UNIVERSITY OF KWAZULU-NATAL

THE INFLUENCE OF LIFESTYLE HABITS ON WORK PLACEMENT

by

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DECLARATION

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DEDICATION

I dedicate this dissertation firstly to God, for blessing me with countless opportunities and for the abundant blessings in my life, especially for this unique opportunity to grow and develop myself. Thank you for Your mercy, guidance and love.

I am lucky to have in my corner two of the most amazing, remarkable people I've ever had the pleasure of knowing, and fortunate enough for God to bless me with them as my parents. I am so grateful for your belief in me, your relentless support and most importantly, your unconditional love. Thank you for everything, I love you far more than I can put into words.

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ABSTRACT

The purpose of this study is to shed more light on the phenomena related to lifestyle habits and its incorporation into hiring and granting promotions practice. The research is descriptive in nature, and the findings provide an insight into the topic of lifestyle habits and how it impacts work placement in organisations

The research employed a quantitative methodology via the use of a questionnaire that was circulated within a hardware company based in Durban, South Africa; and a simple random probability sampling strategy was employed to ensure data collected was reflective of the entire company, from senior management right to blue collar employees. Based on the key findings, lifestyle habits do play a role in where positions are allocated and to specific work placement. Work placement in higher positions tend to have more positive lifestyle habits and vice versa.

The implications of this research for theory and practise are that having intervention and incentive programmes in place fosters the development of good habits within the workplace. As a result, this will decrease the risk of workers developing non-communicable and chronic lifestyle diseases; as well as higher than usual mortality rates by promoting seven healthy lifestyle behaviours that were investigated as part of this study. Good lifestyle habits can be integrated into work placement through developing lifestyle habits learning objectives, establishing teaching and learning activities, and promoting learning outcomes such as self control and motivation.

Self control is the most positive outcome that influences work placement as it promotes good habits over bad habits. Incentives are one of the lifestyle habits objectives that reinforces self control, prevents demotivation and ensures the development of good lifestyle habits in the workplace; which in turn ultimately leads to effective and efficient work placement practises.

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1.1 Introduction

Habits can be defined as inclinations or reactions that are brought about as a response to an event or occurrence Lally et al. (2010). Habits can be characterised by the automatic and instinctive response to scenarios or situations (Lally et al., 2010). Once a habit is formed it becomes an instinctive part of an individual and it can be very hard to unform. In light of this William James (1890, p. 122) has stated that,"…we must make automatic and habitual, as early as possible, as many useful actions as we can…The more details of our daily life we can hand over to the effortless custody of automatism, the higher mental powers of mind will be set free for their own proper work."

Lifestyle habits can be classified as good habits and bad habits. A good habit is beneficial to an individual because it reinforces a pattern of behaviour that can be aligned to goals and a better lifestyle (Galla and Duckworth, 2015). On the other hand, bad habits can be seen as harmful because they perpetuate the taking of lifestyle risks; which can have very negative consequences such as the contraction of non-communicable diseases or other lifestyle diseases. Furthermore, once an individual has formed a bad habit, they continue practising the bad habit even if they understand the risks associated with it. In this regard, again William James (1890, p. 47) sums it up eloquently by saying, "our virtues are habits as much as our vices". Therefore, for the purposes of this study, Lifestyle Habits refer to the compilation of personal habits that incorporate the individual's lifestyle and their frequent behaviours.

Work placement can be defined as the intersection between mental, physical, emotional and functional capabilities of workers (Kaleta et al., 2006). Work placements can take the form of internships, fieldwork, industry-based learning, apprenticeship, fieldwork, or clinical placements. In addition, all these forms of work placements share characteristics and most involve on-the-job training (Von Treuer et al., 2011) Furthermore, work placement also takes into account the health, social conditions and status in the organisation of workers (Kaleta et al., 2006).

Consequently, Work Placement is also associated with the lifestyle behaviours and corresponding habits of individuals in the workplace.

There are seven lifestyle behaviours investigated in this study, namely: reading, prayer, sleeping exercise, smoking, alcohol use, and choice of diet. These lifestyle behaviours are the foundation of the populations' lifestyle habits and can be aligned to specific goals to bring about positive outcomes (Duckworth and Carlson, 2013; Galla and Duckworth, 2015; Gardner et al., 2012). Furthermore, the positive outcomes achieved through the development of healthy lifestyle habits can be reinforced through the implementation of intervention and incentive programmes, both nationally and within an organisation. Therefore, this study will analyse and attempt to understand these lifestyle habits in relation to the individual's position in the workplace environment and the role and distinction it plays.

This chapter will describe the rationale for this study as well as the research problem, the aim and objectives of the study, the limitations of this study and the content of the other chapters in this study.

1.2 Motivation of the Study

Lifestyle habits have always been a determining factor in quality of life, therefore the motivation of this study is to understand its determining influence on work placement in the business world. This study will provide an insightful understanding for how individuals who wish to upgrade their station in life may do so by implementing changes in their lifestyle habits that correspond to what those in higher echelons do. This will also aid companies in finding suitable applicants that would suit work placement positions by understanding how those in different positions tend to habitually behave.

There are seven behaviours that form the basis of good or bad habits that have been investigated as part of this study. This study contributes to the body of knowledge by developing a research tool that identifies the lifestyle behaviours and corresponding lifestyle habits of the workforce, which allows management to put into place controls, such as interventions or incentives. This can ensure that goals are achieved which result in positive work placement outcomes. For example, it was found that blue-

collar workers, especially those with lower levels of education, were more likely to have more than one form of unhealthy lifestyle behaviour (Boström, 2006); and the bad lifestyle habits formed as a result could have a negative impact on workforce ability.

Moreover, it was found that individuals living with poor economic and social conditions were more likely to have more than one form of unhealthy lifestyle behaviour (Galla et al., 2014). Thus, interventions can ensure that the seven behaviours that result in bad habits are realigned towards specific healthy lifestyle habits; whereas incentives can ensure that the seven behaviours are fostered within the workplace to promote good lifestyle habits. Therefore, the results of this study will help provide insight into the point of view of the employees of a hardware company based in Durban. The research tool stemming from the framework formulated through reviewing the literature and evaluated within the findings of this study, would allow companies to implement effective and efficient intervention and incentive programmes that promote positive work placement outcomes.

1.3 Focus of the Study

The aim of this study is to determine the influence of lifestyle habits on work placement. The company chosen for study is Araf Industries (PTY) Limited, a hardware company that is an importer and distributor based in Durban, South Africa and has a contingent of 100 staff. The company's office is based in Durban and distributes hardware throughout South Africa as well as Southern parts of Africa. This study will assist Araf Industries to better tailor their work placement choices to match the right employee for the right position. The study will also help current employees to make changes if they want to improve their position by changing their lifestyle habits. The reason for considering a company based in South Africa was to keep in line with the aim of this study.

1.4 Problem Statement

Diseases linked to lifestyle choices are currently the biggest cause of death worldwide. More specifically, cardiovascular conditions, cancers, chronic respiratory

disorders, obesity and diabetes, represent more than 60% of global deaths, half of which are premature in nature (World Health Organization, 2014) Most of these diseases are fairly associated to common risk factors, namely, tobacco and alcohol use, unwholesome diet and physical inactivity. According to the World Health Organization (2014), this "lifestyle disease" epidemic causes a much greater public health threat than any other epidemic known to man; and millions of lives could be saved if the world, over the next decade, invests $1-3 per person on promoting healthier habits.

Therefore, the purpose of this study is to shed more light on the phenomena related to lifestyle habits and its incorporation into hiring and granting promotions practice. The research is descriptive in nature, the findings will provide an insight into the topic of lifestyle habits and how it impacts work placement in the firm.

The perpetuation of bad habits as a result of not engaging in the seven healthy behaviours often leads to the development of lifestyle diseases. Although the area of lifestyle diseases is well researched in the South African context, there is not much freely available research on the influence of habits on work placement in South Africa. This study will also aim to satisfy the lack of research across these areas and combined with the literature review and recommendations, will make a case for how these lifestyle habits could be incorporated into the hiring practice of a company.

1.5 Objectives

The objectives of this study were:

- To determine if lifestyle habits affect Job Satisfaction
- To determine the importance of lifestyle habits on work placement
- To determine if lifestyle habits make a difference to work placement position
- To establish which lifestyle Habits do employees believe are the most important to their career
- To establish how a change in lifestyle habits would impact work placement
- To determine which habit if changed would make the biggest difference to the individual

1.6 Research Questions

The research questions were derived from the objectives of the study and seek to answer the following:

- Do lifestyle habits affect Job Satisfaction?
- How important are lifestyle habits to work placement?
- Which lifestyle habits make a difference to work placement position?
- What lifestyle habits do employees believe are the most important?
- How would a change in lifestyle habits impact work placement?
- Which habit if changed could make the biggest difference to the life of the individual

1.7 Limitations of the Study

There are certain limitations to this study. Due to the time frame allocated to complete the research study, all aspects of lifestyle habits could not be covered and certain aspects have been omitted. Only employees of one company were chosen because of the time constraints of the study. The method used by hand delivering and collecting the questionnaires is by no means effective. It was determined in the beginning that a large amount of individuals working in the company do not have access to the internet hence online questionnaires were not used. The results would have been skewed as only middle to higher level managers had internet access. A main limitation of this study is that only lifestyle habits studied of employees in one company were studied.

1.8 Summary

The purpose of this study is to determine the influence lifestyle habits have on work placement. The importance of these habits is primarily where an employee is placed in the company which would help in recruitment and in the event of promotional opportunities. This chapter discussed the rationale and aim for the study, which guided the study objectives as well as the questions in the research instrument, all of

which defined the area of focus for this study. The overview of the study was looked at and the limitations of the study were briefly discussed. Chapter two will present the literature reviewed for this study.

CHAPTER TWO: LITERATURE REVIEW

This chapter will commence with an explanation of lifestyle habits, the types of lifestyle habits pertinent to this study and their benefits and pitfalls and will discuss how these lifestyle habits impact work placement and its relationship.

2.1 Introduction

Habits can be defined as inclinations or reactions that are brought about as a response to an event or occurrence (Lally et al., 2010). Lifestyle habits, which refer to the compilation of personal habits that incorporate the individual's lifestyle and their frequent behaviours, can be characterised by the automatic and instinctive response to scenarios or situations; which also determines the way in which they are formed (Lally et al., 2010). In addition, lifestyle habits can fall into two broad categories, namely good habits and bad habits.

Good and bad habits are formed as the consequence of reactions to an event or situation; and eventually these inclinations or reactions occur more instinctively than out of conscious effort (Ouellette and Wood, 1998). However, bad habits can be formed in individuals regardless of their intentions. A study conducted by Ji and Wood (2007) showed that habits were a stronger predictor of behaviour than intentions when looking at individuals' fast food habits.

On the other hand, the benefits of good habits aligned with organisational goals can result in increased workplace productivity; a healthier workforce and lower healthcare costs (Kaleta et al., 2004). Thus, it is important for organisations to identify the influence that lifestyle habits can have within the workforce in order to implement effective and efficient work placements. Bearing this in mind, there are seven behaviours that can be identified as part of a healthy lifestyle.

According to Bojarska and Górski (2002), a healthy lifestyle stems from the economic, cultural and social backgrounds of individuals; and determines their health-related attitudes, values and behaviours. For example, workers with poor education levels – which can be broadly classified as blue collar workers – tend to be employed in positions that are more physically demanding than workers with higher

education levels – which can be broadly classified as white collar workers. As a consequence of this, blue collar workers are more likely to have unhealthier lifestyles than white collar workers.

Moreover, the unhealthy lifestyles of blue collar workers can be characterised by the seven behaviours being investigated in this study. When bad habits are dominant, the seven healthy behaviours can easily be seen as seven unhealthy behaviours; which eventually lead to lifestyle diseases. Bearing this in mind, three frameworks have been identified in the extant literature to support the theoretical framework for this study.

Firstly, the eVITAL framework developed by Salvador-Carulla et al. (2013) illustrates the association between the seven lifestyle behaviours and the types of lifestyle habits. Secondly, the interaction between risk factors and consequences of bad lifestyle habits researched by Ndungi et al. (2017) illustrates how poor application of lifestyle habits lead to non-communicable and chronic diseases such as obesity, diabetes and hypertension. Thirdly, the framework for the evaluation of work placements developed by Von Treuer et al. (2011) illustrates the potential impact that lifestyle habits can have on work placement.

