



Occupational **HEALTH**

SOUTHERN AFRICA

*Official Journal of the SA Society of Occupational Health Nurses (SASOHN)
and the SA Society of Occupational Medicine (SASOM)*

In this issue:

Managing employee incapacity in terms of
the new Labour Relations Act and related
legislation (part 1)

Alcohol and drug abuse in the workplace -
implications of the ammended Labour
Relations Act

Occupational allergy to latex: a case series

Hypertension and compliance

The control of alcohol abuse in industry
provides substantial health and safety
benefits

Vol 2 No 4 July/August 1996

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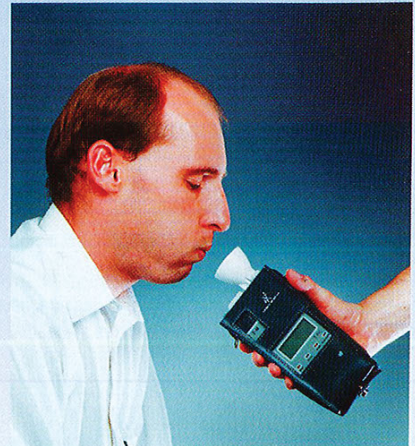
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Occupational HEALTH

SOUTHERN AFRICA

This journal focuses on Occupational Health, Medicine, Hygiene and Safety, Primary Health Care at the workplace, Environmental Health, and other employee health benefits

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CONTENTS

Vol 2 No 4 July/August 1996

2 Editorial

News and Events

- 4 PACOH '97
- 4 Hear hear "Ears alive at 65!"
- 5 ALLSA congress 1996
- 5 Healthy at work week
- 5 Smoke-free workplace
- 6 Syndromic management of sexually transmitted diseases (STDs)

Original and Review Article

- 8 Managing employee incapacity in terms of the new Labour Relations Act and related legislation(part 1)
- 14 Alcohol and drug abuse in the workplace - implications of the ammended Labour Relations Act
- 16 The function and development of the South African Alliance for the Prevention of Substance Abuse (SAAPSA)

Case Study

- 19 Occupational allergy to latex : a case series

Opinion and Short Report

- 22 The policy and procedure manual in an occupational health service
- 24 Hypertension and compliance
- 27 The control of alcohol abuse in industry provides substantial health and safety benefits

Industry News

- 29 Products and services

Personality Profile

- 32 Phil Piek

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In the objectives identified by the journal during its formative phase in 1995, it has to a large extent achieved its purpose of disseminating Occupational Health to those who are interested in the discipline. However, we are continually dependent on feedback from our readers as to the content value of the Journal in terms of its usefulness and purpose. On the one hand, academic criticisms are both valid and formative, and on the other hand we have a deluge of requests for more information on Occupational

Health, (i.e. Health care workers who seek a variety of subjects from Primary Health Care, budgeting in clinics, to Labour Relations and Industrial Relations issues etc.) Obviously, the Editorial Board is conscious of these dilemmas, and is making every effort to accommodate these requirements in order to fulfil its objectives.

Probably the most significant of the topics and themes identified by the Board, is the fact that **Primary Health Care** remains and will remain a significant and integral function of Occupational Health in Southern Africa. To divorce the two has been repeatedly determined as futile, and it is with this in mind that the Board has decided, partly because of the appeals addressed by the various readers, as well as the fact that the Journal itself is dependent on funding obtained from advertising, that **Primary Health Care** issues will be included on a regular basis. Our initial attempt at this will introduce both **Primary Health Care** and Continuing Medical Education articles, supported by various sponsors. In the next issue the start of these articles will hopefully be of benefit to many of the workers in the field of Occupational Health.

It is gratifying to note that while the Journal is continuing to improve in both content and distribution, our financial responsibilities towards the respective Societies (SASOM and SASOHN), have been obviated by the reimbursement of the working capital allocated to the journal in 1995. We are deeply indebted to the respective Societies for the opportunity to develop the Journal from its humble beginnings and we are happy to report that not only current topics, but other issues and information continue to give value to its targeted audience. We also wish to thank Cannon Medical Media for their assistance during the transition period from the previous publisher.

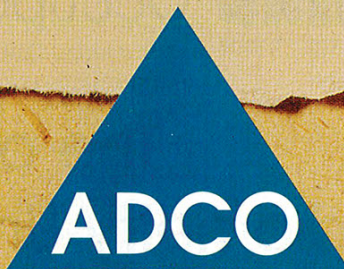
Chris van Selm
Editor



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News and Events

PACOH '97 Pan African Conference on Occupational Health

The South African Society of Occupational Medicine (SASOM) and the South African Society of Occupational Health Nurses (SASOHN) invite you to the 4th Pan African Occupational Health Conference in Durban, South Africa.

The theme of the conference is "Occupational Health Challenges for Africa" and should provide the opportunity to interface with colleagues from Africa and the rest of the world.

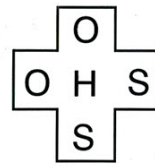
The five day programme will include:

- International speakers
- Formal sessions - plenary and breakaway
- Poster sessions
- Trade exhibitions
- Social programme
- Accompanying persons programmes
- Pre-and post conference tours

Venue: Holiday Inn Crowne Plaza, Durban

Date: Sunday, 31 August - Thursday, 4 September 1997

Further information from Brenda Webster (Conference Co-ordinator) Tel/fax: (012) 46-7424



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Hear hear "Ears alive at 65!"

Hearing loss due to occupational noise exposure is estimated to be one of the most prevalent occupational diseases. Noise adversely affects the quality of life with strong links existing between increased noise levels and accident rates. Loss of hearing results in difficulty in communicating which compromises a worker's efficiency and, to prevent this from happening, hearing conservation programmes should be instituted in companies with high noise levels.

It is important that we know what we are talking about when it comes to noise-induced hearing loss (NIHL). This workshop on-

industrial audiometry Presented by the Pretoria Professional Society of Occupational Health Nurses, will focus on the employee as an individual, his right to compensation and prevention of the disease.

Date: 4 September 1996

Venue: Premos Training Centre, Pretoria West

Time: 08:00 - 13:00

Cost: R150.00 per person

A variety of speakers (experts in their field) will present papers covering the following topics: legislation, impact of deafness on the individual, compensation procedures, prevention through training, role of the occupational hygienist and a case study.

For more details please contact Amanda Lazenby tel: (012) 541-7072 (Nampak Paper) or Brenda Webster tel: (012) 46-7424



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ALLSA congress 1996

Venue: Holiday Inn Crowne Plaza, Durban
 Dates: 2- 4 October 1996
 Topics: Asthma; occupational allergy; allergic rhinitis; food allergy; allergy pharmacotherapy
 For further information contact:
 Mr Colin Thaver (congress organiser)
 Tel: (031) 309-5917 or fax (031) 309-5961
 Dr Ahmed Manjra (convenor)
 Tel: (031) 266-8314 or fax (031) 86-7204

Healthy at work week



Ebrahim Rassool Minister of Health and Welfare Western Cape

SASOM West Cape recently convened a week dedicated to the promotion of Occupational health. The objective was to further the principles of the discipline within the general community and to develop greater insight into the profession and practice amongst both employer and employee.

The week was a resounding success with 308 delegates attending and had comprehensive exposure and coverage in the press. The week long event included a whole day conference addressing various Occupational health issues, a half day seminar on disability management, a full day stress

workshop and a Ramazzini meeting looking at the provision of Primary Care at the workplace.

One of the highlights was the superb poster presentation from Dr Mohammed Jeebhay from the Industrial Health Research group. The patron of the conference was Minister Rassool, the Western Cape Health and Welfare Minister who also opened the conference.

For further information about the conference, contact Dr Terry Berelowitz Tel/fax: (021) 439-8139

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Paracetamol 120mg/5ml, Codeine phosphate 3mg/5ml, Doxylamine succinate 5mg/5ml C/2/9232.

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Smoke-free workplace



Staff working on anti-smoking campaign (from left): Heather Burton, Khumbu Mntinjana, Dr Amanda Ryan

The Industrial Health Unit (IHU) has been working with the Cancer Association in a drive to encourage smoke free workplaces. There is a growing awareness that passive smoking is associated with higher risk of lung cancer, heart disease, and exacerbated conditions such as asthma and bronchial conditions.

Cape Town city council has already taken a step towards banning smoking in public places with fines of up to R100. As the ball gets rolling workplace smoking will also become a target for non-smoking environments.

The IHU highlights the risk of environmental tobacco smoke in the workplace and encourages active participation between workers and management in drawing up workplace smoking policies. It is more likely that the policy will be implemented if all parties feel their interests have been included in the policy.

The cornerstone of these policies is that smokers should not interfere with non-smokers' right to breathe "clean air". Key points in this policy should include:

- A general statement of principle to implement the policy
- Education for all employees regarding the risk of active and passive smoking
- Separate 'shelters' provided for smokers and non-smokers
- An assistance programme for those willing to stop smoking.

Syndromic management of Sexually Transmitted Diseases (STDs)

A symposium organised by the Department of Health was held on 28 March 1996 to promote the syndromic management of STDs.

