AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH
PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL
SETTINGS: A NURSING PERSPECTIVE

by

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FEBRUARY 2002
DECLARATION

I declare that **AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL SETTINGS: A NURSING PERSPECTIVE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature: [Signature]

(AA Huiskamp)

Date: 30 September 2002
SUMMARY

AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL SETTINGS: A NURSING PERSPECTIVE

This research is aimed at furthering the health promotion and occupational health objectives of the government as is set out in the "The White Paper for the Transformation of the Health System in South Africa Notice 667 of 1997".

The aim of this research was to determine the need for occupational health promotion programmes in selected occupational settings from a nursing perspective.

The overall outcome of this research demonstrated that a need exists for occupational health promotion programmes in selected occupational settings. This was illustrated by the literature study and by the information collected through a survey.

Three frameworks are proposed, namely a holistic approach to an occupational health promotion programme, an empowerment occupational health promotion approach, and a health promoting nursing framework. In addition, guidelines for the development and implementation of an occupational health promotion programme and a health promotion and health promoting nursing training programme are recommended. It is also recommended that health promoting nursing be included in all nursing practice and nursing training curricula.

Recommendations for future research centred on the investigation of the present status of occupational health promotion, research regarding the health promoting workplace and campus that involves all stakeholders, the status of health promotion training, and research similar to this one in other regions of South Africa. The division of occupational health and primary health care in occupational health settings needs to be investigated as well.

Key terms:

Health promotion, occupational health promotion, nursing perspective, empowerment, workplace health promotion, the health promoting workplace and health promoting nursing.
Hierdie navorsing het die bevordering van die regering se gesondheidsbevorderingsdoelwitte soos vervat in die Witskrif vir die Transformasie van die Gesondheidsstelsel in Suid-Afrika, Kennisgewing 667 van 1997 (White Paper for the Transformation of the Health System in South Africa Notice 667 of 1997) ten doel.

'n Verdere doel was om die behoefte na beroepsgesondheidsbevorderende programme in geselekteerde beroepsituasies vanuit 'n verpleegkundige perspektief vas te stel.

Die resultate van hierdie navorsing het aangedui dat daar 'n behoefte bestaan aan beroepsgesondheidsbevorderende programme in geselekteerde beroepsituasies. Hierdie behoefte is vasgestel deur middel van die literatuurstudie en deur die versameling van inligting deur middel van 'n opname.

'n Holistiese en bemagtigingsbenadering tot beroepsgesondheidsbevorderende, asook 'n gesondheidsbevorderende verplegingsbenaderingsraamwerk word voorgestel. Addisioneel word riglyne vir die ontwikkeling en implementering van beroepsgesondheidsbevorderings-programme asook 'n gesondheidsbevorderende verpleegopleidingsprogram voorgestel. Daar word aanbeveel dat gesondheidsbevorderende verpleegkunde ingesluit word in alle verpleegkunde praktyke en verpleegkunde kurrikula.

Aanbevelings ten opsigte van toekomstige navorsing sentreer rondom 'n ondersoek na die huidige status van beroepsgesondheidsbevordering, navorsing met betrekking tot die gesondheidsbevorderende werkplek en kampus – wat alle belanghebbendes insluit – die status van gesondheidsbevorderende opleiding; en navorsing gelyksoortig aan hierdie een in ander streke van Suid-Afrika. Die skedeling tussen beroeps- en primêre gesondheidsorg in werkplekke behoort ook ondersoek te word.

**Sleutelbegrippe:**

Gesondheidsbevordering, beroepsgesondheidsbevordering, verpleegkundige perspektief, bemagtiging, werkplek, gesondheidsbevordering, die gesondheidsbevorderende werkplek en gesondheidsbevorderende verpleging.
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# Table of contents

## Chapter 1

**Orientation to the research** ............................................................. 1

1.1 INTRODUCTION ................................................................. 1

1.2 BACKGROUND TO THE RESEARCH PROBLEM ............................... 2

1.2.1 The process of transformation in the workplace ....................... 2

1.2.2 Health promotion and occupational health within the National Health System .......................... 5

1.2.3 Health promoting nursing ................................................. 7

1.3 RATIONALE FOR THE RESEARCH ............................................ 8

1.4 PROBLEM STATEMENT ....................................................... 8

1.5 SIGNIFICANCE OF THE PROBLEM .......................................... 9

1.6 RESEARCH QUESTIONS ....................................................... 10

1.7 AIM OF THE RESEARCH ....................................................... 11

1.8 ASSUMPTIONS ................................................................. 12

1.9 DEMARCATION OF THE RESEARCH ......................................... 13

1.10 RESEARCH METHODOLOGY .................................................. 13

1.11 CLARIFICATION OF CONCEPTS USED IN THIS RESEARCH .............. 14

1.12 OUTLINE OF THE RESEARCH ............................................... 16

1.13 CONCLUSION ................................................................. 17

## Chapter 2

**Literature review** ................................................................. 18

2.1 INTRODUCTION ................................................................. 18

2.2 HEALTH PROMOTION: A CONCEPTUAL ANALYSIS .......................... 19
# Table of contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 What is health?</td>
<td>19</td>
</tr>
<tr>
<td>2.2.2 What is promotion?</td>
<td>20</td>
</tr>
<tr>
<td>2.2.3 What is health promotion?</td>
<td>20</td>
</tr>
<tr>
<td>2.3 THE OTTAWA CHARTER AS THE CORNERSTONE OF HEALTH PROMOTION</td>
<td>23</td>
</tr>
<tr>
<td>2.4 EMPOWERMENT/PRINCIPLES/VALUES-ORIENTED HEALTH PROMOTION</td>
<td>29</td>
</tr>
<tr>
<td>2.5 THE RATIONALE BEHIND OCCUPATIONAL HEALTH PROMOTION</td>
<td>33</td>
</tr>
<tr>
<td>2.5.1 International trends and strategies</td>
<td>33</td>
</tr>
<tr>
<td>2.5.2 The global strategy on occupational health for all: the way to health at work</td>
<td>34</td>
</tr>
<tr>
<td>2.5.3 The workplace as a setting</td>
<td>35</td>
</tr>
<tr>
<td>2.5.4 Benefits of occupational health promotion programmes</td>
<td>36</td>
</tr>
<tr>
<td>2.5.5 Health promotion as an integral part of health care in South Africa</td>
<td>37</td>
</tr>
<tr>
<td>2.6 THE HEALTH PROMOTING WORKPLACE</td>
<td>38</td>
</tr>
<tr>
<td>2.6.1 Employment and health</td>
<td>38</td>
</tr>
<tr>
<td>2.6.2 Occupational health promotion approaches</td>
<td>39</td>
</tr>
<tr>
<td>2.6.3 What are the components of a comprehensive occupational health promotion programme?</td>
<td>42</td>
</tr>
<tr>
<td>2.6.3.1 Holistic view to health and health needs</td>
<td>42</td>
</tr>
<tr>
<td>2.6.3.2 Employee assistance programme</td>
<td>43</td>
</tr>
<tr>
<td>2.6.3.3 Women's health issues</td>
<td>43</td>
</tr>
<tr>
<td>2.6.3.4 Child day care</td>
<td>44</td>
</tr>
<tr>
<td>2.6.3.5 Parenting education programme</td>
<td>44</td>
</tr>
<tr>
<td>2.6.3.6 Well person screening/disease detection</td>
<td>45</td>
</tr>
<tr>
<td>2.6.3.7 Diverse programmes</td>
<td>45</td>
</tr>
<tr>
<td>2.6.3.8 Occupational health and safety programme</td>
<td>46</td>
</tr>
<tr>
<td>2.6.3.9 Affirmative action policy and programme</td>
<td>47</td>
</tr>
<tr>
<td>2.6.3.10 Social responsibility programme</td>
<td>47</td>
</tr>
<tr>
<td>2.6.4 Successful programme development, organisation and management</td>
<td>48</td>
</tr>
<tr>
<td>2.7 NURSING, HEALTH PROMOTION AND TRAINING</td>
<td>50</td>
</tr>
<tr>
<td>2.7.1 Role of the nurse in workplace health promotion</td>
<td>50</td>
</tr>
<tr>
<td>2.7.2 Training needs</td>
<td>53</td>
</tr>
<tr>
<td>2.8 CONCLUSION</td>
<td>55</td>
</tr>
</tbody>
</table>
Chapter 3

Research design and methodology ........................................ 56

3.1 INTRODUCTION ....................................................... 56

3.2 RESEARCH DESIGN .................................................. 57

3.2.1 Selected design .................................................. 57
3.2.2 Rationale for choice of design ..................................... 59

3.3 RESEARCH METHOD ................................................ 59

3.3.1 Motivation for the use of the survey method ...................... 60
3.3.2 Population and sample ........................................... 61

3.3.2.1 Population .................................................... 61
3.3.2.2 The sample .................................................. 62
3.3.2.3 Sampling process ............................................. 62
3.3.2.4 Problems encountered in sampling ............................ 64
3.3.2.5 The setting .................................................... 64
3.3.2.6 Ethical considerations ........................................ 65

3.4 RESUMÉ OF THE STEPS THAT WERE FOLLOWED .................... 66

3.4.1 Conceptual phase .................................................. 66
3.4.2 Empirical phase ................................................... 66

3.5 DATA COLLECTION .................................................. 67

3.5.1 Choice of measurement instrument .................................. 67
3.5.2 Development of the questionnaire ................................... 68
3.5.3 Content of the questionnaire ....................................... 69
3.5.4 Distribution and collection of the questionnaire ................... 71
3.5.5 Responses to the measurement instrument ......................... 72

