The state of workplace health promotion in South Africa: An exploratory study

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Abstract

This study aimed to explore the current situation of health promotion in the workplace in small, medium and large workplaces in Durban, South Africa. An exploratory case study approach was used, whereby data was gathered with both quantitative and qualitative methods. Six organisations and 258 participants participated in this phase of the three-phased study. Quantitative data and qualitative data were analysed using the computer based Statistical Package for Social Sciences and the NVivo computer package respectively.

The findings showed that despite some of the participating organisations offering some health promotion activities, none emerged as entirely health promoting workplaces. Those offering employee health promotion/wellness programmes mainly focused on individual health programmes and none provided comprehensive holistic programmes aimed at providing healthy work environments.

Recommendations include an emphasis on a more comprehensive approach to health promotion programmes, stakeholder involvement and educational preparation of occupational health professionals for this component of their role.

Key words: Health promotion, workplace health promotion, employee health, employee wellness.

INTRODUCTION

Health promotion has been identified as a very powerful tool in the primary prevention of diseases.[1] Primary prevention comprises those preventive measures that forestall the onset of the illness or injury before it occurs.[2] The worksite has been identified as an ideal location for health promotion efforts as it is a defined community with access to social support and has economic reasons for improving health and productivity.[3] Workplace health promotion (WHP) has been applauded as one of the holistic approaches, which addresses both individual risks and the broader organisational and environmental issues.[4] WHP can address lifestyles, workplace hazards, work organisation, professional competence of employees and early detection of disease.[5]

Section 12 of the Occupational Health and Safety Act (OHS Act) (Act 85 of 1993 as amended) states that every employer should identify the work related hazards and risks in the workplace and prevent the exposure of employees to such hazards or to minimise exposure.[6] It further suggests that occupational hygiene programmes, biological monitoring and medical surveillance should be carried out to minimise work-associated risks. What is evident is that even though the importance of health promotion for the employees is mentioned, it is not prescribed. Different organisations have therefore responded to the OHS Act by implementing some health promotion interventions regarding employee health, such as employee assistance programmes (EAP), HIV/AIDS programmes, and continuous employee health surveillance.[7]

Studies evaluating WHP have been conducted in other countries.[8,9,10,11] However, no similar published South African studies were identified. In South Africa, studies focusing on health promotion programmes have been conducted in settings such as schools and hospitals.[12,13,14] There was therefore a need for a baseline study to evaluate WHP health promotion in the South African context. A three-phase multiple case study was conducted, and this paper describes Phase One of the study.

LITERATURE REVIEW

Relevant literature on the concepts of health promotion, wellness and wellbeing were explored as these are sometimes

used interchangeably. Literature regarding workplace health interventions was also explored. Several authors[4,5,8,9,10,11,15] recommend that WHP should deal with the following aspects:

Relevance: Addresses individual and organisational level priorities for health promotion as identified through employee participation. All stakeholders, including trade unions have to be involved in the planning, implementation and evaluation of the programme.

Scope: Programme activities flow from clearly stated theory/model/rationale, while having an explicit link to the arena(s) of practice to which they apply.

Attributes: Aims to create opportunities for choice, sustainability and empowerment, achieved at any level or combination of levels from the individual to the organisational level.

Context: The context, such as employee characteristics, organisational size and type, medical aid benefits and risk level will determine the WHP activities offered. The programme should appreciate the fact that WHP is embedded in a larger health promotion context.

A comprehensive approach to WHP, which incorporates the levels of awareness, lifestyle change and supportive environment, is likely to succeed.[16] Table 1 provides details of the components of these levels.

PURPOSE

The purpose of the study was to explore the current status of health promotion programmes in small, medium and large workplaces in Durban, South Africa. The findings of this study were used to develop policy guidelines for health promotion in the workplace.

RESEARCH OBJECTIVES

1. Describe the current situation of workplace health promotion programmes in small, medium and large worksites, in Durban.
2. Describe workplace characteristics which influence health promotion activities.
3. Determine the process involved in the implementation of health promotion interventions.

METHODOLOGY

Research design

This was a multiple case study that was exploratory in nature. Both qualitative and quantitative methods were used to gather descriptive information about the characteristics of an organisation and its health promotion activities.

" ... employee characteristics such as educational level had no discernible influence on their involvement in health promotion programmes."

