in community organisation is that of participation and relevance, which means that community organizing starts where the people are and engages community members as equals, and this approach may be possible in the South African workplaces.

The Community Organisation Theory viewed in conjunction with the Organisational Development Theory and the framework of the present study show that organizational structures and processes can influence worker behaviour and motivation. It is believed that employees in a health promoting environment can be influenced by the environment they are in, to change their behaviour and live healthy lifestyles. The process of creating health promoting workplaces can be a long one since it involves creating organisational culture and organisational climate (Gilmer 1966, p.23; Glanz et al. 2002). Once an organisation is perceived as a health promoting environment, however, the benefits or outcomes will be long term. The process of transforming an organisation to a salutogenic one therefore needs to be implemented in phases or stages, first focusing on short term outcomes such as employee attitudes and motivation, and then moving towards the long term goals.

An organization willing to use this staging approach can use the Stage Theory as a framework. This Theory is based on the idea that organizations pass through a series of stages as they change. The assumption is that organizations innovate through different goals, programs, and ideas. By first assessing the organizational stage of innovation, it might be easier to implement relevant health promotion programs and a relevant health policy.

The present study also looked into employee characteristics that could influence their motivation, and lead them to participation in health programs. The study findings showed that employee characteristics such as educational level had no discernible influence on their involvement in health promotion programs. This finding could be an indication that employees at lower level of employment perceived worksite health programs differently from how these

programs are perceived in literature and by managers. To this group of employees, health programs could be perceived as traditional methods of physical activities such as playing soccer, and other games. This perception is therefore different from physical fitness activities as defined in existing literature. This finding therefore calls for more innovative and culturally appropriate means of introducing health promotion programs in the workplace that might address the needs of different employee characteristics, such as socio-cultural background and age.

The finding that younger employees were the ones mostly involved in workplace health promotion programs, compared to older ones can be linked to the fact that older employees cannot identify with the programs presently offered, as they do not perceive them as relevant to them, because of their age, or their educational level or even their cultural background. These indicators may need to be explored further to determine how employee participation can be improved in workplace health promotion programs.

Having younger employees involved in health promotion programs is appreciated as a positive finding; however, studies have indicated that the mortality ratio is lower for younger workers than that of older workers even after adjustment for length of employment (Li & Sung 1999, p. 226). Workplace health promotion programs should therefore be more inclusive for older employees too as they are more prone to preventable, diseases such as lifestyle diseases.

Older employees may not regard younger employees, even young health professionals as appropriate role models, as they may see them as too young to give them advice on their health

and lifestyles. In the health sector though, professionals, irrespective of their age, can play a role in giving health related advice to their colleagues and clients. Health professionals can therefore take a leading role and act as role models with regard to engaging in health promotion programs in their workplaces. Previous studies have shown that although health professionals, such as nurses, are exposed to similar health hazards as any other employees, their knowledge about health, is often not applied to their personal lifestyle, so they do not engage in health promoting activities, and that health promotion programs in health institutions have an individual focus and curative approach (Pender 1987; Dines & Cribb 1997; Perish et al. 1991 cited in King 1994; Maben & Macleod 1997). It was therefore discouraging that the health sector and the public sector institutions did not participate in the study, an occurrence which left the study focusing on private sector institutions and the parastatals. This finding left unexplored the question of the importance of employee health programs in the public sector and, more importantly, in health institutions.

Traditionally health professionals are expected to act as custodians for health promotion. It was therefore expected that they would willingly participate in this study, especially in the government institutions. The government, as a policy maker, should be setting a good example in terms of implementing these policies. The government is the largest employer in the health sector, with the health system consisting of a large public sector and smaller but fast growing private sector. The resources are however concentrated in the private sector http://www.southafrica.info/ess_info/sa_glance/health/health.htm . This could mean that employees in the private health sector will have more access to health promotion facilities.

Employees in the public sector could be in need of health promotion programs which may be non-existent, compared to those available in the private sector.

Implementing employee wellbeing programs in large public sector organisations would have a large impact in promoting employee health. The formal sector accounts for the largest share of employment in South African organisations with 64, 9% of employees in this sector (Statistics South Africa 2005, p. 15). The health industry, which comprises mostly skilled workers and elementary occupations that comprises 21, 5% and 22, 9% respectively of the worker population is also another type of industry that can contribute largely to the general welfare of society by putting health promotion programs in place. If this sector had more organized and well implemented health programs, it could act as a trend-setter.

Some hospital managers indicated their reluctance to have the study conducted even though permission had been granted at provincial level. One of the reasons cited for their reluctance to participate was that for them *“health promotion should be directed towards their clients and not employees, since health personnel already knew how to take care of their health”*.

This comment by a senior nurse manager raised a concern about how these health professionals operationalized health promotion. The present study aimed to focus on health promotion programs for workplaces and health personnel, like any other employees, need to have access to health programs that focus on their own health and they in turn can provide health programs to their clients. Also hospitals, as workplaces, have different types of employees, some of

whom are not health personnel and therefore have only lay perception on what a healthy lifestyle is about. These employees therefore need to have their health needs taken care of.

These findings may suggest that it would take more than one research study to persuade organizations to develop sustainable health promotion policies and programs for their workplaces and even to render their workplaces as health promoting ones. Additional large scale studies will have to be conducted that will look into all sectors, especially the government sector, evaluating progress in terms of health promotion programs.

Phase 2: Development of Policy Guidelines

The main findings in this phase were mainly on what experts agreed needed to be included in the policy guidelines. Experts in the field of occupational health and health promotion were all in agreement that a workplace health promotion policy was an important document that workplaces irrespective of their size needed to have.

This was an exciting finding which at the same time raised concern, since the practitioners in the field of occupational health deemed workplace health promotion program as vital in the provision of occupational health services, however, in practice, based on the findings in phase one of the study, this provision was not taking place. The question is therefore how much influence these practitioners have in influencing workplace policies. It had been anticipated that the occupational health practitioners, being the ones practising in the workplaces, would have been able to influence workplace health promotion policies. From the study results (phase 3), however, it transpired that occupational health practitioners in the participating

organisations were feeling marginalised during decision making and felt that they could not influence decisions regarding health related programs. It was not clear whether this was a general feeling in all organisations or if it occurred in relation to the type and size of an organisation. This finding was true for both OHPs working as part of the organisation and practitioners who were working as locums.

This finding may suggest that organisations need to consider having occupational health practitioners in management levels so that they can have input in decision making, rather than having managers with no occupational health background making such decisions. This finding might also have meant that occupational health practitioners, not in management positions do not communicate their views to their managers. As experts in the field of occupational health, occupational health practitioners, especially the nurses, need to be confident and voice their suggestions as professionally trained people and also as they the ones who are mostly involved in employee health issues on a day to day basis. Organisations might also consider getting experts from the outside as consultants in the field of occupational health or health promotion. It is recommended that employers involve occupational health practitioners in health related management decisions because they are experts in their field of practice and may contribute invaluable information.

The experts in the field of health promotion were mostly academics and were therefore not practising in workplaces. These experts can have valuable input during workplace health policy development and even working with government structures in developing such a policy, using research based information. Experts from the academic background agreed with OHPs on how

workplace health promotion policy could be developed. This agreement was considered as a positive finding since it showed that these experts can and should work jointly in developing relevant policies. It was unfortunate that the experts who were at the policy making level, such as those in government departments did not participate in the study, and therefore their views on health promotion policy development could not be determined. This non-participation could have been an indication that for these policy makers, workplace health promotion was not a top priority or it could be linked to the methodology type, the Delphi method, which has been criticized for a poor response rate.

The participation of more academics than OHPs in the study on the other hand, could mean that the academics regarded workplace health promotion related research as one of the priorities or it could be related to their familiarity with research. The question is, however, what role academics can play in policy development. Policy makers, practitioners and government officials all need to be sensitised to the importance of their participation in research as it is one way of improving service delivery and also the integration of academic institutions and other institutions that provide service.

There is also a need for integration between occupational health and health promotion services. One way to achieve this would be having elective health promotion modules offered to occupational health students so that they could relate the two fields of practice. Such an initiative would familiarise occupational health practitioners with the importance of integrating health promotion with occupational health services.

There was also a very strong concurrence between the findings from the experts and literature in terms of what needs to be included in the health promotion policy guidelines, namely, (1) organizational philosophy (2) Stakeholder involvement and (3) programs to be included in the policy. Most organisations are already familiar with policy the development process, however some developed policies did not require employee involvement. The employees' health promotion/wellness policy is one policy that requires the full support of all shareholders as it concerns the health of human capital and can benefit the organisation in other aspects of production.

Involving all stakeholders and experts from the outside such as academics and occupational health experts would be very rewarding in that a comprehensive policy with valuable input from various fields of practice could be developed. For example, the industries are more concerned with the practicality of the program, the benefits and how they will justify the program implementation to the shareholders. For academics, it is also important that a program is guided by relevant theories or models. Having models and theories may, however, not be very important for occupational health practitioners in the field. The recommendation is to implement programs that at least have program objectives in order to guide program implementation and also to allow effective program evaluation.

The findings in this phase had another significant implication for the study since they illustrated that workplace health promotion was valued by experts in both the occupational health field of practice, health promotion practitioners and academics. Employee health promotion policy was viewed as one intervention that would benefit both the employers and

the employees, in that it would improve employee wellbeing, increase productivity and decrease health care costs. These cited benefits were in line with existing literature where employee wellness and increased productivity were the main reasons cited for having a health promotion policy (Leopold, 2004; O'Donnell, 2002).

Phase 3: Implementation of the Guidelines

In this phase of the study, the major finding was an observation that the first phase of the study had a positive influence on the outcome in that the participating organizations (phase 3) had reacted by initiating policy the development process. Although this was a positive finding some shortcomings were still observed during the implementation process.

The response of the participating organizations to the study could have meant that the study had an influence on changing employers' attitudes towards willingness to develop workplace health promotion policies. It could also have meant that organisations initially had the relevant resources that could be used in health promotion policy development, but needed outside assistance to initiate the process. It could be that as much as organisations were willing to start working on the policy, developing a health policy is not an easy task as it requires cooperation from all parties concerned, a stage that these organisations have not yet reached. Implementing these policies, on the other hand, is even more complex since it requires commitment from stakeholders, and may be a longer process.

One observation in this phase, and in phase one, was that organisations seemed to focus mostly on HIV/AIDS programs in developing their health promotion policies. Could this finding mean

that the HIV/AIDS epidemic has redirected the focus of the workplace health promotion programs in South Africa, such that health priorities are focused around this epidemic? Could it mean that health promotion programs now need to be designed based on the country's needs and not that of the employees? Literature and the findings in phase two of the study have advocated employee needs and resource availability as the guiding principles for designing workplace health promotion policies and programs. This argument also brings in the debate on business ethics. Should organisations be taking business ethics into consideration when deciding on what health policies and programs to offer?

With at least 1000 new HIV infections in South Africa every day, the epidemic demands that business responds to social crises in ways that reduce harm and support human wellbeing (King, 2006). Businesses may however argue that HIV/AIDS is a public health problem and should be addressed as such. This epidemic will have massive impact on employee health and businesses need to address the problem with urgency.

Besides gaining profit, companies are expected to have some other tasks such as programs that work for the wellbeing of society, for example taking care of the environment and making the environment a healthy one. Companies may sometimes find it hard to prioritize on the needs of different stakeholders. Ultimately, the decision needs to be based on the organisational ethics which are referred to as company norms, values and habits (Urpilainen & Takala 1996).

Businesses need to operate as open systems and interact with the outside environment in order to survive. This means that although businesses must make profit, they need to balance their

desire for profit against the needs and desires of the society within which they operate (Dimitriades 2006).