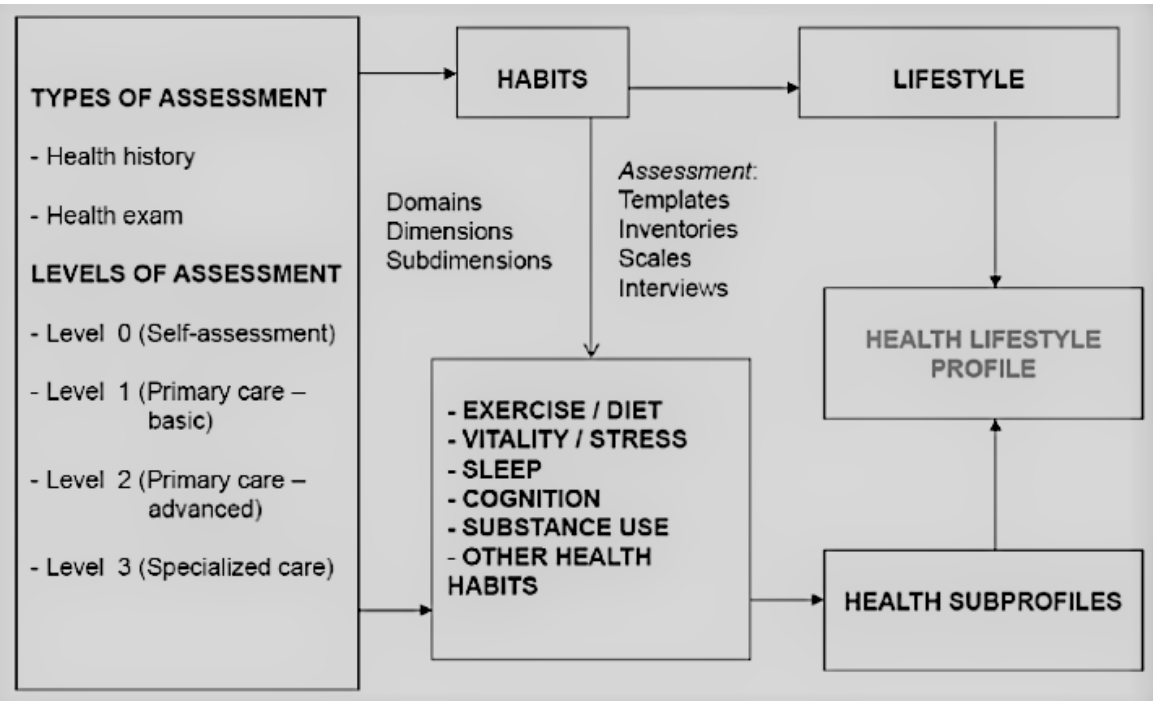
Based on these three models, the simple solution to lifestyle diseases caused by bad habits is to rehabilitate the seven behaviours into becoming good habits. For example. the role of exercise in the reduction from cardiovascular disease risk factors is well established (MAM and Othman, 2010); and the encouragement of commuting and leisure activities among blue collar workers is recommended to further reduce cardiovascular disease risk factors. Innovative solutions to transforming bad lifestyle habits into good lifestyle habits can be achieved through the implementation of intervention and incentives programmes within the workplace

2.2 Types of Lifestyle Habits

There are several behaviours that form the basis of a healthy lifestyle; and according to Lindström et al. (2001), these behaviours stem from an individual's living, economic and social conditions. Once an individual has established a set of reactions to their specific conditions as part of their lifestyle, these form part of their

lifestyle habits. Furthermore it was found that an individual's choice of lifestyle habits can be expressed in several ways (Lindström et al., 2001), for example, their choice of diet; whether they smoke or consume alcohol; and their rest or leisure activities. Taking this into account, the eVITAL framework shown in Figure 2.1 below illustrates the association between lifestyle behaviours and the types of lifestyle habits.

Figure 2.1: eVITAL Framework



Source: (Salvador-Carulla, Alonso, Gomez, Walsh, Almenara, Ruiz and Abellán, 2013, p. 1966)

The eVITAL framework developed by Salvador-Carulla et al. (2013) illustrates the behaviours that underpin specific lifestyle habits. Four types of lifestyle habits have been identified and are presented, namely: exercise habits, smoking habits, alcohol habits, and diet habits.

Exercise Habits

Exercise is one of the lifestyle habits that is very important in ensuring a healthy lifestyle. Exercise encompasses all types of movement that expend energy (Merecz et al., 2003); and include activities related to work, leisure, sports and physical training. More specifically, these can take the form of physical labour, gardening,

athletics or cycling. Exercise usually results in the setting of health or work related goals and can act as a foundation for forming healthy lifestyle habits as the consequence of achieving those goals (Merecz et al., 2003).

Regular exercise contributes to a good state of health and allows an individual to perform optimally in response to certain situations or scenarios. On the other hand, the lack of regular exercise can lead to the development of chronic lifestyle diseases such as cancer, diabetes, high blood pressure, obesity and osteoporosis amongst numerous others (Standage and Ryan, 2012). Unfortunately, many people today live in environments where a sedentary lifestyle is common place and physical activity is counteracted.

Smoking Habits

According to Lindström et al. (2001), it was more common for youth to smoke in the 1970s; but that trend has changed in recent times. They also found that smoking was more prevalent in age groups between 45 and 64 years old in the early 2000s than in age groups between 16 and 24 years old (Lindström et al., 2001). Taking this into account it can be seen that smoking amongst the youth has decreased due to their increased awareness of the risks associated with this lifestyle habit (Ng et al., 2014). Even though there have been large reductions in the prevalence of smoking since the 1980s because tobacco has been identified as a significant health threat, due to population growth, the actual number of smokers has increased; and more so in men than in women (Ng et al., 2014).

Smoking is one of the lifestyle habits that results in negative consequences and contributes to the increase of lifestyle disease risk factors. The consumption of tobacco can be viewed as an addictive drug, which increases the risk and exacerbates the effects of diseases such as lung, throat and liver cancer (Boström, 2006). However, in order to combat these risks, tobacco control policies have been implemented in many countries to decrease the number of smokers and promote healthier lifestyle habits (Ng et al., 2014).

Alcohol Habits

Alcohol use is one of the lifestyle habits that results in negative consequences when the amount of alcohol consumed is in excess. This can typically lead to various

unintended actions that range from uncontrollable behaviour, acts of aggression and eventually alcohol-related diseases (Boström, 2006). Furthermore, the consequences of alcohol abuse don't only apply to the consumers themselves; but also to those around them (Gaziano et al., 2000). In other words, the risk factors of alcohol abuse are not only limited to health conditions; but they can also easily extend to social and economic conditions as well.

It is also worth noting that in 2002, alcohol contributed to almost 10% of the entire disease burden in Europe according to the World Health Organization (2002). Although in 2010 it was found that the two leading contributors of IHD Disability-Adjusted Life Years (DALYs) in all countries in 2010 were physiological risks and dietary risks in aggregate; for Russia, alcohol use was the third leading contributor of IHD DALYs (Moran et al., 2014). Thus, it can be stated that irresponsible alcohol usage contributes to the increase of lifestyle disease risk factors.

Diet Habits

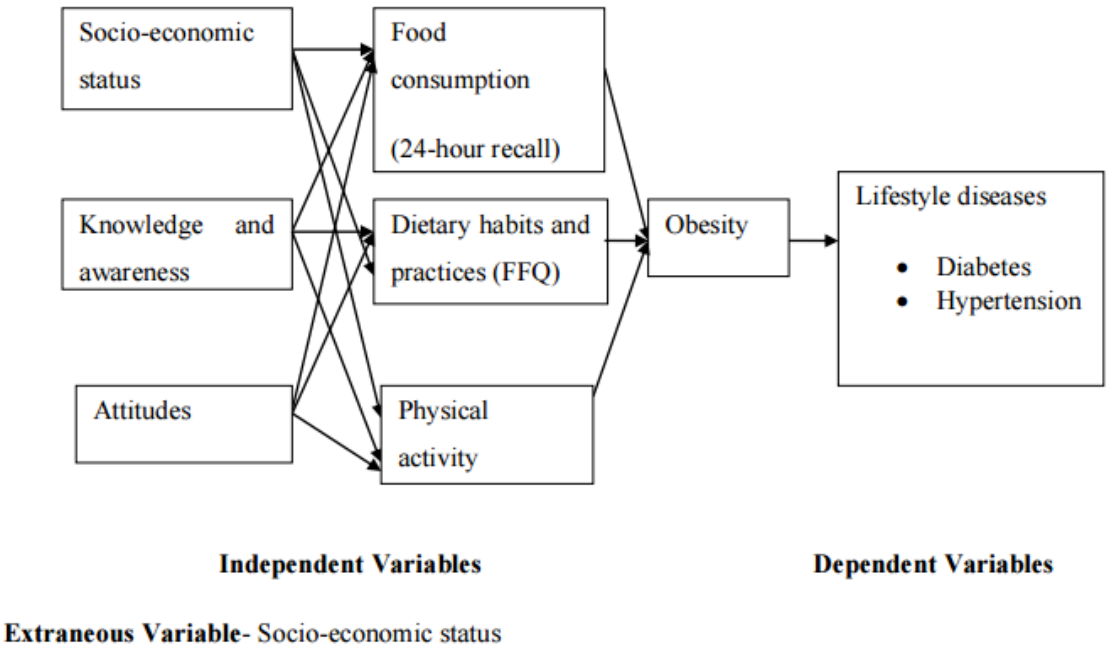
Choice of diet is also one of the lifestyle habits that is very important in ensuring a healthy lifestyle. Diets that consist of fruit and vegetable have been found to reduce the risk of cancers as well as cardiovascular diseases (Potter et al., 2004). A healthy diet ensures that an individual has ample supply of energy and bioactive substances such as antioxidants that empower the body to resist diseases (Potter et al., 2004) .

On the other hand, a poor choice of diet can lead to lifestyle diseases. For example, when high amounts of saturated fats are consumed, such as from high fat milk or vegetable oils, it will increase the risk of cardiovascular diseases (Gardner et al., 2012). The consequences of a poor choice of diet can also typically include diabetes, blood pressure, and obesity health problems; which are highly detrimental to a healthy state of being (Gardner et al., 2012).

2.3 Lifestyle Habits and its Effects

Bad lifestyle habits and poor choices of lifestyle behaviours can lead to the increased risk of developing non-communicable and chronic diseases (Ndungi et al., 2017), as illustrated in Figure 2.2.

Figure 2.2: Interaction between risk factors and consequences of bad lifestyle habits



Source: (Ndungi, Tuitoek and Aboud, 2017, p. 11710)

The Interaction between risk factors and consequences of bad lifestyle habits researched by (Ndungi et al., 2017) illustrates how poor application of lifestyle habits lead to non-communicable and chronic diseases such as obesity, diabetes and hypertension. These poor choices are also exacerbated by socio-economic status, knowledge and awareness, as well as overall attitudes towards the merits in leading a healthy lifestyle. As a result, it is vitally important to understand what influences the formation of good and bad habits.

Good habits form when lifestyle habits are calibrated with goals; and according to Kellogg (1999), routines formed out of habit are essential for productivity. For example, in the case of famous writer Maya Angelou, she rented the same hotel room to possibly create a favourable environment conducive to writing. In that instance, the ritual of constantly choosing the same room and working in the same environment towards the same goal resulted in the formation of a healthy lifestyle habit.

In addition, goals ensure that good habits are maintained. For example, it was found that violin students, who had the goal to become solo artists, would practise at the

same time every day as part of their lifestyle habits (Ericsson et al., 1993). However, violin students who had a differing goal to become music teachers did not have a discernible routine or any specific type of identifiable lifestyle habit due to the lack of intensity required to achieve that specific goal (Ericsson et al., 1993).

Likewise, bad habits form as the result of poor control over lifestyle behaviours. The poor choice of lifestyle behaviours can include lack of exercise or bad diet choices; which in turn could result in lifestyle diseases such as obesity, diabetes and hypertension (Ericsson et al., 1993) When put into a workplace context, young individuals who have just entered the job market with the goal of establishing promising careers would not prioritise the development of healthy lifestyle habits over career progress. As a result, they would fall into a cycle of poor lifestyle behaviour choices, such as lack of exercise, and steadily increase the risk of developing lifestyle diseases.

Exercise is one of the seven behaviours that affects whether an individual develops good or bad lifestyle habits. In a study by Standage and Ryan (2012) it was found that strenuous physical activity performed at least twice a week was only achieved by a quarter of male participants and a fifth of female participants aged between 16 and 44 years. This highlights the lack of importance attributed towards exercise and achieving a state of subjective wellbeing.

Subjective wellbeing can be defined as "…people's evaluations of their lives – the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well" (Diener et al., 2015, p.234). The motivation toward good lifestyle habits, especially with regards to exercise, have been found to be key predictors of subjective wellbeing (Briki, 2016). In addition it was also found that motivation to perform exercise can influence subjective wellbeing through the trait of self control (Briki, 2016).

Smoking is one of the seven behaviours that affects whether an individual develops good or bad lifestyle habits. The trait of self control can govern whether smoking can become a bad habit within the workplace; because a wide range of effective interventions are available to curtail smoking. These include increasing prices of cigarettes and bans on advertising and smoking in public places (Ng et al., 2014). An individual with questionable self control could easily ignore or circumvent these

interventions to enjoy the pleasure of smoking at the risk of contracting several lifestyle diseases.

Alcohol use is one of the seven behaviours that affects whether an individual develops good or bad lifestyle habits. Gaziano et al. (2000) list the negative consequences of alcohol-related lifestyle habits; which include poor mental health, disturbed sleep and mental patterns, as well as increased stress levels specifically amongst female consumer. All these issues that stem from alcohol use have been shown to contribute to impaired subjective wellbeing (Gaziano et al., 2000).