3.6 DATA ANALYSIS ..................................................... 73

3.7 VALIDITY AND RELIABILITY ....................................... 73

3.8 CONCLUSION .......................................................... 74
### Table of contents

<table>
<thead>
<tr>
<th>Chapter 4</th>
<th>Analysis and presentation of research findings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Table of contents</strong></td>
</tr>
<tr>
<td>4.1</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>4.2</td>
<td>EVALUATION OF DATA QUALITY</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Validity</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Reliability</td>
</tr>
<tr>
<td>4.3</td>
<td>ANALYSIS AND PRESENTATION OF DATA GENERATED BY THE QUESTIONNAIRE</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Section 1: The sample</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Section 2: The meaning of the concept health promotion</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Section 3: The contents, organisation and management of a comprehensive occupational health promotion programme</td>
</tr>
<tr>
<td>4.3.4</td>
<td>Section 4: General data about health promotion in the respondent's place of work</td>
</tr>
<tr>
<td>4.3.5</td>
<td>Section 5: Data on the disease and sick leave profile in the respondent's place of work</td>
</tr>
<tr>
<td>4.3.6</td>
<td>Section 6: Role of the nurse in health promotion and health promotion learning needs</td>
</tr>
<tr>
<td>4.4</td>
<td>CONCLUSION</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 5</th>
<th>Conclusions, limitations, recommendations and concrete proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Table of contents</strong></td>
</tr>
<tr>
<td>5.1</td>
<td>INTRODUCTION</td>
</tr>
<tr>
<td>5.2</td>
<td>CONCLUSIONS</td>
</tr>
<tr>
<td>5.2.1</td>
<td>Research objectives 1 and 2: The meaning of the concept health promotion</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Research objectives 3 and 4: The contents, organisation and management of a comprehensive occupational health promotion programme</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Research objective 5: Identification and description of the rationale behind occupational health promotion</td>
</tr>
<tr>
<td>5.2.4</td>
<td>Research objective 6: Exploration and description of the role of the nurse in occupational health promotion</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>5.2.5</td>
<td>Research objective 7: Exploration and description of the health promotion learning needs of nurses</td>
</tr>
<tr>
<td>5.2.6</td>
<td>Research objective 8: Identification and description of the need for occupational health promotion programmes</td>
</tr>
<tr>
<td>5.3</td>
<td>LIMITATIONS OF THE RESEARCH</td>
</tr>
<tr>
<td>5.4</td>
<td>RECOMMENDATIONS</td>
</tr>
<tr>
<td>5.4.1</td>
<td>Recommendations regarding a paradigm shift in occupational health nursing</td>
</tr>
<tr>
<td>5.4.2</td>
<td>A proposed empowerment approach</td>
</tr>
<tr>
<td>5.4.3</td>
<td>Recommended guidelines for the development and implementation of an occupational health promotion programme</td>
</tr>
<tr>
<td>5.4.4</td>
<td>Training</td>
</tr>
<tr>
<td>5.4.5</td>
<td>A proposed framework for health promoting nursing</td>
</tr>
<tr>
<td>5.5</td>
<td>RECOMMENDATIONS FOR FUTURE RESEARCH</td>
</tr>
<tr>
<td>5.6</td>
<td>CONCRETE PROPOSALS</td>
</tr>
<tr>
<td>5.7</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>5.8</td>
<td>CONCLUSION</td>
</tr>
<tr>
<td></td>
<td>LIST OF SOURCES</td>
</tr>
<tr>
<td>Table 4.1:</td>
<td>Content of an occupational health promotion programme</td>
</tr>
<tr>
<td>Table 4.2:</td>
<td>Other qualifications (N=21)</td>
</tr>
<tr>
<td>Table 4.3:</td>
<td>Meaning of the concept health promotion (N=63)</td>
</tr>
<tr>
<td>Table 4.4:</td>
<td>Ten most important topics/activities in the content of an OHPP (N=64)</td>
</tr>
<tr>
<td>Table 4.5:</td>
<td>The ten least important topics/activities in an OHPP (N=64)</td>
</tr>
<tr>
<td>Table 4.6:</td>
<td>Special investigations (N=62)</td>
</tr>
<tr>
<td>Table 4.7:</td>
<td>Presentation methods (N=64)</td>
</tr>
<tr>
<td>Table 4.8:</td>
<td>Potential benefits of an OHPP for employees (N=64)</td>
</tr>
<tr>
<td>Table 4.9:</td>
<td>Potential benefits of an OHPP for employers (N=64)</td>
</tr>
<tr>
<td>Table 4.10:</td>
<td>Responses per hour per level of care (N=62)</td>
</tr>
<tr>
<td>Table 4.11:</td>
<td>Responses: level of care per size of workplace (N=59)</td>
</tr>
<tr>
<td>Table 4.12:</td>
<td>Number of employees ill during 1998 per workplace size (N=49)</td>
</tr>
<tr>
<td>Table 4.13:</td>
<td>Number of lost working days per size of workplace (N=48)</td>
</tr>
<tr>
<td>Table 4.14:</td>
<td>Roles of the nurse in health promotion in the workplace (N=60)</td>
</tr>
<tr>
<td>Table 4.15:</td>
<td>Health promotion learning needs (N=59)</td>
</tr>
<tr>
<td>Table 4.16:</td>
<td>Motivations for wanting to learn about health promotion (N=43)</td>
</tr>
<tr>
<td>Table 5.1:</td>
<td>A proposed framework for an empowerment occupational health promotion approach</td>
</tr>
</tbody>
</table>
List of figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 4.1</td>
<td>Scree Plot from the factor analysis</td>
<td>77</td>
</tr>
<tr>
<td>Figure 4.2</td>
<td>Factor analysis of the findings</td>
<td>78</td>
</tr>
<tr>
<td>Figure 4.3</td>
<td>Occupational setting of the respondents (N=63)</td>
<td>84</td>
</tr>
<tr>
<td>Figure 4.4</td>
<td>Highest qualification (N=64)</td>
<td>85</td>
</tr>
<tr>
<td>Figure 4.5</td>
<td>Additional qualifications (N=60)</td>
<td>86</td>
</tr>
<tr>
<td>Figure 4.6</td>
<td>Gender distribution (N=62)</td>
<td>87</td>
</tr>
<tr>
<td>Figure 4.7</td>
<td>Age (N=64)</td>
<td>88</td>
</tr>
<tr>
<td>Figure 4.8</td>
<td>Years of experience of the respondents (N=64)</td>
<td>89</td>
</tr>
<tr>
<td>Figure 4.9</td>
<td>The next five most important topics/activities</td>
<td>97</td>
</tr>
<tr>
<td>Figure 4.10</td>
<td>Levels of intervention (N=64)</td>
<td>117</td>
</tr>
<tr>
<td>Figure 4.11</td>
<td>Health promotion programme at place of work (N=61)</td>
<td>120</td>
</tr>
<tr>
<td>Figure 4.12</td>
<td>Need for an occupational health promotion programme at workplace (N=61)</td>
<td>121</td>
</tr>
<tr>
<td>Figure 4.13</td>
<td>Adverse influence of workplace (N=61)</td>
<td>123</td>
</tr>
<tr>
<td>Figure 4.14</td>
<td>Training in health promotion (N=63)</td>
<td>131</td>
</tr>
<tr>
<td>Figure 4.15</td>
<td>Need to learn more about health promotion (N=63)</td>
<td>132</td>
</tr>
<tr>
<td>Figure 4.16</td>
<td>Preferred methods of learning (N=41)</td>
<td>135</td>
</tr>
<tr>
<td>Figure 5.1</td>
<td>A proposed holistic approach to an occupational health promotion programme</td>
<td>147</td>
</tr>
<tr>
<td>Figure 5.2</td>
<td>A proposed framework for health promoting nursing: nursing a community</td>
<td>152</td>
</tr>
</tbody>
</table>
## List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>EAP</td>
<td>Employee assistance programme</td>
</tr>
<tr>
<td>HP</td>
<td>Health promotion</td>
</tr>
<tr>
<td>OHPP</td>
<td>Occupational health promotion programme</td>
</tr>
<tr>
<td>RDP</td>
<td>Reconstruction and Development Programme</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>Unisa</td>
<td>University of South Africa</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WHP</td>
<td>Workplace health promotion</td>
</tr>
</tbody>
</table>
### List of addendums

<table>
<thead>
<tr>
<th>Addendum A:</th>
<th>Questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addendum B:</td>
<td>Cover letter to the questionnaire</td>
</tr>
<tr>
<td>Addendum C:</td>
<td>Letter of request for permission to undertake the study</td>
</tr>
<tr>
<td>Addendum D:</td>
<td>Letter of permission from the City Council of Pretoria</td>
</tr>
<tr>
<td>Addendum E:</td>
<td>Letter of permission from Nampak Paper</td>
</tr>
<tr>
<td>Addendum F:</td>
<td>Letter of permission from Technikon Northern Gauteng</td>
</tr>
<tr>
<td>Addendum G:</td>
<td>Letter of permission from the University of Pretoria</td>
</tr>
</tbody>
</table>
CHAPTER 1

Orientation to the research

1.1 INTRODUCTION

This chapter provides an orientation to the research. It is within the health promotion framework that this research investigates the need for occupational health promotion programmes in selected occupational settings from a nursing perspective.

This research is aimed at identifying, according to a nursing perspective, the need for occupational health promotion programmes in selected occupational settings. Occupational health and safety are based on the premise that all workers have the right to a healthy and safe working environment. To create this environment a multi-disciplinary team is involved in rendering a multi-faceted service.

Occupational and campus health nurses form part of the team that is responsible for the health and well-being of the employees and students and at the same time, are also employees themselves. However, the occupational and campus health nurses are also
independent practitioners within their own nursing practice. The traditional practice of occupational health and safety, occupational and campus health nursing is no longer sufficient to meet the needs of the present day employees/students in the workplace, campus setting and to create healthy organisations.

A broader and more creative approach is necessary encompassing different management activities and programmes in the workplace. The achievement of occupational health for all, or indeed health for all, cannot solely be the responsibility of the government. It can only become a reality through the commitment of all stakeholders such as government, employers, corporations, business, employees and the wider community.

In the following section (see 1.2 background to the research problem) an overview to the research problem is provided.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The background overview discusses the contemporary transforming workplace, the position of health promotion in the National Health System of South Africa (White Paper for the Transformation of the Health System (South Africa 1997) as well as health promotion as an approach to nursing.