The inter-relationship between HIV and STDs have made the control of STDs an urgent priority. In a recent randomised control trial in Tanzania, the introduction of effective management of persons with STDs resulted in a 42% reduction in HIV seroconversion.

The syndromic management of STDs is in fact one of the key strategies of the Department of Health in the prevention of AIDS.

The key strategies are:

1. Use of mass communication to popularise key prevention concepts.
2. Life Skills Programme - targeted at youth in and out of school.
3. Increased access to barrier methods (97 million condoms were distributed during 1995 compared with 20 million in 1994 and 6 million in 1995).
4. Treatment and management of STDs.

What is Syndromic Management?

This is the efficient and cost-effective way of treating a group of diseases which may cause one or more signs or symptoms rather than treating a specific disease.

Why Syndromic Management?

- It is not possible to diagnose specific STDs with a high degree of accuracy using clinical criteria alone, e.g. clinicians only correctly identified 30% of syphilis or chancroid in men.

- Mixed infections occur in a high proportion of cases:

e.g. genital ulcer disease

- syphilis 40%
- chancroid 40%
- granuloma inguinale 10 - 15%
- herpes genitalis 10%

e.g. urethral discharge

- N. Gonorrhoea 90 - 95%
- C. Trachomatis 17 - 30%
- T. Vaginalis 4 - 5%

- Laboratory tests are expensive and few centres have the expertise and equipment for an accurate disease-specific diagnosis.

- Treatment failure is unlikely, as syndromic treatment covers all the major pathogens.

Advantages of Syndromic Management

- Effective, comprehensive and good quality care is provided.
- Does not require high technology

and trained specialists.

- Patients are treated at their first point of contact.
- Allows more time for counselling and contact tracing.

Control of STDs - The 4 Cs

Counselling - empathise, discuss

Compliance - full course

Condoms - supply, explain and demonstrate

Contact tracing - sexual partners to be treated

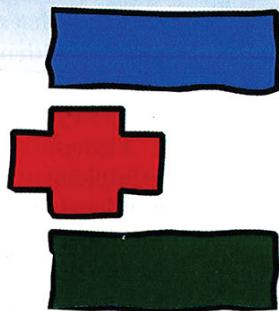
Drug protocols for syndromes

- Urethral discharge (men)
- Abnormal vaginal discharge
- Genital ulcers
- PID and lower abdominal pain
- Painful or swollen inguinal lymph nodes
- Syphilis in pregnancy
- Neonatal conjunctivitis

Protocols have been produced by the various provinces and will be published by MASA, South African Academy of Family Practice, etc. (Should there be a demand from members, these protocols can also be published in the Society journal).

I highly recommend that Occupational Health Nurses attend training courses on the Syndromic Management of STDs which are run by the provinces. Some provinces appear to be willing to provide drugs to Occupational Health Clinics whose staff have attended such courses.

JP Murphy



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Designed by a Nursing Sister/Artist and a Social Worker with more than 6 years "down to earth" experience.

The Manual consists of 18 pages of additional information in the same language as the posters, including a whole section on Home Care. The posters can be used on their own for **Self Education**, or as a **Lecturing Aid** or as a **Flip Chart** when cut into three equal parts.

SUBJECTS COVERED ON EACH POSTER ARE:

Example of Poster No. 8a,b,c.

Size: 500mm x 700mm

- Poster
- (1a) How do you get TB?
 - (1b) Where to go for help?
 - (1c) Have I got TB?
 - (2a) How do the pills work?
 - (2b) You must finish your treatment.
 - (2c) When can I stop my treatment.
 - (3a) What is HIV/AIDS?
 - (3b) AIDS and your immune system
 - (3c) There is no cure for HIV/AIDS.
 - (4a) The signs of HIV/AIDS.
 - (4b) Who can get HIV/AIDS?
 - (4c) Where does HIV live?
 - (5a) You can get HIV through sex
 - (5b) HIV and blood
 - (5c) How do babies get HIV?
 - (6a) STD's and HIV/AIDS.
 - (6b) How you can not get HIV/AIDS.
 - (6c) Safe sex and safer sex.
 - (7a) Caring for someone with AIDS.
 - (7b) Why is AIDS spreading so fast?
 - (7c) The HIV/AIDS test.
 - (8a) What are STD's?
 - (8b) What happens at the Clinic?
 - (8c) Finish your whole treatment.
 - (9a) Have I got a STD?
 - (9b) The silent STD: Syphilis.
 - (9c) What if Syphilis is untreated?
 - (10a) Use a condom for safer sex.
 - (10b) How to use a condom.
 - (10c) Use a condom only once!



This programme has been evaluated by all relevant bodies and approved by the Department of National Health, Ms Q Abdool Karim — Director HIV/AIDS and STD Programme and the Common Wealth Secretariat, Dr H M Bichan — Medical Advisor, Health Department

THIS WHOLE PROGRAMME IS NOW AVAILABLE IN ENGLISH, AFRIKAANS, KHOSA AND ZULU
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Please specify the language/amount of programmes you need.

English..... Afrikaans..... Xhosa..... Zulu..... Others.....
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Managing employee incapacity in terms of the new Labour Relations Act and related legislation (part 1)

Peter Strasheim*
in consultation with
Andre Botha#

Introduction

The new Labour Relations Act's provisions and guidelines for addressing and managing employee incapacity and ill-health in the workplace in terms of fair labour practices should be widely welcomed by all medical roleplayers as well as employer, trade union and employee stakeholders in the field. For many years this area of medical and industrial relations/labour law practice had been characterised by uncertainty, misunderstanding and often widely divergent approaches. These in turn exposed roleplayers to the risk of allegations of unfair labour practice and possible litigation.

Provisions in the Act¹ and the Code of Good Practice² issued under it now provide the necessary clarity on the processes and procedures to be followed for promoting good labour practices in addressing temporary as well as permanent employee incapacity and ill-health at the workplace. The roles and functions of the various participants can now be clearly identified and the respective rights and duties, entitlements and expectations of both the incapacitated employee and employer have been clarified.

Other current as well as future legislation also affects the medical and employer management of workplace incapacity. The Interim Constitution of SA contains clauses protecting the rights of disabled and aged persons.³ Government is presently working on a national disability strategy.⁴ Current policy proposals for future employment equity and affirmative action legislation contain provisions advancing impaired persons' representation and participation in employment.⁵ The Occupational Health and Safety Act also has direct relevance.⁶

Significance for medical roleplayers

The new legislation, principles and processes inherent to ensuring fair labour practices for the incapacitated employee will have far-reaching significance and consequences for all roleplayers in medical incapacity assessment and management. The impact of the provisions will largely depend on each roleplayer's responsibility or duty to comply with, consider or apply the provisions.

Significance to Occupational Health Medical Practitioners

The new legislation and guidelines have the direct effect of introducing new labour law requirements into all current medical management procedures for workplace incapacity established in terms of an employer's conditions of service, the common law and other statutory legislation. The provisions would therefore be of critical significance to Occupational Health Medical Practitioners (OHMPs) either working for, or consulting to employers. Within an organisation, the staff functionaries that an OHMP interacts with to address employee incapacity would also need to know and apply the provisions. These may include Industrial Relations (IR), Human Resources/Personnel (HR), Occupational Health Nursing Sisters (OHNS), Organisational Development (OD), Health and Safety (H&S), Legal Services and Social/Psychological Wellbeing Services.⁷

Significance to Specialists and Occupational Therapists assessing incapacity/impairment

The Act's guidelines should also prove indispensable to General Practitioners/Specialists, as well as Occupational Therapists, when assessing physical or mental impairment/incapacity relative to

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fund and
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incapacity
management with
co-author.*

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a large industrial
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working in close
co-operation with
co-author.*

*Occupational Health SA
1996, Vol 2, No 4: 8 - 12*

occupational post requirements, insured disability benefits (PHI/CAPDIS) or ill-health retirement (IHR). Continuing organisational change and job-insecurity have resulted in unprecedented claims volumes and adverse claims experiences across many benefit funds. For some claimants, serious secondary and often unforeseen consequences have been post-retirement unemployment, unemployability or financial difficulties.

These have in turn generated increased retiree litigation, disputes and conflict with the former employer, sometimes involving the medical assessor who recommended retirement. Litigants, through a court or their former trade union, demand re-employment on the basis of alleged victimisation through unfair or unwarranted premature retirement instead of being permitted by the employer, or being recommended by the medical assessor, to remain in service with appropriately restructured outputs, or by having the incapacity accommodated in the workplace by the employer - as recommended in the new Labour Relations Act's Code of Good Practice provisions.

The new Act and Code therefore make available a wider range of fairer and empowering alternatives - other than "boarding" or dismissal - for both employees and medical assessors of disability/impairment, where individual circumstances indicate that these options are appropriate, fair, in the interests of the employee, and warranted by the facts and findings.