Because alcohol abuse negatively impacts subjective wellbeing, it can lead to increased risk of chronic lifestyle diseases and ultimately death. Simpura and Karlsson (2001) investigated the mortality rates linked to alcohol-related diseases between 1950 and 2002; and found that the mortality rate of males is approximately four times higher than females. Alcohol poisoning, which is a consequence of alcohol use, was also found to have tripled amongst younger women (aged 15-24) and doubled amongst men of a similar age group (Schildt et al., 1998).

Furthermore, alcohol poisoning contributes to increased healthcare costs as it results in many people requiring hospital care at a rate which increases each year (Wickholm et al., 2003). Moreover, the link between alcohol abuse and diabetes has also been established because even at low levels of alcohol use it has been found that there are considerable risks (Standage and Ryan, 2012). Therefore bad habits associated with alcohol can have a significant impact in the workplace.

Choice of diet is one of the seven behaviours that affects whether an individual develops good or bad lifestyle habits. Good dietary lifestyle habits would include the consumption of fruit, vegetables, fish and meat as recommended by the National Food Administration (Merecz et al., 2003). However, it was found that individuals between the ages of 18 to 29 years ate the least amount of fruit and vegetables, indicative of bad dietary lifestyle habits (Merecz et al., 2003). Individuals in that age bracket (18-29) are also more likely to be entering the workplace; hence they need to be made aware of the negative consequences and lifestyle diseases associated with a poor choice of diet from such a young age.

2.4 South Africa and Lifestyle Diseases

Lifestyle diseases are influenced by risk factor profiles which stem from bad lifestyle habits and the poor application of the seven behaviours. Chronic lifestyle diseases, such as metabolic syndrome, high blood pressure and cholesterol are results of poor lifestyle habits and contribute to the disease burden in both developed and developing regions (Ezzati et al., 2002). However, there is limited comparative information in South Africa with regards to the healthy lifestyle choices of urban and rural communities, which serve as the South African proxies for developed and developing regions. In a study conducted in the Free State Province it was found that distinct risk factor profiles exist for both urban and rural communities; but these are poorly controlled resulting in the prevalence of untreated lifestyle diseases (Van Zyl et al., 2012).

Exercise forms part of a major risk factor for chronic lifestyle diseases especially when it was found that less than a third of South Africans met the Disease Control and Prevention (CDC) recommendations for healthy levels of exercise. In addition, it was also found that members of urban communities are more likely to exercise in line with recommended guidelines for healthy living than members of rural communities (Malambo et al., 2016).

Hypertension is one of the results of poor lifestyle habits as it was ranked as the highest risk factor for urban and rural communities in South Africa (Van Zyl et al., 2012). Further to this, the South African Centre for Health Systems Research and Development found that hypertension (41%) was the condition most commonly reported (Statistics South Africa, 2005), and is commonly associated with a lack of exercise.

Malambo et al. (2016) suggest that culturally or community tailored interventions to promote healthy levels of exercise should target individuals at an early age; and preferably before they enter the workplace. They also assert that if no effective public health interventions are implemented, further decrease in exercise levels will lead to the high risk of developing major chronic lifestyle diseases, such as hypertension, among South Africans (Malambo et al., 2016).

Smoking forms part of a major risk factor for chronic lifestyle diseases especially when it has been found by a study conducted by Groenewald et al. (2007) to result in more than 10% of deaths in South Africans over the age of 35 years. High blood pressure, hypertension and diabetes are results of poor lifestyle habits such as smoking; but these lifestyle diseases are also aggravated due to poor health control systems in rural communities (Van Zyl et al., 2012). As a result, interventions and incentives to reduce levels of smoking within communities are required.

Poor choice of diet forms part of a major risk factor for chronic lifestyle diseases especially when it results in a large proportion of a community being obese. Standage and Ryan (2012) found that a waist circumference measurement of greater than 88cm was an indicator of obesity amongst women; and that more than 50% of their study population had a waist circumference measurement greater than 88cm. Furthermore, one of the top ranked risk factors for chronic lifestyle diseases facing South Africans was found to be high BMI (Van Zyl et al., 2012), which could also be the result of bad dietary habits.

The major risk factors identified in urban and rural communities for chronic lifestyle diseases included hypertension, lack of exercise and obesity. It was found that the major threats for the rural communities were hypertension and obesity; and for the urban communities it was lack of exercise as well as obesity (Van Zyl et al., 2012). This demonstrates that obesity and hypertension are results of poor lifestyle habits whilst further establishing the relationship that exists between the two lifestyle diseases.

Obesity is also one of the lifestyle diseases that poses a global challenge as there is an increasing trend of diabetes developing across all age groups in urban communities (Nojilana et al., 2016). Even though there have been interventions introduced that include focusing policies to improve nutrition and socio-economic conditions, no country in the world has been effective at addressing the dual issues of obesity and diabetes (Nojilana et al., 2016).

Several factors were found to influence lifestyle diseases in the South African context. For example, the CDC Health Effects of Cigarette Smoking information fact sheet, published in 2004, indicated that smoking approximately can double an individual’s risk for stroke (Nojilana et al., 2016). In addition, gender-related lifestyle

habits such as a tendency for women to be overweight and obese; and men to smoke and drink also contribute to a high prevalence of lifestyle diseases in South Africa (Nojilana et al., 2016). Unfortunately, these issues are compounded when the lack of health insurance amongst the poorer rural communities results in untreated and uncontrollable lifestyle diseases (Nojilana et al., 2016).

Eventually these factors also contribute to higher mortality rates. Poor lifestyle habits such as alcohol abuse and poor choice of diet, often develop into major risk factors for chronic lifestyle diseases, which ultimately increase mortality rates (Nojilana et al., 2016). A comparative risk assessment study into South African mortality rates by Norman et al. (2007) ranked deaths attributable to lifestyle diseases as follows:

1. High Blood Pressure
2. Smoking
3. Alcohol
4. High BMI
5. High Cholesterol
6. Diabetes
7. Lack of Exercise

As is evident in the adapted rankings above, lifestyle diseases significantly contribute to premature mortality in South Africa especially despite the challenges AIDS poses to the urban and rural populations (Nojilana et al., 2016). Consequently, socioeconomic development is stifled especially when out of approximately 230,000 South Africans who died from lifestyle diseases in 2010, 36% had not reached the average life expectancy of 60 years (Nojilana et al., 2016). The dual impact of lifestyle diseases with the AIDS epidemic on both mortality rates and escalating healthcare costs definitely demands attention in the form of lifestyle intervention programs designed to improve the overall health profile of both urban and rural communities (Norman et al., 2007).

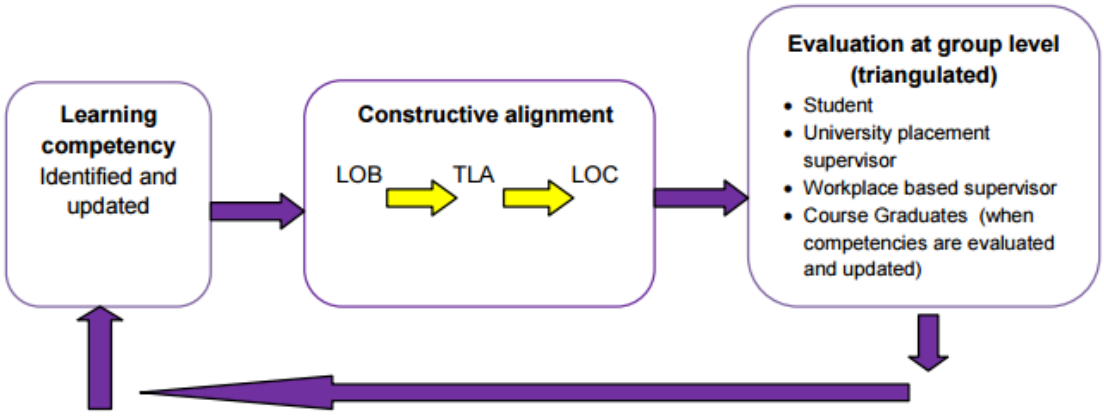
Intervention programs are thus necessary to reduce healthcare costs and the risk factors for chronic lifestyle diseases; and can take the form of weight loss and exercise programs through the establishment of community fitness centres (Van Zyl et al., 2012). However, the intervention efforts should not be allowed to be limited in scope to just be at a community level because nationwide intervention programmes

are also required. In light of this, South Africa launched a Strategic Plan for the Prevention of Non-communicable Diseases 2013-17 in September 2013, which provides an overarching framework for chronic disease prevention by promoting health and wellness at community and individual levels and strengthening primary healthcare (Nojilana et al., 2016). The Strategic Plan has identified key population-wide interventions to prevent and control lifestyle diseases through legislation and regulation, which are slowly filtering their way through South African workplaces to reduce mortality rates and reinforce healthy lifestyle habits.

2.5 Work Placement Influencers

Work placement can be defined as the intersection between mental, physical, emotional and functional capabilities of workers (Kaleta et al., 2006). Work placements can take the form of internships, fieldwork, industry-based learning, apprenticeship, fieldwork, or clinical placements. In addition, all these forms of work placements share characteristics and most involve on-the-job training (Von Treuer et al., 2011) Furthermore, work placement also takes into account the health, social conditions and status in the organisation of workers (Kaleta et al., 2006) as indicated in Figure 2.3.

Figure 2.3: Framework for the Evaluation of Work Placements



Source: (Von Treuer, Sturre, Keele and McLeod, 2011, p. 202)

The framework for the evaluation of work placements developed by Von Treuer et al. (2011) illustrates the potential impact that lifestyle habits can have on work

placement. Lifestyle habit objectives (LOB in the model) can include the promotion of good habits and the prevention of bad habits. Learning and teaching objectives (TLA) can promote awareness of the seven healthy behaviours and the dangers of lifestyle diseases. Finally, work placement outcomes (LOC in the model) can take the form of promoting self control and preventing demotivation.

Self control is one of the work placement outcomes that has been found to be associated with good habits (Neal et al., 2013). Self control can be characterised by individual differences in lifestyle habits, which may include reading, sleeping, exercising and a healthy diet. Thus it was further found that self control can actually predict good habits (Galla and Duckworth, 2015). The association between self control and good habits has been established especially when individuals rely on their levels of self control to contribute towards their goals (Duckworth and Carlson, 2013). Self control also leads to the development of stronger lifestyle habits, resulting in the eventual improvement on other desirable health behaviours.

Research has found that good habits reinforce the relationships between self control and positive outcomes (Duckworth and Carlson, 2013; Gardner et al., 2012) Self control aided stronger study habits, this reduced intrusive thoughts, negative mood and behavioural impaired desires following a work or leisure conflict. The data suggested that with reliance on routines and stable habits, the individuals who had better self control are able to enact important behaviours more effortlessly and automatically (Gardner et al., 2012).

Good lifestyle habits can influence self control and result in positive outcomes. When analysed over extended periods of time, habits were also important mediators on self control on the accomplishment of meditation practice goals three months after a meditation retreat, this was also found in earning higher grades in high school which also persisted through college (Duckworth and Carlson, 2013). Furthermore, motivation is another work placement outcome in the same vein as self control.

Galla and Duckworth (2015) suggest that the importance of habits lies in its ability to reduce the level of effortful inhibition required to maintain healthy lifestyle behaviours. This allows individuals to prioritise activities based on the level of motivation felt. For example, day-to-day leisure activities might be postponed when motivated by the pressure of a looming work deadline (Galla and Duckworth, 2015).

Likewise, bad habits can influence motivation and result in negative outcomes just as easily as good habits. However, interventions in the form of goals have been found to prevent the development of bad lifestyle habits (Neal et al., 2013).

In that regard, behaviours motivated by specific goals and ambition are less likely to result in the formation of habits, because once the goal has been achieved, the motivation behind the behaviour also dwindles. Similarly, temptation was found to influence the promotion of good lifestyle behaviours through the development of effective self control strategies (Ogden et al., 2012). However, the impact of temptations can be mitigated through the introduction of incentives programmes in the workplace.

Incentives can influence work placement outcomes through the establishment of proactive strategies. Proactive self control strategies that pre-emptively remove competing alternative goals (Galla et al., 2014) should reduce the need to re-evaluate the desired behaviour in relation to an available alternative which in turn may clear the way for repetition of the desired behaviour, this will then create the development of automaticity.

To highlight the contrast, reactive self control strategies involve deliberate and direct comparisons of conflicting goals. When relying on effortful inhibition every time a desired action or behaviour needs to be enacted, this could have the effect of stalling the development of automaticity (Lally and Gardner, 2013). Therefore, research suggests that the development of self control strategies are effective in promoting good lifestyle behaviours.

2.6 Lifestyle Habits in the Workplace

Research has shown that good habits result in better self control in individuals; and ultimately leads to goal adherence. The majority of human behaviour is energised and guided by goals (Kruglanski, 1996), however goal pursuit is not always easy or straightforward. Thus research shows that individuals with better self-control rely on habits to fulfil long term goals (Galla and Duckworth, 2015). Therefore, goal adherence as a result of good habits can be predictive of positive outcomes.