Case protocol

The case protocol included (a) an overview of the case study project, (b) project objectives, (c) data collection procedures, and (d) guide for the report.[17] A case in this study was a workplace or an organisation, with all its embedded health promotion activities. There were multiple cases with several units of analysis embedded in each case, namely the staff profile, organisational characteristics and the process of health promotion programmes.

Sampling

The sample was drawn from workplaces in Durban, as these were easily accessible to the researcher. Sampling was conducted to select organisations as cases and then participants within these cases. Six cases were selected, representing three groupings, namely the private sector, the parastatals and the health sector. Organisations were further categorised according to the number of employees, into small (<100), medium (100 – 500) and large (>500). The selection of cases with these characteristics was based on the study assumptions that the characteristics of an organisation would have some influence on the process of health promotion programmes.[5,8,15]

The KwaZulu-Natal Top Business Portfolio[18] was used to derive the sampling frame for private organisations. The parastatal organisations were purposively sampled based on their size and proximity to the researcher. To sample the health sector, the researcher used a list of all hospitals in the Ethekwini health district of KwaZulu-Natal, taken from the *Hospital and nursing yearbook for southern Africa.*[19] These institutions were divided into public sector, private sector and public/private sector strata. It was hoped that the health sector would represent the public sector and that they would be more willing to participate due to the nature of the research

Table 1. Levels of a comprehensive WHP programme[16]

Level 1: Awareness	Level 2: Lifestyle change	Level 3: Supportive environment
Special events	Smoking cessation	Employee ownership
Fliers	Physical exercise	Corporate policies
Posters	Stress management	Corporate culture
Brown bag lunch seminars	Healthy diet	Ongoing processes and structure
Meetings	Weight loss	
Newsletter		

topic. In the end only one hospital, in the private sector was willing to participate.

In total, 258 participants were selected. In all six cases convenience or volunteer sampling was used whereby employees were recruited via notices sent by management and unions.

Management was sampled using theoretical sampling. The researcher started with a few eligible study participants, usually the risk managers or the human resources manager (whichever was applicable in the organisation). Purposive sampling was used to select occupational health nursing practitioners (OHNPs). For labour organisations, participants were selected using convenience sampling. Shop stewards of different labour unions in each organisation were identified through human resources or the organisation's contact person. The shop stewards on duty during that day were approached and if they were willing to participate they were interviewed. A summary of the sample is provided in Table 2.

Data collection procedures and instruments

Quantitative data was collected from employees via questionnaires. Qualitative data was obtained through focus group interviews with labour unions, and individual interviews for management and OHNPs. Employees were asked questions relating to their demographic characteristics. Management and OHNPs provided information regarding organisational characteristics. All participants were asked questions relating to the existence of health promotion activities and policies in their workplaces, and their involvement in such activities. All instruments had an attachment where concepts such as policy, health promotion, health promotion programmes, health promoting workplace and safe physical environment, were defined.

Data analysis

The data collection process occurred simultaneously with data analysis. Data from the first case was analysed and then the researcher moved to the next case, continuing in this manner until all data was analysed. Quantitative data was analysed using the computer based Statistical Package for Social Sciences software package where it was coded into different variables. Only descriptive statistics were used in analysis and presentation of this data. For qualitative data analysis, the NVivo computer package was used. Interpretational analysis was used where the researcher found constructs, themes and patterns. Data was segmented to meaningful units and coded into categories. Relationships among categories were then established. Cross case analysis for all findings was done and presented in matrices. Pattern matching was performed from the emerging data.

Quality of research design

To establish the quality of empirical research such as case studies[17] four tests are conducted namely, (a) construct validity (b) internal validity (c) external validity and (d) reliability. To enhance the quality of the research design and of the study as a whole, the researcher addressed these requirements for both the study and the instruments.

Ethical considerations

Ethical approval for the study was obtained from the University of KwaZulu-Natal's Ethics Committee. Permission letters were sent to identified organisations. Letters of information were written for individuals and organisational representatives explaining the conditions of participation in the study. Participants gave written consent to participate in the study.