Implications for insured disability benefit insurers

The Act and Code's provisions on managing incapacity in the workplace establish clarity for the insurer, employer and the recipient employee on the role and function of insured disability benefits, such as Permanent Health Insurance (PHI) or Capital Disability Lump Sum (CAPDIS) benefit.⁸

Employers will not be permitted to use a PHI benefit - designed to replace income during temporary incapacity - as an alternative to, or supplementary payment at permanent retrenchment on the grounds of incapacity. The Code requires the employer in suitable circumstances to secure a temporary replacement for a temporarily ill employee over the period of absence. Thus a PHI benefit becomes contextualised as a supplementary method for managing

incapacity fairly: the PHI payment replaces income over the temporary period of incapacity, and upon recovery the recipient returns to service and the temporary replacement's services cease.

Structure of this article

This article addresses its subject in two parts: the first part published in this issue of Occupational Health Southern Africa focuses on the key provisions of the new Labour Relations Act, the Interim Constitution and related legislation which establish the new legal/labour context in which the management of incapacity and ill-health take place; the second part which will be published in the next issue focuses on the Code of Good Practice: Dismissal issued under the Act and explains, analyses and discusses the specific provisions, principles and procedures for managing incapacity/ill-health in terms of fair labour practices.

Part one: The new Labour Relations Act and related legislation

The Labour Relations Act, 1995

The new Labour Relations Act (LRA), No 66 of 1995 will reportedly come into full effect on 1 August 1996. The Act is a formidable body of legislation, which will either directly or indirectly affect every citizen. The Act has been described as the first piece of legislation in South Africa's 'third revolution' in labour law,⁹ the changes to which are intended to take place over five years. The Act creates a single integrated framework for all labour and industrial relations procedures, including those which formerly existed in separate and fragmented form for the state, agriculture, university, domestic worker and SA Police Service sectors respectively. The SADF, National Intelligence Service and SA Secret Service do not fall under its ambit.¹⁰

Objectives of the Act

In broad terms, the purposes¹¹ of the LRA are to legislatively incorporate all labour rights which exist in the current Interim Constitution; to simplify labour legislation making it accessible; to provide for the organisational rights of trade unions; to facilitate collective bargaining between trade unions and employers; to establish the structures for workplace democratisation and employee participation in decision-making with employers; to create a body to effectively resolve labour

disputes at an early stage via the Commission for Conciliation, Mediation and Arbitration (CCMA); to reconstitute the Labour and Labour Appeal courts and to align SA's labour law to public international law.

Scope and application of the Act

The Act applies to all employees at workplaces. The phrase is widely defined to cover most envisaged employment situations or arrangements. Accordingly, an "employee" is defined as 'any person who works for another person or for the State and who receives or is entitled to receive any remuneration' (excluding an independent contractor), or 'any person who in any manner assists in carrying on or conducting the business of an employer'.¹² A "workplace" is defined as 'the place or places where employees of an employer work', but has a specific definition in relation to the public service and sectors thereof.¹³

Social democratic principles and collective bargaining

The legislators sought to address the historically adversarial nature of SA labour relations by creating statutory methods to engender a shared vision between capital and labour, which would be characterised by joint goals, relationships which tend toward joint problem solving instead of conflictual antagonism and recognition of an inherent mutual dependency between organised labour and employers. A philosophy of partnership and shared values through effective communication, ongoing dialogue, employee participation, and trade union rights to organise and associate is aimed toward.

Collective bargaining between organised labour and employers is not a statutory duty and voluntarism is promoted. The parties are encouraged to agree collective bargaining terms and to determine their own arrangements for negotiations, topics, bargaining levels and frequency of negotiations. Agreements reached through effective collective bargaining are intended to be supported by both the employer and labour, with disputes being resolved rapidly and effectively by the parties themselves, the CCMA, or other bodies. Trade union rights in the domestic sector are more limited.¹⁴

Workplace Forums¹⁵

Functions of Workplace Forums

To enhance workplace democratisation and employee participation, the Act introduced the somewhat radical and currently contentious concept of workplace forums

(WFs). These forums are subordinate to, and intended to supplement, the collective bargaining forum. WFs have the statutory functions of enhancing workplace efficiencies and the interests of all employees, unionised and ununionised.¹⁶ An application is made to the CCMA to assist in establishing a WF, and creating a constitution providing for elections, voting, meetings and procedures where the workforce is greater than 100.¹⁷

Rights of Workplace Forums

In order to give substance to the concept of workplace democratisation and to facilitate employee participation in decision-making at the WF level, the Act grants several key rights to the WF's employees:

- **To make representations to the employer:** The WF may make representations¹⁸ to the employer, which the employer must allow, consider and respond to with reasons;
- **To be consulted by the employer:** The employer must consult¹⁹ with the WF and must attempt to reach consensus on various matters including²⁰ restructuring, changes to work organisation, retrenchment, redundancy, job grading, bonuses, health and safety, education and training, and any other subjects²¹ as agreed between the employer and the WF;
- **Joint decision-making:**²² The employer is required to consult with the WF and must reach consensus on matters regarding Disciplinary and Grievance Procedures, advancement of disadvantaged employees, rules of employer-controlled employee benefit schemes, and any other subjects²³ as agreed between the employer and the WF;
- **Information sharing:** The employer has a duty to disclose to the WF sufficient information,²⁴ subject to the statutory limitations, in order to permit the WF to exercise its rights to make representations, to consult and to jointly make decisions with the employer.²⁵

Limitations on the duty to require disclosure or to make disclosure include legal privilege, prohibitions in other legislation, information which is confidential and could substantially harm the employer or the employee, as well as information which is private personal employee information, unless disclosure is consented to.²⁶

Disputes concerning disclosure are referred to the CCMA, which must adjudicate the dispute by first deciding

whether the information is relevant, then balancing the harm if disclosed with the harm if kept confidential and must set terms for disclosure where necessary.²⁷

Implications of WFs for OHMPs in terms of incapacity management

At a workplace, the incapacity/ill-health principles and procedures as well as the necessary strategies to address and manage affected employees on the shopfloor is likely to be raised by the employer or trade union at WF level, since incapacity would be a subject for consultation as either a health and safety, redundancy, retrenchment or restructuring matter. Where an Incapacity Management Procedure was proposed by either the employer or WF, it would probably become a procedural matter subject to negotiation and joint decision-making between the parties.

Consulting OHMPs, or OHMPs in full-time employment would have a key guiding and facilitating role in a WF during consultation or negotiation between the parties on the subject of incapacity and ill-health management. A sound knowledge of the Code of Good Practice's guidelines and some exposure to implementing and managing the process would be essential elements, where the OHMP is held responsible and accountable for the overall management and effectiveness of the strategy.

The Constitution and related legislation

Constitutional labour and equality rights

The "labour relations"²⁸ and "equality"²⁹ rights in the interim Constitution of the Republic are also fundamental to lawful, effective and fair management of incapacity. Of the former, the provision that "every person shall have the right to fair labour practices"³⁰ is directly important. A stated objective of the LRA, and thus the Code, is to give effect to the constitutional labour rights.³¹

The equality rights provide specifically for protection of the aged and disabled: "No person shall be unfairly discriminated against, directly or indirectly... on one or more of the following grounds in particular race, gender, sex, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture or language."³² In addition "every person shall have the right to equality before the law and to equal protection of the law".³³

Implications for Incapacity Management

Workplace processes and procedures for addressing employee incapacity which are inadequate, inefficient or non-existent will be at risk. Aggrieved employees may allege that the arrangements, or lack of them, are not only an unfair labour practice under the LRA and the Code, but also constitutionally discriminatory on the grounds of either disability or age.

This could potentially hold serious labour relations consequences where conflict, disputes, grievances or even industrial action took place in support of an employee regarded as unfairly treated by some or all roleplayers involved.

Other disability-related legislation

Government's Integrated National Disability strategy

For disabled and impaired persons, Government is developing an integrated national strategy, to give effect to constitutional equality principles. Policies identified for effective participation of the impaired and disabled are awareness, medical care, rehabilitation and support services. Priority areas for action are environmental accessibility, education and training, employment, income maintenance and social security. The lead-in takes place over 1995-96, and a permanent office is to be established.³⁴

Employment equity/affirmative action: disabled persons

Draft policy proposals for envisaged employment equity and affirmative action by employers aim to support equality of treatment for impaired and disabled persons.³⁵

A current policy paper to facilitate equitable representation of all sectors of the population includes disabled/impaired persons afflicted by physical, mental, psychiatric, sensory or learning impairment. It envisages at least 2% of the public service comprising disabled employees. Reportedly compulsory ratios will not be introduced in the private sector, although incentives such as fines or tax advantages could be utilized to facilitate equity by employers.