South African workplaces have now become part of the global market, and employee wellbeing and health promoting workplaces are becoming more important and relevant. Organisations need to do extremely well to compete within the global market. One way this can be achieved is through the production of high quality products and this can be achieved if employee well being is preserved. Workplaces are compelled by business ethics to take care of their employees' health during the production process to demonstrate their good practice. The dilemma at this stage is that there is not enough infrastructure in place as far as workplace health promotion is concerned since there are no policies guiding workplace health promotion.

Workplace wellness programs are offered on a humanitarian basis but human capital is indispensable as it forms part of invaluable organisational assets. Employers need to strive to preserve human life since employees are the ones who operate the machinery, and without their skills and wellbeing, it would be impossible to continue with the production process.

Organisations need to identify their priorities, their strengths and weaknesses and their resource availability before embarking on initiating a policy development process. A relevant assessment tool developed in this study can assist organisations to assess related barriers.

Organisations also need to make it a habit to do stock taking and assess existing policies that might be irrelevant to the existing employee profile. This review could assist them to save

costs by developing comprehensive relevant policies such as integrating the health promotion policy with the environmental and safety policy.

So what are the deciding factors in developing employee wellness policy/ workplace health promotion policy? In developing the company's health promotion policy, there has to be intense planning and consideration of such factors as employee needs, resource availability, government legislation, and organisational priorities. In this phase it again emerged that workplaces prefer the use of the term "wellness" or "wellbeing" instead of "health promotion", as it was noted in phase one of this present study. This finding calls for a common terminology referring to workplace health promotion that will be used as a point of reference in policy documents. Having such as uniformity would avoid confusion regarding health promotion related programs and policies.

STUDY LIMITATIONS

The following were some of the limitations that were identified during the research process:

Ethical issues

- The researcher had aimed to study documents such as policy documents and health program records, within the participating organisations, to determine if policies existed. Owing to organisational ethics, these documents could not be accessed which resulted in the lack of valuable information.

Participants

- The non-participation of policy makers in this study was unfortunate since the study lacks their significant input, which would have provided elucidation on what government plans are in place. The findings of the study could not determine the role that the government plays in supporting health promotion programs in workplaces. The health promotion programs provided in the public sector could also not be determined, because of the non-participation of public sector organisations. This limitation would make it difficult to apply the findings in the health sector, as this sector was not well represented in the study.
- The labour unions in some organizations were did not participate in the study, which deprived the study of vital data which could not be obtained from other participants.
- In some organizations, demographic data of race could not be obtained.

Methodology

- The methodology used for the study was limiting in that case study findings cannot be generalised to other contexts. The findings can therefore be generalised only in similar cases. The methodology used also resulted in a small scale study which only focused on one province, that is, KwaZulu Natal.
- The Delphi technique used in phase 2 of the study is limited by its poor response rate, which resulted in many identified experts not participating in the study.
- One major limitation of the study was that it focused on a wide range of sectors namely, the public, private, parastatal and health sector. Each of these sectors had different

hierarchical structures, policies and logistics and these differences caused delays and made it difficult for the researcher to obtain the required information from all sectors.

Literature

- One of the challenges during the study was that there was not enough relevant literature on workplace health promotion. Most importantly there was a lack relevant literature on research conducted in South Africa. Reviewed literature was therefore mostly based on studies conducted in countries outside South Africa.

RECOMMENDATIONS

The following study recommendations will assist in the execution of sustainable employee health promotion programs. These recommendations are for the following areas:

Policy Makers

In the South African context, organisations in both the private and the public sector align their policies with government initiated policies or legislations. Such legislation for example, the OHS Act and the Tobacco control legislation, have been reinforced by the government in workplaces in all sectors. Other Government Legislations relating health promotion have not been successfully implemented in the workplaces, such as the South African Health Promotion Draft Policy (1994) which is based on the Alma Ata Declaration (WHO, 1978) and the Ottawa Charter (WHO, 1986) on health promotion. This policy is still a draft at this stage, and has been in this phase for the past twelve years.

The South African government, in this draft document, indicates that one of the priority areas for developing health promotion in South Africa (RSA, 1994, p 12) is research on health promotion. The main areas that were identified for health promotion research were (a) baseline research, (b) appropriate needs assessment, (c) research to determine feasibility of the program (d) research for program development; and (e) formative and summative evaluation. During this study it could not be determined if these areas have been tackled. The study participants were, however, not aware of such government initiatives. This could mean that this draft policy needs to be reviewed and the barriers to its implementation assessed.

The workplace health promotion policy could also be linked to other existing documents, such as the Department of Health HIV and AIDS and Sexually Transmitted Diseases in the workplace: HIV and AIDS Policy Guidelines.

Recommendations:

- The findings of this study indicate that the policy makers need to engage collectively with the private sector as suggested by the WHO (2001) where tapping into all sectors and creating partnerships between different sectors was identified as one strategy in fighting ill health in workplaces.
- It is recommended that policy makers work with organisations in the development of a comprehensive employee wellbeing policy that will be flexible for use in any work setting.

- The existing legislation (OHS Act) needs to be linked to more explicit standards to be used by employers on how health and safety could be individually monitored and evaluated in workplaces.

Research

There is still an urgent need for research focusing on health promotion in general, but the study findings revealed that research needs to be conducted in different settings of health promotion, as identified in the settings approach to health promotion. Researchers have so far been immersed in health promotion research in communities, and have neglected workplaces, a setting where the majority of adults are embedded. This study could play a role in providing a starting point for evaluation research focusing on employee wellbeing.

South Africa, especially KwaZulu Natal province is embroiled in the war against infectious disease such as HIV/AIDS and Tuberculosis. In the meantime, lifestyle diseases are continuing to cause morbidity and mortality in the population. Some of these diseases are preventable and health promotion research on a larger scale could play a vital role in providing baseline data on what programs are in place for employees. The findings of this study have demonstrated that the provision of workplace health programs should not only be based on the country's health priorities, but there is also a need for the identification of stakeholders' needs. In this case, employees' needs in terms of relevant health promotion programs must be determined and this can be achieved through relevant research.

Recommendations:

- A countrywide evaluation study aimed at obtaining baseline data on workplace health programs. The baseline data can then be utilised to build on a follow-up study which will determine stakeholders' needs. The findings of the study could then be used as a policy framework which can be used in any workplace.
- Another study should target only the health sector to explore their progress in terms of work based health programs. The study could be conducted by the Department of Health. Such a study could contribute largely to new programs that have a focus on employees' health promotion in the health sector and to provide baseline data to further the goal of health promoting hospitals.
- A similar study should be conducted on a larger scale, which would serve to promote employer awareness and the importance of wellness programs.

Workplace

The findings of this study had major implications for South African workplaces. According to the National Steering Committee for health promotion in the workplace (1998), workplace health promotion can be defined as those educational, organizational and economic activities that are designed to improve the health of workers and therefore the community at large. This type of health promotion involves workers and management participating on a voluntary basis in the implementation of jointly agreed policies. This committee further argues that health-promotion programs in the workplace are distinct and separate from the responsibilities which employers have in the implementation of proper occupational health and safety measures in the workplace.

It emerged from the findings of this study that workplaces are still offering health programs that are prescribed by the government as part of occupational health and safety programs. Workplaces need to move a step further and provide employee health promotion programs as way of showing that they care for their employees and also as part of cost reduction.

During the policy development process it emerged that not all employers involve employees in planning for employee wellness policies. This lack has a major implication in policy development since the experts in the field of health promotion and occupational health and the supporting literature strongly recommended employee involvement during the planning phase of policy development to encourage their participation in such programs.

Recommendations:

- Employers need to start regarding their employees as stakeholders who are involved in decision making pertaining to their own health, in that way employees will have a sense of self-reliance and program ownership.
- It is recommended that workplaces conduct needs assessment to determine employees' needs, existing barriers and supporting factors to policy development, prior to development of health promotion or a wellness policy.
- In executing an employee wellbeing policy, it is suggested that organisations combine all three levels of health programs namely, awareness, lifestyle change and providing a supportive environment. The benefits of having such a program include reduction in health care costs and absenteeism, enhancing organisational image, and stimulating improvements in productivity.

- Organisations have to implement a comprehensive health and safety program that would address health and safety issues equally. One way of implementing such programs would be to employ a health and safety coordinator who is qualified in both health and safety.
- Organisations that already have health promotion programs need to conduct process evaluation and outcome evaluation. Process evaluation will assist in determining program utilisation and hence cost effectiveness. Outcome evaluation will assist organisations in determining health literacy, social action and organisational practice that is employee attitudes, motivation participate in health programs and also program success or malfunction.
- Employers need to put more structured health programs in place and include such programs in the company's budget. Including health programs in the budget would allow employers to calculate cost effectiveness of these programs and evaluate them every financial year as part of their occupational health and safety programs.
- South African Labour Unions should be encouraged to put more effort in involving themselves in health promotion related discussions and to place on their agenda ways in which they will negotiate with employers for employees' health needs in general.
- It is recommended that employers involve occupational health practitioners in health related management decisions because they are experts in their field of practice and can contribute invaluable information.
- Organisations need to identify their strengths and weaknesses before initiating policy development process. The use of relevant tools can assist organisations to overcome barriers such as hierarchical structures, so that they can use their support factors.

- Organizations will have to make use of policy implementation guidelines developed in this study

Training recommendations

- Training institutions can introduce relevant qualifications whereby the candidates will be trained equally in occupational health and safety modules. These courses could also be offered as additional skills for people already in the field or as a basic qualification for new candidates. Such an initiative would be cost effective and prevent fragmented program structure such as having, for example, an EAP manager, an Occupational Health manager and a Safety manager. One manager could coordinate these three areas and have responsible people reporting to him/her.
- There is a need for integration between occupational health and health promotion services in academic institutions. One way to achieve this could be to have elective health promotion modules offered to occupational health students so that they can relate the occupational health and health promotion fields of practice. Such an initiative could familiarise occupational health practitioners with the importance of integrating health promotion with occupational health services in their practice

CONCLUSION

In defining the concept of health promotion, Maben and Clarke (1995) suggested that the concept needs to be described in terms of its (a) essential attributes (b) new/traditional paradigms and (c) empirical understanding in the field of practice.

According to the proponents in the field of health promotion, the essential attributes of a health promotion program are that it should aim to further or encourage wellbeing, information giving and that it should be environmental or organisational intervention designed to facilitate the achievement of health (Maben & Clark 1995, Tones 1985, Tones et al. 1990). The traditional paradigm in health promotion has been that health promotion programs should have all these antecedents and it was furthermore believed that health promotion needs to go hand in hand with health education (Downie et al. 1990).

This study focused on one setting for health promotion, the workplace. The study findings revealed that there is a paradigm shift in health promotion interventions, from disease prevention in general and behaviour change, largely towards targeting one health problem in particular. The health promotion focus was mainly on HIV/AIDS programs. This paradigm shift was the result of a specific public health problem, and pressure from the government, which was forcing the organisations to utilise their limited resources in dealing with the HIV/AIDS epidemic which is threatening the human capital (Phase 1 and 3).

Interestingly, the empirical understanding from the practitioners' point of view, it emerged from the findings, was that as much as they understood the need for this paradigm shift, the common belief was that the country's health needs need not determine the health promotion programs to be offered in workplaces, but the determining factors should be the employees' needs and the availability of resources (Phase 2). This finding was in line with literature and it called for more stakeholder involvement in decision making during program or policy

development. The major observation in the study was, however, that there was not much employee participation in policy and program development.

There is therefore a need for organisations to move from determining health promotion based mainly on the government's or the country's needs, towards focusing on employees' needs, organisational benefits and using the country's legislation as a framework for designing work setting based health promotion programs.

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KEY POLICY ELEMENTS

Four of the 5 respondents agreed with the suggested key policy elements. One respondent disagreed with the inclusion of organisational philosophy and stakeholder involvement, but no explanation was given for this disagreement.

POLICY IMPLEMENTATION PLAN

All 5 respondents agreed with the suggested policy implementation plan.