Being able to predict positive outcomes due to the result of good habits and self control determines the efficacy of intervention or incentive programmes with regards to the relevant – or problematic – lifestyle habits encountered in the workplace. Reading is one of the seven healthy behaviours that promotes education in the workplace. The literature shows that people with lower levels of education more frequently take on work involving more physical labour than those individuals who have higher education, and this creates bad lifestyle habits in workers from poorer backgrounds (Boström, 2006).

Exercise is one of the seven healthy behaviours that promotes physical capabilities in the workplace. Accordingly, blue-collar workers can be characterised as being unskilled or semi-skilled individuals; and they are usually exposed to higher physical demands than white-collar workers. As a result, they rarely reach retirement age due to the consistently demanding nature of their positions in the workplace (Gupta et al., 2015). Similarly, lack of exercise is a bad lifestyle habit that has many negative consequences; and contributes to poor physical capabilities in the workplace. On the contrary, it was found that exercise can contribute to high levels of physical and emotional health in an aging workforce (von Bonsdorff et al., 2016).

In a similar vein, healthy sleep and resting patterns are one of the seven healthy behaviours that promotes good work ability in the workforce. It was found that individuals with good work ability possessed the necessary physical and emotional resources to adequately cope with demands in the workplace (von Bonsdorff et al., 2016). On the other hand, the lack of sleep or poor resting patterns contributes to poor performance in the work place, especially when there is an imbalance between employee resources and job demands. However, it must be acknowledged that work ability is a concept which indicates the balance between employee resources and respective work demands. Hence, an individual with good resources in an extremely high-strain job may report poor work ability. Vice versa, an individual with low resources in an extremely light job may report good work ability (von Bonsdorff et al., 2016).

Prayer is one of the seven healthy behaviours that can reinforce employees' attitudes, motivation and values impacting on the work ability of the workforce. As work ability is partly built on employees' attitudes, motivation and values, it is

plausible that better work ability, stemming from higher motivation for participation and positive attitudes towards work, is reflected in old age mobility (von Bonsdorff et al., 2016). More specifically, these work-related attitudes, motivations and values may be reflected in intra-individual factors, such as the reliance on prayer or spirituality. Thus, even individuals who retire due to disability, may in terms of maintaining mobility in old age, benefit from positive midlife work attitudes and a sense of competence that only prayer can provide.

Smoking is one of the seven behaviours that can contribute to poor performance in the workplace. It was found that daily smokers percentage among men aged 16-84 has proportionally declined by 19% since 1980, for both blue-collar workers and those white-collar workers at middle and upper levels. Women daily smokers declined proportionally by 8% among blue-collar workers and by 11% among white-collar workers at the middle and upper levels. In 2002 more than double the number of blue-collar workers (both genders) were daily smokers in comparison to white-collar workers at intermediate and upper levels (Wickholm et al., 2003).

However, it was 40% more common for female blue collar workers who had low incomes to be daily smokers than it was for female blue collar workers with high incomes. With the male blue-collar workers, there was 2 and a half times more daily smokers who had low incomes than there were compared to those with high incomes (Wickholm et al., 2003). Despite progress in reducing prevalence of daily smoking since 1980, the number of smokers has increased steadily worldwide, and there are preliminary indications that global prevalence among men increased in recent years. Although many countries have implemented control policies, intensified tobacco control efforts are particularly needed in countries where the number of smokers is increasing (Ng et al., 2014).

Alcohol use is one of the seven behaviours that can contribute to poor performance in the workplace. A primary example is the proportion of alcohol consumers who suffer problems due to when their drinking increases as well as when the total consumption of alcohol in the population increases and its corresponding effects. In Sweden, the chief goal for alcohol policy has been to reduce total alcohol consumption, this was in order to reduce the number of alcohol injuries. The goal was sought to be achieved, through: limitation of the availability of alcohol; a policy of

high prices; transition from stronger to weaker alcoholic drinks, increased knowledge of the damage caused by alcohol, and investment in alcohol-free leisure time activities for young people (Galla and Duckworth, 2015).

Choice of diet is one of the seven behaviours that can contribute to poor performance in the workplace. The research shows that it is far more common for blue collar workers and people with little to no education to eat minimal amounts of fruit and vegetables than it is for highly educated people who were in white collar stations at middle and upper levels to do so (Merecz et al., 2003). Literature data and research show repeatedly that unhealthy weight may lead to serious health complications, which has a direct effect on lowered work ability.

A possible explanation of this finding is that people who prioritise correct diet habits are likely to have other healthy habits, e.g. take exercise regularly and do not smoke cigarettes, which will help to prevent work ability deterioration. An additional possibility is that correct diet is able to reduce the risk of serious diseases, influence health positively and therefore improve work ability.

2.7 Concerns of Lifestyle Habits in the Workplace

Interventions can influence work placement outcomes through the establishment of well defined goals. In a complementary way, habits are a way to help prevent mental fatigue that could impair self-control for the times when it is needed, for example, in the event of unpredictable encounters with strong temptation. Perhaps individuals who get thrown off their existing habits and routines due to a change in their regular circumstances probably will experience far more self-control difficulties and inevitable difficulty sticking to their goals (Lally and Gardner, 2013).

The use of interventions can serve as an actionable way for organisations to control the possible influence that lifestyle habits have on work placements. Habit theory defines how it is normative for people to form strong automatic associations with frequented, familiar, environmental cues and their own behavioural responses (Neal et al., 2013). This leads to the development of habitual behaviour; which intervention programmes should be designed to promote healthy lifestyle habits in the workplace.

Habitual behaviour is of a non-conscious, automatic nature thus making it less vulnerable to processes such as rationalisation, frequent forgetfulness or easily being replaced by competing activities, as habits don't have to be deliberated. Behaviours that are formed and become habituated are likely to persist. There is however two sides to the coin of habits, the very same features that make habits so desirable in relation to positive, desired behaviours, also are the walls or barriers that make old habits so difficult to break (Neal et al., 2013).

An intervention can limit the impact of bad lifestyle habits in the workplace by the development of implementation intentions. Implementation intentions are specific plans regarding where, when and how to act, these are demonstrated to substantially increase the likelihood of acquiring new habits and goal attainment. The positive nature of implementation intentions is that it serves as a vehicle to kick start new habits, the cue response links which are initially formed as planned implementation intentions become the cue response links underpinning new habits (Lally et al., 2010).

An intervention programme can limit the impact of bad lifestyle habits in the workplace by forming implementation intentions, for example, that help to predict both the adoption of healthy eating habits and the development of a physical activity regime. The combination of implementation intentions which had an intervention in a supportive social environment has shown positively to result in substantially greater goal achievement than the use of just implementation intentions alone (Lally and Gardner, 2013).

According to Gupta et al. (2015), the general recommendations for conducting workplace health intervention is that success is more likely if:

- it considers all aspects of worker's well-being,
- does not feel forced upon workers,
- follows a structured approach that builds upon itself,
- fosters participation, and
- uses resources effectively to develop new interventions.

2.8 Success Factors of Lifestyle Habits in the Workplace

The use of incentives can serve as an actionable way for organisations to direct the possible influence that lifestyle habits have on work placements. Gillison et al. (2014) argue that a positive relationship exists between self control and good lifestyle habits. For example, individuals with high levels of self control are more likely to develop stronger habits for exercise and eating healthy snacks. They would also be less inclined to develop habits for smoking and alcohol abuse as they would be able to appreciate the risks associated with these bad lifestyle habits.

An incentive can promote the impact of good lifestyle habits in the workplace because the strength of a habit can be measured by how often it occurs within a situational context (Neal et al., 2013). As a result, incentive programmes in the workplace can be designed to promote good habits by offering intrinsic and explicit rewards for the increased frequency of good lifestyle habits. Furthermore it was found that individuals with higher levels of self control relied on good habits to develop routines designed to achieve personal goals (Lally and Gardner, 2013).

A well designed incentive program can strengthen the impact of good lifestyle habits in the workplace by aligning the personal goals of individuals in the hope of developing team goals. For example, teaching and learning activities can be introduced to increase awareness of the benefits of seven healthy behaviours; which can be contrasted against the risks of lifestyle diseases associated with seven unhealthy behaviours. However, when faced with temptation, health goals at both the individual and team levels can fluctuate dramatically (Hall and Fong, 2007).

In light of temptations and the urges for immediate gratification, motivation is vitally important to develop good lifestyle habits (Gillison et al., 2014). Self Determination Theory (SDT) is a framework for motivation based on the premise that social and economic conditions determine the levels of satisfaction associated with specific lifestyle behaviours (Gillison et al., 2014). In light of this, when senior management incentivises healthy lifestyle habits, it promotes a support structure for blue collar and white collar workings that can increase motivation levels, and their attempts to lead healthier lifestyles (Ogden et al., 2012)

Even through significant efforts, motivational interventions do not always have the desired effect that will result in positive work placement outcomes such as promoting self control and preventing demotivation. This could be due to the influence of habitual behaviour which is of a non-conscious and automatic nature. For example, research has shown young adults and adolescents to be notoriously difficult to invest in health promotion initiatives, mostly due to their low levels of perceived health risk (Standage and Ryan, 2012).

Introducing innovative ways of communicating with the younger workforce can be achieved through teaching and learning activities aimed at increasing awareness of the lifestyle diseases and risks that arise from bad lifestyle habits. Furthermore, these communications can be reinforced through incentive programmes such as free or subsidised gym memberships to promote exercise, or free or subsidised groceries to promote healthy diets. Financial incentives have also been found to be effective especially for individuals who have just entered the work force who would be earning at a lower rate than at the outset of their careers wages (Van Zyl et al., 2012). Thus, incentive programmes within the workplace can contribute to changing bad habits to good habits by promoting self control and preventing demotivation.

2.9 Conclusion

From the studies presented and discussed, it can be concluded that the lifestyle habits that are formed, as a result of the seven behaviours investigated, influence the work placement of individuals. A clear need was also established for the creation of intervention and incentives programmes to promote healthy lifestyle habits, such as: increasing exercise; managing smoking, stopping/reducing drinking and eating healthily.

The benefits of good habits and the risks of bad habits were also identified within the extant literature. With regards to the seven behaviours investigated, if individuals in the workplace exhibited one or more bad habits – often as a direct consequence of poor social and economic conditions – they were considerably more likely to have impaired mental health. The unhealthier lifestyle habits one practised, the more likely they were to have poor mentally impaired health or general health (Galla and Duckworth, 2015).

There was also strong support in the literature for the view that individuals with better levels of self control had stronger habits; and were more inclined to develop good lifestyle habits, such as studying to improve education levels and become more eligible for promotions (Lally and Gardner, 2013). However, when individuals are not motivated to develop lifestyle habits aligned with self improvement, there is a good chance that they will fall into bad lifestyle habits, given the popularity of leading sedentary lifestyles in both rural and urban communities within South Africa (Van Zyl et al., 2012)

Finally, the literature review identified how lifestyle habits played a definitive role in quality of life and improved work performance. This correlates directly to improved work placement as those with better lifestyle habits consistently were those in white collar positions in comparison to those with negative lifestyle habits, who were found in blue collar work stations.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This research methodology chapter discusses how the research hypotheses were evaluated from the quantitative nature of the information collected. Whatever issues relating to instruments and procedures that were used in gathering the data utilised for this research will be discussed.

3.2 Research Strategy

The Quantitative research strategy was used in order to capture the data required for this study. Being deductive and particularistic, and based upon formulating the research hypothesis and verifying them empirically on a specific set of data sums up the aim of quantitative research (Matveev, 2002). The quantitative research strategy is value-free and has no bias based on researcher's preferences, or biases which may compromise the results. The communication process can be viewed by researchers as concrete and easily able to analyse without necessitating contacting the people involved to divulge further information (Ting-Toomey, 1984).

Matveev (2002) states the strengths of the Quantitative research strategy:

- Clearly specifying both the dependant and independent variables under investigation;
- Due to controlled observations, achieving high levels of reliability of gathered data, laboratory experiments, mass surveys as well as other forms of research manipulations;
- The research goals clearly being followed and allowing more objective conclusions, hypothesis testing and enabling more accurate issues of causality.
- The research problem is stated very specifically and in a set manner;
- Longitudinal measure of subsequent performance of research subjects were allowed;
- Minimising or elimination subjectivity of judgement.

Matveev (2002) includes the weaknesses of the quantitative research strategy:

- The environment that the respondents provide the answers to in the survey is not possible to be controlled completely;
- Information about the context of the present situation about where and how the studied phenomenon occurs is not fully provided;
- The research phenomenon is not encouraged to evolve and continue to be investigated;
- The questions are of a closed format and a structured set so it avails itself to only limited outcomes.

Strengths and Weaknesses are associated with gathering data from secondary data. Such as:

Strength of physical data and documents:

- Insight is provided on what people think and do;
- The results are gathered unobtrusively, therefore investigator effects are very unlikely;
- There is no set time period and can go back historically;
- Useful background and historical data are provided that diversify on a variety of groups;
- Can be grounded in local and foreign settings;
- Extremely useful for exploration, especially if budget constraints.