RESULTS AND DISCUSSION

The **context** included such characteristics as demographic characteristics (staff profile), organisational characteristics and stakeholders. The staff profile included age, educational level and gender of participants, while organisational characteristics include such attributes as health promotion programmes and policies. The context was explored in relation to stakeholder awareness of health programmes and their involvement in the planning and implementation of workplace health promotion programmes. The **process** was

Table 2. Summary of sample

Description of organisations in sample				Participants in sample				
Case number	Type of organisation	Sector	Approx. number of employees	Employees	Managers	OHNPs	Labour unions	Total
1	Large, manufacturing	Private	1200	39	2	1	5	47
2	Medium, food blending	Private	200	38	2	2	-	42
3	Small, heavy engineering, using heavy iron materials	Private	100	31	1	-	5	37
4	Large, heavy engineering, mechanical	Parastatal	1400	44	2	1	11	58
5	Large, academic institution	Parastatal	1400	39	1	2	-	42
6	Medium, hospital	Health (private)	480	30	1	-	1	32
Total		-	-	221	9	6	22	258

programme structure, health promotion approach/model and programme objectives.

Context

Staff profile

Age of participants

In all six cases the majority of respondents in the employee category were in the age group 20 to 30 years. Involvement in the health promotion programme was higher in both the young employees (20–30 years) and the middle age group (31–40 years) than in the older age group.

Gender of participants

Male participants constituted 61% of the sample, and females only 39%. The only organisations that had more female employees were Case 5 (30%) and Case 6 (32%).

Educational level

The majority of participants with tertiary education qualifications were in Cases 4 and 5, with 80% and 90% respectively.

Based on the findings of previous studies,[7] employee characteristics were expected to have a significant influence on employee involvement in health programmes. Participants in such programmes were expected to be younger, well educated, female, non-smokers and white collar workers.[5] The findings of the study however showed that employee characteristics such as educational level had no discernible influence on their involvement in health promotion programmes.

Organisational characteristics

HIV/AIDS programmes existed in all cases, whereas programmes such as smoking cessation, weight control programmes and women's health were not offered in any of the cases (Table 3). Physical fitness programmes were offered in all cases, except in Case 3. Of these, only Case 1 had a formal physical fitness programme with a biokineticist on site, while in other sites the fitness programmes were informal programmes.

" ... activities were, however, largely influenced by management and OHNPs, while labour unions and other employees were not fully involved ..."

Table 3. Participants' explanations of the activities within their WHP programmes

Case number	OHNPs	Employees	Management	Labour unions
Case 1	HIV/AIDS EAP Health education Physical fitness	HIV/AIDS (24%) EAP (9%) Health education (3%) Physical fitness (9%) Disease management (6%) No programmes (58%) **(n=33)**	HIV/AIDS EAP Physical fitness Medical surveillance	HIV/AIDS Physical fitness Drug and alcohol rehabilitation No programmes
Case 2	Newsletters Information brochures HIV/AIDS	Health and safety (31%) Health screening (3%) No programmes (63%) **(n=35)**	Medical surveillance	–
Case 3	–	HIV/AIDS (7%), Health and safety (3%) No programmes (87%) **(n=30)**	Drug and alcohol rehabilitation	No programmes
Case 4	HIV/AIDS EAP TB/DOTS	HIV/AIDS (27%), Health and safety (2%) Stress management (2%) Disease management (5%) Health screening (5%) Health education (5%) No programmes (61%) **(n=41)**	HIV/AIDS Drug and alcohol rehabilitation Medical surveillance	EAP HIV/AIDS Health days Health education
Case 5	HIV/AIDS Physical fitness	HIV/AIDS (8%), Physical fitness (3%) Health and safety (8%) Health education (5%) No programmes (77%) **(n=39)**	HIV/AIDS Hearing conservation	–
Case 6	–	HIV/AIDS (62%), Health and safety (3%) Weight control (2%) Back care (31%) Stress management (24%) No programme (31%) **(n=29)**	HIV/AIDS Wellness	No programmes

Stakeholder awareness of health promotion programmes

In Case 6 the majority, 70% of employees, were aware of health promotion programmes. Only 5% of employees in Case 3 and 9% in Case 5 were aware of the health promotion programmes.

Differences in employee awareness on existing health promotion programmes were found by job type. Employees in non-management job levels were not aware of any health promotion policies and programmes and were hence not involved in such programmes, whereas the majority of participants in medium and lower management positions were aware of health policies and programmes (Table 3).

Different stakeholders in these organisations were expected to strongly influence the needs and goals of an organisation.[7] Health promotion activities were, however, largely influenced by management and OHNPs, while labour unions and other employees were not fully involved in such processes as workplace health policy development.