POLICY EVALUATION

All respondents agreed that the health promotion policy document needed to be monitored and evaluated at regular intervals.

Evaluation focus

On the focus areas for evaluation all respondents agreed on the majority but one respondent disagreed on evaluating health literacy and another respondent disagreed with evaluation of organisational practice.

DEVELOPMENT OF POLICY GUIDELINES

The data obtained from rounds 1 of the Delphi were used to develop the policy guidelines for health promotion in the workplace. The draft document of the policy guidelines was developed based on the results of phase 1 and round 1 Delphi. This draft document was sent together with the round 2 Delphi questionnaire to the participants to comment on it.

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APPENDICES

QUESTIONNAIRE FOR EMPLOYEES**Organization Number: I****UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING****STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES FOR
HEALTH PROMOTION IN THE WORKPLACE****Investigator: Ms. Gugu Mchunu****Contact Number: 082 877 9677****SECTION A: DEMOGRAPHIC DATA****Please indicate your answer with a tick (✓) in the appropriate box.****Race (Optional, For statistical purposes)**

African	Asian	Colored	White
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Type of employment

Permanent	Contract	Other (Explain below)
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1. Gender

[1] Male

[2] Female

2. Age

[1] Below 20 years

[2] 20-30 years

[3] 31-40 years

[4] 41-50 years

[5] Above 50 years

3. Highest Level of Education

- [1] No formal Education
- [2] Primary Education
- [3] Junior Secondary Education
- [4] Senior Secondary Education
- [5] Tertiary Education

4. Level of Employment

- [1] Senior Management level
- [2] Medium Management level
- [3] Lower management level
- [4] Non- management position
- [5] Other

(Please specify)

5. Occupation (e.g. Laboratory Technician, General Assistant)

6. Period of employment in this organization

- [1] Less than 1 year
- [2] 1-5 years
- [3] 6-10 years
- [4] More than 10 years

7. Do you suffer from any chronic medical condition?

[1] Yes

[2] No

8. Are you a member of a Medical Aid Scheme

[1] Yes

[2] No

If NO, Why?

SECTION B

******Please note that the following terms are defined in the last page:**

(Policy, Health promotion, Health promotion programs, Health promoting workplace, Safe physical environment)

1. Are you aware of any policy in your workplace that deals with health promotion programs?

[1] Yes

[2] No

If YES, Please explain:

2.Are you aware of any health program(s) aimed at improving employees' health in your workplace?

[1] Yes

[2] No

If YES, please describe the program (s) shortly

3. Are you involved in any of the health promotion/wellness program in your workplace?

- [1] Yes
- [2] No

If Yes, Which one?

If No, Why?

4. Does your workplace have any of the following programs (YOU CAN CHOOSE MORE THAN 1)?

- [1] Employee Assistance Program (EAP)
- [2] HIV/AIDS Program
- [3] Physical Fitness Program
- [4] Stress Management Program
- [5] Smoking Cessation Program

[6] Women's health program

[7] Weight Control Programs

[8] Nutrition and Lifestyle program

[9] Chronic Disease Management

[10] Other

(Please specify).....

5. In your opinion, are the health interventions in your workplace aimed at: (YOU CAN CHOOSE MORE THAN 1)

[1] Educating employees on targeted health issues

[2] Prevention of occupational illnesses

[3] Empowering employees in the workplace

[4] Changing the work environment to be healthy

[5] Changing employees behaviors to be more healthy

[6] Curing occupational illnesses as they occur

Please explain your answer:

6. Please respond to the following statements about your workplace (Please tick (✓) in the most appropriate box)

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
6.1 My workplace is a health promoting workplace					
6.2 My workplace is a safe physical environment					
6.3 Policies focusing on health promotion are in place in my workplace					
6.4 We need more health promotion programs					
There are enough resources for health promotion programs					
6.6 Health promotion activities are relevant for me					
6.7 It is the duty of my employer to put health promotion programs in place					

Thank you for your participation!

DEFINITION OF TERMS

◆ **Policy** refers to “a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”.

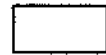
◆ **Health promotion** refers to activities designed to improve or maintain health status of an individual and his /her environment, with the focus on disease prevention.

◆ **Health promotion programs** in this study, is defined as any “formal, planned sessions that address any health related issue”. Examples include worksite based programs such as (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) Safety in the workplace (e) Spirituality (f)

weight control (g) nutrition and food (h) physical fitness (i) smoking or substance abuse cessation (j) stress management, (k) chronic disease management and others.

- ◆ **Health promoting workplace** is the one that actively promotes wellness through health promoting programs and addresses workers health concerns.

- ◆ **Safe physical environment** refers to an environment that is free of hazards or risks that could affect the person's health or safety.



IMIBUZO YABASEBENZI INKAMPANI: F

UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING

STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES

FOR HEALTH PROMOTION IN THE WORKPLACE

Umewaningi: Nkk. Gugu Mchunu

Inombolo yocingo: 031-260 1075/ 2602499

ISAHLUKO A: DEMOGRAPHIC DATA

Bonakalisa impendulo yakho ngophawu (✓) ebhokisini elifanele

1.Ubulili

[1] Owesililisa

[2] Owesifazane

2.Iminyaka yakho

[1] Ingaphansi kuka 20

[2] Iphakathi kuka 20 no 30

[3] Iphakathi kuka 31 no 40

[4] Iphakathi kuka 41 no 50

[5] Ingaphezu kuka 50

3. Ibanga lemfundo oyiphothulile

[1] Angizange ngiye esikoleni

[2] Ngigcine emabangeni aphantsi (ePrimary)

[3] Ngigcine emabangeni ase Secondary

[4] Ngigcine ebangeni leshumi

[5] Nginemfundo ephakame

4. Isikhundla emsebenzini

[1] Ngiyimenenja esezingeni eliphezulu

[2] Ngiyimenenja esezingeni eliphakathi

[3] Ngiyimenenja esafufusa

[4] Angiyona imenenja

[5] Esinye esikhundla esingabaliwe lapha

(Chaza kafushane)

5. Umsebenzi owenzayo (isibonelo: Laboratory Technician, General Assistant)

6. Isikhathi osusisebenzile kulenkampani

[1] Ngaphansi konyaka

[2] Unyaka owodwa kuya kwemihlanu

[3] Iminka eyisithupha kuya eshumini

[4] Ngaphezu kweminyaka eyishumi

7. Ngabe sikhona isifo esingamahlalakhona (noma esingalapheki – njengesifo

sikashukela) onaso

[1] Yebo

[2] Cha

8. Uyilungu le Medical Aid?

[1] Yebo

[2] Cha

Uma ungelona, kwenziwa yini noma yini ndaba?

ISAHLUKO B

******Qaphela ukuthi lamagama alandelayo achaziwe ngasekugcineni:**

(Umgomo, Ukuthuthukiswa kwempilo, Izinhlelo zokuthuthukiswa kwezimpilo, Indawo yokusebenzela ethuthukisa izimpilo, indawo ephiphile)

1. Ingabe ikhona imigomo oyaziyo elapha emsebenzini wakho ebhekene nezinhlelo zokokuthuthukiswa kwezimpilo zabasebenzi?

[1] Yebo

[2] Cha

Uma ikhona, uyacelwa ukuba uyichaze kafushane:

**2. Ngabe zikhona izinhlelo zezempilo ozaziyo kulendawo ezibhekene nokwenza
ngcono impilo yabasebezi (ngokwezempilo)?**

- [1] Yebo
- [2] Cha

Uma zikhona, ucelwa ukuba uzichaze kafushane

**3. Ngabe uyilungu kolunye lwalezi zinhlelo zokuthuthukiswa kwezimpilo zabasebenzi
lapha emsebenzini wakho?**

- [1] Yebo
- [2] Cha

Uma uyilungu, ukuluphi uhlelo?

Uma ungelona ilungu, kungani?

4. Ingabe lapha emsebenzini wakho zikhona lezizizinhlelo ezilandelayo?

(UNGAKHETHA KUBE NGAPHEZU KOKUKODWA)

- [1] Uhlelo lokusiza abasebenzi abanezinkinga ezahlukene (EAP)
- [2] Izinhlelo eziphathelele negciwane lengculazi (HIV/AIDS)
- [3] Izinhlelo zokuzivocavoca umzimba
- [4] Ukusiza abaphatheke kami emoyeni (i-Stress)
- [5] Izinhlelo zokusiza abafuna ukuyeka ukubhema
- [6] Izinhlelo zokugcina abesimame bephilile
- [7] Ukwehlisa izinga lokukhuluphala
- [8] Ukudla ukudla okunempilo nokunakekela impilo yakho
- [9] Ukubonelela abasebenzi abanezifo ezingamahlala khona

[10] Okunye

(Ucelwa ukuba uchaze).....

5.Ngokwakho ukubona, ingabe izinhlelo zezempilo emsebenzini wakho ziqondiswe kulokhu okulandelayo? (UNGAKHETHA KUBE NGAPHEZU KOKUKODWA)

- [1] Educating employees on targeted health issues
- [2] Prevention of occupational illnesses
- [3] Empowering employees in the workplace
- [4] Changing the work environment to be healthy
- [5] Changing employees behaviors to be more healthy
- [6] Curing occupational illnesses as they occur

Ucelwa ukuba uchaze impendulo yakho:

6.Ucelwa ukuba ukhethe impendula okuyiyona mayelana nendawo osebenza kuyo.

Bonakalisa impendulo yakho ngophawu (✓) ebhokisini elifanele

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
6.1 My workplace is a health promoting workplace					
6.2 My workplace is a safe physical environment					
6.3 Policies focusing on health promotion are in place in my workplace					
6.4 We need more health promotion programmes					
6.5 There are enough resources for health promotion programmes					
6.6 Health promotion activities are relevant for me					
6.7 It is the duty of my employer to put health promotion programmes in place					

Ngiyabonga kakhulu!

UKUCHAZWA KWAMAGAMA

- ◆ **Ungomo:** Lokhu kuchaza umqulu obhaliwe osuselwa kwizinkolelo zeqembu noma inkampani. Lomqulu ubalula ngokucacile imigomo ezolandelwa emayelana nokuqaliswa kwezinhlelo zokuthuthukiwa zwezimpilo zabantu kulendawo yosebenzela.
- ◆ **Ukuthuthukiswa kwempilo:** Ilezo zinto ezenziwa ukuze zithuthukise noma zigcine impilo yomuntu nendawo akuyo kusezingeni eliphezulu lempilo, inhloso yakho konke loku ukuvikela izifo

- ◆ **Izinhlelo zokuthuthukiswa kwezimpilo:** Kulolucwaningo, lokhu kuchaza noma iziphi izinhlelo ezikhona ezisuke zilungiselwe ukubhekelana nezempilo. Lokhu kungaba izinhlelo ezifana nalezi ezilandelayo ezisezindaweni zokusebenzela:
 - (a) Izinhlelo eziphathelele negciwane lengculazi (HIV/AIDS) (b) Uhlelo lokusiza abasebenzi abanezinkinga ezahlukene (EAP) (c) i-ergonomics (d) ukuphepha ezindaweni zokusebenzela (e) Spirituality (f) ukwehlisa isisidno somzimba (g) ukudla okunempilo (h) ukuzivocavoca (i) ukuyeka ukubhema nokuphuza (j) ukwelapha abanemimoya ehlukekile (k) ukunakekelwa kwabanezifo ezingmahlalakhona.

- ◆ **Indawo yokusebenzela ethuthukisa izimpilo:** Lena indawo yokusebenzela ekhuthaza impilo ngokuba nezinhlelo zokuthuthukiswa kwezimpilo zabasebenzinokukhathalela izidingo zabo zezempilo.

Indawo ephephile: Indawo engenangozi engase ibe nemiphumela engemihle kwezempilo noma kwezokuphepha.