Archived Research Data Strengths:

- A wide array of topics are available on archived research data;
- Usually are reliable and valid;
- Inexpensive;
- Data Analysis already done or of ease to do;
- Study trends easily;
- Based often on large probability samples or high quality samples.

Physical Data and Documents Weaknesses:

- Only one perspective may be representative;

- Possibly Incomplete;
- Not applicable to general populations;
- Limited content accessibility;
- Not applicable to persons study based on differing physical data;

Archived Research Data Weakness:

- Not available for particular relevant population;
- Data is dated and no longer applicable;
- Research questions not relevant or of interest;
- Qualitative data too open ended and not of relevance;
- Most important findings have already been mined
  (Johnson and Christensen, 2008)

The most popular and useful method of conducting this research was through the usage of the questionnaire or survey method. This is the method that was used for the purposes of this research to collect primary data from participants. The next section details how these participants were identified and selected.

3.3 Location and participants of Study

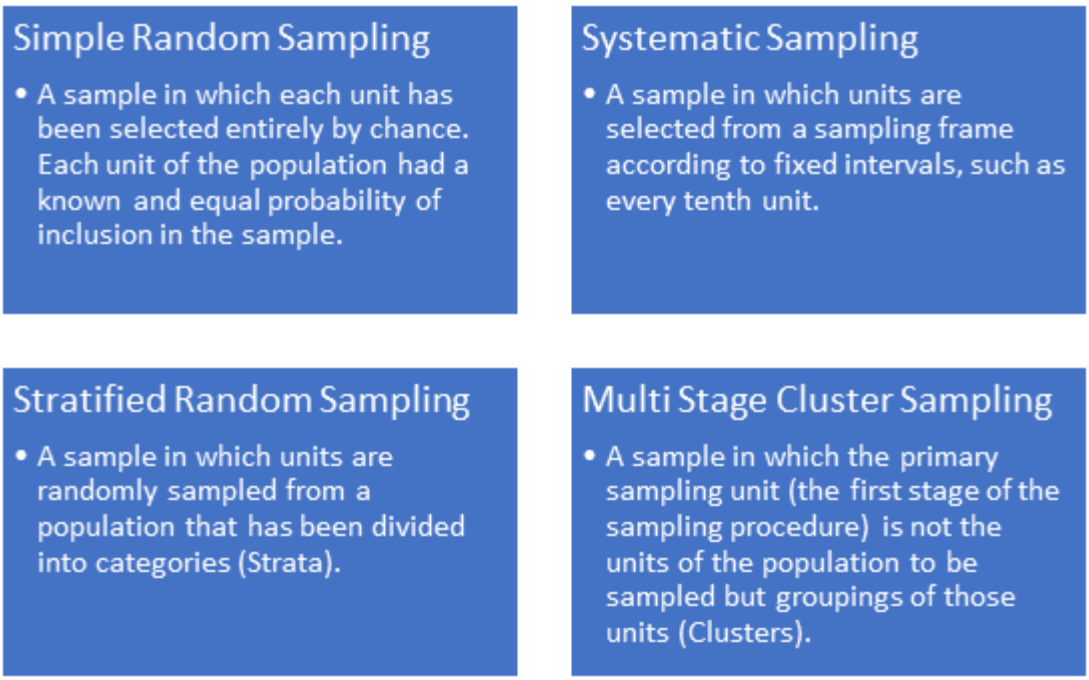
This study was conducted in Durban, South Africa. The participants were the majority of the staff of Araf Industries (PTY) Ltd based in Briardene, River Horse Valley in the North of Durban. The participants were based from the owners through senior management, middle management, supervisors and regular employees. All races, both sexes and 80 out of the 100 staff who were available on the day were duly surveyed.

3.4 Sampling

A sample can be defined as the subset of a population that is specifically chosen for research purposes; and there are two broad classifications of sampling, namely: probability sampling or non-probability sampling (Bryman and Bell, 2007). Figure 3.1 illustrates the various probability sampling methods which are characterised by each

sampling unit within a given population having a known probability for selection (Bryman and Bell, 2007).

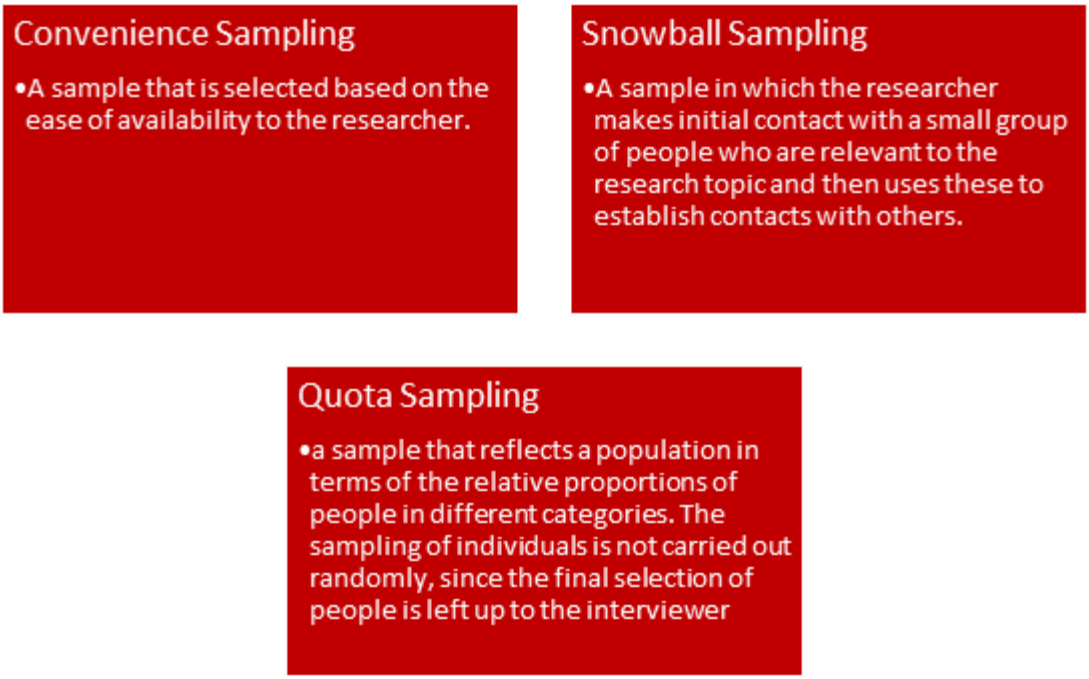
Figure 3.4: Probability Sampling Methods



Source: (Bryman and Bell, 2007)

On the other hand, Figure 3.2 illustrates the non-probability sampling methods which are characterised when sampling units are chosen based on criteria determined by the searcher. This usually results in some sampling units being more likely to be chosen based on specific selection criteria (Bryman and Bell, 2007).

Figure 3.5: Non-Probability Sampling Methods



Source: (Bryman and Bell, 2007)

Probability Sampling was used in this study which utilised the Simple Random Sampling method being adopted. What made this method appropriate was the direct answers and how lifestyle habits affected each individual, regardless of their work placement position. The sample would have to represent everyone in the company so that the sample data would qualify as effective and reliable for analysis.

For a population of 100, a sample size of 80 is required (The Research Advisors, 2006). The sample was taken from Araf Industries (PTY) Ltd, a hardware company based in Durban. A total of 100 questionnaires were circulated amongst all the employees of Araf Industries (PTY) Ltd; and 80 fully completed questionnaires were returned. This is a response rate of 80% which has a confidence of 95% and a margin of error of 5%. Saunders et al. (2009) suggest that a larger sample size reduces the likelihood of error in generalising to the population. But having larger sample sizes does not necessarily guarantee accuracy from the results. Therefore, 80 valid responses were regarded as sufficient and then used as part of the data analysis process.

3.5 Research Design and Methods

Firstly, the primary instrument used as part of the quantitative research design will be discussed. Thereafter, the tools used to ensure that reliability and validity of the chosen research method (questionnaire) will be presented.

3.5.1 Questionnaire Design

Primarily the questionnaire was designed to ascertain the objectives of the study. Data is critical to collect feedback on which habits correlate with which work position, the impact of such a lifestyle habit and what its results give us. We also wanted to determine if people thought that their lifestyle habits did play a role on affecting their work placement.

- The research objectives directed which questions were asked
- Understandable, Unbiased questions
- Ease of understanding through simple language to overcome language barriers;
- Questions short and to the point;
- Questionnaire designed to be completed with ease and in a short period of time.

The Quantitative Research questions entailed Yes, No answers and choosing an answer from multiple options for respondents in which to answer. Due to the variety of respondents from all levels of the company I opted to hand deliver each one and ensured each one was filled out completely without missing a question. This manual format was not the easiest as each questionnaires data had to be filled in on to SPSS to be captured so this did prolong the process but was effective in gathering a response from all levels of the company without bias.

A fair and effective representative mix was the main objective and having manual surveys fulfilled my underlying objective. The questionnaires were designed to be filled in quickly and with ease so that respondents from all levels would not get bored or lose interest. There were 21 questions in total and this was not too short or too long and enabled me to succinctly achieve my objectives.

3.5.2 Reliability and Validity

Reliability and Validity are naturally cornerstones of scientific discovery and investigations. Reliability can be defined as the measure of how reliable a particular technique, when applied repeatedly to the same or similar research participant, would yield the same or similar results (Mouton and Babbie, 2001) Bearing this in mind, truly diligent scientists are known to take measurements many times, this has the effect of minimising the chance of malfunction and thereby maintains reliability and validity. However, on the other hand, those experiments that make use of human judgement will always come under question.

Human judgement is always subjective and can vary widely between observers, even the same individual can be guilty of rating things differently dependent on the mood they are in or time of day it is. These type of experiments become more difficult to replicate, and almost impossible to repeat which make them inherently less reliable; hence the reason why a quantitative research method in the form of questionnaires were chosen over a qualitative method for the purposes of this study.

Validity can be defined as the extent to which a research instrument (e.g. questionnaire) reflects the concepts or constructs that it is intending to measure (Mouton and Babbie, 2001). In addition, external validity examines the findings elicited via the research instrument to determine potential relationships between variables that were measured. Taking this into account, the scientific research design puts forward a possible cause that is understood for the studied effect. Unknown factors could always contribute to the findings or results. As techniques are honed and refined, discovering extraneous causal relationships may become more apparent (Sekaran and Bougie, 2013; Shuttleworth, 2008).

When the research instrument contains reliability and validity, the findings are far more acceptable to the scientific community. To ensure the results stand up to rigorous testing, having correct controls and duplicate samples is essential (Sekaran and Bougie, 2013; Shuttleworth, 2008). Reliability and validity were considered when designing the questionnaire as the researcher was clear about what the information requirements were. In addition, the way in which the respondents understood the

questions was the same way intended by the researcher; and the data were then decoded by the researcher in the same way that the respondents intended.

3.6 Administration of Questionnaires

The study utilised objectives to prove or disprove the research problem. The questions were designed based on the research objectives for the questionnaire which was the primary data collection instrument. The company sample population was based in Durban and reflective of the full company, from senior management right to blue collar employees. The questionnaires were distributed manually as respondents available on the internet were limited and not a full reflection of the sample study. The questionnaire design was formulated to uncover the research objectives in a simple, coherent format which made it easy of all levels of employment to answer to bypass any intellectual or language barriers.

3.7 Data Analysis

The data collected were analysed using SPSS to compute the findings for this research. The following two types of statistics were calculated:

- Descriptive statistics, such as frequencies, percentages and graphs, were used to describe the demographic profile of respondents and their physical and exercise activities. The reason descriptive statistics were used in this study was to provide a numerical description of all variables in order to identify any trends within the data (Saunders et al., 2009).
- Inferential statistics in the form Chi-Square tests of association were used to determine differences in proportions between specific categories, more specifically, between good habits and bad habits categories. Chi-Square tests were chosen in this study to determine whether two variables were significantly associated (Saunders et al., 2009). In other words, to determine whether any associations existed between a demographic category and good or bad habits in groups.

3.8 Ethical Considerations

For the purpose of this study, ethics refers to the researcher's responsibility to ensure that the rights of the people participating and affected the study are protected (Saunders et al., 2009).

The following ethical considerations were taken during the duration of the research:

- the significance and aims of the study were clearly communicated.
- the anonymity of participants and confidentiality of their responses was maintained through every stage of the research process.
- questionnaires were circulated and completed within a safe environment.
- participants were allowed to opt out of the research at any stage; and each participant took part in the study on a strictly voluntary basis.

3.9 Conclusion

This chapter provided a breakdown of the research methodology that was developed and implemented in order to achieve the objectives of the research. The next chapter (4) will provide a presentation of the results and provide an analysis based on the data collected from the questionnaires.

CHAPTER FOUR: PRESENTATION AND ANALYSIS OF RESULTS

4.1 Introduction

This chapter presents the results of this study. Firstly, the profile of respondents in terms of their demographics is presented. This is followed by the summary and grouping of respondents' lifestyle habits. Thereafter, the results pertaining to each research objective are analysed and presented.

4.2 Profile of Respondents

A total of 80 participants completed the questionnaire.