Organisational size

Larger organisations had more health promotion programmes and provided these on site through their occupational health services. Even though all workplaces indicated that they had formal health promotion policies, none had "a written document based on the philosophy of the organisation, which stipulates the guidelines on how health promotion programmes/activities are implemented in the workplace" as defined in the study (Table 4). As such, when asked to describe the policy, participants pointed at the OHS Act or their health and safety policy, which had a section referring to health requirements for their employees.

Process involved in implementing health promotion interventions

Cases 3 and 6 had no OHNPs, hence health promotion programmes were not offered. In Cases 1 and 2, which were both private organisations, a comprehensive structure was used in the execution of health promotion programmes. Cases 4 and 5, which were parastatal organisations, had targeted structures. A comprehensive programme structure is defined as the one that includes a well-planned, well funded programme, with long range objectives and wide participation.[5] The targeted programme on the other hand is one which targets one programme at a time, for example the organisation offering either an HIV/AIDS management programme or an EAP. Comprehensive health approaches to health promotion would have a strong emphasis on organisational and psychological factors.[20–22]

All cases, except for Case 3, had HIV/AIDS prevention programmes in place. These programmes were exclusively for the prevention and management of HIV/AIDS, and excluded employees with other health needs (Table 3). This finding demonstrated that the participating organisations had resources that were available for the wellbeing of employees, but that such resources were used exclusively for HIV/AIDS programme at present, owing to the priorities of the country.

Table 4 provides a summary of the study findings with respect to the context and process of WHP.

CONCLUSIONS

There is still an urgent need for research focusing on health promotion in different settings, as identified in the settings approach to health promotion. This study could play a role in providing a starting point for evaluation research focusing on employee wellbeing.

The situation amongst the six cases studied was that they all had some health promotion/wellness activities in place, although they were not well organised in the form of policies. This was a positive finding because the existing health promotion activities could provide a good starting point for implementing more organised and effective wellness programmes. Health promotion interventions mainly focused on individual health and hence the health promotion activities did not provide a comprehensive holistic approach. As such, one health problem in particular, namely, HIV/AIDS, was targeted rather than focusing on disease prevention in general. Larger organisations however seemed to have a more comprehensive approach compared to smaller ones. This focus on a specific public health problem was attributed to the pressure from the public for all sectors to address the AIDS epidemic with whatever resources they have. Organisations are in the process forced to utilise their

" ... participating organisations had resources that were available for the wellbeing of employees, but ... were used exclusively for HIV/AIDS programmes ..."

limited resources in dealing with this epidemic, which is threatening the human capital.

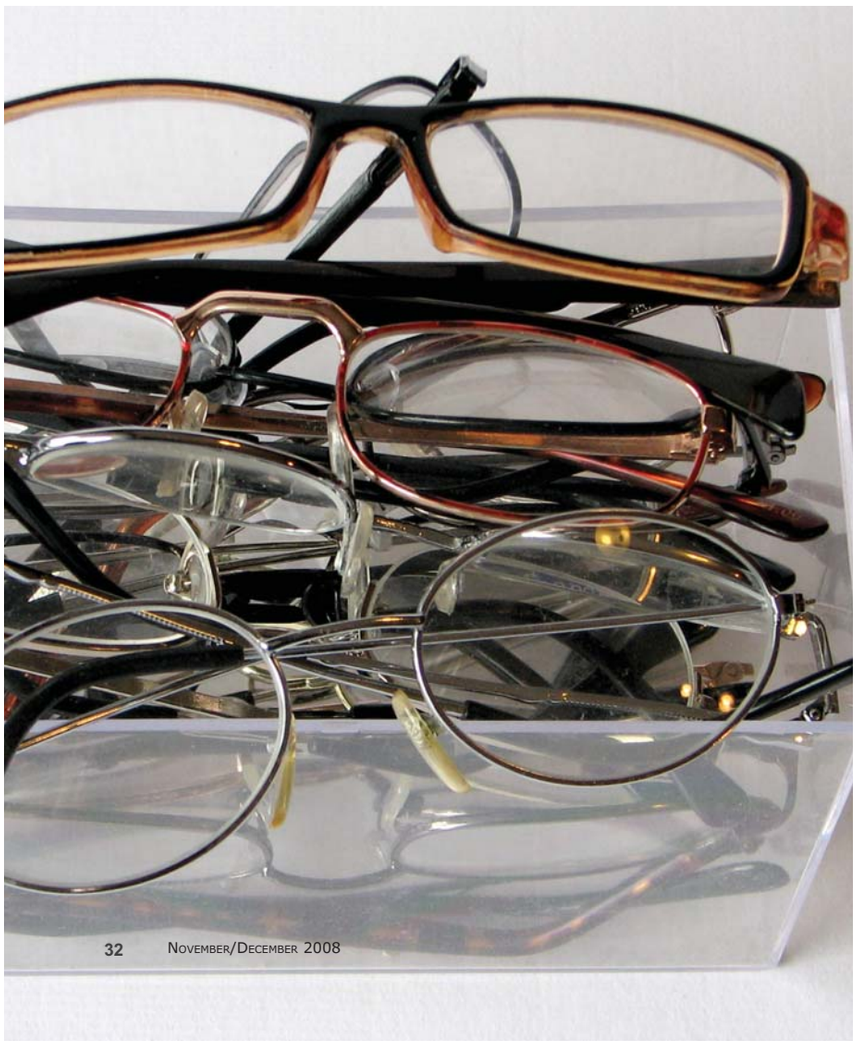
Employees, as stakeholders were not involved at different levels of WHP implementation. It came out strongly that there was a lack of employee involvement in decisions that affect their health. This was a concern since different stakeholders can influence the health needs and goals of an organisation including health policy.