QUESTIONNAIRE FOR TRADE UNIONS Organization Number: A

UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING

**STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES
FOR HEALTH PROMOTION IN THE WORKPLACE**

Investigator: Ms. Gugu Mchunu

Contact Number: 082 877 9677

Please indicate your answer with a tick (✓) in the appropriate box

1. Age

- [1] Below 20 years
- [2] 20-30 years
- [3] 31-40 years
- [4] 41-50 years
- [5] Above 50 years

2. Highest Level of Education

- [1] No formal Education
- [2] Primary Education
- [3] Junior Secondary Education
- [4] Senior Secondary Education
- [5] Tertiary Education

3. What level of post do you hold in this company/institution?

- [1] Senior Management level
- [2] Medium Management level

- [3] Lower management level
- [4] Non- management position
- [5] Other

(Please specify) _____

4. Period of employment in this company/institution

- [1] Less than 1 year
- [2] 1-5 years
- [3] 6-10 years
- [4] More than 10 years

5. Period being a representative of this Trade Union

- [1] Less than 1 year
- [2] 1-5 years
- [3] 6-10 years
- [4] More than 10 years

6. What position do you hold in this Trade Union?

- [1] Shop Stewart
- [2] Chairperson
- [3] Other (Please Specify)

7. Do you suffer from any chronic medical condition?

- [1] Yes
- [2] No

2. Are you aware of any health program aimed at improving employees' health in your workplace?

- [1] Yes
- [2] No

If Yes, please describe the program (s) shortly

4. Are you involved in any of the health promotion/wellness program in your workplace?

- [1] Yes
- [2] No

If Yes, Which one?

If No, Why

5. How important does your trade union think health promotion is in this workplace?

Very Important	Important	Slightly important	Not important at all	
----------------	-----------	--------------------	----------------------	--

Why?

6. Does your workplace have any of the following programs?

(YOU CAN CHOOSE MORE THAN 1)?

- [1] Employee Assistance Program (EAP)
- [2] HIV/AIDS Program
- [3] Physical Fitness Program
- [4] Stress Management Program
- [5] Smoking Cessation Program
- [6] Women's health program
- [7] Weight Control Programs
- [8] Nutrition and Lifestyle program
- [9] Chronic Disease Management
- [10] Other

(Please specify) _____

7. In your opinion, are the health interventions in your workplace aimed at:

(YOU CAN CHOOSE MORE THAN 1)

- [1] Educating employees on targeted health issues
- [2] Prevention of occupational illnesses
- [3] Empowering employees in the workplace
- [4] Changing the work environment to be healthy
- [5] Changing employees behaviors to be more healthy
- [6] Curing occupational illnesses as they occur

Please explain your answer:

8. Please respond to the following statements about your workplace (Please tick (✓) in the most appropriate box)

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
8.1 My workplace is a health promoting workplace					
8.2 My workplace is a safe physical environment					
8.3 Policies focusing on health promotion are in place in my workplace					
8.4 We need more health promotion programs					
8.5 There are enough resources for health promotion programs					
8.6 Health promotion activities are relevant for me					
8.7 It is the duty of my employer to put health promotion programs in place					

Thank you for your participation

DEFINITION OF TERMS

- ◆ **Policy** refers to “a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”.

- ◆ **Health promotion** refers to activities designed to improve or maintain health status of an individual and his /her environment, with the focus on disease prevention.

- ◆ **Health promotion programs** in this study, is defined as any “formal, planned sessions that address any health related issue”. Examples include worksite based programs such as (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) Safety in the workplace (e) Spirituality (f) weight control (g) nutrition and food (h) physical fitness (i) smoking or substance abuse cessation (j) stress management, (k) chronic disease management and others.

- ◆ **Health promoting workplace** is the one that actively promotes wellness through health promoting programs and addresses workers health concerns.

- ◆ **Safe physical environment** refers to an environment that is free of hazards or risks that could affect the person’s health or safety.

4. Period of employment in this organization

- [1] Less than 1 year
- [2] 1-5 years
- [3] 6-10 years
- [4] More than 10 years

CHARACTERISTICS OF AN ORGANIZATION

1. In your opinion are there any health hazards that exist in this work place?

- [1] Yes
- [2] No

If yes, Explain briefly

2. What is the health risk level for employees in this organization?

- [1] High
- [2] Medium
- [3] Low
- [4] Other (Please specify)

3.Number of employees

- [1] Less than 500
- [2] Between 500 and 3000
- [3] More than 3000

4. Does the organization have Medical Aid Benefit for employees?

- [1] Yes
- [2] No
- [3] Other

(Please specify) _____

5.Occupational health service Outsourced or part of the organization?

- [1] Outsourced
- [2] Part of the organization
- [3] Other **(Please specify)**

6.Are there any labor organizations?

- [1] Yes
- [2] No

7. If yes, How many?

- [1] Only 1
- [2] More than 1

SECTION B

******Please note that the following terms are defined in the last page:**

(Policy, Heath promotion, Health promotion programs, Health promoting workplace, Safe physical environment)

1.Is there a policy in this workplace that deals with health promotion program(s)?

[1] Yes

[2] No

If yes, Please explain:

2.Are there any health promotion program (s) in this workplace?

[1] Yes

[2] No

If Yes, Please describe the program shortly

3. Do you have any of the following programs in this workplace?

(YOU CAN CHOOSE MORE THAN 1)

- | | | |
|--------|-----------------------------------|--------------------------|
| [1] | Employee Assistance Program (EAP) | <input type="checkbox"/> |
| [2] | HIV/AIDS Program | <input type="checkbox"/> |
| [3] | Physical Fitness Program | <input type="checkbox"/> |
| [4] | Stress Management Program | <input type="checkbox"/> |
| [5] | Smoking Cessation Program | <input type="checkbox"/> |
| [6] | Women's health program | <input type="checkbox"/> |
| [7] | Weight Control Programs | <input type="checkbox"/> |
| [8] | Nutrition and Lifestyle program | <input type="checkbox"/> |
| [9] | Chronic Disease Management | <input type="checkbox"/> |
| [10] | Other (Please specify) _____ | <input type="checkbox"/> |

4. In your opinion, are there any health interventions in this workplace aimed at:

(YOU CAN CHOOSE MORE THAN 1)

- [1] Educating employees on targeted health issues
- [2] Prevention of occupational illnesses
- [3] Empowering employees in the workplace
- [4] Changing the work environment to be healthy
- [5] Changing employees behaviors to be more healthy
- [6] Curing occupational illnesses as they occur

Please explain your answer:

5. Does the employee medical aid in this company cover employees for any health promotive activities?

- [1] Yes
- [2] No

6. Please respond to the following statements about your workplace (Indicate corresponding with an X)

Statement	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
6.1 This workplace is a health promoting workplace					
6.2 This workplace is a safe physical environment					
6.3 Policies focusing on health promotion are in place in this workplace					
6.4 We need more health promotion programs in this workplace					
6.5 There are enough resources for health promotion programs					
6.6 Health promotion activities are relevant for employees					
6.7 It is my duty as the employer to put health promotion programs in place					

Thank you for your participation

DEFINITION OF TERMS

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- ◆ **Health promotion programs** in this study, is defined as any “formal, planned sessions that address any health related issue”. Examples include worksite based programs such

as (a) HIV/AIDS programs (b) employee assistance programs (EAP) (c) ergonomics (d) Safety in the workplace (e) Spirituality (f) weight control (g) nutrition and food (h) physical fitness (i) smoking or substance abuse cessation (j) stress management, (k) chronic disease management and others.

- ◆ **Health promoting workplace** is the one that actively promotes wellness through health promoting programs and addresses workers health concerns.

- ◆ **Safe physical environment** refers to an environment that is free of hazards or risks that could affect the person's health or safety.



QUESTIONNAIRE FOR OH PRACTITIONERS **Organization Number: A**

UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING

STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES

FOR HEALTH PROMOTION IN THE WORKPLACE

Investigator: Ms. Gugu Mchunu

Contact Number: 031-260 1075/ 2602499

Section A: Demographic Data

1. Age

- [1] Below 20 years
- [2] 20-30 years
- [3] 31-40 years
- [4] 41-50 years
- [5] Above 50 years

2. Level of Employment

- [1] Senior Management level
- [2] Medium Management level
- [3] Lower management level
- [4] Non- management position
- [5] Other

(Please specify) _____

3. Occupation (e.g. Occupational health nurse, medical doctor)

_____ (Optional)

4.Period of employment in this organization

- [1] Less than 1 year
- [2] 1-5 years
- [3] 6-10 years
- [4] More than 10 years

Characteristics of an organization

1.Type of Organization

- [1] Public + Health Sector
- [2] Private + Health sector
- [3] Private Business Sector
- [4] Parastatal
- [5] Other

(Please specify) _____

2.Number of employees seen at the health center per month

- [1] Less than 100
- [2] Between 100 and 200
- [3] More than 200

3. Medical Aid Benefits

- [1] Yes
- [2] No
- [3] Other

(Please specify) _____

4.Occupational health service Outsourced or part of the organization?

[1] Outsourced

[2] Part of the organization

[3] Other

(Please specify)

SECTION B

******Please note that the following terms are defined in the last page:**

*(Policy, Heath promotion, Health promotion programs, Health promoting workplace,
Safe physical environment)*

1.Are you aware of any policy in this workplace that deals with health promotion interventions?

If yes, Please explain this policy in detail

If No, Why

5. Is there health promotion program in this workplace?

- [1] Yes
- [2] No

If Yes, please describe the program shortly

[3] Stopping recurrence and establishment of the chronic illness

(Tertiary prevention)

[4] Giving health education about illness

[5] Addressing social determinants of health and focusing on environment

[6] Persuade individuals to change behavior and adopt healthy lifestyles

[7] Assist people to identify their health concerns and develop skills to deal with these

[8] Creating healthy workplaces

9. Please explain your approach briefly

10. In implementing your health promotion activities/interventions, do you

[1] Target one health problem at a time

13. Does your workplace have any of the following programs?

(YOU CAN CHOOSE MORE THAN 1)

- [1] Employee Assistance Program (EAP)
- [2] HIV/AIDS Program
- [3] Physical Fitness Program
- [4] Stress Management Program
- [5] Smoking Cessation Program
- [6] Women's health program
- [7] Weight Control Programs
- [8] Nutrition and Lifestyle program
- [9] Chronic Disease Management
- [10] Other

(Please specify) _____

14. In your opinion, are the health interventions in your workplace aimed at:

(YOU CAN CHOOSE MORE THAN 1)

- [1] Educating employees on targeted health issues
- [2] Prevention of occupational illnesses
- [3] Empowering employees in the workplace
- [4] Changing the work environment to be healthy
- [5] Changing employees behaviors to be more healthy
- [6] Curing occupational illnesses as they occur

Thank you for your participation

DEFINITION OF TERMS

- ◆ **Policy** refers to “a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace”.

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- ◆ **Health promoting workplace** is the one that actively promotes wellness through health promoting programs and addresses workers health concerns.

- ◆ **Safe physical environment** refers to an environment that is free of hazards or risks that could affect the person’s health or safety.

DELPHI QUESTIONNAIRE RE-HEALTH PROMOTION IN THE WORKPLACE

(Round 1)

RESEARCHER: GUGU MCHUNU

INSTITUTION: UNIVERSITY OF KWAZULU-NATAL, SOUTH AFRICA

E-mail address: mchunug@ukzn.ac.za

INTRODUCTION

Case studies of six organizations, from differing sectors (state, para-statal and private) and different kinds of industries (telecommunication, manufacturing, education, etc) were done. In order to inform your input about possible policies, information from the case studies with regard to each item of the questionnaire are summarized at each item.