1.2.1 The process of transformation in the workplace

The democratisation process in South Africa since the early 1990s has brought about changed landscapes in all facets of the processes, structure and organisation of the South African society, including the workplace and the health care delivery system. The contemporary workplace in South Africa has undergone many changes and is still transforming through new and changed laws such as the Employment Equity Act 55 of 1998 (South Africa 1998a), Basic Conditions of Employment Act 75 of 1997 (South Africa 1997a), the amended Occupational Health and Safety Act 85 of 1993 (South Africa 1993) and the Skills Development Act 97 of 1998 (South Africa 1998b). Through the affirmative action policy many more South Africans of colour, women, and people with disabilities are now employed and are in managerial positions.
Changes in the workplace and prevailing conditions in the transforming society of South Africa have lead to many threats to health in the workplace and in society in general. Change in itself is a major stressor and a threat to health. Many employees are uncertain about job security, are subjected to unfavourable working conditions, feel alienated, or are not adequately trained for the positions they occupy. Changes have also occurred in the health care system with than extended focus on primary health care as the many approach to health care delivery.

Features of the contemporary South African workplace and workforce include a high rate of unemployment, retrenchment of workers due to rationalisation, multi-skilled people leaving to work abroad or start their own businesses, and shortages of people with certain skills such as in the managerial and information technology market.

It is assumed that the contemporary South African workplace is not a health promoting workplace because it is characterised \textit{inter alia} by:

- Conflict and violence, which is a feature resulting from abuse of power, often create racial tensions because certain groups of workers feel threatened, experience fear of losing their jobs, experience a lack of a shared work culture, and are exposed to excessive affirmative action.

- Excessive union activities, that is, through demand setting and strikes contribute to tension and conflicts.

- High levels of stress due to lack of training and support for persons appointed in affirmative action positions, global competitiveness, performance demands and changes.

- Job dissatisfaction due to politicising of actions, racism, discrimination and a non-caring environment in general.

- Non-compliance of many workplaces with the legal requirements of the Occupational Health and Safety Act No 85 of 1993 (South Africa 1993). Many workplaces
have come under fire over the last year for endangering the lives of their employees and/or compromising their health through unsafe and unhealthy working conditions.

- Physical aspects of the work environment receiving more consideration than the psycho-social aspects of the work environment.

- Diverse needs of the worker and the worker as a holistic human being not being addressed.

- Lack of adequate occupational health services being a feature of many smaller industries. Occupational health and safety services are also fragmented.

- Transformation of the workplace being seen as revolutionary instead of evolutionary and resulting in a negative impact on the morale of the workers and the organisation.

- A shortage of skilled and trained personnel especially in the health services, leading to great work loads and pressure which has a negative influence on health. Many South African health professionals seek employment in other countries to improve their quality of life through better salaries and working conditions.

- Public health problems such as abuse of alcohol and drugs, and HIV/AIDS creates a great strain on and challenge to employers and fellow workers.

Since the early 1990s South Africa is irrevocably part of the global community and an emerging economic market. To promote sustainable economic development and to be a global economic competitor, human resources need to be developed and productivity increased. To this end a healthy and happy workforce is vital. This can be achieved through transforming the workplace into a caring and health promoting environment in which human potential, including health potential, can flourish.

Large, medium and small workplaces are not only legally required to create healthy workplaces, but can also contribute to promoting the health of employees, their families
and students so as to contribute to the attainment of the goal of Health for All (WHO 1988:14).

1.2.2 Health promotion and occupational health within the National Health System

Health promotion is gaining momentum worldwide, not only in the developed countries, but also in the developing countries, although to a lesser extent in the latter.

Through the initiatives of the World Health Organization (WHO) (1986,1994), governments, non-governmental organisations, business, and communities themselves, health promotion programmes are being implemented worldwide. The health promotion movement is supported and enforced by public health policy and legislation in South Africa as is illustrated in, for example, the "No Smoking Policy" in public places which include the workplace, the provision of housing and safe, clean water, amongst others.

In addition, the Directorate for Health Promotion and Communication of the National Department of Health is responsible for ensuring that opportunities for health promotion are maximised in all settings and in relation to all topics (White Paper for the Transformation of the Health System) (South Africa 1997b:19). The need for health promotion in occupational and campus settings are thus confirmed by this responsibility.

The National Health Department of South Africa’s vision of health includes the improvement of health through equitable social and economic development, the right of every person to achieve optimal health, through primary health care and a single comprehensive, equitable and integrated National Health System. In addition, the provision of health care will be co-ordinated among national, provincial and district authorities and unite with non-governmental organisations and the private sector to realise common goals (White Paper for the Transformation of the Health System) (South Africa 1997b:14).

One of the goals and objectives of the National Health System is the development of health promotion activities with emphasis on the following aspects which are particularly relevant to this research:
promotion of a healthy environment
improvement of the psychological well-being of people and communities
reducing alcohol and drug abuse, with particular emphasis on tobacco, glue, marijuana, cocaine, Mandrax and heroin
promotion of healthy behaviour to prevent sexually transmitted infections and HIV transmission
prevention of the transmission of communicable diseases such as tuberculosis, and the encouragement of a healthy lifestyle to prevent the development of hypertension and diabetes
reduction of the incidence of intentional and unintentional injuries (White Paper for the Transformation of the Health System) (South Africa 1997b:15)

According to the ANC's *Health Plan for South Africa* (ANC 1994a:41), health promotion is viewed as central to the success of primary health care and requires the skills of a multidisciplinary team consisting of people such as teachers, health workers, community developers, artists and a range of others. In addition, health promotion should entail the fostering of responsibility for community participation and development, enhancing of education, active involvement of the mass media, and encouragement of awareness campaigns and disease prevention actions.

The White Paper for the Transformation of the Health System (South Africa 1997b:146) states that occupational health programmes must focus on providing services, conducting research and disseminating information to improve workers' health status within a multidisciplinary approach that includes the nurse as a core role player. Occupational health services (OHS) has a responsibility regarding the identification, control and the prevention of adverse health effects caused by the work environment. No reference is made to health promotion in occupational health. However, the ANC's *Health Plan for South Africa* (ANC 1994a:49-50) states that OHS must be comprehensive and should include preventive, promotive, curative and rehabilitative interventions/measures with emphasis on work-related health problems.
According to the White Paper for the Transformation of the Health System (South Africa (1997b:146), the health of workers are affected by diverse hazards which have profound effects on productivity, and on the economic and social well-being of workers, their families and dependents. Furthermore, occupational health services is a key priority of the National Health Department.

From the above discussion on the process of transformation in the workplace and the position of health promotion and occupational health in the National Health System, it is clear that a need for formalised health promotion programmes and initiatives exists in occupational settings.

1.2.3 Health promoting nursing

Health promotion is not only the domain of nursing, but also a multi-disciplinary and intersectoral effort to increase the quality of life and health for all. However, the WHO (1988) has called for nurses to be the leaders in the health promotion movement. It is evident that nursing needs to incorporate health promotion to be able to keep up with international trends in nursing and contemporary health care delivery. Benson and Latter (1998:101) are of the opinion that: "health promoting nursing practice is seen as the way forward for the nursing profession". These authors also argue that all nursing interactions have the potential to be health promoting and that nurses should be trained so that health promotion is seen as an integral part of everyday nursing practice rather than a separate activity.

Professional nurses are employed in diverse occupational settings as part of a multi-disciplinary team and form the core of the delivery of health care services. Therefore occupational and campus health nurses are in a favourable position to initiate, develop, implement and evaluate health promotion programmes for employees and students. To this effect Hodges (1997:7) states that promoting health in the workplace at three levels, namely at the individual, social and societal is an important activity for the occupational health nurse. Health promoting nursing practice and health promotion are also applicable to the campus health nurse who has a target audience of students and employees.
It can be surmised that many tertiary education institutions have in place health promotion programmes that address the HIV/AIDS pandemic and public health problem. However sexual behaviour is only one aspect of being, human and a holistic approach and programme is therefore indicated.

The discussion that follows provides an overview of the rationale, statement and significance of the problem, the aim of the research, research questions, assumptions, the demarcation of the research and the research method that is applied.

1.3 RATIONALE FOR THE RESEARCH

The researcher through personal experience as an employee in a transforming workplace, realised that many threats to health exist and that the needs of the workers are often not met in the contemporary work environment. In addition, no planned health promotion initiatives exist for employees and students. For this reason the researcher focussed on occupational health promotion as one initiative and management activity, to transform the workplace into a caring, humane environment aiming at enhancing the health and well-being of employees and students.

Woods (1996:447) maintains that health promotion, occupational health and employee assistance programmes perform a vital function in helping employees take care of their health in the midst of organisational change.

1.4 PROBLEM STATEMENT

A career or employment does not only satisfy the economic needs of a human being. Psycho-social needs such as a sense of identity, self-esteem, meaning, purpose, need for belonging to a group, and acceptance, are also satisfied in the work place. Work not only has a positive or healthy effect; it can also be harmful to health. Physical and psycho-social threats exist in the workplace. The workplace is in a particular environment and forms a particular community that can support lifelong healthy or unhealthy lifestyle behaviour.
Dramatic changes in the needs of the contemporary workforce and students have taken place. These changed needs should be accommodated in order to create healthy organisations, healthy working and learning environments and a healthy workforce. Employees and students have the need to feel they belong, to participate in the organisation, and that they are valued and cared for.

The absence or presence of health care and health promotion programmes in the workplace has a negative or positive influence on peoples' health. The organisational culture and environment, in terms of values and norms, politics, human relations, social groups and physical aspects, also play an important role on the influence of health in the workplace. According to the ANC's National Health Plan (ANC 1994a:41), health promotion is not well understood in South Africa and many people equate health promotion (HP) with health education. Therefore HP has not reached its full potential in the workplace because the health promoting workplace goes beyond the legal requirements to a work culture of caring and nurturing in which human beings are valued.

Within the human relations approach to management, workers are recognised as human beings and so is the importance of quality of work life. One of the requirements of a quality of work life programme is a safe and healthy working environment, as this applies to the physical, political and psycho-social working environment. Organisations thus have a social responsibility towards the health and well being of their employees.