Table 4. Summary of findings for context and process of workplace health promotion within the organisations

	Case 1	Case 2	Case 3	Case 4	Case 5	Case 6
Type	Private manufacturing	Private production	Private engineering	Parastatal engineering	Parastatal academic	Health private
Size	Large	Medium	Small	Large	Large	Medium
Risk level	Medium	Low	High	High	Low	Low
Medical aid benefits	Yes (Optional)	Yes (permanent staff)	Yes (optional)	Yes (optional)	Yes (optional)	Yes (optional)
Programme coordination	Part of organisation	Partially outsourced	None	Part of organisation	Part of organisation	Outsourced
Policy awareness (Employee)	Yes: 23 (59%) No: 16 (41%) n=39	Yes: 27 (73%) No: 10 (27%) n=37	Yes: 3 (10%) No: 28 (90%) n=31	Yes: 24 (55%) No: 20 (45%) n=44	Yes: 11(28%) No: 28(72%) n=39	Yes: 19 (63%) No: 11 (37%) n=30
Policy existence (Managers)	OHS ACT	OHS ACT HIV/AIDS	None	OHS ACT HIV/AIDS	OHS policy Hearing conservation	HIV/AIDS
Policy existence (Unions)	Online HIV/AIDS Drug and alcohol rehab. OHS ACT No awareness	—	None	Yes Fragmented HIV/AIDS OHS ACT No awareness	—	No policy
Policy existence (OHNP)	Health and safety HIV/AIDS EAP	Health policy HIV/AIDS	—	Drug and alcohol rehab.	HIV/AIDS	—
Programme awareness (Employees)	Yes: 20 (51%) No: 19 (49%) n=39	Yes: 14 (38%) No: 23 (62%) n=37	Yes: 5 (16%) No: 26 (84%) n=31	Yes: 18 (40%) No: 26 (60%) n=44	Yes: 9 (23%) No: 30 (77%) n=39	Yes: 21 (70%) No: 9(30%) n=30
Programme awareness (Unions)	HIV/AIDS Physical fitness Rehabilitation No programme	—	None	Health days Health education HIV/AIDS EAP	—	No
Involvement	Yes: 3 (8%) No: 35 (92%) n=38	Yes: 5 (14%) No: 32 (86%) n=37	Yes: 0 (0%) No: 31 (100%) n=31	Yes: 6 (14%) No: 37 (86%) n=43	Yes: 1 (3%) No: 38 (97%) n=39	Yes: 5 (17%) No: 25 (83%) n=30
Importance of programmes	Very important	—	Very important	Very important	—	Important
Availability of infrastructure (Management)	Supportive information Resources	Resources (budget) PHC clinic	Supportive information	Supportive information Resources PHC clinic	Busy with programme PHC clinic	Supportive information

RECOMMENDATIONS

- Organisations need to implement health promotion activities that are appropriate to their staff profile. This can be achieved through conducting employee needs assessments. Programmes that address employee health needs may increase employee participation.
- Employers need to start involving employees and labour organisations in decision-making pertaining to their own health. In that way employees will have a sense of self-reliance and programme ownership.
- It is important that organisations put in place comprehensive heath and safety programmes that address a wide range of health and safety issues equally. One way of implementing such programmes would be to employ a health and safety coordinator who is qualified in both fields or to have a coordinator for each programme.
- Organisations need to work on developing formal health promotion policies, which will guide the implementation and evaluation of employee wellness programmes.