1. HEALTH PROMOTION POLICIES

Availability of health promotion policies:

1.1 The study findings showed that none of the organizations had a wellness or health promotion policy. Many managers and labor organizations indicated that they were not interested in such policies or programs.

Do you agree that organizations in general, irrespective of their size and type need to have health promotion policies focusing on the wellbeing of their employees?

Agree

Disagree

Please comment on the reasons you think could be given to organizations to motivate such a need:

Factors which could convince managers:

Arguments which could convince labor unions:

Arguments which could convince occupational health practitioners:

1.2 In this study, a health promotion/wellness policy is defined as “a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace” This document should furthermore stipulate exactly who is responsible for execution of all health promotion activities in the organization.

1.2.1 Do you agree with this definition? Agree Disagree

1.2.2 If you disagree, please provide the suggested definition.

1.3 Organizational size

1.3.1 The findings of this study indicated that large organizations had policies targeting specific health programs such as HIV, health and safety, and none had a health promotion/wellness policy. Medium sized and small organizations had few or no policies. In your opinion, what type of health related policies should exist in different sized organization?

1.3.1.1 Small organizations

1.3.1.2 Medium sized organizations

1.3.1.3 Large organizations

2. INVOLVEMENT IN HEALTH PROMOTION PROGRAMS

The study findings, and previous literature suggest that employees in small and **medium** organizations had very low or no awareness of existing health promotion programs and policies in their workplaces. Awareness was higher in large and private sector organizations.

Policies are expected to be accessible to all stakeholders including employees, managers and trade union members.

2.1 Which of the following methods do you think might increase employee awareness of workplace health policies and programs, based of the organizational size and type? Please check (✓) next to the ones you feel are more appropriate for each type and size of organization.

size	Private	Parastatal	Health
Large	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information
Medium	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information
Small	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information	Internet Information booklets Weekly meetings Posters Pay slip information

2.2 Should you disagree with any of the above-mentioned methods, please say which one you dislike and why:

2.3 Should you want to suggest alternative methods, kindly indicate the method suggested and the type of organization it can be used at.

Method (Briefly explain where possible)	Organization size	Organization type

3. TYPE OF HEALTH PROMOTION PROGRAMS

Literature shows that larger organizations tend to have more health promotion programs than smaller organizations. In this study the findings showed that medium and large organizations had a minimum of 2 health promotion programs, while small organizations having no programs at all. No specific programs were designed for specific demographics of the employee population, for example workplaces with a majority of females did not have women's health programs.

3.1 Which of the following factors should be taken into account when designing health promotion programs? (Check (✓) the relevant response. You can choose more than one response.)

- Employee needs
- Employee demographics
- Organizational needs
- Availability of resources

Motivate your response:

4. THE CONTEXT

The findings of the study showed that the health programs offered in all the studied organizations were not based on the context such as the employee characteristics (e.g. age, gender), and the organization characteristics (e.g. the risk level, size, and type).

3.2.1 Do you feel that these characteristics should play a vital role in developing the organizational health promotion policy and programs?

Agree Disagree

3.2.2 What health promotion programs can you suggest for an organization with the following employees in majority?

4.1 Employee characteristics

AGE

Young employees ages 20 to 30 years

Middle aged employees 31-50 years

Older employees above 50 years

EDUCATIONAL LEVEL

No education

Primary education

Secondary education (10 to 12 years of school)

Tertiary education

GENDER

Male

Female

4.2 Organizational characteristics

RISK LEVEL

High risk

Low risk

4.3 Stakeholders

What role should the stakeholders play in health promotion policy formulation?

Please check those roles you think each stakeholder should play. You can tick more than one for each group.

Group	Role in policy			
	Develop policy	Select program	Implement	Monitor or evaluate
Occupational health practitioners				
Trade unions representatives				
Employees				
Management				

In your opinion, how should the health promotion program approach used be selected in workplaces?

5. HEALTH PROMOTION MODELS AND APPROACHES

5.1 According to the literature, there are a range of models or theories on which health promotion strategies can be based. In this study it was found that none of the organizations used any model in their planning of policy or programs.

Which of the following models do you think is most appropriate for work setting health promotion?

Model	Appropriate (Yes or No)	Reason
Health belief model		
Stages of Change model		
Social Learning Theory		
Theory of Reasoned Action		
Community Organization Theory		
Organizational Change Theory		
Other		

5.2 According to the literature the structure of the program can be targeted (targets one health problem at a time) or comprehensive (promotes awareness on a wide range of health problems, prepares an individual to change behavior, and provides supportive work environment linked to behavior change). In this study it was found that both targeted and comprehensive structures were used. Which approach do you consider to be the most appropriate for a workplace health promotion program, and why?

5.3 The following six approaches to health promotion that have been identified in the literature. The findings of the study showed that educational approach was commonly used in all organizations. In this study these approaches were defined as follows:

- 5.3.1 **Preventive approach**- the focus is on the disease prevention (primary prevention), or slowing the existing illness (secondary prevention).
- 5.3.2 **Educational approach** -educating the employees about various diseases, that is, providing information and leave the employees to make their choices

- 5.3.3 **Healthy environment approach**- creating healthy environments for the employees whereby the idea is to work with the surrounding communities in creating healthy environments.
- 5.3.4 **Behavioural change approach**- the aim is to persuade employees to change their lifestyles or their health behaviour and adopting healthy lifestyles, for example healthy eating, physical activity.
- 5.3.5 **Empowerment approach**- employee centred, and the health promoter facilitates the implementation of programs thereby empowering employees to identify their health concerns.
- 5.3.6 **Curative approach**- Curing occupational illnesses as they occur

Which of these approaches would you prefer in the execution of health promotion programs? Please check (✓) next to the approach and provide the reason for your preference.

Approach	(✓)	Reason
Educational		
Preventive		
Behavioral change		
Empowering		
Curative		
Healthy work environment		

THANK YOU FOR YOUR PARTICIPATION

DELPHI QUESTIONNAIRE (ROUND 2)
THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES
FOR HEALTH PROMOTION IN THE WORKPLACE
RESEARCHER: GUGU MCHUNU
INSTITUTION: UNIVERSITY OF KWAZULU-NATAL, SOUTH AFRICA
E-mail address: mchunug@ukzn.ac.za

PLEASE HIGHLIGHT THE CORRECT RESPONSE

SECTION A: DELPHI FINDINGS

1. HEALTH PROMOTION POLICY

1.1 Need for a health promotion policy

There was an agreement that there is a need for health promotion policies in the workplace. The reasons for this need were:

- *Improved employee wellbeing*
- *Increased productivity*
- *Cost effectiveness*
- *Comprehensive occupational health and safety programs*

Agree Disagree

1.2 Definition of a health promotion or wellness policy

There was agreement with the definition that health promotion policy should be defined as "*a written document based on the philosophy of the organization, which stipulates the guidelines on how health promotion programs/activities are implemented in the workplace*" and that "This document should furthermore stipulate exactly who is responsible for execution of all health promotion activities in the organization".

Agree Disagree

1.3 Organizational size

There was an agreement that the size of an organization should not be used to determine the focus of the health promotion policy. Basically the agreement was that every organization needs to have a health promotion or wellness policy irrespective of its size, the content of the policy will then depend on the needs of employees and the organization.

Agree

Disagree

1.4 Content of the policy

Respondents were in agreement that the policy firstly needs to be based on employee needs. The content of the policy also needs to demonstrate that the documentation came into being through negotiation between all the stakeholders. The focus should be employee wellbeing, but most importantly every organization must show it's commitment to employee wellbeing.

Agree

Disagree

2. EMPLOYEE AWARENESS OF HEALTH PROMOTION PROGRAMS

There was agreement that increasing awareness on health promotion issues was very important. There however did not seem to be so much agreement on strategies that could be used in different sized or sector organizations to increase employee awareness.

For large and medium sized organizations, the preferred methods were as follows, order of preference:

- The Intranet
- the posters
- Pay slips.
- Weekly meetings

Agree

Disagree

If you disagree, please rerank

For small organizations

- Posters and
- Pay slip

Agree

Disagree

If you disagree, please rerank

3. TYPE OF HEALTH PROMOTION PROGRAMS

On identifying factors that should be taken into account when designing health promotion programs, respondents were all in agreement that factors such as employee needs, demographics, organizational needs and availability of resources will all influence health program design.

Agree Disagree

4. THE CONTEXT

Some respondents agreed that the context should play a vital role in the development of organizational health policy and programs. The responses demonstrated largely that employee characteristics such as age and gender should have more influence on the policy development than the educational level of employees. Organizational characteristics such as risk level on were not perceived to be vital in policy development on its own, but that it should be viewed in conjunction with employee characteristics.

Agree Disagree

If you disagree, please indicate your suggestions below

SECTION B: POLICY GUIDELINES

Please indicate your agreement or disagreement (A/D) on the following sections of the guidelines:

1. Choosing employee health promotion/wellness program

(Who and what should influence the health promotion policy?)

1.1 The comprehensive health promotion program can include one or more of the following:

Health promotion program	Agree or disagree? (A/D)
Employee assistance program (EAP)	
Spiritual exercise e.g. prayer meetings	
Weight control	
Healthy diet/Nutrition	
Physical fitness	
Control of smoking/substance abuse	
Stress management	
Chronic disease management	
Prevention targeted to specific groups e.g. young employees, older employees	

1.2 Decision on which programs to be offered will depend on:

- Employee needs Agree Disagree
- Organizational needs..... Agree Disagree
- Employee demographics..... Agree Disagree
- Availability of resources..... Agree Disagree
- Country’s health priorities..... Agree Disagree

1.3 All stakeholders (employees, management, labor organizations, occupational health practitioners) should be involved at all levels of policy development.

Agree Disagree

2. Key policy elements (What should be included in the policy?)

Key policy elements	A/D
Purpose of the policy (why the policy has been developed)	
Organizational philosophy and vision	
Stakeholder involvement (if and how all stakeholders were involved in policy development)	
Benefits for the stakeholders	

3. Policy implementation plan (How should a policy be implemented?)

Policy implementation should aim at deciding on the following:

Implementation plan	A/D
Selective or comprehensive health promotion programs	
Outsourced or work-based programs	
Strategies for creating awareness on existing programs	
Facilitating behavioral change	
Models and approaches to guide health promotion programs	

4. Policy evaluation (How should health promotion program be evaluated?)

4.1 Health promotion programs need to be monitored and evaluated at regular intervals.

Agree Disagree

4.2 Evaluation needs to focus on the following areas:

Evaluation	A/D
Health literacy (knowledge, awareness, motivation, behavioral intention)	
Social action (employee participation, employee opinion)	
Organizational practice (policy statements, resource allocation)	

Thank you for your participation

Date _____ Observation tool (Field notes) Case number:

Phase 3: Policy guidelines implementation

UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING

**STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES
FOR HEALTH PROMOTION IN THE WORKPLACE**

Investigator: Ms. Gugu Mchunu

Contact Number: 082 877 9677

1. Background

2. Observation

2.1 Who is involved in policy development?

2.5 What health promotion programs are included in the policy?

Program	Short description

3. Other factors

3.1 Barriers

3.2 Support

Other observations:

Date _____ Observation tool (Checklist) Case number:

Phase 3: Policy guidelines implementation

UNIVERSITY OF KWAZULU NATAL, SCHOOL OF NURSING

**STUDY TITLE: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES
FOR HEALTH PROMOTION IN THE WORKPLACE**

Investigator: Ms. Gugu Mchunu

Contact Number: 082 877 9677

SECTION A: SHORT BACKGROUND:

SECTION B: ADHERENCE TO POLICY GUIDELINES

Observation	Short explanation	Y/N
Was the policy structure addressed?		
Were awareness programs introduced?		
Will the organization provide supportive environment		
<i>Financial</i>		
<i>Human</i>		
<i>Structural</i>		
Other		

Observation	Short explanation	Y/N
Will behavioural change be facilitated		
Are plans for program evaluation?		
<i>Health literacy</i>		
<i>Social action</i>		
<i>Organizational practice</i>		
<i>Stakeholder benefits</i>		

SECTION C: SHORT TERM OUTCOMES

Health literacy

Outcome observed	Explanation	Y/N
Awareness		
Beliefs		
Motivation		
Behavioural intention		
Self efficacy		

Social action

Outcome observed	Explanation	Y/N
Employee participation		
Physical activity		
Employee opinion		

APPENDIX 2: PERMISSION LETTERS



UNIVERSITY OF KWAZULU-NATAL

RESEARCH ETHICS COMMITTEE

Student: GUGU GLADNESS MCHUNU

Student No: 901368120 Qualification: PhD

Research Title: THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES FOR HEALTH PROMOTION IN WORKPLACE

A. The proposal meets the professional code of ethics of the Researcher:

(YES) NO

B. The proposal also meets the following ethical requirements:

Table with 3 columns: Question, YES, NO. Rows include: 1. Provision has been made to obtain informed consent of the participants. 2. Potential psychological and physical risks have been considered and minimised. 3. Provision has been made to avoid undue intrusion with regard to participants and community. 4. Rights of participants will be safe-guarded in relation to: 4.1 Measures for the protection of anonymity and the maintenance of confidentiality. 4.2 Access to research information and findings. 4.3 Termination of involvement without compromise. 4.4 Misleading promises regarding benefits of the research.