The researcher is of the opinion that the workplace can and should be transformed not only by government intervention but also by making the workplace a more humane, caring and health promoting environment. Health promotion in the workplace is one method of attaining the health goals of South Africa. Transforming the workplace and particularly the campus into a health promoting setting may contribute to the quality of life.

1.5 SIGNIFICANCE OF THE PROBLEM

Empowerment is a central feature of health promotion as well as to the reconstruction and development of South Africa, and improvement of the quality of life of all South Africans. Similarly an empowerment approach to health promotion is required for the transformation
of the present day workplace into an environment in which a quality of work-life prevails through the process of empowerment. Empowerment not only refers to participation in decision-making, affirmative action, and training, but also to the level of making informed choices on health and health-related issues. The workplace and campus setting is an ideal environment in which empowerment can be realised through participation, decision making, enhancement of skills and knowledge.

In the literature search no relevant literature was found with regard to occupational health promotion in South Africa. Therefore this research can contribute to the body of knowledge and practice in occupational health, health promotion, occupational health and campus health nursing.

It is evident from the background discussion that transformation is needed in the workplace to meet the diverse holistic needs of contemporary employees and students. The challenges that faces private and public enterprises are to create health promoting workplaces, and invest in health and human resources. The professional nurse is in a favourable position to practise health promoting nursing in the workplace and campus, and to facilitate the transformation of the workplace into a health promoting setting.

1.6 RESEARCH QUESTIONS

The following research questions are addressed by this research:

• **What** is meant by the concept “health promotion” according to the literature?

• **What** do nurses understand by the concept “health promotion”?

• **What** should the content, organisation and management of a comprehensive occupational health promotion programme consist of?

• **What** should the content, organisation and management of a comprehensive occupational health promotion programme consist of from a nursing perspective?
1.7 AIM OF THE RESEARCH

The overall aim of this research is to determine if a need exists for occupational health promotion programmes and to look at the content, organisation and management of such a programme. In order to achieve this aim the following objectives motivate this research:

- The identification and description of the meaning of the concept “health promotion” according to the literature.

- The identification and description of the meaning of the concept “health promotion” according to occupational and campus health nurses.

- The description of the contents, organisation and management of a comprehensive occupational health promotion programme according to the literature.

- The description of the contents, organisation and management of a comprehensive occupational health promotion programme according to occupational and campus health nurses.

- The identification and description of the rationale behind occupational health promotion.

- Exploration and description of the role of the nurse in occupational health promotion.
• Exploration and description of the health promotion learning needs of nurses.

• The identification and description of the need for occupational health promotion programmes.

1.8 ASSUMPTIONS

Assumptions are statements that are taken for granted or are considered true, even though they have not been scientifically tested (Burns & Grove 1999:38). The research questions of this research are based on the following assumptions:

Assumption 1:
Health promotion means to enhance health through various activities.

Assumption 2:
Nurses perceive health promotion as health education and prevention of disease.

Assumption 3:
Health promotion in the workplace focusses primarily on lifestyle and behaviour change aspects.

Assumption 4:
The contents of an occupational health promotion programme focus primarily on the traditional occupational health and safety aspects from a nursing perspective.

Assumption 5:
The rationale behind occupational health promotion is that the workplace is a suitable venue for health promotion initiatives.

Assumption 6:
Nurses view their roles in health promotion as that of co-ordinator and facilitator.
Assumption 7:
Occupational health and campus health nurses have a need for training in health promotion and occupational health promotion.

Assumption 8:
A need for occupational health promotion programmes exists in occupational settings.

1.9 DEMARCATION OF THE RESEARCH

The research is demarcated in terms of time, population, and one category of professional nurses as explained by the following criteria:

- **Time dimension.** The study is a cross-sectional study executed at a particular time, namely in August 1999.

- **Population.** The population consists of the professional occupational and campus health nurses of the Greater Pretoria Metropolitan Area (now called the City of Tshwane Metropolitan Municipality).

- **Occupational and campus health nurses.** This study is limited to professional nurses and does not include other categories of nurses.

1.10 RESEARCH METHODOLOGY

The research executed is non-experimental, quantitative, and a descriptive survey as is fully described in chapter 3 of this dissertation.

The population consists of occupational and campus health nurses in the Greater Pretoria Metropolitan Area (now called the City of Tshwane Metropolitan Municipality). Purposive and network or snowball sampling approaches (see section 3.3.2 of chapter 3) are employed because this research is about a specific topic, in a particular setting, and from a nursing perspective.
No hypotheses are formulated in this research because the outcomes are not predicted and the research is guided by specific research questions. The survey method is chosen for this research so as to enable the researcher to collect data systematically, in an objective and unprejudiced manner in order to attain answers to the research questions and assumptions as stated earlier in this chapter.

The required data is collected through self-administered questionnaires, distributed to the respondents selected for this research.

A detailed description of the research methodology is provided in chapter 3.

1.11 CLARIFICATION OF CONCEPTS USED IN THIS RESEARCH

Although some of the concepts explained in this section are not contained in the title of this research, they are considered important in giving direction and relevance to the research.

- **Campus health nurse.** Campus is defined by the Funk and Wagnalls Standard Desk Dictionary (1980:89) as the grounds of a school or college. Nurse is defined by the Funk and Wagnalls Standard Desk Dictionary (1980:449) as a person who cares for the sick or injured and one who fosters, nourishes, protects or promotes.

  For the purpose of this research the campus health nurse is a registered professional who nurses the entire tertiary education community comprehensively, and who facilitates holistic health and the well-being of primarily students by means of primary, secondary and tertiary prevention nursing interventions.

- **Empowerment.** Smith and Maurer (1995:7) describe empowerment as "the process of assisting others to uncover their own inherent abilities, strengths, vigor, wholeness, and spirit".

- **Health promotion.** The Ottawa Charter for Health Promotion (WHO1986:1) defines health promotion as the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-
being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

- **Need.** The Funk and Wagnalls Standard Desk Dictionary (1980:439) define need as the fact, quality, or condition of lacking or feeling the lack of something necessary or desirable.

- **Nursing perspective** refers to the opinions and viewpoints of occupational and campus health nurses with regard to occupational health promotion and aspects pertaining to occupational health promotion.

- **Occupational health nurse.** Acutt and Campbell (1997:204) define the occupational health nurse as “a registered professional nurse with specialized knowledge and skills to protect the health of employees at the workplace by preventing and treating illness and injury and creating a safe and healthy work environment”.

- **Occupational health promotion programme.** According to Popp (1989:114-115), occupational health promotion programmes aim to reduce the threats to health by risk reduction education and by the creation of a healthy atmosphere. For the purpose of this research an occupational health promotion programme can be seen as the systematic and planned efforts of an organisation to enhance the well being of its members through education, behavioural change and a supportive environment. In this research the concept workplace health promotion programme is synonymous with the concept occupational health promotion programme.

For the purpose of this research occupational and campus health nursing are seen as an extension of community nursing, and the workplace as a community. Occupational and campus health and health promotion will be seen as components of primary health care.
• **Occupational settings.** Means the locations where people work.

1.12 OUTLINE OF THE RESEARCH

This dissertation is presented in the following chapters:

**Chapter 2: Literature review**

This chapter deals with the literature that was reviewed and the concept health promotion is explained. The Ottawa Charter (WHO 1986), further development, principles of health promotion and the rationale behind occupational health promotion is discussed. An overview of the settings approach to health promotion is presented and the content, organisation and management of a comprehensive occupational health promotion programme are discussed. Nursing roles in health promotion, and training needs of professional nurses are also reviewed and discussed.

**Chapter 3: Research design and methodology**

A description of the research design and the method that is employed to determine the need for occupational health promotion programmes is given. This chapter describes and motivates the research methodology and provides an overview of the problem, assumptions, research questions and ethical issues of the study. The development of the measurement instrument, the method of data collection, and the sampling process are explained and motivated.

**Chapter 4: Analysis and presentation of research findings**

An overview of the statistical procedures and methods that are used to analyse the data is provided. A demographic profile of the sample is provided and the validity and reliability of the study is discussed. The data is interpreted and the findings are presented per section of the questionnaire and in relation to the research questions.
Chapter 5: Conclusions, limitations, recommendations and concrete proposals

This chapter provides a discussion, answers to the research questions, and conclusions on the findings of the study. The limitations of the study are described, and the recommendations based on the findings of the study are made in respect of occupational and campus health nursing practice and research, and future research in general.

1.13 CONCLUSION

This chapter, the introductory orientation and background to the research, explores the rationale and significance of the problem. The aim and objectives of the research, research questions, assumptions, research methodology are outlined and the concepts are clarified.

In the following chapter a review of the literature is provided.
CHAPTER 2

Literature review

2.1 INTRODUCTION

The previous chapter provided an overview of the changing work landscape in the democratised South Africa, clarifications of the concepts used in this study, and an outline of the research. This chapter includes an overview of the literature consulted relevant to the research.

To enable the researcher to execute this research project, facilitate understanding and acquire knowledge, an extensive literature review was undertaken on various aspects pertaining to the topic. The meaning of the concepts "health promotion" and "occupational health promotion" are described, an overview of the Ottawa Charter (WHO 1986:1-2) and subsequent health promotion developments as well as an empowerment occupational health promotion approach are described. The rationale behind health promotion, the contents, organisation and management of a comprehensive occupational health promotion programme are outlined. Finally, a review is given on the role of the nurse in health promotion, and the health promotion training needs of nurses are discussed.
Textbooks, journal articles, Internet sources, policies and acts of parliament, and fact sheets of the WHO provided the sources for the literature review.

2.2 HEALTH PROMOTION: A CONCEPTUAL ANALYSIS

From the literature reviewed it is evident that there is no consensus about the meaning of the concept "health promotion". Differences exist between countries and authors as to the conceptualisation and operationalisation of the concept. To arrive at a description of the concept "health promotion" it is necessary to first examine the meaning of the two concepts that comprise health promotion.