Part two of this article will appear in Occupational Health Southern Africa Vol 2 No 5 September/October issue

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2. The Code of Good Practice: Dismissal appears as Schedule 8 to the Labour Relations Act, and was published simultaneously with the Act itself in the same Government Gazette
3. Constitution: Section 8(1) and (2); s10
4. "Integrated National Disability Strategy of the Government of National Unity", published by the Ministry in the office of the President in the form of a discussion document for public comments, in Government Gazette 14 March 1996 (No 17038, volume 369). See also Cape Times 4 December 1995.
5. Sowetan 24 February 1996
6. Act 85 of 1993
7. These titles may change, but these management functions generally exist in any organization, either officially or practically. The size of the organization and its structure will determine the circumstances
8. Where these are offered or exist (automatically or by employee election) in the organisation concerned, in terms of its Conditions of Service
9. Mr A van Niekerk, IPM Conference 24 Oct 1995 (Business Day 25 Oct 1995)
10. LRA Section 2
11. LRA Section 1
12. LRA Section 213. Note that section 78 defines "employee" differently for the purposes of workplace forums
13. LRA Section 14
14. Rights afforded to trade unions in the domestic sector are more limited, in terms of LRA Section 17. The limitations are that the right to enter a home is subject to the employer's agreement, and that the right to information from the employer does not apply
15. LRA Chapter V: Sections 78-94
16. LRA Section 79
17. LRA Section 80
18. LRA Section 85(2) and (3)
19. LRA Section 85
20. LRA Section 84
21. LRA Section 84(2)
22. LRA Section 86
23. LRA Section 86(2)
24. LRA Section 89
25. LRA Section 89(1)
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28. Constitution Section 27
29. Constitution Section 28
30. Constitution Chapter 3, Section 27(1)
31. LRA Section 1
32. Constitution Chapter 3, Section 8(2)
33. Constitution Chapter 3, Section 8(1)
34. See footnote 4 above
35. Sowetan 4 February 1996

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MICRO-NUTRIENT DILUTION - WHAT IS THE CULPRIT?

The clean bill of health given to sugars in relation to chronic and other disease makes it seem incongruous that there is disagreement on an answer to the question **“Is sugar consumption at current levels a cause of nutrient-inadequate diets?”** It is theoretically possible that nutrient intakes for an individual could fall below his or her own requirement if the diet contained an excess energy source such as sugar^(1,2). The question should rather be examined in terms of whether or not current sugar consumption levels represent safe intakes for most individuals^(2,3).

Do diets provide the nutrients that are needed?

Despite the fact that, at population level, most “industrialized” countries enjoy diets that are adequate in energy and nutrients, intakes of particular nutrients in specific groups of these populations may be at risk. For example, in the United Kingdom there is evidence in both adults and children that iron intakes, particularly in women and girls, are below recommended levels^(4,5,6). And in Arkansas (USA), it appears from a study that the RDA’s for vitamin B6, zinc and iron are the most difficult to meet⁽⁷⁾.

How does the level of sugar consumption impact on nutrient status?

Studies in the UK have indicated that in most cases nutrient intakes are higher (often much higher) in those people with a high intake of sugar. They also have higher overall energy intakes. These individuals tend to consume more of everything⁽⁴⁾.

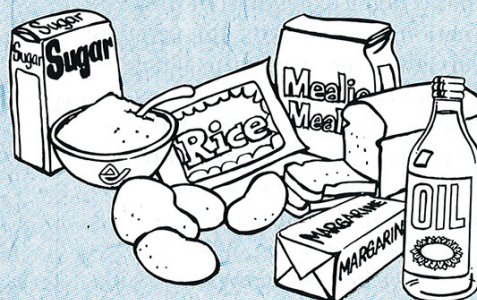
The UK COMA report on sugars comments, “sugars intake is a weaker predictor of absolute micro-nutrient intakes than total energy consumption”⁽⁴⁾.

In all the studies that were described by Ottley, it was found that as the proportion of dietary energy from sugar rose, the proportion of energy from fat, protein and in adults, alcohol, fell. The intakes of protein were still well above recommended levels in most cases. With respect to attaining targets for fat and alcohol intake it would appear that dietary quality is better with a higher sugar intake⁽⁴⁾.

No consistent pattern of changes in nutrient intake related to level of sugar consumption could be identified across different populations. This suggests that other dietary factors were more influential on micro-nutrient intakes. It seems that the proportionately large intake of foods not rich in sugar had the most influence on nutrient status⁽⁴⁾.

When nutritious foods are displaced in the diet this can indirectly contribute to deficiencies of vitamins and minerals. This can occur when any foodstuff, be it sugar, complex carbohydrate, protein or fat, is consumed to the exclusion of other foods that provide required nutrients. Sugar is rarely consumed in isolation, but rather tends to be eaten in combination with other foodstuffs.

Consuming a nutritionally balanced diet made up of a wide variety of foods should meet the known nutrient needs of most healthy persons⁽⁸⁾



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Alcohol and drug abuse in the workplace - implications of the ammended Labour Realtions Act

Ronelle Sartor

For several decades the abuse of alcohol and other mood-altering drugs has posed a major problem in industry, as it impacts adversely on employees' health, work performance and public and industrial safety. What were once isolated incidents, have become almost an epidemic, especially with the increasing abuse of illicit drugs in the workplace.

Schickerling¹ estimates that alcohol and drug abuse costs South Africa more than R2 billion per year. Although no accurate statistics are available on exactly how high the toll is that is being exacted from workers' health and national productivity, this estimate gives an overview of the cost of this illness to South African industry.

The drug problem is not confined to specific groups of people. No occupation or demographic group is immune. Service workers, labourers, middle and top management, men and women, White and Non-white; all have among them people with substance abuse problems. It is estimated that approximately between 6% and 16% of the average workforce is likely to be alcohol and drug dependent² and a further 20% will experience drug related problems. The cost of drug abuse and excessive alcohol consumption to the commercial and industrial sector is so astronomical that it can no longer be ignored. The amended Labour Relations Act makes it even more difficult for employers to ignore worker impairment resulting from the abuse of mood-altering substances, or to follow the short sighted policy of "find the abusers, and fire them".

Labour Relations Act³

The amended Labour Relations Act; Section 209¹ states that:

Where an employee is incapacitated on account of ill health, an employer should conduct an investigation to establish the extent of that incapacity and the prognosis.

Where it is established that the employer is unable to perform the work for which he or she was employed, or that he or she is likely to be absent for an unreasonably long period, the employer should investigate possible alternatives to dismissal. Relevant factors include the nature of the job, the period of absence or seriousness of the illness and the possibility of securing a temporary replacement.

- The employee should have a right to be heard in this process, with assistance from a trade union representative or fellow employee, where appropriate.
- The degree of incapacity is relevant to the fairness of any dismissal. The cause of the incapacity may also be relevant. In the case of certain kinds of incapacity e.g. alcoholism or drug abuse, counselling and rehabilitation may be appropriate steps for an employer to consider".

Implications of this Act in industry as it relates to alcohol and drug abuse in the workplace

The response to the problem of drug abuse in the workplace has not always been fair and realistic. Until fairly recently, some companies still adopted punitive disciplinary methods, believing that by finding and firing the abuser, the problem of drug abuse in their companies would be eradicated. What appeared to be a simple answer, only served to exacerbate the problem, and it impeded timeous identification of alcohol and drug related issues.

Trade unions involvement in all spheres of South African industry, coupled with the amended Labour Relations Act, give workers a powerful tool to use to their own advantage.

The Implications of this Act are:

- Employees may no longer summarily be dismissed on the grounds of incapacity arising from ill health caused by substance abuse and dependence.

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Occupational Health SA
1996, Vol 2, No 4: 14 - 15

- It is now the responsibility of the employer to investigate and establish the cause of the incapacity, and to provide an opportunity for appropriate treatment, counselling, and rehabilitation, prior to dismissing the employee.

This sets the tone for effective intervention, and ultimate prevention of substance abuse in the workplace.

Occupational Alcohol Programmes and Employee Assistance Programmes

The development of the original Occupational Alcohol Programme (OAP) in the 1970s was the first attempt at addressing alcohol abuse in the workplace. These programmes showed great promise in terms of identifying and successfully treating the alcohol dependent, and constantly showed high recovery rates, by ensuring continued gainful employment as an integral goal recovery.⁴

Googins & Godfrey⁵ identified five assumptions on which OAPs were based:

- Alcohol abuse is relatively evenly distributed across the population.
- The workplace as a central institution in society is directly affected by problem drinking in terms of costs, inefficiency and impaired work environments.
- The workplace is an appropriate focus for intervention and uniquely suited to disrupting patterns of dysfunctional drinking behaviour.
- Treatment of alcohol problems must be integrated into the basic institutions of society rather than isolated among social welfare agencies.
- Alcohol, (and now also drug) abuse is a treatable illness.

The emergence of Employee Assistance Programmes (EAPs) which are broader based programmes, addressing all personal problems that have the potential to affect, or are affecting or impairing job performance, introduced a new strategy and expanded the aims of OAPs.

The assumptions underlying the rationale for EAPs are:

- Prevention is more likely in occupational settings.
- Work organisations share the responsibility for the health of their employees. (This assumption is now enforced by the Labour Relations Act).
- Substance abuse is affecting the workplace, and
- Problem intervention is more effective when integrated into existing social institutions⁵.

Conclusion

The amended Labour Relations Act will positively influence future constructive economic development, as it reinforces the principle that it is better to offer assistance to employees experiencing personal problems (including substance abuse problems), than to dismiss them, as recovering employees become more productive and effective.