Signature of Student: [Signature] Date: 20/04/2004

Signature of Supervisor: [Signature] Date: 20/04/2004

Signature of Head of School: [Signature] Date: 20/04/2004

Signature of Chairperson of the Committee: [Signature] Date: 5/10/2004

Faculty of Community & Development Disciplines

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Joint Campuses: Edgewood



25 January 2005

Ms G G Mchunu
Department of Nursing
HOWARD COLLEGE

Dear Ms Mchunu

PROTOCOL : The development and implementation of policy guidelines for health promotion in the workplace. G G Mchunu, Nursing. Ref.: E211/04

The Research Ethics Committee considered the abovementioned application and made various recommendations. These recommendations have been addressed and the protocol was approved by consensus at a full sitting of the Biomedical Research Ethics Committee at its meeting held on 25 January 2005. This approval is valid for one year from this date. To ensure continuous approval, an application for recertification should be submitted a couple of months before the expiry date.

Yours sincerely

PROFESSOR A DHAI
Chair : Research Ethics Committee

**Nelson R Mandela School of Medicine, Faculty of Health Sciences,
Head: Bioethics, Medical Law and Research Ethics**

Postal Address: Private Bag 7, Congella 4013, South Africa

Telephone: +27 (0)31 260 4604

Facsimile: +27 (0)31 260 4529

Email: dhai1@ukzn.ac.za

Website: www.ukzn.ac.za

27 April 2005

Gugu Mchunu
School of Nursing
Howard College Campus
University of Kwa Zulu Natal
Durban
4001

Dear Madam,

RE :- STUDY – HEALTH PROMOTION IN THE WORKPLACE

Further to your request for permission to conduct a study on the “Development and Implementation of Policy Guidelines for Health Promotion in the Workplace” in our organisation.

We hereby grant to you the necessary consent to undertake your studies amongst our employees and conduct the necessary interviews that are relevant to your dissertation.

Hoping we have been of assistance to you.

Thanking You
Yours Faithfully



Human Resources Manager

11th April 2005

University of Kwazulu-Natal
School of Nursing
Howard College Campus
DURBAN
4041

Attention: Gugu Mchunu

Dear Gugu

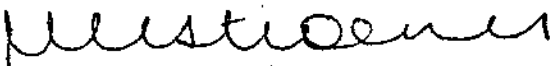
RE: REQUEST TO CONDUCT RESEARCH

Our office is a Head Office and as such we have a highly educated workforce, who require very little intervention in terms of healthcare. Our manufacturing facility is outsourced.

does, however, grant you permission to conduct a study into our organisation relating to **"The Development and Implementation of Policy Guidelines for Health Promotion in the Workplace"** if our organisation is relevant to your study.

Please do not hesitate to contact me should you require any further information.

Yours sincerely



Financial Director

Ms Gugu Mchunu
University of Natal
School of Nursing
Howard College Campus
Durban
4041

2 November, 2004

Dear Ms Mchunu

Permission is hereby granted for you to conduct a research project at Hospital. We appreciate that you respect the confidentiality of the interviewees and the Company.

I look forward to seeing the assignment on completion.

Yours Sincerely

A handwritten signature in cursive script, appearing to read 'M. Mchunu'.

Nursing Manager

9. In the third phase of the study two participating organizations will be selected to participate in the implementation of the policy guidelines, but this participation is also voluntary.

Your assistance in this regard will be highly appreciated.

Yours sincerely

Gugu Mchunu (Ms.)
Student

.....

I have read this documentation and voluntarily consent to participate in this study



Subject's signature

OKS MGR

Date

25/8/2004

I have explained this study to the above subject and have sought his/her understanding to informed consent.

Investigator's signature

Date

1 December, 2004

Ms Gugu Mchunu
University of KwaZulu Natal
School of Nursing
Durban 4041

Dear Ms Mchunu

re: Doctoral Research Project "The Development and Implementation of Policy Guidelines for Health Promotion in the Workplace".

With reference to our discussion on Wednesday the 3rd of November I hereby confirm that you may include Mondi as a site in your research and conduct the required interviews on site.

Please note that any commercial information you may come across in the course of your research must be regarded as confidential.

If you need to go into the factory you will have to go through the safety induction training and sign the appropriate indemnity. You should only enter the mill when accompanied by a employee.

While we respect the independence of your research findings we would like to have sight of your report before it is published and reserve the right to remove references to Mondi by name.

Yours sincerely



Health Services manager

Dear Gugu Mchunu

RE: PERMISSION TO CONDUCT RESEARCH AT

This letter serves as written permission to conduct research at _____ for your PHD regarding health promotion.

_____ employees, contractors and Occupational Health Practitioners will be available for interviews. The necessary appointments must be set up prior to arrival on site. Liaison must take place through our SHEQ Co-ordinator,

Please ensure that you conform to all FlavourCraft requirements.

Your faithfully



Operations Director

APPENDIX 3: CONSENT LETTERS



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE-BASED NURSING & MIDWIFERY



THE JOANNA BRIGGS INSTITUTE



11 August 2004

Attention: Mr. Marshall McDonald

Occupational Health and Safety Manager

~~University of KwaZulu-Natal~~

DURBAN

4041

Dear Sir

Re: Request to Conduct Research

Permission is hereby requested to conduct a study in your organization). I am a doctoral student at the university of KwaZulu-Natal, School of Nursing, and this study is part of my studies. The title of the study is “ **The Development and Implementation of Policy Guidelines for Health Promotion in the Workplace**”. The study explores the current practice with regard to workplace health promotion programs. The information obtained from the study will be utilized to develop policy guidelines for any South African workplace. The study focuses on the Public and Private sectors and parastatal organizations (please refer to the attached short research proposal).

Conditions of participation in the study are as follows:

1. The researcher agrees that she is conducting the study in her personal capacity, as a requirement to complete her doctoral degree;
2. Participation in the study is voluntary;
3. The names of participating organizations will not be disclosed in the writing of the report;
4. All the obtained information will be destroyed as soon as it is entered in the database system for analysis;
5. The names of all the participants will not be divulged to any other party;

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

Email:

Website: www.ukzn.ac.za

6. Refusal to participate in the in the study will not have any influence on the organization;
7. The participating organization can withdraw at any stage of the of the study;
8. No rewards will be given to any participating organization in exchange for information, but will be given a full research report;
9. In the third phase of the study two participating organizations will be selected to participate in the implementation of the policy guidelines, but this participation is also voluntary.

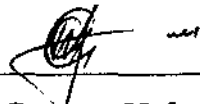
Attached are the copies of the following **documents**:

1. A short copy of my research proposal,
2. An ethical clearance form (to show that this research will not harm the participants),
3. A copy of a letter of consent, which will be given to the study participants – to obtain their consent to participate in the study.

I would like to start collecting data at the beginning of September 2004, if possible.

Your assistance in this regard will be highly appreciated.

Yours sincerely



Gugu Mchunu (Ms.)
Student



Professor L.R. Uys
Research Supervisor



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE-BASED NURSING & MIDWIFERY



THE JOANNA BRIGGS INSTITUTE



UNIVERSITY OF
KWAZULU-NATAL

08 November 2004

Consent Form

Dear Sir/Madam

You are hereby requested to participate in the study being conducted in your organization. I am a doctoral student at the university of KwaZulu-Natal, school of nursing, and I need to conduct this study to complete my degree. The title of the study is “ **The Development and Implementation of Policy Guidelines for health Promotion in the Workplace**”. The study explores the current practice with regard to workplace promotion programs. The information obtained from the study will be utilized to develop policy guidelines for any South African workplace. The study focuses on the Public and Private sectors and parastatal organizations.

Conditions of participation in the study are as follows:

1. The researcher consents that she is conducting the study in her personal capacity, as a requirement to complete her doctoral degree;
2. Participation in the study is voluntary;
3. All the obtained information will be destroyed as soon as it is entered in the database system for analysis;
4. To maintain confidentiality, the names of all the participants will not be divulged to any other party (not even to the employers);
5. Your participation or non-participation in the study will not interfere with you work in anyway.
6. You can withdraw your participation in the study at any stage;
7. Participants will not be receiving any rewards for their participation, but you organization will be given a copy of the findings;
8. The study carries no risks to the participants;

School of Nursing, Howard College Campus

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 2499

Facsimile: +27 (0)31 260 1543

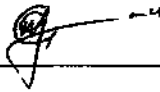
Email:

Website: www.ukzn.ac.za

9. In the third phase of the study two participating organizations will be selected to participate in the implementation of the policy guidelines, but this participation is also voluntary.

Your assistance in this regard will be highly appreciated.

Yours sincerely



Gugu Mchunu (Ms.)

Student

*** PLEASE SIGN THE SECTION BELOW, CUT THROUGH THE DOTTED LINES AND DROP IT IN THE BOX MARKED "CONSENT FORMS"**

X.....

I have read this documentation and voluntarily consent to participate in this study

Subject's signature

Date

I have explained this study to the above subject and have sought his/her understanding to informed consent.

Investigator's signature

Date



THE SOUTH AFRICAN CENTRE
FOR EVIDENCE-BASED NURSING & MIDWIFERY



THE JOANNA BRIGGS INSTITUTE



23 August 2005

Ngiyakubingelela

Imvume yokubamaba iqhaza ocwaningweni

Isihloko socwaningo: “ **The Development and Implementation of Policy Guidelines for health Promotion in the Workplace**”.

Umcwani: Gugu G. Mchunu

Inkampani: University of KwaZulu-Natal

Uyacelwa ukuba ubambe iqhaza ocwaningweni oluzokwenziwa enkampanini osebenza kuyo. Ngenza izifundo zami zobuhlelengikazi enyunivesi yakwa Zulu Natali. Njengengxenywe yezifundo zami kumele ngenze lolucwaningo. Kafushane nje lolucwaningo luzama ukubheka ukuthi kulendawo yokusebenzela ingabe zikhona yini izinhlelo ezibhekela ukuthuthukisa izimpilo zabasebenzi.

Imiphumela ezotholakala kulocwaningo iyosetshenziswa ukwakha umhlahlandlela (guidelines) wokwakha umthethosisekelo (policy) walezizinhlelo. Lomthetho sisekelo uyobe usungasetshenziswa kunoma iyiphi indawo yokusebenzela, lapha eningizimu Afrika.