2.2.1 What is health?

To provide a framework for conceptualising and practising "health promotion", the concept "health" needs to be understood. Katz, Peberdy and Douglas (2000:18) state that an understanding of the concept 'health' is central to health promotion.

The concept "health" has different meanings to different people and has evolved from a general term to a narrow one and back again to a broad interpretation.

The old English word "health" referred to the quality of soundness and wholeness in a very broad sense with physical prowess, wit, intelligence and spiritual salvation included as a person's wholeness (Greene & Simons-Morton 1984:6). According to Mackintosh (1996:1-3), health has personal relevance and meaning for individuals and each individual attaches a value to his or her idea of health, resulting in individual beliefs about health influenced by life experience. It is thus clear that people hold different perceptions about health, it can be seen as positive, as having energy and feeling happy or it can be equated with the absence of negative factors like illness, pain or unhappiness.

The focus in nursing theory is on holistic care, that is, the human being as an integration of the physical, social, emotional, environmental, spiritual components of humanness. In the same way, Mackintosh (1996:3-5) perceives health as a complex concept made up of various dimensions such as health for survival, health of the emotions, health of the mind,
health of the environment, health of the body and spirit. This author summarises health as a multidimensional, holistic concept, perceived by individuals in different ways, not just as an absence of illness and as a human value.

The WHO in 1946 defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (http://www.who ...). The WHO defines health as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (Preamble to the Constitution of the World Health Organisation 1948). According to Nutbeam (1986:113) health is considered less as an abstract state and more of the ability to achieve one’s potential and to respond positively to the challenges of the environment, within the context of health promotion. In those terms, health is seen as a resource for everyday life, not the object for living and as a positive concept emphasising social and personal resources as well as physical capacities (Nutbeam (1986:113-114).

Both descriptions of the concept “health” clearly indicate that health is not merely the absence of disease and thus a holistic approach to health promotion is contained.

2.2.2 What is promotion?

For the purpose of this study promotion is seen as a concept meaning to enhance and to put health forward.

2.2.3 What is health promotion?

By examining the literature (Maben & Macleod Clark 1995; WHO 1986) it is evident to the researcher that different interpretations and meanings are attached to this relatively new concept health promotion which was introduced in the 1980s. The interpretations of the concept range from as being synonymous with health education or to being used as equivalent to health development and public health.

Maben and Macleod Clark (1995:1160) discuss the different views and understandings of the concept health promotion as follows:
(1) In the early 1980s health promotion was used as an all-encompassing term referring to any activity that fosters or enhances health. However, health promotion has come to mean more than to designate any activity applied to foster health. According to Maben and Macleod Clark (1995:1160), more defining attributes are given to the concept “health promotion”.

(2) The traditional approach to health promotion as concerned with lifestyle behaviour change, which attempts to persuade or cajole individuals to change their lifestyle, is less commonly used. The so-called modern approach puts emphasis on positive health, social and mental facets, the acquisition of life skills and self-esteem and is a two-way participatory process between the health promoter and an individual.

(3) Health promotion is health education but health promotion is more than health education. Though it is a prerequisite, it extends beyond the individual level to wider influences on health. Health promotion is seen as an approach or method, which encompasses a set of values which include empowerment, equity and collaboration, and encompass a bottom up strategy. Maben and Macleod Clark (1995:1159) further state that from the linguistic definitions of health and promotion it could be expected that health promotion means to further well being or to help forward or encourage well-being. The same authors identify the essential attributes of the modern concept as follows:

- Health promotion attempts to improve the health of an individual or community and is concerned with the prevention of disease.
- Health education through information-giving, advice support and skills training is a necessary prerequisite to health promotion.
- Empowerment, equity, collaboration and participation are the means or methods of achieving health promotion, and health promotion also fosters an ability to cope with illness or disease.
At a wider and broader level health promotion is concerned with the wider influences on health, on legislation and the desire to effect social change to improve health (Maben & Macleod Clark 1995: 1163).

Raeburn and Rootman (1998:9-10) also echo some of the features of the modern approach stated by the above authors as they describe health promotion as follows:

- Health promotion is concerned with positive health and well-being, with prevention of disease and relief of sickness as an integral aspect of the meaning of health promotion. However the enterprise has as central tenet healthiness and wellness.

- Health promotion is also concerned with the whole of life and people and their health nested in their natural environments and daily community settings and is concerned with daily life and everyday living environment.

- Health promotion is defined as "an enterprise involving the development over time, in individuals and communities, of basic and positive states of and conditions for physical, mental, social and spiritual health". The control of and resources for this enterprise need to be primarily in the hands of the people themselves, but with the back-up and support of professionals, policy-makers and the overall political system. Central to this enterprise are the concepts of personal and community development and empowerment (Raeburn & Rootman 1998:11). The viewpoints of Raeburn and Rootman position health promotion as an activity between the individual lifestyle approach and the social model.

According to the Ottawa Charter (WHO 1986:1), health promotion is defined as “the process of enabling people to increase control over, and to improve their health”.

Tones (2001:4) considers health promotion as the militant wing of public health with two essential components namely: healthy public policy and health education giving rise to the formula:

\[ \text{Health promotion} = \text{Healthy public policy} \times \text{Health education} \]
Tones (2001:4) is of the opinion that these two components are interdependent. Health education need healthy public policy to influence healthy choices and public policy need health education to develop and implement especially politically sensitive policies.

All the interpretations of the concept health promotion as discussed above provides evidence of the move away from the individual lifestyle behaviour as focus to that of embracing aspects of the social model of health.

All the descriptions of health promotion also have the imperatives empowerment, prevention of disease, holistic health and social actions as central to the definitions.

In an attempt to clarify the concept health promotion for teaching purposes O'Neill (1998:15) proposes that the concept health promotion be used to refer to a group of specialised practices aimed at planned change of health-related lifestyles using interventions developed through scientific research in health education. These practices are aimed at individual learning about health, social marketing and persuasive communication and changing the environment (the socio-political rather than physical) through strategies like political action, community organisation and organisational development. These practises can be implemented among individuals or groups, healthy or sick, by a diverse group of people, professional and non-professional.

2.3 THE OTTAWA CHARTER AS THE CORNERSTONE OF HEALTH PROMOTION

This section gives a review of the Ottawa Charter, the development after the Charter and the contemporary premises and concerns of health promotion.

The Ottawa Charter serves as the cornerstone of health promotion and came into being as an action for achieving Health for All by the year 2000. The Ottawa Charter resulted from the First International Conference on Health Promotion held in Ottawa, Canada in 1986 in an attempt to facilitate health promotion in industrialised countries.

The conference built on the progress made through the Alma Ata Declaration and the targets for Health for All document of the WHO. The Ottawa Charter is also recognised
as the beginning of the new public health movement (Wass 1994:14).

The Ottawa Charter for Health Promotion presents an ecological view of health, underlined by the importance given to the environment and ecological sustainability in promoting world health. The Charter states that health is seen as a resource for every day life and a positive concept emphasising the social and personal resources as well as physical capacities. Health promotion is therefore not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (WHO 1986:1). According to the Ottawa Charter, peace, shelter, education, food, income, a stable ecological system, sustainable resources and social justice are seen as the fundamental resources and conditions for health. Development and improvement in health requires a solid foundation in these prerequisites. Through advocacy, enablement and mediation health can be achieved, as is further discussed and explained below.

Good health is an important component of a quality of life and necessary for social, economic and personal development. Political, economic, social, cultural, environmental, behavioural and biological factors can be conducive or detrimental to health. These factors also apply to the workplace.

Through advocacy, health promotion actions aim to make these factors favourable to health. Through the role of advocate, health promotion practice, and nursing the occupational and campus health nurse can and should make these factors favourable to health. Quality of life can be translated to the workplace as quality of work life, and the requirement for a safe and healthy workplace. Workers need to be healthy to be productive in the workplace.

Health promotion aims at establishing equity in health by reducing differences in current health status and ensuring equal opportunities and resources to enable people to achieve their fullest health potential. Equity and the achievement of health can be achieved in a supportive environment by means of access to information, through life skills and opportunities for making healthy choices. People can achieve their fullest health potential if they are able to take control of those things that determine their health. The workplace should provide an opportunity for equity in health by providing multidimensional activities like health education, skills training and a supportive environment.
Health promotion demands coordinated action by governmental departments on all levels, industry, media, non-governmental and voluntary organisations. Health personnel, professional and social groups have a major responsibility to mediate between differing interests in society for the pursuit of health. Inherent in the role of nurse, is the role of mediator. The occupational health and campus health nurse then mediates conflicting interests between trade unions, workers and management.

The Ottawa Charter (WHO 1986:1) further states that health promotion action means the following:

- Building healthy public policy in all sectors and not only in the health sector. The achievement of health and health promotion goes beyond health care to all levels of society and living such as, education and housing. Health promotion aims to remove the obstacles for the adoption of healthy policies in non-health sectors and to facilitate coordinated actions to achieve health, income and greater equity. Diverse approaches are used in health promotion policy such as legislation, taxation, fiscal measures and organisational change. Healthy policies with the participation of all workers should be developed and implemented to create healthy organisations.

- Health cannot be separated from the other goals of living and people and their environments are inextricably linked. Creating supportive environments through caring for each other, our communities and the natural environment are the guiding principle for all nations, regions, communities and the world. The Ottawa Charter (WHO 1986:1) further states that work and leisure should be a source of health. Through health promotion, living and working conditions are created that are safe, satisfying and healthy. Employers should implement health promotion initiatives because they genuinely care for their employees and not from a paternalistic view. The essence of nursing is caring which enables the nurse to create a supportive environment and be a role model for caring.

- Health promotion works through strengthening community action by empowerment, ownership and control by communities themselves. Communities direct the process of community and health development by utilising the human and material
resources. Communities need comprehensive and continuous access to information and education for health. A comprehensive occupational health promotion programme, with the central tenet of empowerment can fulfil this need for information and education.

- Health promotion supports social and personal development through providing information, education for health, and enhancing life skills and lifelong learning in the school, work, home and community settings. The skills development programme in the workplace supports lifelong learning and personal development.