Figure 4.6: Gender

Gender					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	65	81.3	81.3	81.3
	Female	15	18.8	18.8	100.0
	Total	80	100.0	100.0	

Figure 4.1 shows that the majority of the participants were male (81%).

Figure 4.7: Age

Age					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-30	30	37.5	37.5	37.5
	31-40	35	43.8	43.8	81.3
	41-50	13	16.3	16.3	97.5
	51-60	1	1.3	1.3	98.8
	60+	1	1.3	1.3	100.0
	Total	80	100.0	100.0	

Figure 4.2 shows that the majority of respondents were 40 years or younger (81%).

Figure 4.8: Race

Race					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Indian	45	56.3	56.3	56.3
	Coloured	6	7.5	7.5	63.8
	Black	28	35.0	35.0	98.8
	White	1	1.3	1.3	100.0
	Total	80	100.0	100.0	

With regards to participants' race, Figure 4.3 shows that more than half (56%) were Indian followed by Black (35%).

Figure 4.9: Marital Status

Marital Status					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	38	47.5	47.5	47.5
	Married	36	45.0	45.0	92.5
	Divorced	6	7.5	7.5	100.0
	Total	80	100.0	100.0	

Figure 4.4 shows that about half of the participants were single (47.5%) and 45% were married.

Figure 4.10: Number of Children

Children					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	26	32.5	32.5	32.5
	1	12	15.0	15.0	47.5
	2	27	33.8	33.8	81.3
	3	8	10.0	10.0	91.3
	4(+)	7	8.8	8.8	100.0
	Total	80	100.0	100.0	

Figure 4.5 illustrates that when asked about number of children they have, more than half mentioned of having two or more children (52.5%).

Figure 4.11: Employment Category

Employment Category					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employee	46	57.5	57.5	57.5
	Supervisor	8	10.0	10.0	67.5
	Management	6	7.5	7.5	75.0
	Senior Management	4	5.0	5.0	80.0
	Other	16	20.0	20.0	100.0
	Total	80	100.0	100.0	

Figure 4.6 shows that more than half of the participants were working as employee and only 5% were senior manager.

Figure 4.12: Education Level

Education Level					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	High School	19	23.8	23.8	23.8
	Matriculated	33	41.3	41.3	65.0
	Diploma	15	18.8	18.8	83.8
	Degree	8	10.0	10.0	93.8
	Honours(+)	5	6.3	6.3	100.0
	Total	80	100.0	100.0	

Figure 4.7 shows that more than a third of the participants (41%) had matriculation and only 6% had honours or higher qualification.

4.3 Summary and Grouping of Lifestyle Habits

To determine lifestyle habits of the participants, a total of seven questions were asked and the results are summarised below.

Table 4.1: Distribution of seven behaviours

Variables		Frequency	Percent
Hours Sleep	<6	15	18.8
	6	28	35.0
	7	28	35.0
	8	9	11.3
Exercise	0	20	25.0
	1	9	11.3
	2	20	25.0
	3	17	21.3
	4(+)	14	17.5
Read	0	9	11.3
	1	11	13.8
	2	17	21.3
	3	13	16.3
	4(+)	30	37.5
Smoker	Yes	31	38.8
	No	49	61.3
Alcohol	0	58	72.5
	1	11	13.8
	2	5	6.3
	3	5	6.3
	4(+)	1	1.3
Junk Food	0	6	7.5
	1	20	25.0
	2	24	30.0
	3	13	16.3
	4(+)	17	21.3
Pray	0	7	8.8
	1	7	8.8
	2	5	6.3
	3	5	6.3
	4(+)	56	70.0

Table 4.1 illustrates that only a tenth of the participants (11%) slept eight hours as required, less than a fifth (17.5%) does exercise four or more times in a week, more than a third (37.5%) reads four or more times, 61% were non-smokers, more than two-thirds (72.5%) did not drink alcohol, 7.5% did not eat junk food at all, and 70% mentioned that they prayed four or more times per week.

To compare the overall habit of the participants, all the seven behaviours were added and descriptive statistics were computed as presented in Table 4.2. Thereafter the overall score calculated was tested for normality. The Shapiro-Wilk test (normality test) showed that the overall score was normally distributed as illustrated in Figure 4.8.

Table 4.2: Descriptive Statistics of Overall Habits

Descriptive Statistics			
		Statistic	Std. Error
overallhabit	Mean	20.7875	.37004
	Median	21.0000	
	Std. Deviation	3.30972	

Tests of Normality		
Shapiro-Wilk		
Statistic	df	Sig.
.971	80	.070

Figure 4.13: Normality of Overall Habits

Overall habit

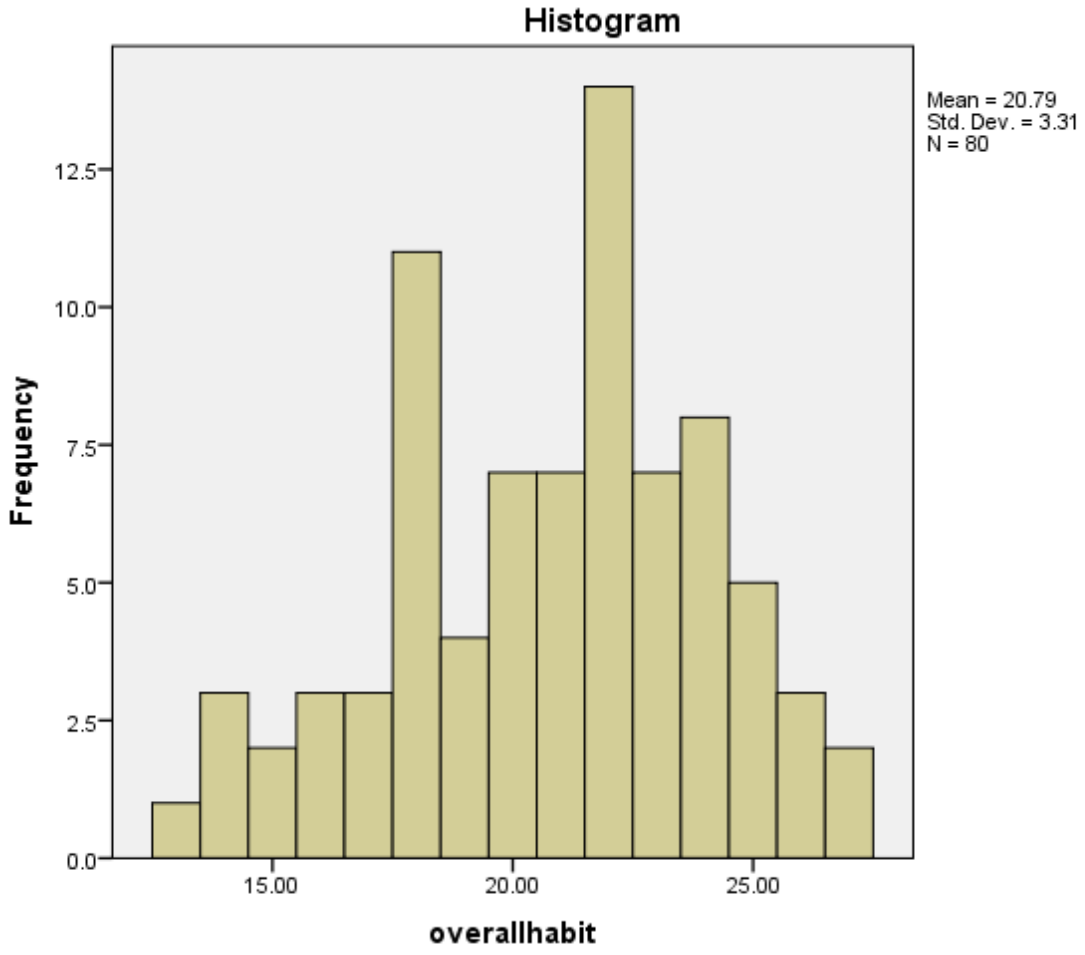


Table 4.3: Grouping of Good and Bad Habits

Overall habit					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	13.00	1	1.3	1.3	1.3
	14.00	3	3.8	3.8	5.0
	15.00	2	2.5	2.5	7.5
	16.00	3	3.8	3.8	11.3
	17.00	3	3.8	3.8	15.0
	18.00	11	13.8	13.8	28.8
	19.00	4	5.0	5.0	33.8
	20.00	7	8.8	8.8	42.5
	21.00	7	8.8	8.8	51.3
	22.00	14	17.5	17.5	68.8
	23.00	7	8.8	8.8	77.5
	24.00	8	10.0	10.0	87.5
	25.00	5	6.3	6.3	93.8
	26.00	3	3.8	3.8	97.5
	27.00	2	2.5	2.5	100.0
	Total	80	100.0	100.0	

Table 4.3 indicates that 95% of the participants scored 15 or more from a total of 28 points. This indicated that most of the participants' habits were good.

4.4 Objective One Results

Table 4.4: Rating of Job Satisfaction

		Frequency	Percent
Valid	0-25%	12	15.0
	25-50%	7	8.8
	50-75%	30	37.5
	75-100%	31	38.8
	Total	80	100.0

Table 4.4 shows that when participants were asked to rate their job satisfaction, it was found that just over a third of them were very satisfied (38.8%)

Table 4.5: Overall Habits Correlation Results

Correlations			
		Overall habit	Job Satisfaction
Overall habit	Pearson Correlation	1	.341**
	Sig. (2-tailed)		.002
	N	80	80
Job Satisfaction	Pearson Correlation	.341**	1
	Sig. (2-tailed)	.002	
	N	80	80
**. Correlation is significant at the 0.01 level (2-tailed).			

The Pearson correlation test presented in Table 4.5 shows that there was a significantly low positive correlation exists between habit and job satisfaction (r=0.341, p=0.002). This meant that those having bad habits were also satisfied at work. I think this was more out of fear as to whether the owners would come to know the results or identify the respondent.

4.5 Objective Two Results

Table 4.6: Which Position would you aspire to be?

		Frequency	Percent
Valid	Employee	12	15.0
	Supervisor	8	10.0
	Manager	19	23.8
	Senior Management	20	25.0
	Other	21	26.3
	Total	80	100.0

Table 4.6 shows that a quarter of the participants aspired to be a senior manager, and another 24% wanted to be a manager.

Table 4.7: Personal Habits make a difference to your current position

		Frequency	Percent
Valid	Yes	41	51.3
	No	39	48.7
	Total	80	100.0

Table 4.7 illustrates that when asked if Personal Habits make a difference to their current position, just over half of them (51%) responded positively.

Table 4.8: Do you feel that you are in the Company Position you should be in?

		Frequency	Percent
Valid	Yes	45	56.3
	No	35	43.8
	Total	80	100.0

Table 4.8 shows that about half of the participants felt that they were not in a position that they were supposed to be.

4.6 Objective Three Results

Table 4.9: Distribution of habits

Habits Difference					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	43	53.8	53.8	53.8
	No	37	46.2	43.8	97.5

Table 4.9 illustrates that when participants were asked if lifestyle habits make a difference to their income, more than half (54%) responded positively.

Table 4.10: Aspire for a Higher Company Position

		Frequency	Percent
Valid	Yes	36	45.0
	No	44	55.0
	Total	80	100.0

Table 4.10 shows that more participants (55%) did not think that by making changes in their personal habits it would affect their opportunity to be in a higher company position.

Table 4.11: Association between position aspired and habits of the participants

			Habit in groups			P value
			Bad habit	Good habit	Chi-squared	
Position Aspire	Employee	Count	3_a	9_b	12.218	0.016
		% within Habit in groups	50.0%	12.2%		
	Supervisor	Count	2_a	6_b		
		% within Habit in groups	33.3%	8.1%		
	Manager	Count	0_a	19_a		
		% within Habit in groups	0.0%	25.7%		
	Senior Management	Count	0_a	20_a		
		% within Habit in groups	0.0%	27.0%		
	Other	Count	1_a	20_a		
		% within Habit in groups	16.7%	27.0%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		
Each subscript indicates a specific association that exists between a demographic category and good or bad habits in groups at the .05 significance level.						

Table 4.11 illustrates that there was a statistically significant association existing between aspiration of employees with their habit (p=0.016). This meant that those who aspired to be manager or senior manager had better habits than their counterparts.

Table 4.12: Association between Personal Habits difference and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Pers Habits Diff	Yes	Count	3_a	38_a	0.004	0.949
		% within Habit in groups	50.0%	51.4%		
	No	Count	3_a	36_a		
		% within Habit in groups	50.0%	48.6%		
Each subscript indicates a specific association that exists between a demographic category and good or bad habits in groups at the .05 significance level.						

Table 4.12 shows that no significant difference of habit was found between employees who indicated Personal Habits make a difference to your current position or not (p=0.949)

Table 4.13: Association between Company Position and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Company Position	Yes	Count	3_a	42_a	0.103	0.748
		% within Habit in groups	50.0%	56.8%		
	No	Count	3_a	32_a		
		% within Habit in groups	50.0%	43.2%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		
Each subscript indicates a specific association that exists between a demographic category and good or bad habits in groups at the .05 significance level.						