Imigomo yokubamba iqhaza ikanjena:

1. Ukubamba iqhaza kulolucwaningo akuphoqelekile;
2. Imininingwane etholakala kulabo abamba iqhaza iyobe isilahlwa /noma ishiswe uma isifakwe emshinini;
3. Amagama alabo abayobamba aghaza awayikunikezelwa komunye umuntu (ngisho nabaqashi ngeke babazi);
4. Ukubamaba kwakho iqhaza kulolucwaningo, akuyukubanamthelela emsebenzini wakho;
5. Ungayeka noma inini ukuzibandakanya nalulucwaningo;

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Website: www.ukzn.ac.za

Learning Centres:

— Edgewood

— Howard College

— Mt. Edgecombe

— Pietermaritzburg

6. Akukho miklomelo noma mivuzo eyotholwa ilabo abazobamba iqhaza kulolucwaningo, kodwa niyokwaziswa ngeziphumo zocwaningo;
7. Lolucwaningo alunabungozi kulabo abazobamba iqhaza;
8. Esiqingatheni sesithathu socwaningo izinkampani ezimbili ziyocelwa ukuba zibambe iqhaza lapho sekwakhiwalomgwaqosiseko, aziphoqelelwe ukwenza lokhu.
9. Umcwaning wenza lolucwaningo nje kuphela ngoba kudingeka ukuba agogode izifundo zakhe, akasebenzeli inkampani ethize.

Usizo lwakho ngingaluthokozela kakhulu.

Ozithobayo

Gugu Mchunu (Nkk)

Umfundi

.....

Ngiyifundile imigomo yalencwadi yocwaningo futhi ngiyavuma, ngingaphoqiwe, ukubamba iqhaza.

Ukusayina Kobamba iqhaza

Usuku

Ngiyaqinisekisa ukuba ngimchazelile lona ozisayine ngenhla futhi uyazi imigomo yookubamba iqhaza kwakhe kulolucwaningo.

Ukusayina Komcwaningi

Usuku

May 2, 2006

To whom it may concern

Dear Sir/Madam

You are hereby requested to participate in the study titled "**THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES FOR HEALTH PROMOTION IN THE WORKPLACE**". I am a doctoral student at the University of KwaZulu-Natal, School of Nursing, and the study is part of my research project. The study explores the current practice with regard to workplace health promotion programs. The information obtained from the study will be utilized to develop policy guidelines for any South African workplace. The study focuses on the Public and Private sectors and parastatal organizations.

This is a three phased study and this phase, phase two, aims to use the Delphi technique to obtain the experts' views on workplace health promotion in order to develop the policy guidelines. You have been purposely selected to participate in the study as an expert either in the field of health promotion or occupational health. In sampling the participants, the researcher searched from different databases, sectors, academic institutions, and industries, for experts in the field of health promotion/wellness, occupational health.

If you agree to participate in this study, you are requested to complete the accompanying questionnaire and return it to me, by no later than the 25th of June 2006. A follow up questionnaire for the second, and the last, round of Delphi will be mailed to you before the end of June. In the second round you will be requested to respond to the findings of the first round and to indicate the extent to which you agree or disagree with the findings.

Conditions of participation in the study are as follows:

1. The researcher is conducting the study in her personal capacity, as a requirement to complete her doctoral degree;
2. Participation in the study is voluntary;
3. The names of participants will not be disclosed in the writing of the report;
4. In order to maintain confidentiality throughout this phase, all participants will use false names so that their true identity cannot be revealed.
4. All the obtained information will be destroyed as soon as it is entered in the database system for analysis;
5. Refusal to participate in the in the study will not influence your work in any way
6. Participants can withdraw at any stage of the of the study;
7. No rewards will be given in exchange for information

Your participation in the study will be highly appreciated.

Sincerely

Gugu Mchunu
Ph.D Candidate

Professor Leana Uys
Research Advisor

September 29, 2006

Dear Participant

Thank you for your participation in the first round of the Delphi, for the study titled "**THE DEVELOPMENT AND IMPLEMENTATION OF POLICY GUIDELINES FOR HEALTH PROMOTION IN THE WORKPLACE**".

Data analysis from the first round of the Delphi is now complete and the first draft of the policy guidelines has been developed (please see attachment). You are hereby requested to indicate the extent to which you agree or disagree with the findings and hence the developed guidelines. You are free to change your initial responses. This is the last round for the Delphi, as indicated in the initial document.

Due to time constraints I will kindly request that the responses be mailed back to me by the 6th October 2006.

Your participation in the study is highly appreciated.

Sincerely

Gugu Mchunu
Ph.D Candidate

Professor Leana Uys
Research Advisor

Conditions of participation in the study are as follows:

1. The researcher is conducting the study in her personal capacity, as a requirement to complete her doctoral degree;
2. Participation in the study is voluntary;
3. The names of participants will not be disclosed in the writing of the report;
4. In order to maintain confidentiality throughout this phase, all participants will use false names so that their true identity cannot be revealed.
4. All the obtained information will be destroyed as soon as it is entered in the database system for analysis;
5. Refusal to participate in the in the study will not influence your work in any way
6. Participants can withdraw at any stage of the of the study;
7. No rewards will be given in exchange for information

APPENDIX 4: DEVELOPED TOOLS

POLICY GUIDELINES
FOR HEALTH
PROMOTION IN THE
WORKPLACE

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EXECUTIVE SUMMARY

One of South Africa's legislations that aim to guarantee healthy and safe working conditions of workers is the Occupational Health and Safety Act (OHSAct) (Act 85 of 1993). This act covers workers/ employees in both private and public sector organizations. A number of organizations have done tremendous work in ensuring that their employees remain healthy and to protect them from any ill health. While safety of employees has received a much needed attention, provision for employee health is still questionable in some areas. Having employee wellness programs is not obligatory, but it is one way that organizations can demonstrate how they value their employees.

These policy guidelines are directed towards implementing a more comprehensive employee wellness program to accommodate all employee health and safety programs, with HIV/ AIDS programs on top of the list. This does not suggest that organizations that already have HIV/AIDS policies should now reject them but the aim is to for the policy to be inclusive in preventing other health problems, such as chronic diseases, occupational injuries, mental health problems and others.

Organizations will benefit in that they will address a wide range of health and safety problems, based on one comprehensive policy and not to have different policies to address different health and safety issues. Having such a policy will also make it easier for relevant program implementation, monitoring and evaluation. The policy can be made flexible to meet the needs of an organization and to plan, based on the organizational budget.

1. WHY DOES AN ORGANIZATION NEED TO IMPLEMENT WORKPLACE HEALTH PROMOTION?

With increasing use of technology in the workplaces and globalization, there is a tremendous change in the health and safety needs of employees. Some employees working with machinery are required to perform more sedentary work and hence becoming physically inactive. Other factors such as organizational characteristics and employee demographics may also have negative effects on the health and safety of employees. For example, the aging employees are more prone to chronic disease, musculoskeletal problems, cardiovascular disease and respiratory conditions, and other health problems such as obesity. The WHO (2003) has argued that physical inactivity may result in obesity and overweight, which in turn pose a major risk for chronic diseases, including diabetes type 2, cardiovascular disease, hypertension and stroke, and certain forms of cancer.

Employees who suffer from such health problems will not only suffer ill-health, but may also be a safety hazard. For instance, due to limited mobility, these employees are more likely to require extra help during emergencies, trying get out of the building, with elevators out of service and crowds rushing to escape (Canada Safety Council , Weighing the Risks: Obesity and Safety). Also, emergency workers may find it difficult to move an obese person.

South Africa is presently embroiled in a fight against other communicable diseases with HIV/AIDS being the leading cause of death. As such, South African workplaces are starting to feel the financial impact of the HIV/AIDS epidemic which also causing a notable financial burden. According to Pelsler, Ngwena & Summerton in Benatar, et al. (2004: 299), AIDS related illnesses and deaths affect a business/industry by increasing expenditure in the

form of health care costs, training and recruitment of recruitment employees; and is also reducing revenues, due to absenteeism and lost productivity.

Employees that are bored by less stimulating jobs may suffer mental health problems such as stress or depression. Employees with mental health problems also are not only a health risk to themselves, but may pose a safety hazard to themselves and their colleagues. Should these employees be involved in machinery operation, there may be a higher risk of accidents taking place.

Unhealthy employees are costing organizations millions of Rands. Chronic medical problems and other communicable disease can result in higher healthcare utilization, lowered workplace productivity, increased absenteeism, and elevated health and disability insurance premiums.

A change in unhealthy lifestyle can therefore yield some positive benefits for both the employers and employees. Employers can play an important role in providing a healthy work environment and offsetting or reducing the financial burden to the workplace resulting from illnesses. It is however the individual responsibility of employees to do their part in addressing their health problems and to strive to improve their health through healthy lifestyle choices.

Some employers in South Africa have already put some strategies in place in order to keep their employees healthier for longer, and to assist those who are already affected. These strategies were in the form of wellness programs and other health promotion activities. The problem identified was that some of these programs were not guided by any specific policy or health promotion models/ framework. Having a clearly identified framework guiding the

wellness program would make it easier to evaluate the program outcomes and outputs, and hence to make necessary adjustments.

2. KEY POLICY ELEMENTS AND UNDERLYING ASSUMPTIONS

For an organizational health promotion policy to be successfully developed and implemented, the following policy elements are recommended:

2.1 The purpose of the health promotion policy

The policy should clearly state the following:

- Why the policy has been developed and its purpose
- Organizational commitment to health and safety of its employees
- The organization's commitment to Occupational health and safety act (OSH Act).

The underlying assumption is that if employees are aware that the policy exists because the organization is committed to their health and safety, they are more likely to utilize the programs offered.

2.2 Organizational philosophy

The organizational philosophy and vision shall appear at the beginning of the document.

This organizational philosophy should reflect the organization's standing or vision on the health of employees, and also how important the organization view their employees.

Including the vision statement will demonstrate that the organization has a long term plan for improving employees' health and safety.

2.3 Stakeholder involvement in policy development

Stakeholder involvement needs to form basis of the implementation process, and this can be achieved through effective communication amongst those involved. Employee involvement in the planning process will enhance the possibility of greater positive health behavior change (Hunt et al, 2000: 223). It is recommended that the policy illustrates if and how all the stakeholders have been involved in policy development. To be included in this section is the process that was followed in policy development, including employee needs assessment and how stakeholders were involved in every step of this process. Experts in the field of health promotion and occupational health suggest that stakeholder involvement in policy development follow the process summarized in table 1:

Table 1: Stakeholder involvement in policy development

Phase of policy development	Stakeholders involved
Planning for policy development	OHP, Trade unions, employees & management
Program selection	OHP, Trade unions & employees
Implementation	OHP, employees
Monitoring and evaluation	OHP, employees, & management

All stakeholders need to be involved in policy planning, monitoring and evaluation.

Monitoring and evaluation of such policy or health programs should involve employees and occupational health practitioners (OHP).

Involving stakeholders from the beginning, that is, needs assessment, up until evaluation, will guarantee successful policy implementation and will ensure that employees are aware of policy existence.

3. CHOOSING AN EMPLOYEE HEALTH PROMOTION/WELLNESS

PROGRAM

Present literature reveals that workplace health promotion (WHP) (employee wellness programs) will produce physical and mental health improvement among employees.

The suggestion is for an organization to have a comprehensive wellness program with relevant health promotion activities to meet the needs of an organization, and based on availability of resources. The program can include one or more of the following, which is not a complete list of possibilities:

- HIV/AIDS prevention
- Employee assistance programmes (EAP)
- Provision for spiritual exercise e.g. workplace prayer meetings
- Weight control
- Healthy diet/food
- Physical fitness
- Smoking/substance abuse cessation
- Stress management
- Chronic disease management and others
- Prevention targeted at specific groups at the workplace, e.g. young women, older women and men

Organizations need not necessarily provide all these health promotion programs or activities, but intensive engagement of all stakeholders will assist in deciding which of these programs are necessary in a particular organization. The assumption is that deciding on which programs to have will depend on factors such as employee needs, organizational needs, employee demographics, availability of resources and the country's health priorities.