- Reorienting the health services so that the responsibility for health promotion is shared among individuals, community groups, health professionals, health service institutions and governments. Health care services need to move in the health promotion direction with a stronger attention to health research, and effect changes in the education and training of professionals. The occupational health services also need to move in the health promotion direction, with all professionals and workers working cooperatively sharing the responsibility for health at the workplace. To this end professionals need further training.

The new approach to improving and promoting public health, Settings for Health, came into being after the adoption of the Ottawa Charter. Settings for Health emphasise practical networks and projects to create healthy environments such as healthy schools, health promoting hospitals, healthy workplaces and healthy cities. Settings for Health builds on the premise that there are health development potentials in practically every organisation and/or community (WHO 1998b:1). The settings for health approach then paved the way for health promotion in the workplace.

Wass (1994:15) is of the opinion that the social and ecological emphases from the Ottawa Charter are developed further in the second and third international conferences on health promotion.

The Second International Conference on Health Promotion was held in Adelaide in 1988 (WHO 1998:2). The conference started from the position that health is both a fundamental
human right and a sound social investment.

Governments were urged to promote health through linked economic, social and health policies and force new alliances for health promotion with corporations, businesses, trade unions, community groups and non-governmental organisations.

Four key priority areas for healthy public policy were identified:

- improving the health of women – the world’s primary health promoters
- food and nutrition – ensuring adequate amounts of healthy food for all
- tobacco and alcohol use as major health hazards that deserve immediate action
- creating supportive environments so that health is nurtured and protected

Many countries and international organisations have since adopted public health policies that embody the spirit of Adelaide.

In South Africa these public health policies are evident in the No Smoking Policy in public places as well as in feeding schemes for children, free health services for mothers and children, housing schemes and the supply of water.

The Sundsvall Conference in 1991 emphasised that there is a link between health and the physical environment given that the physical environment is not only visible structures and services but also have spiritual, social, cultural, economic, political and ideological dimensions. The conference grouped strategies for environmental change in support for health into seven categories: policy development; regulation; reorientation of organisations; advocacy; building alliances/creating awareness; enabling; and mobilising/empowering. The conference also focussed on six areas, within the broad determinants of health namely: education, food and nutrition, home and neighbourhood, work, transport and social support and care (WHO 1998b:2).

The next major event in the development of health promotion was the Fourth International Conference on Health Promotion, held in Jakarta in July 1997 and resulted in the Jakarta Declaration (WHO 1998b:2). This Declaration offers a vision and focus for health
promotion into the next century and the key messages are:

• Health promotion is a **valuable investment** and is being recognised as an essential element of health development.

• Health is seen as a **basic human right** and essential for social and economic development. Health promotion is an investment because it acts on the determinants of health to maximise the health gain for people and builds social capital through the reduction of inequities in health and ensuring human rights.

• The ultimate goal of health promotion is to increase **health expectancy** and decrease the differences in health expectancy between countries and groups.

• The Jakarta Declaration states the priorities for health promotion in the 21st century as:
  
  ➤ promote social responsibility for health  
  ➤ increase investments for health development  
  ➤ consolidate and expand partnerships for health  
  ➤ increase community capacity and empower the individual  
  ➤ secure an infrastructure for health

One of the important follow-up activities of the WHO in 1998 pertaining to this research, is the developing of "Health Promoting Workplaces". It is clear from this activity that the WHO places a high priority on health promotion in the workplace (WHO 1998b:3).

The 51st World Health Resolution on Health Promotion calls on the WHO to take the lead in elaborating a Global Alliance for Health Promotion and all member states are urged to adopt the five priorities of the Jakarta Declaration. Member states are also urged to adopt an evidence-based approach to health promotion policy and practice.

The Fifth International Conference on Health Promotion in Mexico in 2000 built on the priorities set out by the Jakarta Declaration and confirmed by the WHO Health Assembly
Resolution on Health Promotion (WHO1998b).

Leadership of the health promotion programme has been placed under the Social Change and Mental Health cluster in the transformed WHO.

2.4 EMPOWERMENT/PRINCIPLES/VALUES-ORIENTED HEALTH PROMOTION

The concept of empowerment is a familiar concept in the democratised South Africa and is gaining support not only in the economical field but also in the health promotion movement. Empowerment is central to health promotion and therefore the meaning of the concept needs to be explained.

Smith and Maurer (1995:7) describe empowerment as “the process of assisting others to uncover their own inherent abilities, strengths, vigor, wholeness, and spirit”.

The authors further state that empowerment is a process by which possibilities and opportunities for the expression of an individual's being and abilities are revealed and it is based on hope. Therefore the empowerment approach to health promotion is based on the recognition of the rights of individuals and communities to determine their own health needs, to make their own health choices and to take action on achieving their health goals and needs. In addition Ewles and Simnett (1999:266) are of the opinion that the process of empowering people involves modifying the way people feel about themselves through improving their self-esteem and self-awareness.

Values, beliefs, skills and knowledge are contained within the empowerment concept and empowerment in health promotion focusses on individual or self-empowerment and community empowerment.

Bundgen and Cameron (1999:274) are of the opinion that if empowerment simply means to take power, the implications in health care are that empowered individuals and communities will make positive use of the power they gain by being able to:
• think critically
• act in their own best interests
• create more equitable access to resources
• develop their own resourcefulness
• work well with others
• respect their own and others diversity

To assist individuals or communities to achieve the above, professionals need to facilitate the process of empowerment. Therefore professionals in the field of health promotion need to be empowered facilitators in order to make the process of empowerment available. Williams (1995:37) suggests that an empowerment approach offer a means whereby health promotion professionals can raise awareness of health inequalities and of the underlying socio-political causes of ill-health, and facilitate social and political change to promote health.

The principles and values of health promotion underpin the empowerment approach to health promotion. Health promotion aims to reduce ill-health and facilitate health and the quality of life, the framework also incorporates the principles and values governing the processes and structure of the democratic South African society.

The principles and values enshrined in the Ottawa Charter (WHO 1986) are also those reflected in the Health Plan of the African National Congress (ANC 1994a), the White Paper for the Transformation of the Health System in South Africa (South Africa 1997b) and the Reconstruction and Development Programme of the African National Congress (ANC 1994b).

According to the WHO European Working Group on Health Promotion Evaluation (WHO 1998a:15), health promotion action, programmes, policies and other planned activities are guided by the following principles:

• Health promotion initiatives should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health, thus empowering them. These initiatives should involve those
concerned in all stages of planning, implementation and evaluation, thus they should be participatory.

- Health promotion initiatives should foster physical, mental, social and spiritual health, thus be holistic and involve the collaboration of agencies from relevant sectors, thus they should be intersectoral.

- Health promotion initiatives should be guided by a concern for equity and social justice, thus be equitable and should bring about changes that individuals and communities could maintain once initial funding has ended, thus they should be sustainable.

- Health promotion initiatives should use a variety of approaches, including policy development, organisational change, community development, legislation, advocacy, education and communication, in combination with one another, thus making use of a multi-strategy approach.

Similarly certain principles guide the Health Vision of the Health Plan of the African National Congress (ANC 1994a:9-20) and the White Paper for the Transformation of the Health System in South Africa (South Africa 1997b). The principles relevant to this research are:

- **Equity.** Health will be secured through equitable health care and social and economical development such as education and employment. The promotion of healthy lifestyles as well as the provision of accessible health care services should be addressed.

- **Right to health.** According to the Bill of Rights of the Constitution of the Republic of South Africa No108 of 1996 (South Africa 1996), everybody has the right to attain optimal health care and the State must provide the environment in which this can be achieved.

- **Primary health care approach.** Through the primary health care (PHC) approach
as described by the WHO health services will be restructured and promotion of health through education and prevention of disease will be achieved through the participation of the community.

- **Promotion of health.** Areas that will also be given attention to are health education on sexuality, child spacing, substance abuse, and environmental and occupational health. All health workers will promote general health and encourage healthy lifestyles.

- **Respect for all.** All people will be treated with dignity and respect. People also have the right to participate in policy-making.

- **Empowerment and respect.** Health promotion activities should be designed to increase and enhance the control that communities and individuals have over their own health; in the process traditional values and beliefs will be reaffirmed and respected.

- **Peace and security.** According to the RDP, empowerment is central to the process and is based on peace and security as a requirement. While peace and security is not yet a reality within the South African landscape, this aspect poses a challenge to all South Africans and communities to be empowered to prevent violence and crime.

"Empowerment" is central to all the principles described above.

Health promotion practice in the workplace has the potential to be empowering if it is planned, implemented and evaluated in a participatory and an upstream manner. Upstream meaning that it is a process driven by the employees with the support of professionals in a facilitative manner.
2.5 THE RATIONALE BEHIND OCCUPATIONAL HEALTH PROMOTION

The needs of the contemporary workforce in the workplace have undergone many changes in the last two decades. These needs are reflected in greater mobility that is taking place, people change their workplaces and careers more often, need for actualisation and recognition, in the need for working in a healthy environment in which the diversity of human needs are satisfied. Health promotion in the workplace can contribute to the creation of a healthy organisation and thus a productive and satisfied workforce. This research argues that health promotion in the workplace is an integral part of the modern and contemporary management of the workplace as well as of occupational health and safety. A discussion on the thinking behind occupational health promotion is discussed below.

2.5.1 International trends and strategies

It is evident from the Ottawa Charter (WHO 1986), the Jakarta Declaration (WHO 1998b) and the Settings for Health approach that the workplace is a very important setting in achieving the goals of health promotion and Health for All, in the 21st century.

The Jakarta Declaration of 1997 (WHO 1998b) sets out the direction of health promotion for the 21st century with emphasis on multisectoral cooperation and partnerships in addressing public health challenges. The Jakarta Declaration also stresses the Settings approach as one of the main strategies on the way forward. According to Chu, Breucker, Harris, Stitzel, Gan, Gu and Dwyer (2000:155), the workplace, along with the school, hospital, city, island and marketplace, has been established as one of the priority Settings for Health promotion in the 21st century.