Social responsibility has become an important sphere of the South African corporate world. EAPs and Industrial Alcohol and Drug Programmes can benefit industry in several ways:

- Cost effectiveness: South African industry loses millions of rands each year due to impaired job performance as a result of substance abuse.
- Improved labour-management relations^{6,7,8}. The response to the problem of workplace drug abuse will be based on cooperation, communication and trust, and will reduce labour-management conflict.
- Enhance corporate image. It establishes a culture of caring, concern and wellbeing.
- It is furthermore clear that EAPs can enhance job performance, and providing an opportunity for appropriate treatment of drug dependent employees, definitely reduces absenteeism and labour turnover, and improves productivity.

Companies concerned with the cost effectiveness, productivity and social responsibility need to invest in their workforce, and adopt a constructive strategy to address and combat substance abuse in the workplace. The labour legislation now simply reinforces this responsibility.

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The function and development of the South African Alliance for the Prevention of Substance Abuse (SAAPSA)

Samantha Oliver

Within South Africa there was recognition by many organisations concerned with substance misuse, that they could not deal with the emerging problems alone and that they needed to work together if effective prevention was to be achieved. In 1994 and early 1995, three additional factors came together which facilitated the development of SAAPSA. (SAAPSA First Assembly report; 1995:3)

First, President Mandela placed substance abuse high on the agenda as a threat to the peaceful transition and development of South Africa. Second, the Reconstruction and Development Programme gave high priority to tackling substance abuse as a precondition for the success of the plan. Third, the World Health Organisation (WHO) in developing the Global Initiative on the Primary Prevention of Substance Abuse, focused on four regions of the world experiencing rapid social change. Southern Africa was one of the regions. With the desire of organisations to co-ordinate their activities and work together, and the commitment to substance abuse prevention, South Africa provided all the ingredients required for concerted action to promote substance abuse prevention.

For WHO, whose primary interest is health in its widest meaning, stability and peace were a pre-requisite. However, as an organisation it did not have good answers to what was appropriate and effective prevention in countries facing rapid change and development. The Global Initiative on the Primary Prevention of Substance Abuse is, therefore, an effort to develop knowledge and undertake actions that could

benefit many countries. SAAPSA was thus an example to the world. It had shown that it was possible to put aside differences and come together around a joint agenda rather than work in isolation. Moreover, through its capacity to mobilise people for prevention and through the experience gained, it could offer models of prevention that might save wasted effort and investment of resources in ineffective actions. The primary health care approach to prevention needs active community involvement. For WHO, the promotion and support of alliances for prevention was essential to show a way forward. It looked to SAAPSA and to other alliances within the Global Initiative to provide knowledge and information that could be transferred to other parts of the world. It was in this spirit and with this desire that WHO sought support and facilitates work for primary prevention of substance abuse through SAAPSA.

Substance abuse was placing significant burdens on already overloaded health services and denying people the benefits of their development. Counter measures had to be found and SAAPSA could provide appropriate and specific recommendations to other countries, not only to stop unhealthy behaviour but also to improve the quality of life.

Our mission statement adequately describes our role. "The Alliance is established for the purpose of facilitating networking amongst all organisations, government, non-government and representatives of civil society, concerned with drugs and alcohol abuse in South Africa, with a view to optimising

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*Occupational Health SA
1996; Vol 2, No 4: 16-17*

co-operation in the prevention and treatment of alcohol and drug abuse in order to improve the quality of life and to promote peace and development for all South Africans.

In furtherance of its mission the Alliance will:

- Seek active participation of youth
- Strive to promote affordable treatment services
- Promote constructive educational and other preventative programmes
- Promote collaborative projects involving its members
- Be accountable to open evaluation of activities undertaken in the name of the Alliance
- Facilitate sharing of information and experience
- The alliance will not become a new organisation, nor will it become a direct service provider.”

How will community organisations participate in the Alliance?

Community organisations will benefit from the sharing of information, experiences and networking with other structures. The Alliance will offer organisations guidance in the sharing of experiences and liaison

between organisations. Smaller organisations can then also benefit from what bigger organisations are doing. Members are encouraged to generate prevention projects, then to submit project proposals to SAAPSA for screening, and if appropriate SAAPSA will then assist in searching for funds for these projects. SAAPSA is also developing a newsletter or bulletin to keep its members informed of events in the substance abuse prevention field and other related fields. SAAPSA is also hoping to have workshops or conferences on topical issues, to facilitate networking, liaison and sharing of information and experiences.

The workplace can be an important area for preventing substance abuse and promoting mental health. SAAPSA can be used as a resource for industry regarding prevention of substance abuse and policy issues. SAAPSA could facilitate networking between business and non-governmental organisations in promoting joint programmes, to meet the organisations' social responsibility needs as well as community prevention needs. Make contact and you could contribute to networking and building peace and development in South Africa!

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Occupational allergy to latex : a case series

Neil White

Introduction

It is interesting and informative to consider the implications of occupational allergy, particularly when actual experience is recounted. This is especially the case when the problem occurs among colleagues working in a health care setting, doing jobs that we all know about and to which we can relate. Because of its usefulness latex is ubiquitous in the hospital environment.¹ Latex allergy is a very real and present problem for health care workers.² With an emphasis on safe work and universal protective measures, health care workers use more latex gloves and increase their exposure to this unique natural rubber.

Awareness of the problem of latex allergy in our hospital group increased greatly in the wake of a survey of the immunological status of personnel requesting "non-latex" gloves. This survey, carried out during 1994 out by UCT's Department of Clinical Science and Immunology, resulted in a number of referrals to our Occupational Medicine service. Four case histories are presented from among these referrals. All four are nurses and the histories are presented anonymously with consent.

Case Histories

Case 1 : A 41 year old theatre sister first seen by me in 1993 because of poorly controlled asthma.

She had a history of iron deficiency and hypertension. She had perennial rhinitis for many years. Her asthma had begun in 1974 when she had an episode of bronchospasm whilst on night duty. In 1993 most of her asthma symptoms were nocturnal and not clearly associated with work. She did not recount that she had had a problem of dermatitis with latex gloves some years before and was now wearing hypoallergenic gloves. Her skin prick tests were positive to house dust and grass pollen.

Initially she responded well to inhaled corticosteroids. She did not return a self-administered peak flow monitoring chart. Her asthma control worsened and she had two acute severe asthma attacks in 1994. In late 1994 she was told about her positive RAST for latex that arose out of the survey. Only then was the occupational nature of her asthma properly appreciated. She was moved to the sterile stores department - a low latex area of the hospital - where she was never required to wear gloves. This move and high dose inhaled corticosteroids improved her initially, although she had a further two attacks of acute severe asthma in 1995. Enquiry revealed that other people were using latex gloves within 20 m of her work area. Steps were taken to prevent this and the situation is still being monitored.

Case 2 : A 52 year old midwife who worked in a Midwife Obstetric Unit.

She developed contact dermatitis in 1987 and this was improved with use of hypoallergenic gloves. In winter 1993 she first developed persistent rhinitis. In December 1993 she first saw her general practitioner with bronchospasm. She saw him with the same problem four or five times during 1994. At the end of 1994 she was informed about her positive RAST for latex and was referred to the occupational medicine clinic.

Initially reasonable control was achieved through moving her to the ante-natal booking clinic and commencing high dose inhaled steroids. By May 1995 she was having lots of problems. She had developed dermatitis on her palm from constantly using the baumanometer bulb. Latex gloves were used around her by others. She felt unwilling to continue with work where there was a risk to her health. After counselling over a period of time it became apparent that there was no alternative employment appropriate to her training.

*Dr Neil White:
'Workhealth',
respiratory
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Groote Schuur
Hospital.*

*Occupational Health SA
1996, Vol 2, No 4: 19 - 21*

Case Study

In June 1995 she was given sick leave pending her medical boarding which took effect from January 1996. She was then assisted with UIF. Fortunately she had an insurance policy which included disability cover which paid the balance of the bond on her flat. A workmen's compensation claim was entered in November 1994 but is still pending. Her asthma has improved considerably since she left nursing.

Case 3: A 30 year old trainee theatre nurse with a history of perennial allergic rhinitis since age 9.

In 1993 she first noticed dermatitis related to use of gloves. She also began to develop chest problems that were ascribed to asthma. A positive RAST from the survey resulted in her referral to Occupational Medicine where she was also found to have positive skin pricks to house dust, cat, tree and grass pollens. Asthma was confirmed on self-administered peak flow charting. High dose inhaled steroids and moving to the theatre recovery area improved control of her asthma. After counselling she applied for a community health nursing course, was not accepted but has applied again. A workmen's compensation claim was entered in December 1994 but is still pending.

Case 4: A 29 year old trainee theatre nurse with a history of perennial allergic rhinitis since age 18.

These symptoms were present before she started nursing and were currently worst at night. They had worsened since moving to Cape Town to start theatre training. She was referred to Occupational Medicine by her surgeon husband. She had positive skin pricks to house dust and moulds and had a strongly positive RAST to latex. After counselling she decided on a career change to nursing education and has been much improved by the move.

Discussion

Occupational asthma may have very few features that distinguish it from non-occupational or environmental asthma, as was illustrated by Case 1. A high index of suspicion, knowledge of occupational allergens and availability of appropriate investigations is essential so as not to miss this important diagnosis.