The following matrix can be used in deciding on the types of programs to be implemented:

Table 2: Choosing relevant workplace wellness programs

Program	Target group	Required resources	Objectives	Benefits
EAP	Employees with personal problems	Professional counselling services EAP counsellor	To reduce stigma associated with mental illnesses Assist employees to get appropriate professional help	Improved job performance Reduced absenteeism Helps employees resolve personal problems Increased safety awareness
Healthy diet/nutrition	Overweight, middle aged, employees with chronic illnesses such as diabetes type 2 and hypertension Sedentary employees	On site services such as: Healthy food options Professional advice Awareness and information	Prevention of diseases such as cardiovascular diseases, cancers, obesity, osteoporosis, back pain	Reduction in health care costs and absenteeism Increased productivity
HIV/AIDS	All employees	VCT services ART services Support system	Prevention of HIV infection Assisting infected employees to stay healthy Offer assistance for affected employees	Improved quality of life Increased awareness Increased productivity Decrease absenteeism
Physical activity	Employees of all ages Special focus on middle aged employees Sedentary employees	Gym facilities on site / offsite facilities supported by management Swimming pool facilities Walking space	Prevention of diseases e.g. hypertension, heart disease, Diabetes type 2 Improving quality of life Reduce risk of developing depression	Reduction in medical aid claims and absenteeism Increased employee morale
Smoking/substance abuse cessation	Smokers and substance abusers	Counselling therapy Support system, Rehabilitation program	Prevention of diseases such as lung cancer. Prevention of secondary smoking to other employees	Reduction in absenteeism rate Increased safety standards Increased quality of life
Stress management	Employees involved in stressful jobs e.g. noisy environment, monotonous jobs	Organizational change Support system-skills training Counselling services	Modify/eliminate stressors Increase stress management skills	Reduction in medical costs Reduction in stress related accidents
Weight control	Obese/overweight employees	Gym facilities Support system	Prevention of diseases e.g. heart diseases, stroke, colon cancers	Improved quality of life Decreased medical costs Improved self esteem
Advanced driving lessons	Young employees	Driving instructor	To reduce motor vehicle accidents Improved safety in the workplace	Reduced medical costs and absenteeism
Retirement preparation	Employees within 5 years of retirement	A consultant	To reduce stress related to retirement To improve succession planning Improved mental and physical health after retirement	Less medical expenses after retirement Improved quality of life

Modified from O'Donnell. *Health Promotion in the Workplace*, 2002

4. POLICY GUIDELINES IMPLEMENTATION PLAN

In implementing these policy guidelines, organizations should aim for the best workplace health promotion programs. Health promotion should be viewed as geared towards changing employees' unhealthy lifestyle through behavior change. According to O'Donnel (2004), "lifestyle change can be facilitated through a combination of efforts to enhance *awareness*, change *behavior*, and creates *environments* that support good health practices" p 49. These three factors should therefore be the guiding principles in implementing these guidelines to create health promoting workplaces. Also important in workplace health promotion policy implementation is ensuring that the programs constantly monitored and evaluated.

4.1 Putting the structure in place

Once the organization has decided on the specific programs that will be put in place, it is imperative to decide on the structure each program will take. This means that specific activities to be included in each program need to be identified place. A selective program will target specific health problem and specific activities addressing such health problems will be put in place. The advantage with this type of program structure is that it is easy to monitor and evaluate. For example, to evaluate employee involvement in physical activity program, management needs to check the number of people who attend the gym or involved in other physical activities. The disadvantage is that it is costly as each problem is addressed individually. A comprehensive program that will target a number of health problems using few health promotion activities is therefore recommended. Certain programs can be combined to address different health issues as indicated in table 3. Deciding on the program and the structure it will take can also depend on the organizational size. The following example can be used as a guideline:

Table 3: Structuring a WHP program

Organizational size	Structure	Possible programs
Small	-Outsourced services -Workplace wellness consultant to design the program	-HIV/AIDS -Other programs as indicated by worker profile
Medium	Some services outsourced Use of wellness consultant Program manager dealing with safety and wellness	-HIV/AIDS -EAP addressing stress management, substance abuse and smoking control - Disease prevention- Weight control, physical activity, nutrition Safety programs
Large	Comprehensive program with Wellness program manager/coordinator working with safety manager	- All programs, individually but some may be combined as in medium sized organizations

4.2 Enhancing awareness

Organizations need to clearly define the whole process of policy guidelines implementation to the stakeholders, with deadlines clearly stated. There has to be clear communication channels which will be decided upon by the stakeholders. The first step will therefore to create employee awareness regarding the proposed program. This can be in the form of posters, pay slip information, intranet, information booklets and regular meetings. The organization can select any method that is feasible and also accessible to the employees. Through this communication method/s, employees will be made aware of the need to elect/employ one individual who will coordinate the process of health promotion programs implementation in the workplace. This individual can be named “wellness program coordinator/manager” (WPC). The WPC will be responsible to coordinate all the tasks involved in the development of wellness policy in the workplace, and implementation of the wellness programs. Having one person coordinating the process will ensure smooth running of program implementation and the stakeholders will know who to liaise with regarding the program.

Once the WPC has been identified the first step will be to hold meetings with all stakeholders, to identify people who will be engaged in discussions on the health promotion programs, representing all stakeholders. In these discussions there has to be negotiations on planning the program, what needs to be included in the program, and deadlines will be set. These representatives can draw up a time line or a Gantt chart for illustrating a series of activities that will occur during the implementation of this program, when each activity will take place, and who will be responsible. This time line will include different phases of program plan, such as (a) program planning phase which can involve negotiation and drawing up a budget; (b) implementation phase which will involve policy formulation, stakeholder involvement, prioritizing on relevant health promotion programs, conducting relevant surveys for program monitoring; and (c) evaluation of the program. This timeline needs to be communicated with other stakeholders, so that they can have an idea on what will be happening and when. In that way they will feel that they are also involved in the process.

The program objectives have to be set by all stakeholders involved in the project as they need to clearly understand their respective roles in achieving these objectives. The objectives have to be SMART in order to facilitate monitoring and evaluation

Having a well organized implementation process such as this one will assist in program evaluation. The evaluator will be able to identify one phase of the program for evaluation and hence identify areas of concern.

Communication amongst the working group and other stakeholders should therefore be maintained through out the all stages of this process.

4.3 Creating supportive environments

Workplaces need to aim at being health promoting workplaces (comprehensive approach) rather than providing health promotion in the workplaces (selective approach). The selective approach only focuses on certain areas or individuals within the workplace and tends to focus on a single illness or risk factor, whereas the comprehensive approach health promoting workplaces means that health promotion programs have to focus on both individual risk factors and the broader organizational and environmental issues, starting from policies to management attitudes (Chu et. al, 2000). The suggestion is therefore for workplaces to have comprehensive wellness policies that incorporate health and safety issues, as these will both ensure the wellbeing of all employees.

Supportive environments will comprise the following components:

- Provision of necessary resources (financial, human and structural) for health promotion.
- Encouraging and rewarding participation in health promotion activities.

4.4 Encouraging behavioural change

For employees to be healthy, they need to change unhealthy behaviors and participate in health promotion programs. To encourage employee involvement in health programs, organizations can provide incentives for employees involved in such programs.

Behavioral change is however not easy. A number of models and approaches that can be used as a foundation for workplace health promotion programs in order to facilitate behavioral change. These models and approaches can assist in guiding implementation of workplace health promotion, and hence provide framework for implementation and

evaluation. Policy development can be based on either of these models and approaches, which can be decided upon by stakeholders, based on program objectives. The following matrix shows recommended models for certain health promotion programs:

Table 4: Recommended models for certain programs

Program(s)	Recommended model(s)
Smoking cessation Control of Substance use	Stages of change
Physical activity	Stages of change
Stress management	Organizational change
Healthy diet/Nutrition	Stages of change Social cognitive

The following six approaches to health promotions programs have been identified in the literature. The findings of this study showed that educational approach was commonly used in all organizations. In this study these approaches were defined as follows:

4.4.1 Preventive approach- the focus is on the disease prevention (primary prevention), or slowing the existing illness (secondary prevention).

Example: Wearing ear muffs in noisy areas

5.4.2 Educational approach -educating the employees about various diseases, that is, providing information and leave the employees to make their choices

Example: Education on HIV/AIDS infection

5.4.3 Healthy environment approach- creating healthy environments for the employees whereby the idea is to work with the surrounding communities in creating healthy environments.

Example: Providing healthy snacks at the work based canteen

5.4.4 Behavioural change approach- the aim is to persuade employees to change their lifestyles or their unhealthy behaviour and adopting healthy lifestyles

Example: Providing physical activity program.

5.4.5 Empowerment approach- employee centred, and the health promoter facilitates the implementation of programs thereby empowering employees to identify their health concerns.

Example: Blood pressure management and support groups

5.4.6 Curative approach- Curing occupational illnesses as they occur

Example: DOTS TB program

Experts in the fields of health promotion and occupational health suggested educational, preventive, behavioral change, empowering approaches as the most appropriate ones as a starting point.

5.5 Monitoring and evaluation

Program monitoring and evaluation refers to assessing with the aim of improving implementation or parts of the program. The overall purpose of program monitoring and evaluation is to measure program effectiveness, identify problem areas, gather lessons learned and improve overall performance (WHO, 2004:1). In implementing policy guidelines, it is imperative to monitor if the program is implemented according to plan and if the program is achieving the set objectives.

Evaluation can be targeted towards one of the following namely, ***inputs*** such as availability of resources, ***process*** such as service utilization by target population, awareness activities; and ***outcomes*** such as change in employee attitudes, motivation, participation in health promotion activities and change in organizational practice.

Evaluating short term program outcomes will therefore include evaluation of the following aspects of the program:

- **Health literacy**- awareness, beliefs, knowledge, attitudes, motivation and behavioral intention
- **Social action**- employee participation, physical activity and employee opinion
- **Organizational practice** –Policy statement, resource allocation and organizational practice

CONCLUSION

Implementing a comprehensive workplace health promotion policy will benefit both the organization and its employees. Not only can organizations save millions of Rands through such a program, but other added benefits will be reduction in medical cost, enhancement organizational image, increase in employee morale, improvement of employee health, and hence reduction in absenteeism rate.

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DEFINITION OF TERMS

Stakeholders - Comprise of any individual, groups or organizations that may influence the decision making within the organization. In this document such people will include employees, trade unions, occupational health practitioners and management.

Employee- The OH & S Act (Act 85 of 1993) defines any employee as “any person who is employed by or works for an employer and who receives and is entitled to receive any remuneration or who works under direction or supervision of an employer or any other person”.

Philosophy: Organizational beliefs and values

Monitoring- Routine tracking of a program, using data that are collected on a regular basis. This process assesses planned activities are carried out according to schedule (WHO, 2004).

Evaluation- Evaluation is classified as either process or outcome evaluation. **Process** evaluation is used to measure the extent to which the intended target population (employees) uses services. The aim in process evaluation is to improve program effectiveness. **Outcome** evaluation on the other hand, measures program results and the effect on target population. This type of evaluation is used to assess the influence of program activities by measuring changes in knowledge, attitudes, behavior, skills and health status of population.

GLOSSARY

DOTS- Directly observed treatment short course

EAP- Employee Assistance Program

HP- Health Promotion

NIOSH- National Institute for Occupational Health and Safety

OHP- Occupational Health Practitioner

OSHACT- Occupational Health and Safety Act

SMART objectives- Simple, measurable, achievable, time bound

TB- Tuberculosis

WHO- World Health Organization

WHP-Workplace Health Promotion

WPC-Wellness Program Coordinator

Policy guidelines for health promotion in the workplace algorithm