These authors also maintain that the workplace is one of the most important settings affecting the physical, mental, economic and social well-being of workers, and in turn the health of their families, communities and society. They go further to say that the workplace "offers an ideal setting and infrastructure to support the promotion of health of a large audience" (Chu et al 2000:155). However, St Leger (1997:99-101) maintains that although there are positive evidence to support the settings approach to health promotion, there are
a number of barriers that limit the effectiveness of the settings approach. These challenges are:

- developing strategic directions which are shared by key stakeholders
- increasing the commitment and participation of more individuals and groups
- gathering sufficient evidence of what works effectively and riding the boundaries with other sectors
- looking at the big picture – the organisational structures, policies and practices
- achieving some early tangible gains and affirming them to people
- building the intersectoral teams and supporting constituencies at the beginning
- investing in multi-disciplinary education and training and integrating the different elements, stakeholders and approaches

Hagard (1994:3) identifies five forces that have been stimulating the development of health promotion at work since the early 1980's: the need to control health care costs, the growing epidemics of non-communicable diseases, the acknowledgement of disease preventability and the recognition of the role of health promotion. The other forces are the growing recognition of employers that employee good health makes good business sense and recognition by health promoters that work sites offer possibilities of reaching a significant proportion of the adult population in a constant setting over long periods of time.

2.5.2 The global strategy on occupational health for all: the way to health at work

Objective 3 of the Global Strategy Objectives and Actions for Occupational Health for All (WHO 1994) has as objective the development of healthy work practices and promotion of health at work. To effectively control and avoid many occupational hazards workers need to be provided with information and knowledge, tools, work organisation and aids that enable them to perform work tasks without risks to health.

It is recommended that health education should be given on lifestyle issues and occupational exposures. Health promotion initiatives should be directed towards healthy lifestyles and the maintenance of such lifestyles. Actions to achieve objective 3 at national level includes the following:
The national occupational health programmes should encourage enterprises to implement occupational health promotion programmes.

- Health education on healthy and safe working practices and healthy lifestyle education should be provided.

- Occupational health personnel should receive training in health promotion so as to enable them to carry out these activities as part of their occupational health practice.

Health promotion in the workplace is clearly seen as a strategy for achieving occupational health for all.

2.5.3 The workplace as a setting

It is evident from the literature that the workplace is seen as an effective setting for health promotion for economical, population and other reasons. These reasons include that a great number of people can be reached because the working population is increasing. This population in turn can be role models to their families and friends. The majority of the workforce is stable thus making long-term intervention and evaluation possible. Girdano (1986:12) states that research has demonstrated that people tend to make better use of programmes offered at work than they do of similar programmes offered in other settings. Health promotion programmes and activities can contribute to curbing escalating health care costs.

Naidoo and Wills (2000:265) are of the opinion that the workplace gives access to a target group, healthy adults, who are often difficult to reach in other ways, that employees in the workplace are a captive audience for health promotion. The cohesion of the workgroup provides peer pressure and support to conform to healthy lifestyles. Other factors include facilities available to support healthy lifestyle changes such as a canteen or gymnasium.

The workplace is a suitable setting venue for health promotion initiatives as is supported by the above discussion.
2.5.4 Benefits of occupational health promotion programmes

The literature reveals that several authors are of the opinion that there are definite benefits to employers and employees alike despite of a lack of extensive research on this issue.

Lusk (1992:417) and Breucker and Schröer (1999:7) reflect that various researchers found positive outcomes regarding absenteeism, health care costs, reduction of accidents, observed possible overall improvement in productivity, cost savings in current health care costs and improvement in employees attitudes and morale.

In addition Grant and Brisbin (1992:xii) state that it is well documented in medical literature that individuals who are physically healthy and who have low levels of work-related stress miss fewer days of work due to injury and illness.

Chu et al (2000:155-156) are of the opinion that the health promoting workplace can bring about positive changes which support the overall success of an organisation and can ensure a flexible balance between customers’ expectations and organisational targets and employees’ skills and health needs. This combination of meeting the needs of all stakeholders in work organisations is desirable for competing in the contemporary world. In addition Zuma (1995:47), argues that business can play a major role in improving the health of employers and their families with a full reward in higher productivity alone.

To meet the challenge to improve the quality of health, quality of life and quality of work life in the new democracy, the workplace in South Africa can play a major role, and in particular the occupational and campus health nurse.

According to Woods (1996:447), health promotion, occupational health and employee assistance programmes perform a vital function in helping employees take care of their health in the midst of organisational change.
2.5.5 Health promotion as an integral part of health care in South Africa

The major thrust of health care service and systems in South Africa is the PHC approach. The goals of primary health care include health education, health promotion and prevention of disease. The philosophy of PHC gives direction for a particular strategy of health care organisation namely that of a balanced system of illness treatment, disease prevention and health promotion. Health promotion and its importance in today's society, is a term encountered in many nursing and health related literature. In South Africa the importance is also evident in that the Department of Health has a Health Promotion Directorate as well as the provincial government sections and National Health Promotion Forum.

Health promotion is addressed in chapter 18 of the White Paper for the Transformation of the Health System in South Africa Notice 667 of 1997 (South Africa 1997b). The paper highlights the principles of the reconstruction and development programme as important corner stones for developing health promotion initiatives. The objectives of health promotion are to:

• contribute to the development and achievement of a healthy nation, national health goals and targets
• promote standards of excellence in health promotion practice, drawing on both international and local experience
• promote and develop health promotion activity in government and civil society
• develop a skilled cadre of health promoters

PHC and occupational health is contained within the new public health movement has come into being as a response to the twentieth century crisis of economic and urban deprivation focussing on the global health crisis of poverty, unemployment, homelessness, health inequality, health and safety threats at work, pollution and others. The new public health has as aim the reduction of poverty and the creation of a healthier environment for all and through the Ottawa Charter (WHO 1986), proposes a new approach to public health by means of health promotion. Zuma (1995:47) is of the opinion that the workplace is a strong starting point for the promotion of PHC, because the first contact workers have with
health services is often at the workplace.

In the Occupational Health and Safety Act 85 of 1993 (South Africa 1993) no specific mention is made of occupational health promotion programmes. The Act, however, implies that employers are responsible for creating a healthy and safe environment through a health and safety programme. Section 8 of the Occupational Health and Safety Act 85 of 1993 (South Africa 1993) is specific and clear about the responsibility of employers to provide and maintain a workplace that is safe and without risk to the health of their employees. Section 8 (1) can be regarded as a broad health and safety policy.

2.6 THE HEALTH PROMOTING WORKPLACE

The concept of the health promoting workplace is a relatively recently developed concept evolving from workplace health promotion previously called occupational health promotion and also wellness programmes. Earlier programmes had as focus healthy lifestyle whereas the contemporary approach is more holistic and integrative in nature taking into consideration both the individual risk factors and the broader organisational and environmental issues (Chu et al 2000:156).

2.6.1 Employment and health

Most people spend more than a third of their adult life in their places of work and commuting to and from work. The workplace is a particular environment, which can support healthy or unhealthy lifestyle behaviour. It can therefore be argued that the absence or presence of health care/health programmes in the workplace then has an influence on peoples' health.

A career or employment does not only satisfy the economic needs of a human being. Psycho-social needs like sense of identity, self-esteem, meaning, purpose, need for belonging to a group and acceptance, are being satisfied in the workplace. Work not only has a positive or healthy effect, it can also be harmful to health. Through globalisation, changes in the workplace, more advanced technology, competitiveness and pressures to perform many more demands are placed and more threats, especially psychosocial threats
exist in the workplace. Breucker and Schröer (1999:5) maintain that the stressors in the workplace consists no longer of only the traditional health risks and hazards but also the unspecified psychosocial stressors. This research assumes that many unspecified psychosocial stressors are features of the contemporary South African workplace because transformation and changes that comes into being continuously places great stress on all employees and employers.

However, Woods (1996:447) maintains that health promotion, occupational health and employee assistance programmes perform a vital function in helping employees take care of their health in the midst of organisational change.

According to Cooper and Williams (1994:1), "unhealthy work organisations can create enormous human and financial costs". The authors state that positive change starts with the recognition of the need to change and a clear vision of the outcome of the change process. Healthy organisations are created by the implementation of a planned programme of health initiatives.

2.6.2 Occupational health promotion approaches

The approach or approaches that will be used in occupational health promotion practice will be influenced by the meaning that is attached to health and health promotion. Health is also explained from different models.

A short description of these models will be given because these models influence health promotion practice. The medical model of health focusses on the pathogenesis of disease, reasons why people become ill and the treatment of individuals. For this reason the medical model seems less relevant for health promotion although health promotion has ties with the medical model of health. A salutogenic approach to health focusses on why some people remain healthy despite adverse circumstances and what keeps people healthy. The salutogenic paradigm suggests that people are neither diseased nor healthy but somewhere on the health-ease-disease continuum. This approach emphasises the dynamic relationship between people and their environment.
The social model of health underpins the multi-causal theories of health. Health is influenced by political, economic, social, psychological, cultural, environmental and biological factors. The guiding principles of the social model of health are commitment to empowerment, local participation, equity in health, accountability, and cooperation and partnership with different sectors and agencies (Jones 2000:33). The principles of the social model of health are similar to those that underpin health promotion.

Naidoo and Wills (2000:92-100) describe the approaches to health promotion as:

- The medical model or preventive model has as focus medical interventions to prevent or ameliorate ill-health, expecting patients or people to comply with preventative medical procedures for the benefits defined for them by medical and health practitioners.

- Social change approach takes the view that social and economic factors exert the greatest influence on health. Aim is to identify ways of to change the social processes that influence the causes of death and ill-health in poor people- aiming to work with local people to meet health needs, aiming to reduce inequalities and improve public health.

- Behaviour change aims to persuade individuals and groups to change their health behaviour and adopt healthy lifestyles.

- Educational approach has as purpose to equip people with knowledge and skills so that they make an informed choice on their health behaviour.

- An empowerment approach assists people in identifying their health concerns and in developing skills to act upon those. The health promoter acts as facilitator and then withdraw. It focusses on self and community empowerment.
To create a health promoting workplace it is necessary to use a combination of these models.