Like most other occupational asthma, latex allergy tends to worsen over time, even with high dose appropriate treatment. Job relocation to low latex exposure areas

may improve things for a while, but even low dose exposures can precipitate asthma attacks. A no exposure situation is preferable but there are very few truly latex free environments in health care. Most of the nurses affected by this problem are theatre, trauma or emergency unit nurses whose jobs involve frequent glove changes or prolonged usage. These are high latex exposure areas because of release of airborne latex antigen.³ There has been some discussion of making one of the theatre areas at Groote Schuur Hospital latex free, for both latex sensitive staff and patients.

Job relocation or medical boarding is a very sensitive matter and must be handled with careful counselling and time taken to consider all possible options. The affected person will almost always perceive a loss of status in relocation since the new job will require few of the skills acquired in the old job. Other possible problems requiring counselling that can flow from this include resentment, lack of motivation and even depression.

The cost of a single medical boarding plus the costs of loss of efficiency from the loss of trained staff from critical areas such as theatres must greatly exceed savings to be made from use of cheaper brands of latex gloves that result in higher exposures to natural rubber proteins. Expenditure on quality gloves that can be shown to result in low rubber protein exposure are a good investment in human resources.

Workmen's compensation was not applied for in Case 4, since occupational rhinitis is not a scheduled disease under COIDA. Instead we opted for early job relocation. In Case 1 we did not apply since her symptoms dated from before January 1993 when occupational asthma was first scheduled as an occupational disease. The Workmen's Compensation Commissioner has previously shown that he is not willing to compensate such people, even if they are still working and still have the problem. The long time taken to administer the claims of Cases 2 and 3 shows that the administration of COIDA is less efficient than the state pension fund, private insurance and the UIF.

Compensation is therefore not as useful as it should be as a form of income support for people who have to look for a new jobs because of occupational asthma.

Case Study

It is notable that all of the cases presented had atopy with allergy to house dust and other environmental allergens, as well as latex. High levels of allergen exposure, smoking and atopy are all known risk factors for occupational asthma. Given the prevalence of atopy in the general population (roughly 30%) it does not make sense to screen atopic people out of work where they will be exposed to occupational allergens. It is also incorrect to assume that the presence of atopy means that asthma or rhinitis is merely being aggravated by occupational exposure. Atopy should be viewed as a risk factor for occupational asthma, rather than as an alternative explanation for the problem.

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The policy and procedure manual in an occupational health service

Jenny Acutt

A policy and procedure manual is a management instrument that contains the scope of departmental responsibilities and a framework within which the health service objectives are implemented - in writing - complete with dates and signatures. It is a valuable legal document.

An occupational health policy

The policy of an occupational health service will reinforce the philosophy and goals of the company from a health perspective, ensuring a standard framework within which the health workers carry out their duties to safeguard the company, its employees and the health worker.

It is a guide that spells out responsibilities and prescribes the actions to be taken in a given set of circumstances. (DiVincenti 1986:105)

An occupational health procedure

A health procedure on the other hand is the established and uniform method of performing a health service procedure based on principles. These principles may have legal, ethical, medical or nursing backing or conform to company policy.

A procedure prescribes the steps that should be followed in order to conform to or carry out a policy. (DiVincenti 1986:105)

Aims of written policies and procedures

The aims are as follows:

- To act as a guide in decision making
- To safeguard both clients and health workers
- To avoid the chaos brought about by random activity of staff members by directing, co-ordinating and articulating the whole operation of the Occupational Health Service
- To prescribe the steps that should be followed in order to carry out the policy or conform to it

- To assure standardisation of care and uniformity of action
- To settle conflicts and other issues in terms of the written policy rather than in terms of personalities
- To ensure continuity of care and administration during staff turnover and for orientation of new staff members

The development of the policies and procedures

This is a team effort involving all affected parties including the Occupational Health Nurse (who usually co-ordinates the on-going process), the company physician, the service director, personnel department, safety officer, industrial hygienist, buying department, outside agencies and suppliers. Each team member is responsible for setting up guide-lines for effective service and liaison between the Occupational Health Service and themselves.

Basic principles to remember when planning for the development of policies include:

- Policies should fit the occupational health service of the specific company (its philosophies, managerial climate, etc)
- Policies should be unambiguous, broad and durable, adaptable to interpretation for specific circumstances
- Policies should guide both the Occupational Health Service and other agents that co-ordinate with the Service for smooth administration and uniformity, continuity and standardisation of methods
- Policy statements must be general enough not to need continual updating and changes must be thought through very carefully before being instituted. All changes must be communicated to the staff

Written procedures are living documents and are constantly updated and revised as new information and

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Opinion and Short Report

developments in the medical, technical and business worlds become known. New legislation must be implemented immediately.

It is wise to have a policy committee that meets on a self-determined basis to review policies or develop new ones as the need arises. However procedures need updating as new information comes through and it is good to delegate certain aspects to members of the team or to make one person responsible for all the updating and communication of changes to all concerned.

The contents of a policy and procedure manual

In order to make the manual 'user friendly' it is imperative that it is readily available, easy to use, neat and correct.

Although it is easily updated on the computer the manual should be physically available, usually in a loose leaf file, and contain the following:

- Title page
 - Foreword (introduction to the company, its mission statement)
 - Table of contents - Sections and headings and page numbers
 - Introduction to the manual
 - Statement of philosophy of the Occupational Health Service
 - Objectives of the Occupational Health Service
 - Organigram of the company and of the Occupational Health Team
 - Sections usually in alphabetical order
- eg:

Administration; Community resources; Company policies; Conditions of service; Disaster plan/evacuation procedure; Emergency procedures; First aid; Hazardous substances; Health education/promotion; Injuries-on-duty; Job descriptions; Legislation; Medical protocol; Medicine control; Nursing procedures; Occupational hygiene; Research; and Safety etc, etc.

- Index

The organisation of the manual is important to make it practical. Different sections can be typed on different coloured pages or the title pages can be of different colours. Tags that show on the sides of the title pages will make sections easily accessible.

The numbering of pages should also be given some consideration in order to make sense as pages are added or deleted. Each

section could be allocated a set of numbers and as pages are deleted the numbers remain unused until another page needs to be inserted.

Samples of records, order and report forms could be inserted in the relevant section to facilitate the orientation of new staff.

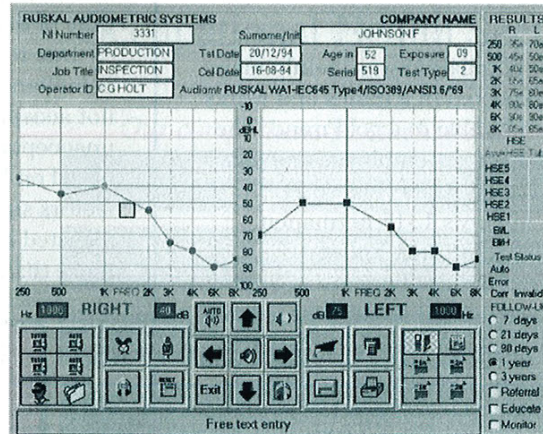
Conclusion

The benefits of a good policy and procedure manual include the standardisation of care and a measure for quality assurance and self audits. It serves as an impressive piece of evidence of the extent of an effective Occupational Health Service.

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Hypertension and compliance

I Viljoen

A retrospective survey was conducted, looking at our Company's* known hypertensives, to determine how many of these employees are compliant. Compliance of hypertensive workers in the workforce has long been considered a problem in this Company.

We defined compliance as the attendance at the Blood Pressure Clinic at work and taking of prescribed medication over a period of six months.

Age in years	Diastolic threshold	and/or	Systolic threshold
Under 30	90		150
30-65	95		160
Over 65	95		165

Figure 1: Definition of hypertension

The WHO definition of hypertension was used as a measure:¹

The study population was mainly male as could be expected in a mines and works situation, comparable to a gold mine. The age distribution of the employees ranged between 19 and 65 years (Figure 2).

Of the Company's 1315 permanent employees 116 (8.8%) are known hypertensives. Of these known hypertensives 63 (54%) are non compliant (Figure 2). A study conducted in 1983² at this Company, proved the percentage of hypertensive patients to be 8.03%. The percentage of hypertensive employees has changed very little, despite natural attrition. This may possibly be attributed to the fact that many of the employees have been with the Company for a number of years and have developed hypertension as they grew older.

The Company's Medical Centre, which operates during normal office hours, provides a monthly Blood Pressure Clinic, which all employees are free to attend. Notification of this clinic's days and times is distributed in two ways:

1. Dates for the whole year's clinics are given to each patient attending the clinic

2. Notices are sent out each month for display on each department's notice board, informing everybody about each particular month's clinic date.

The client is advised on lifestyle changes such as weight reduction, reduction of salt intake, smoking etc., and advice is given regarding any other queries the patient may have. Interpreters are used where necessary and if the blood pressure is considered to be unacceptably elevated, the employee is required to return at least weekly until his blood pressure has stabilised.

Annual medical examinations are carried out on all employees, which also ensures that a good baseline for each worker is maintained and any change in medical condition is noted and attended to where necessary. Most of the present known hypertensives were detected at the time of these annual examinations.