REFERENCES

1. WHO. Ottawa Charter for Health Promotion: First International Conference on Health Promotion. Ottawa, Canada, 17-12 November. Geneva: WHO; 1986. Accessed 13/11/2003 via http://www.who.int/hpr/archive/docs/ottawa.html
2. Cottrell RR, Girvan JT & McKenzie JF. Principles and foundations of health promotion and education. 3rd ed. San Francisco: Pearson Benjamin Cummings; 2006.
3. O'Donnell MP. Health promotion in the workplace. 3rd ed. Delmar, USA: Thompson Learning; 2002.
4. Chu C, Breucker G, Harris N, Stitzel A, Gan X, Gu X et al. Health promoting workplaces – international settings development. Health Promotion International. 2000;15(2):155-167.
5. Peltomaki P, Jahannson M, Ahren W, Sala M, Wesseling C, Brenes F et al. Social context for workplace health promotion: Feasibility considerations in Costa Rica, Finland, Germany, Spain and Sweden. Health Promotion International. 2003;18(2):115-126.
6. Republic of South Africa. Occupational Health and Safety Amendment Act, No. 181 of 1993. Pretoria, 1993. Accessed 21/01/2007 via http://www.info.gov.za/acts/1993/a85-93.pdf
7. Huiskamp AA. Health promotion in the workplace. Occupational Health Southern Africa. 2003;9(2):4-6.
8. Linnan L, Bowling M, Childress J, Lindsay G, Blakey C, Pronk S, Wieker S & Royall P. Results of the 2004 National Worksite Health Promotion Survey. American Journal of Public Health. 2008;98(8):1503-1509.
9. Xiangyang T, Lan Z, Xueping M, Tao Z,Yuzhen S & Jagusztyn M. Beijing health promoting universities: practice and evaluation. Health Promotion International. 2003;18(2):107-113.
10. Johansson M & Partanen T. Role of trade unions in workplace health promotion. International Journal of Health Services. 2002;32:179–193.
11. Novak B, Bullen C, Howden-Chapman P & Thornley S. Blue collar workplaces: a setting for reducing heart health inequalities in New Zealand. N Z Medical Journal. 2007;120(1261):2704.
12. Coulson N. Health promotion in South Africa. Health Systems Trust Newsletter. Durban: Health Systems Trust; 2000. Accessed 15/06/2004, available at http://new.hst.org.za/pubs/index.php/381
13. Promtussananon S & Peltzer K. The development of a health promoting hospital model: a case-control study in the Limpopo Province, South Africa. A conference paper presented at the 50th anniversary conference. Primary Health Care: learning from the past and looking to the future, 21-24 July, 2003. Durban, South Africa.
14. Vergotine H. (2003). The management of occupational health services at the provincial, regional and district level in South Africa. Durban: South African Institute of Environmental Health; 2003. Accessed 28/06/2003 via http://www.saieh.co.za/Vergotine.doc
15. Lahtinen E, Koskinen-Ollonqvist P, Rouvinen-Wilenius P, Tuominen P & Mittelmark MB. The development of quality criteria for research: A Finnish approach. Health Promotion International. 2005;20(3):306-315.
16. O'Donnell MP. How to design workplace health promotion. 5th ed. American Journal of Health Promotion; 2000.
17. Yin R. Case study research. 3rd ed. Thousand Oaks: Sage; 2003.
18. Dhasiar-Ventura L (Publisher) KwaZulu-Natal Top Business Portfolio, 2004.
19. Alex White Holdings (Publishers) 2005/6 Hospital and nursing yearbook for southern Africa. Johannesburg: Alex White Holdings; 2005.
20 . Lusk SL, Kerr MJ, Ronis DL & Eakin BL. Applying the health promotion model to development of worksite intervention. American Journal of health Promotion. 1999;13(4):541.
21. Collins BS. Worksite wellness program. Nursing Management. 1991;27(12):19-21.
22. Aust B & Ducki A. Comprehensive health promotion interventions at the workplace: Experiences with health circles in Germany. Journal of Occupational health psychology. 2004;9(3):258-270.