Table 4.13 shows that participants habits were similar when compared between employees who felt that they are in the Company Position they should be in or not.

Table 4.14: Association between Employment Category and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Employment Category	Employee	Count	4	42	1.230	0.873
		% within Habit in groups	66.7%	56.8%		
	Supervisor	Count	1	7		
		% within Habit in groups	16.7%	9.5%		
	Management	Count	0	6		
		% within Habit in groups	0.0%	8.1%		
	Senior Management	Count	0	4		
		% within Habit in groups	0.0%	5.4%		
	Other	Count	1	15		
		% within Habit in groups	16.7%	20.3%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		

Table 4.14 indicates that participants habit was similar irrespective of their position at work (p=0.873).

4.7 Objective Four Results

Table 4.15: Association between Higher Company Position and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Higher Comp Position	Yes	Count	2_a	34_a	0.357	0.550
		% within Habit in groups	33.3%	45.9%		
	No	Count	4_a	40_a		
		% within Habit in groups	66.7%	54.1%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		
Each subscript indicates a specific association that exists between a demographic category and good or bad habits in groups at the .05 significance level.						

Table 4.15 indicates that changes in personal habits would affect opportunities to be in a higher company position had similar habits to those did not indicate so (0.550).

4.8 Objective Five Results

Table 4.16: Association between habit changes and overall habits of the participants

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Habit Changed	Exercise	Count	2_a	14_a	1.622	0.951
		% within Habit in groups	33.3%	18.9%		
	Sleep more	Count	0_a	5_a		
		% within Habit in groups	0.0%	6.8%		
	Read/Study	Count	1_a	9_a		
		% within Habit in groups	16.7%	12.2%		
	Pray	Count	1_a	19_a		
		% within Habit in groups	16.7%	25.7%		
	Eat Healthy	Count	1_a	9_a		
		% within Habit in groups	16.7%	12.2%		
	Stop smoking	Count	1_a	15_a		
		% within Habit in groups	16.7%	20.3%		
	Stop drinking	Count	0_a	3_a		
		% within Habit in groups	0.0%	4.1%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		
Each subscript indicates a specific association that exists between a demographic category and good or bad habits in groups at the .05 significance level.						

The Chi-squared test of association presented in Table 4.16 shows that there was no significant association between habit changes and overall habits of the participants (p=0.951).

Table 4.17: Association between Race and Habit in groups

			Habit in groups			P value
			Bad habit	Good habit	Chi-squared	
Race	Indian	Count	2	43	3.032	0.387
		% within Habit in groups	33.3%	58.1%		
	Coloured	Count	0	6		
		% within Habit in groups	0.0%	8.1%		
	Black	Count	4	24		
		% within Habit in groups	66.7%	32.4%		
	White	Count	0	1		
		% within Habit in groups	0.0%	1.4%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		

Table 4.17 shows that participants race was not associated with their habit (p=0.387).

Table 4.18: Association between Marital Status and Habit in groups

			Habit in groups			P value
			Bad habit	Good habit	Chi-squared	
Marital Status	Single	Count	5	33	3.397	0.183
		% within Habit in groups	83.3%	44.6%		
	Married	Count	1	35		
		% within Habit in groups	16.7%	47.3%		
	Divorced	Count	0	6		
		% within Habit in groups	0.0%	8.1%		

Table 4.18 shows that Marital status was not found to be associated with habit of the participants (p=0.183).

Table 4.19: Association between no. of Children and Habit in groups

			Habit in groups			P value
			Bad habit	Good habit	Chi-squared	
Children	0	Count	4	22	10.621	0.031
		% within Habit in groups	66.7%	29.7%		
	1	Count	0	12		
		% within Habit in groups	0.0%	16.2%		
	2	Count	0	27		
		% within Habit in groups	0.0%	36.5%		
	3	Count	0	8		
		% within Habit in groups	0.0%	10.8%		
	4(+)	Count	2	5		
		% within Habit in groups	33.3%	6.8%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		

Table 4.19 highlights that Number of children had a significant impact on their behavior (p=0.031). The table clearly shows that participants having no children or having four or more children were more likely to have worse habits than their counterparts.

4.9 Objective Six Results

Table 4.20: Habit Changed

		Frequency	Percent
Valid	Exercise	16	20.0
	Sleep more	5	6.3
	Read/Study	10	12.5
	Pray	20	25.0
	Eat Healthy	10	12.5
	Stop smoking	16	20.0
	Stop drinking	3	3.8
	Total	80	100.0

Table 4.20 illustrates that when asked which habit if changed would make the biggest difference to their life, 25% mentioned praying, followed by exercising and

stopping smoking (20% respectively). Stop drinking was mentioned by only 4% participants.

Table 4.21: Association between Gender and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Gender	Male	Count	5	60	0.018	0.891
		% within Habit in groups	83.3%	81.1%		
	Female	Count	1	14		
		% within Habit in groups	16.7%	18.9%		

Table 4.21 illustrates that the habit was found to be similar between male and female participants (p=0.891).

Table 4.22: Association between Age and Habit in groups

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Age	18-30	Count	2	28	1.518	0.823
		% within Habit in groups	33.3%	37.8%		
	31-40	Count	2	33		
		% within Habit in groups	33.3%	44.6%		
	41-50	Count	2	11		
		% within Habit in groups	33.3%	14.9%		
	51-60	Count	0	1		
		% within Habit in groups	0.0%	1.4%		
	60+	Count	0	1		
		% within Habit in groups	0.0%	1.4%		

Table 4.22 indicates that Age did not have any significant effect on their behavior (p=0.823).

Table 4.23: Association between education level and habit.

			Habit in groups		Chi-squared	P value
			Bad habit	Good habit		
Education Level	High School	Count	4	15	7.050	0.133
		% within Habit in groups	66.7%	20.3%		
	Matriculated	Count	1	32		
		% within Habit in groups	16.7%	43.2%		
	Diploma	Count	1	14		
		% within Habit in groups	16.7%	18.9%		
	Degree	Count	0	8		
		% within Habit in groups	0.0%	10.8%		
	Honours(+)	Count	0	5		
		% within Habit in groups	0.0%	6.8%		
Total		Count	6	74		
		% within Habit in groups	100.0%	100.0%		

Table 4.23 shows that Education of the participants was not associated with their habit (p=0.133).

4.10 Conclusion

This chapter provided a detailed presentation of all the findings from the data that was collected and analysed in order to support the objectives of the research. The next chapter (5) will provide a discussion of the results in light of the existing literature to determine whether sufficient evidence exists to provide answers to the research questions; and ultimately lead to achieving the objectives of the research.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

The findings of the previous chapter must be interpreted in conjunction with an explanation from the literature review and the findings it purported to explain. These results from the primary data (Questionnaire) are merged with the results from the secondary Data (Case studies, reports, journal articles and the like). The findings were therefore validated and contextualised with each research objective to ascertain the findings correctly and accurately.

By utilising the results obtained from the Statistical Analysis based on the questionnaire, as well as utilising research done from secondary data, evidence that either supported or rejected the objectives were revealed. This thereby makes the conclusions and recommendations in the next chapter far more meaningful and useful to companies and human resource facilities.

The findings of the study will be discussed by presenting the six objectives and will ascertain as to whether each objective has been met.

5.2 Objective One: To determine if lifestyle habits affect job satisfaction

The first objective was determining whether lifestyle habits did in fact affect job satisfaction. The findings are represented in Table 4.4, Participants were asked to rate their job satisfaction. It was found that over a third of them were very satisfied (38.8%). 37.5% of them were satisfied whilst less than a quarter (23.8%) were found to not have job satisfaction. The Pearson correlation test, Table 4.5, showed that there was a significantly low positive correlation existing between habit and job satisfaction ($r = 0.341$). This meant those with bad habits were also satisfied at work. This could probably be more out of fear as psychologically they maybe thought that the owners would see the resulting questionnaire and identify the respondent even though it was clearly defined as an anonymous questionnaire.

These findings are supported in the literature as due to temptations and the urges for immediate gratification, motivation is vitally important to develop good lifestyle habits

(Gillison et al., 2014). Self Determination theory (SDT) is a framework for motivation based on the premise that social and economic conditions determine the levels of satisfaction associated with specific lifestyle behaviours (Gillison et al., 2014). In light of this, when senior management incentivises healthy lifestyle habits, it promotes a support structure for blue collar and white collar workings that can increase motivation levels, and their attempts to lead healthier lifestyles (Ogden et al., 2012)

Even through significant efforts, motivational interventions do not always have the desired effect that will result in positive work placement outcomes such as promoting self control and preventing demotivation. This could be due to the influence of habitual behaviour which is of a non-conscious and automatic nature. For example, research has shown young adults and adolescents to be notoriously difficult to invest in health promotion initiatives, mostly due to their low levels of perceived health risk (Standage and Ryan, 2012).

5.3 Objective Two: To determine the importance of lifestyle habits on work placement

The findings of objective two were highlighted in Table 4.6. it was found that a quarter of the participants aspired to be a senior manager (25%) and another 23.8% wanted to be a manager. A notable observation is that 26.3% wanted to be an 'other', possibly an entrepreneur or retired with financial freedom. In Table 4.8, when the respondents were asked if they felt they were in the company position they should be in, approximately half of the participants felt that they were not in a position that they were supposed to be in.

These findings are supported in literature as blue-collar workers can be characterised as being unskilled or semi-skilled individuals; and they are usually exposed to higher physical demands than white-collar workers. As a result, they rarely reach retirement age due to the consistently demanding nature of their positions in the workplace (Gupta et al., 2015). Similarly, lack of exercise is a bad lifestyle habit that has many negative consequences; and contributes to poor physical capabilities in the workplace. On the contrary, it was found that exercise can contribute to high levels of physical and emotional health in an aging workforce (von Bonsdorff et al., 2016).

Furthermore Malambo et al. (2016) suggest that culturally or community tailored intervention to promote healthy levels of exercise should target individuals at an early age; and preferably before they enter the workplace. They also assert that if no effective public health interventions are implemented, further decrease in exercise levels will lead to the high risk of developing major chronic lifestyle diseases, such as hypertension, among South Africans (Malambo et al., 2016).

5.4 Objective Three: To determine if lifestyle habits make a difference to work placement position

Table 4.9 indicated that when participants were asked if lifestyle habits make a difference to their income, more than half (54%) responded positively. However, in Table 4.10, when asked that if by changing their personal habits it would affect their opportunity to be in a higher company position, more participants (55%) thought that it would not. The present study found that there was a statistically significant association existing between aspirations of employees with their habits (p=0.016). this meant that those who aspired to be a manager or senior manager had better habits than their counterparts which is a revelatory result, as shown in Table 4.11.

In Table 4.12, there was no significant difference between those who answered whether personal habits make a difference to your current position or not. Likewise Table 4.13 illustrates that participants habits were similar when compared between employees who felt that they are in the Company Position they should be in or not. The association between employment category and habits in groups (Table 4.14) indicated similar percentages of those with good and bad habits in the relevant groups.

These findings are supported in the literature as the effective solution to lifestyle diseases caused by bad habits is to rehabilitate the seven behaviours into becoming good habits. For example, the role of exercise in the reduction from cardiovascular disease risk factors is well established (MAM and Othman, 2010); and the encouragement of commuting and leisure activities among blue collar workers is recommended to further reduce cardiovascular disease risk factors. Innovative solutions to transforming bad lifestyle habits into good lifestyle habits can be

achieved through the implementation of intervention and incentives programmes within the workplace.

5.5 Objective Four: To establish which lifestyle Habits do employees believe are the most important to their career

Those indicating that changes in personal habits would affect their opportunity to be in a higher company position had similar habits to those that indicated that it would not (0.550) in Table 4.15. These findings are supported in the literature as it is far more common for blue collar workers and poorly educated people to have 2-7 of the unhealthy habits studied, simultaneously (Boström, 2006). Furthermore a significant proportion of the work tasks in industrial production is performed by blue-collar workers.

It was also found that blue-collar workers generally experience higher fatigue and need for recovery and increased risk of reduced or impaired work ability. These conditions make it challenging for blue-collar workers to remain in the workforce until the age of retirement (Gupta et al., 2015). According to Gupta et al. (2015), the general recommendations for conducting workplace health intervention is that success is more likely if:

- it considers all aspects of worker's well-being,
- does not feel forced upon workers,
- follows a structured approach that builds upon itself,
- fosters participation, and
- uses resources effectively to develop new interventions.

5.6 Objective Five: To establish how a change in lifestyle habits would impact work placement

In Table 4.16 we tested a chi – square of association which showed there was no significant association between habit changes and overall habits of the participants (p=0.951). The participants race was not associated with their habit (p=0.387) as

shown in Table 4.17. Marital status was not found to be associated with the habits of the participants (p=0.183) in Table 4.18 and in table 4.19 neither did number of children significantly have an impact on their behaviour (p=0.031) in fact the table depicted that those with no children and those with 4 or more children were most likely to have bad habits in comparison with their counterparts.