Due to the high level of non-compliance, applicants for positions are not accepted if they are found to have an unacceptably elevated blood pressure, based on WHO criteria, taking into account factors such as stress³, etc. Persons with elevated blood pressure are re-checked on more than one occasion and usually by

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Uranium
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1996; Vol 2, No 4: 24 - 25

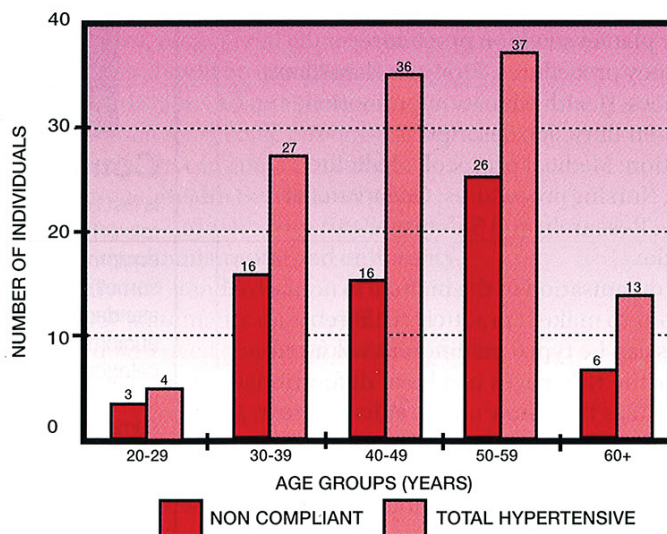


Figure 2: Distribution of hypertensives by age and compliance

more than one staff member. Mild hypertensives are usually accepted for employment, as subsequent monitoring can be done to ensure that, should they need medication, such can be prescribed. Should a candidate state that he is hypertensive, but is taking medication prescribed by his own doctor, the applicant is usually accepted for employment if his blood pressure is found to be stable. The medical staff then request the candidate to attend the monthly Blood Pressure Clinic for monitoring.

This approach to selection criteria aids in preventing a loss of production, an overloading of the Company's medical aid fund, especially its chronic medication scheme and some of the results of uncontrolled hypertension eg. excessive work absence.

The Provident fund is also protected. Should an employee, due to non compliance, eventually go into renal failure, have a stroke, affected eyesight etc, the employee will be put onto ill health retirement, becoming an added financial burden to the other contributors.

I wish to thank ERGO Management for permission to publish.

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Correction

With apologies for the oversight Dr J T Mets the author of "Haematological reference values for biological monitoring of employees exposed to inorganic lead in South Africa", which was published in the May/June 1996 issue of Occupational Health Southern Africa (Vol 2 No3: 8-13), has notified the Editor that an error appeared on page 10.

Referring to the work of Williams (ref¹) and quoting: "Converted to present day terminology his formula to calculate the 'corrected lead in blood concentration' would read"...

The formula given after this section of the text should read as follows:

$$\frac{46}{\text{Observed Hct}} \text{ or } \frac{146}{\text{Observed Hb}} \text{ times Observed Pb-B}$$

Of historical interest is that Williams proposed to "standardise" observed blood lead levels by dividing the observed blood lead level by the observed Haemoglobin level of the individual expressed as a percentage of normal e.g.: If the observed Haemoglobin value was 70% of normal and the observed Pb-B was 80 µg/100 ml, the standardised value, for clinical consideration, would be 80 divided by 70/100, equals 114 µg/100ml.

The formula given on page 12, for present day usage, is correct.

Dr JT Mets

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The control of alcohol abuse in industry

provides substantial health and safety benefits

Because the effects of alcohol abuse in the workplace impact negatively in the areas of safety and health, considerable benefits can be achieved by controlling them, and they should be of utmost concern to all organisations. The problem is generalised, varying only in severity from one organisation to the next. This concern should be shared by both management and workers - not only because the toll in human suffering through injuries and deaths is unacceptable, but because of the other alcohol related losses which affect the welfare of both the organisation and its employees.

The negative effects of alcohol interact with, and compound each situation. For example any injury arising from an alcohol-related accident gives rise to a health problem for the individual concerned, and this will also impact on the company. Conversely, alcohol contributes to problems in work performance and target organ damage, which can contribute to accidents as well.

What is the significance of alcohol's involvement in industrial accidents?

At a recent COSATU¹ sponsored safety and health conference the following was revealed:

For every day in South African industry on average

5 people die from injuries received

430 people are injured

52 people are permanently disabled

This undesirable and destructive state of affairs should not be allowed to continue.

Studies² show that between 20% and 40% of industrial accidents are alcohol related. A SANCA random survey³ indicated that of all persons in industry identified as "troubled", there was an alcohol involvement in 11% to 59% of cases. This compares closely with a similar American study which indicated a mean figure of 28%³.

The impact of alcohol abuse in industrial health is considerable

The company clinic is often the first place where the extent of alcohol involvement is first quantified. Here, similar figures to those for accidents are noted with alcohol's involvement in 20% to 40% of injuries. Blood alcohol measurements have shown that alcohol may be involved in up to 60% of deaths.⁴

Many other less obvious and adverse effects of alcohol consumption on employees' health occur.

Vision

Alcohol affects both the lateral field of vision and depth perception. At a recent study,⁵ intoxicated persons revealed up to a 44% deterioration after consumption and five hours later a 16% deterioration was still evident.

Blood pressure

Alcohol abuse remains a common associative cause of raised blood pressure, being three times more common in heavy drinkers than in the general population.

Gastric problems

The majority of the recurring unidentified cases of short term gastrointestinal problems are attributable to alcohol excess.⁶

Muscular/skeletal effects

Long-standing heavy drinkers often have weak muscles especially abdominal, as a result of disuse and injury.⁷ This gives rise to a higher than normal incidence of lower back pains and other problems.

Respiratory problems

There is a higher incidence of recurring chronic chest infections and tuberculosis through excessive alcohol depressing the immune system.⁷

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1996, Vol 2, No 4: 27-28*

Other well documented effects are dizziness, black outs and enhanced fatigue, whilst on the emotional side, depression, mood swings, irritability, nervousness, over-sensitivity to criticism and paranoid tendencies are well documented.

What steps can be taken to improve the situation?

1. Prevent accidents.

Historically, attention is normally paid to the problems arising from alcohol abuse either after an accident or incident has occurred or after a person is observed to be inebriated.

It is difficult to detect the degree of intoxication of individuals, by observation, and experienced drinkers hide the effects of alcohol.

2. The use of reliable breath alcohol detectors at site entrance points on a random basis can not only deter and prevent intoxicated persons from entering the workplace, but can further be used to educate personnel who may not be aware of the alcohol levels they attain. They should also be used to retest previous offenders on a regular but diminishing basis.

3. Incorporate an alcohol safety program. Few organisations pay serious or sufficient attention to alcohol problems when compared to efforts applied in other safety and health sensitive areas.

4. Various alcohol policy models are now available and they can be adapted for specific circumstances. Obtain agreement on the policy through negotiations between management and workers. This should create a basis for consistency and fairness.

Follow this with a program which would include:

The training of supervisors to understand the policy and the practical items involved. They must be able to explain the policy to the employees and know what action to take. Educate employees as to the dangers of alcohol abuse and the effect alcohol has on them. They must understand the reason for the policy, its disciplinary code and the consequences of transgressing it to provide assistance to troubled employees where possible, and ensure that they know what assistance is available.

What can be achieved?

A Natal pulp mill developed and negotiated an alcohol policy/program incorporating random testing utilising breath alcohol detectors at site entrance points.⁷

Simultaneously and without introducing any additional special safety programs, disabling and non-disabling injuries were reduced by around 50% (Figure 1).

Those organisations who have applied these methods, and conducted intensive campaigns have, within a period of months, realised substantial improvements and benefits. The payoffs are many, and go well beyond the areas of health and safety.

Bonus benefits gained in other areas include improved productivity and product quality; improved management-employee relationships; reduced equipment down-time and replacement costs; absenteeism; health care costs; late arrivals; violence and theft.

References

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4. De Miranda - (SANCA) 'Alcoholism: the incidence, treatment and rehabilitation - South African "perspective" 1988. (Actually states more than 50% of all South African fatal traumatic injuries are alcohol related.)
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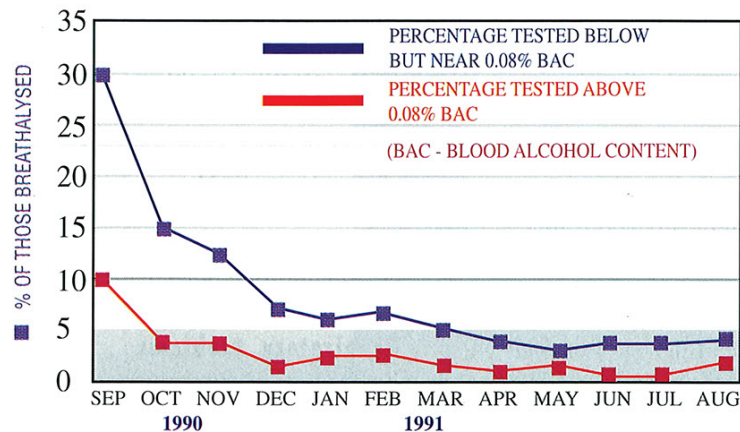


Figure 1: After the introduction of testing, disabling injuries were reduced by 52.3% and non disabling injuries by 44.6%.

Clinic permit system

Representatives from SASOHN and SASOM met with Mr Pharasi, Chief Director in the Department of Health as well as other senior members of the Department on 14 May concerning the frustrations experienced by industry relating to the permit system. These include

- Enormously long delays in granting permits. In some instances people have been waiting over two years for a response
- Lack of feedback on clinic inspections

There are several different bodies involved in getting a permit approved and it would appear that the hold-up lies at provincial level, especially Gauteng and Northern Province. It is recommended that people who experience problems go directly to the MEC.

Unfortunately it appears that in some areas there is little appreciation of what industry is doing as regards providing Primary Health Care, especially for people who are not members of a medical aid scheme, thus reducing the load on the state service.

Some of the criteria applied by the department include:

1. Must be a bona fide service, i.e. linked to an industrial/occupational environment.
2. Must be the exception and not the norm.
3. Must not disrupt private health care providers.



Prof Olga Venter, Group Manager Nursing, Goldfields and Mr Marius Fourie, Pharmaceutical Services, Department of Health



From left Dr Gudrun Dammefeldt, SANA; Dr C Fölscher, Chief Nursing Services Manager; Sister Bev Hoggins (back) and Sister Shirley Hall both of SASOHN

Provinces are free to add their own criteria. It does appear that some of the several bodies concerned appear to be applying a rigid application of the existing and sometimes unsatisfactory laws, particularly as regards items 2 and 3 above.

Both societies have indicated their support for the recently published Standard Treatment Guidelines and Essential Drug list. It is also agreed that nurses who dispense medicines must have the necessary competence. Until further details on accredited courses are available it is suggested that nurses complete a pharmacology course recognised by SANA, and which pertains to the Essential Drug List

A further meeting is planned for September. In summary, therefore, until there is clarity on the criteria of issuing of permits/licences, it is suggested that people who are experiencing delays in the granting of their permits approach the local MECs directly.

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Mobile Occupational Medicine

Screening services on-site for occupational medicine has always been a part of occupational health practice in South Africa. Mobile Occupational Medicine was established as a part of one of the largest occupational health consultancies in South Africa during 1990 to satisfy the need in the marketplace for micro and small industries. The service however grew so rapidly that MoM became a legal entity in its own right in 1994. MoM now services more than 100 clients per annum ranging from Micro (<10 employees) to large (<1000 employees) organisations.

The principles of SABS quality systems are followed throughout. Regular contact with clients facilitate open communication. MoM is committed to legendary service, lifetime clients and a sustainable industry.

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- Pathology services
- Electrocardiograms
- Full medical examinations

For further information contact Lizelle, tel: (012) 46-5490

Occupational therapy open week

The Rand Mutual Hospital's occupational therapy department participated once again in the National Occupational Therapy open week; 12-17 May 1996. The open week provides a golden opportunity to promote our profession not only to our colleagues, but to the general public as well.

Occupational therapy plays a major role in restoring the patient to health, the principle of health being to place the patient back into the community at the optimum level of function.



Leana de Jager nominated as Occupational Therapist of the year Gauteng South area

The Rand Mutual Hospital's Occupational Therapy department has a fully equipped workshop and six specialized therapy areas. Treatment is provided for patients with physical and psychological conditions, and the healthy

worker is also included, with work assessments and preventative care. Diagnoses of patients seen in our department include spinal cord and head injuries; orthopaedic injuries; burns; the blind; CVA; rheumatoid and osteoarthritis and psychiatric conditions.

Our profession has expanded into the occupational health and safety sphere, where we offer work visits; stress management; ergonomics; and the handling and placement of the 'problem' worker (e.g. back injury).

Visitors are most welcome, and appointments may be made with Leana de Jager, Control Occupational Therapist, by telephoning (011) 493-4300: pager 56

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ICOH membership

The latest membership directory (1995) of the International Commission on Occupational Health has been received and it is of interest to note that:

- There are 24 South African members
- SASOM is an affiliate member and has been since 1972
- There are some South Africans who serve on some of the (30) ICOH Scientific committees, namely:

Chemical industry - Dr M Coombs

Fibres - Prof A Coetzee and Prof I Webster

Health services research and evaluation - Prof J Myers

Occupational health nursing - Mrs J Acutt, Mrs S Coetzee and Mrs J Serfontein

The official South African representative is:

Dr FCA Smith
Department of Community Health
University of Pretoria
PO Box 667
Pretoria

0001
Tel (012) 323-5394

Fax: (012) 323-8534

If anybody wishes to join the ICOH, they should contact Dr F Smith

Health Educational Services

Since 1990 Tine and Nelly van der Maas have been lecturing on AIDS in schools, youth groups, factories, businesses, farms, churches and informal settlements - to people of all walks of life. Tine, an artist and nursing sister, and Nelly, a social worker, designed their own programme as there was not much available to explain this "difficult to understand disease" to the man in the street.

The programme consists of a set of 10 illustrative posters and a manual, dealing with all basic facts of TB, HIV/AIDS, STDs and How to Use a Condom. The posters (size 500 x 700mm) are:

- Easily understood by all - the most simple text in any of the SA languages is used with each picture. (Now available in English, Afrikaans, Xhosa and Zulu, but will be available in other languages when there are enough requests)

- Either to be used as flip charts, lecturing aids or for self-education.

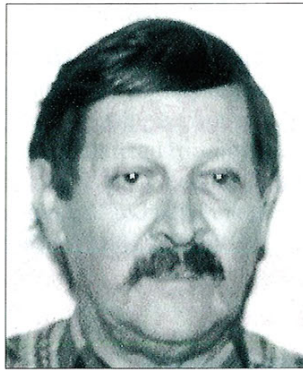
The programme has been approved by the Department of National Health and the Health Department of the Common Wealth. Some people comment that the programme is too simple, too easy to understand. Tine and Nelly reply - "Why not?" When lecturing, more difficult information can be added from the manual. But the best measure of the programme's success is the smile of understanding as the people grasp the information.

Phil Piek

Phil started in Occupational Health by chance at the time of the Erasmus Commission. Predictably the recommendations of the Commission have not been implemented while Phil realized the severe lack of knowledge concerning Occupational Health in the camps of Government, organised labour, employers and sadly the Academia.

Phil initiated Occupational Health Services in more than 130 Company Clinics utilizing an occupational health nurse. Apparently all these Clinics are still functioning today. During 1982 Phil's role changed from being the day-to-day company doctor to that of an Occupational Health Advisor to both the mining industry and the non-mining industry.

Teaching has always been a very important part of Phil's life (extending to marrying one of his students!) Phil has taught Occupational Health at the University of Pretoria and is presently Head of Occupational Health at the University of the Orange Free State. He has initiated a distance learning programme for the Diploma in Occupational Health which is completed over a two year period.



The first group of 10 doctors qualified last year and there are already 43 applicants for 1997. There is one contact session in Bloemfontein each year to discuss principles and problem-solving and candidates at present also write their final exams in Bloemfontein.

He is also assisting the Department of Community Health, Natal University in teaching post graduate Occupational Health. Work that he really enjoys is teaching Occupational Health to nurses and under graduate medical students (third year, fourth year and final year).

Over and above his teaching, he is an advisor to various Governmental, non-governmental and private organisations as well as community development projects.

Phil is far more optimistic about the future of Occupational Health than he was in the post Erasmus Commission era. The reason for this is that the Government of National Unity has targeted Occupational Health as one of the country's health priority areas.

Phil and his family are happy in their new surroundings (already 4½ years) and the family's cricket loyalties lie with VRYSTAAT!

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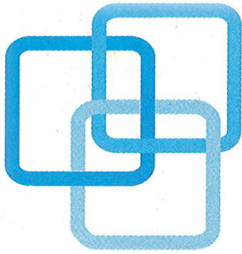
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This directory will appear on the last page of every issue of Occupational Health Southern Africa.
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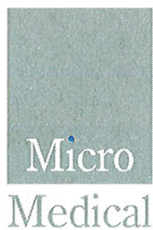
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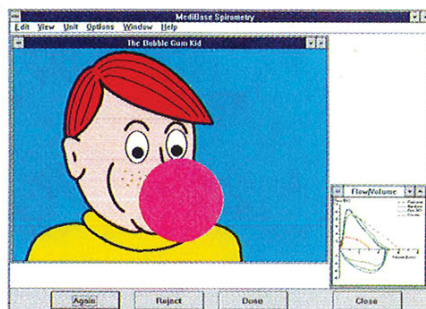
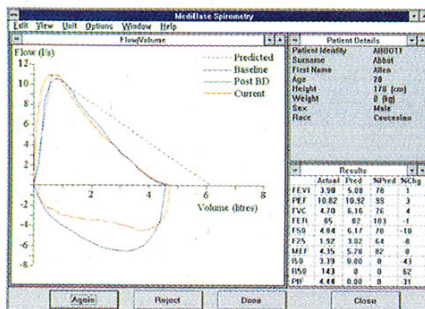
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