These findings are supported in the literature as motivation toward physical exercise (MPE) and trait self-control (TSC) were identified as key predictors of subjective wellbeing (SWB) (Briki, 2016). Subjective wellbeing (SWB), which can be defined as "…people's evaluations of their lives – the degree to which their thoughtful appraisals and affective reactions indicate that their lives are desirable and proceeding well" (Diener et al., 2015, p.234) Regular physical activity contributes to improved well-being and also increases one's possibilities of preserving functional ability and independence longer into old age. Statistics South Africa released that National cause of death statistics revealed that 20% of deaths in the 35-64 year age group were a result of chronic lifestyle diseases (Statistics South Africa, 2005).

Non Communicable Diseases (NCDs) contribute to premature mortality in SA, threatening socioeconomic development. While NCD mortality rates have decreased slightly, it is necessary to strengthen prevention and healthcare provision and monitor emerging trends in cause-specific mortality to inform these strategies if the target of 2% annual decline is to be achieved (Nojilana et al., 2016).

The proportion of people who don't exercise is larger among people in blue collar occupations and among poorly educated people than among white collar occupations and highly educated people. The importance of physical activity for the health of children and the youth is not that well documented, however, researchers have found that in total, physical activity affects many bodily functions positively and quality of life increases for all ages, including young people (Gillison et al., 2014).

5.7 Objective Six: To determine which habit if changed would make the biggest difference to the individual

When asked which habit if changed would make the biggest difference to their life. 25% mentioned to pray followed by exercising more and stopping smoking (20%

respectively). Stopping drinking was mentioned only by 4%, gathered from Table 4.20. Habits were found to be similar between male and female participants (p=0.891) indicated by Table 4.21. Age did not have a significant effect on their behaviour (p=0.823) in Table 4.22. an unexpected result was that education level of the participants was not associated with their habits (p=0.133), taken from Table 4.23.

These findings are supported in the literature by a comparative risk assessment study into South African mortality rates by Norman et al. (2007); which ranked deaths attributable to lifestyle diseases as follows:

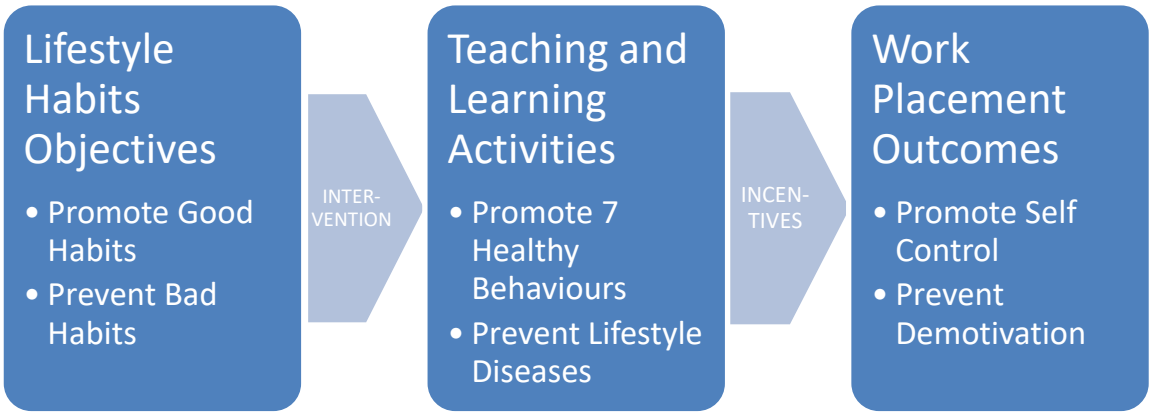
1. High Blood Pressure
2. Smoking
3. Alcohol
4. High BMI (Body Mass Index)
5. High Cholesterol
6. Diabetes
7. Lack of Exercise

As is evident in the adapted rankings above, lifestyle diseases significantly contribute to premature mortality in South Africa especially despite the challenges AIDS poses to the urban and rural populations (Nojilana et al., 2016). Consequently, socioeconomic development is stifled especially when out of approximately 230,000 South Africans who died from lifestyle diseases in 2010, 36% had not reached the average life expectancy of 60 years (Nojilana et al., 2016). The dual impact of lifestyle diseases with the AIDS epidemic on both mortality rates and escalating healthcare costs definitely demands attention in the form of lifestyle intervention programs designed to improve the overall health profile of both urban and rural communities (Norman et al., 2007).

5.8 Conclusion

This chapter presented the theoretical support in lieu of the findings identified in this study. As a result, the following framework illustrating the influence of lifestyle habits on work placement was developed, as indicated in Figure 5.1 below.

Figure 5.14: Framework for the Influence of Lifestyle Habits on Work Placement



Source: Researcher's own construction

Lifestyle habit objectives can be developed to promote good habits and prevent bad habits. The next step is to establish learning and teaching activities which promote awareness of the seven healthy behaviours and the dangers of lifestyle diseases. Finally, work placement outcomes, reinforced by intervention and incentives programmes, will promote self control and prevent demotivation in the workplace.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The findings from the research were discussed in the previous chapter which utilised statistical evidence to understand the research and this was reiterated by the validated, reliable information sourced from previous literature in this field. These results looked at in cohesion portrayed a picture highlighting how important lifestyle habits of an individual do in fact play a vital role in determining where the individual ends up in an organisation and how within that realm, they also have the capacity to change their state by changing their own, individual habits. Some results were clearer than others and some had less of an influence according to the findings of the research. Some portrayed insufficient details and not enough useful evidence was discovered or sufficient correlation indicated whereas others were extremely pertinent and clear.

This chapter will conclude the study and suggest how to effectively extract knowledge from this research and how it can help impact companies through their hiring and individuals who want to make a change. Key findings will be discussed followed by the main recommendations from this study, limitations of the study, specific recommendations for future studies and the overall conclusion of the study.

6.2 Key Findings

The study found that only a third of participants were very satisfied with which position they were in, in the company whilst a quarter had no job satisfaction. This means there is massive scope for improvement as by taking control over their own initiative and self-behaviour, they would be able to change this predicament. Smoking is a much large factor in those in blue collar positions who achieve low income, this is a clear correlation as the ratio was two and a half times more smokers in lower positions who were smokers than those in higher positions. Those who applied themselves physically in jobs or a combination of physical and mental work were found to have the poorest health in men and women. Those in the best

health and most able work ability were those men and women involved in mental work.

A quarter of participants wanted to be in senior management and another quarter in management whilst another quarter wanted to be doing ‘other.’ This is aspirational as they did want to raise their position whilst the other possibly wanted to start their own business, be involved in charity work but didn’t have the means or wanted to be doing something else completely but had to do the job to sustain themselves. Those who had lower levels of education were found to be in blue collar jobs and work that involved physical loads. The higher the education the higher the position as was expected. The women who had mentally strenuous work and high job control were those associated to have a healthy diet. Again those in lower positions were not keen on physical activity after hours and did not exercise in their own time. Those who did exercise in their own leisure time had generally higher positions.

Those in blue collar positions ate very little fruit and vegetables whilst senior management and upper levels or white collars were far more inclined to do so and eat healthily. These results clearly show a correlation between healthy lifestyle behaviours and improved station in the company and life. However, when asked if lifestyle habits make a difference to their income only half (54%) responded positively, this clearly shows that half the participants have no idea how much their ability to change their position in life lies in their own hands and through their lifestyle habits. This was reiterated once again when participants were asked if by changing their personal habits would it affect their opportunity to be in a higher company position, even more participants said it would not (55%), this clearly indicates that they think what they do does not play a role in their ability to raise their position and they are resigned to stay where they are without knowing that their habits are the key to change.

The study found that it was far more common to find those in lower positions to have more than 2, up to 7 of the bad habits mentioned than it was for those in the white collar positions. In addition, 44% of respondents had 2-7 of the unhealthy loving habits, the female white collar workers only had 7% who had 2 or more of the bad habits which shows most were in tune with living a healthy lifestyle.

6.3 Recommendations from this Study

The findings of the survey have uncovered a few specific strategies that can improve individuals and employees in the work force and help them on a personal and professional level.

- By introducing education and awareness programs of the impact that focusing on the current emerging trend of chronic diseases of lifestyle and metabolic syndrome and by changing lifestyle habits can negate these and also have a highly positive influence on their motivation levels to advance their careers.
- Having lifestyle intervention programs in schools, universities and the work place that are targeted and efficient and focus on intensive exercise and dietary programs to reduce the risk factors that were identified in this study.
- Primary healthcare and interventions provided by work and social community health care centres would help people with unhealthy lifestyle consequences like diabetes, hypertension and addictions and help them change their unhealthy habits.
- Faculties of Health Sciences are needed in South Africa to create awareness and implement community relevant health professional training and intervention programs.
- A sequence of follow up studies that would investigate the impact of implementing lifestyle programs in rural and urban communities that offer guidance and help.

6.4 Study Limitations

- Due to the company interviewed having more male than female employees there was a gender skew in the survey. It would be interesting if the sexes matched if the findings would be the same or if they would differ.
- The primary research was done in one company in Durban, South Africa, if there were more companies over different fields it would be interesting to see if the results matched.
- With time constraints a prevalent issue, the research was conducted over the 7 main lifestyle habits that people have concern with in their lives and have

the most impact on their lives. Other habits could have been explored which potentially could be checked if they made a difference.

6.5 Recommendations for Future Studies

- Variety of companies from different industries could be interviewed to see a broad spectrum of research and to get a more complete spectrum of reliable and valid research results.
- To be able to track employees progress over a period of time once their habits have changed to see if it makes a difference.
- The sales of a company can be measured to see if habits are changed and if it has a monetary effect.
- Other habits can be compared for their importance in relation to the ones measured here to see if they make more of an impact.
- To understand from a different perspective and to get different ideas a qualitative study that could involve focus groups and with more open ended questions could be implemented.

6.6 Conclusion of the Study

By not having intervention and incentive programmes in place that foster the development of good habits within the workplace, there will be an increasing risk of workers developing non-communicable diseases and higher than usual mortality rates. Interventions are critically important in order to prevent this from happening. Good lifestyle habits can be integrated into work placement through learning objectives, teaching and learning activities and learning outcomes. Self control is the most positive outcome that influences work placement as it promotes good habits over bad habits. Incentives are one of the lifestyle habits objectives that reinforces self control, prevents demotivation and ultimately leads to the development of good lifestyle habits in the workplace.

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APPENDIX ONE: INFORMED CONSENT LETTER

UNIVERSITY OF KWAZULU-NATAL

GRADUATE SCHOOL OF BUSINESS AND LEADERSHIP

Dear Respondent,

MBA Research Project

Researcher: Zamir Dada (083 786 7525)
Supervisor: Dr. Abdul Kader (082 901 0225)
Research Office: Ms P Ximba 031-2603587

I, Zamir Dada, an MBA student at the Graduate School of Business and Leadership, of the University of KwaZulu Natal, hereby invite you to participate in a research project entitled, 'The Influence of Lifestyle Habits on Work Placement.' The aim of this study is to obtain a better understanding of the influence an individual's personal habits has over the type of work placement they tend to be in and to understand if there is a correlation.

Your participation in this project is entirely voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There is no monetary gain from participating in this survey/focus group. Strict confidentiality and anonymity of records identifying you as a participant will be maintained by the Graduate School of Business and Leadership, UKZN.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above. The survey should take you about five minutes to complete. I look forward to and appreciate you taking the time to complete this questionnaire.

Sincerely,

Investigator's signature_____

Date_____

APPENDIX TWO: QUESTIONNAIRE

Questionnaire for Masters Business Administration (MBA) Research

Please mark X where appropriate

1. Gender

Male	Female

2. Age

18-30	31-40	41-50	51-60	60+

3. Race

Indian	Coloured	Black	White	Other

4. Marital Status

Single	Married	Divorced	Widowed

5. Children

0	1	2	3	4(+)

6. Employment Category

Employee	Supervisor	Management	Senior Management	Other

7. Level of Education

High School	Matriculated	Diploma	Degree	Honours(+)

8. Hours of Sleep per Night

<6	6	7	8	9(+)

9. Number of times you Exercise per Week (20 minutes +)

0	1	2	3	4(+)

10. Number of times you Read per Week (Newspapers, Books, Magazines – 20 minutes+)

0	1	2	3	4(+)

11. Smoker

Yes	No

12. Number of times you consume Alcohol per Week (2 glasses or more)

0	1	2	3	4(+)

13. Number of times you consume Junk Food per Week (Burgers, Pizzas etc)

0	1	2	3	4(+)

14. Number of times you Pray per week

0	1	2	3	4(+)

15. Do you think your lifestyle habits make a difference to your income?

Yes	No

16. Rate your Job Satisfaction

0-25%	25-50%	50-75%	75-100%

17. Which habit if you changed would make the biggest difference to your life?

Exercise	Sleep more	Read/Study	Pray	Eat Healthy	Stop Smoking	Stop Drinking

18. What Position would you aspire to be?

Employee	Supervisor	Manager	Senior Management	Other

19. Do you think your Personal Habits make a difference to your current position?

Yes	No

20. Do you feel that you are in the Company Position you should be in?

Yes	No

21. Do you think if you make changes in your personal habits it would affect your opportunity to be in a higher company position?

Yes	No

The End.

Thank you for your participation.