The literature reveals that different approaches are used in workplaces with different understandings attached to occupational health promotion.

Breucker and Schröer (1999:3) describe the following approaches that are currently in use as:

- Workplace health promotion as behavioural prevention is widely practised and focusses on reducing the traditional risk factors associated with behaviour. Health education and methods of behaviour-directed prevention are employed in this approach.

- Modern occupational health and safety incorporates factors such as work organisation and work design and regard workplace health promotion as essential component of a holistic interpretation of health and safety.

- Health promotion in the workplace is also used as a strategy to influence health determinants at the workplace.

- Workplace health promotion is offered as part of a company's human resources policy in support of a strategy to reduce absenteeism.

- Workplace health promotion as a component of an organisational development strategy: Modern management approaches such as the total quality management approach emphasise the function of human resources in order to realise economic aims. To this end Breucker and Schröer (1999:3) are of the opinion that workplace health promotion creates the necessary preconditions for optimal creativity and productivity of employees.
2.6.3 What are the components of a comprehensive occupational health promotion programme?

This section of the literature review discusses and describes the contents, organisation, structure and management of a comprehensive occupational health promotion programme. The literature reveals that a comprehensive occupational health promotion programme must not only focus on the physical aspects but also on the social, emotional and spiritual health aspects as is demonstrated by the following discussions.

2.6.3.1 Holistic view to health and health needs

O'Donnell (1994:xi-xii) identifies five dimensions of optimal health that should be addressed in health promotion programmes in the workplace:

**Physical health** refers to the physiological workings of the body with the influence of smoking, nutrition, physical activity and alcohol on the body well documented. Most health promotion programmes address these issues.

**Emotional health** is according to O'Donnell (1994:xi), the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure programmes.

**Social health** refers to the ability to form healthy relationships with friends, family, neighbours and colleagues. This aspect may be addressed by child and frail parent care programmes, support groups, group recreation and sports team. The author also believes that incorporating social health programmes into occupational health promotion programmes may represent the greatest opportunity available for improving the impact of health promoters.

According to O'Donnell (1994:xii), **spiritual health** is "the condition of one's spirit, including having a sense of purpose in life, the ability to give and receive love, and feeling
charity and goodwill towards others”. Religion may or may not be the central component of spiritual health. Research in this area is limited but growing.

**Intellectual health** refers to achievements in the work, school, and community services of cultural pursuit aspects. Intellectual health programmes are rare in workplace health promotion programmes, however, it may include programmes to enhance self-esteem and career development.

Similarly Kotze (1997:365) argues that a comprehensive programme that approaches the employees in totality is more desirable than single focus programmes.

The important message to employees will be to strive towards a balance in all the above mentioned areas and not sacrificing one area to achieve excellence in the other.

### 2.6.3.2 Employee assistance programme

A comprehensive health promotion programme also caters for employees with personal problems such as family problems, ageing or emotional difficulties. Sherman (1990:62-65) defines employee assistance programmes a core wellness activity in the workplace. Employee assistance programme is seen as a health promotion essential although it focusses on existing problems instead of on prevention.

Employee assistance programmes deliver two direct services: counselling and consultation and are designed to help employees resolve personal problems such as chemical dependency, emotional problems or family conflicts that may affect the workplace.

### 2.6.3.3 Women’s health issues

Women's health issues should be included because more women are in the labour market and estimated 70% and in child bearing years. Health concerns to be addressed are breast examination, prenatal and postnatal care, breast-feeding, reproductive health and violence/abuse. The Adelaide Conference (WHO1988) identified the promotion of women’s health as a priority. Kotze (1997:371) states that preventive health programmes
at work for women and children can be very beneficial and contribute to a healthy workforce.

2.6.3.4 Child day care

Concerns about child day care arrangements can have a negative impact on employee’s health and productivity. However, no evidence exist that on-site childcare is more beneficial than off-site facilities. On-site facilities may have the benefits of access to the child, being available in an emergency and parents’ participation in the running of the facility, thus having input into quality care. However, Coulson, Goldstein and Ntuli (1998:154) are of the opinion that a workplace crèche would ensure that working mothers have child care facilities.

2.6.3.5 Parenting education programme

Frye and Veatch (1989:423-424) are of the opinion that a parent education programme in the workplace not only benefits the individual parent but also the employer in the following ways:

- a more harmonious home life results in less distracted employees
- parents who have secure and satisfying child care arrangements can work with less guilt and more enthusiasm
- company loyalty can be enhanced, resulting in less employee turnover
- many of the skills taught in work/family seminars, including time management, organisation and stress management, can help an employee become a more efficient employee
- reduced health care costs
- more skilled parents use less time at work to gain support from fellow workers and thus increase productivity
- prenatal classes can lead to healthier babies and thus less time off work

According to Frye and Veatch (1989:424), the occupational health nurse is an appropriate professional in the workplace to facilitate parental support programmes and promote
parenting skills, because of obstetric and paediatric experience, adult education skills and being seen in a less threatening manner by employees.

2.6.3.6 Well person screening/disease detection

Wachs (1997:479-482) is of the opinion that screenings of vision, hearing, cholesterol, pulmonary function and blood pressure should be part of a comprehensive programme. Similarly select screening programmes are also put forward by Saphire (1995:572) as part of a comprehensive programme.

2.6.3.7 Diverse programmes

Saphire (1995: 572) proposes programmes in each of the areas:

- Lifestyle change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise.
- Self-care programmes such as education that empowers on self health management for example on posture.
- Chronic disease management programmes such as diabetes and high blood pressure.
- Informed choice programmes such as rationales for the use of personal protective equipment.
- Prenatal and postnatal programmes.
- High-risk reduction programmes such as hazard communication, safety, use of seat belts and ergonomics.
- Immunisation programmes for influenza, tetanus and travel preparedness.

In addition to the above programmes Wachs (1997:479-482) also includes aspects such as the following for a comprehensive programme:

- Family health which include topics like raising healthy children, aging parents effective communication, effective and assertive communication as topics under mental health, ageing well and spiritual wellness.
Nutrition related topics include low fat/high fibre, cooking class, shopping class and dental health.

Coping enhancement: time management, balancing home/work, sleeping well, travel seminar.

Exercise/fitness-walking club, aerobics, team sports, hiking.

Health risk appraisal, home and car safety, first aid, and self-defence.

Reducing communicable diseases like HIV/AIDS, importance of immunisations.

Alcohol and drug education, cancer prevention and defeating depression.

Nutrition assessment, cholesterol and weight control.

Stress management and smoking cessation.

Self-examinations, fitness assessment and blood pressure control.

Similarly to the above Zuma (1995:47) maintains that many important health activities can be accomplished at the workplace such as:

- smoking cessation
- diet modification
- physical conditioning
- employees assistance with regard to alcohol and drug abuse
- HIV/AIDS prevention
- basic hygiene (including the prevention of the spread of pink eye)
- prevention of accidents and injuries
- handling of managerial and poverty related stress

2.6.3.8 Occupational health and safety programme

Breucker and Schröer (1999:4) argue that workplace health promotion is essential to the modern understanding of occupational health and safety and opens new opportunities to guarantee health and safety at the workplace. Therefore prevention has to become part of the entire corporate strategy. Health promoting environmental and organisational design should be taken into consideration in occupational health and safety practice.
2.6.3.9 Affirmative action policy and programme

Coulson et al (1998:154) perceives a commitment to an effective plan of affirmative action as central to any health promoting workplace presently in South Africa. However, it needs a comprehensive training programme to empower the previously disadvantaged people appointed in affirmative action positions.

2.6.3.10 Social responsibility programme

Ziglio (1999:9) is of the opinion that it is essential for enterprises to look beyond their own premises and reach out into the community where their employees and their families live.

Woods (1996:449) is of the opinion that a comprehensive health promotion programme addresses the identified employee health needs through raising awareness levels, providing support services, promoting lifestyle behaviour changes and supporting work cultural enhancement programmes and policies.

O'Donnell (1994:xiii-xv) states that workplace health promotion programmes can have three levels of impact namely the following:

✦ Level 1: Awareness

Employees' awareness and interest are raised by means of newsletters, health fairs, posters, interactive counselling and educational classes with the aim of improved health or behaviour change. However, the authors maintain that the outcome on most cases is not so, and see them as of no value. It can fulfil a public relations function for the employer and also be an inexpensive way of starting an occupational health programme and help stimulate management to develop more extensive programmes.

✦ Level 2: Lifestyle change programmes

The desired outcome with these programmes are lifestyle-related behaviour change, like quitting smoking, managing stress more effectively or exercising on a regular basis.
Successful lifestyle change programmes use a combination of health education, behaviour modification, and experiential practice and feedback opportunities. Lifestyle change programmes, however, fail to sustain long-term behaviour change.

Level 3: Supportive environment

Supportive environments are vital and critical to help employees sustain lifestyle changes and healthy lifestyles. Implementing ongoing programmes enhancing employee ownership of programmes and changing the physical setting, corporate culture and policies can create these supportive environments.

2.6.4 Successful programme development, organisation and management

An examination of the literature reveals that the some actions are key indicators vital to the success of the occupational health promotion programmes. A discussion on these factors follows.

Chu et al (2000:163) cite the following factors as key indicators of a successful programme:

• Participation of all staff members in all phases of the programme. The Volkswagen AG (VW), a leading car manufacturer in Germany maintains worker participation by:
  ▶ health circles (problem-solving groups with the task of identifying health-related problems and possible measures for improvement)
  ▶ extended job inspection routines involving employees
  ▶ regular employee surveys on health matters
  ▶ special training modules for health and safety education (Chu et al 2000:159)

• Project management. Orientation to project management action involving the stages of the problem-solving cycle namely: analysis, setting priorities, solution seeking, evaluation, planning, implementation, continuous control and evaluation.
• Integration. Programmes should be integrated into the overall management plan and practices.

• Comprehensiveness. Programmes must include individual-directed and environmental-directed measures from various fields.

• Senior management support and commitment.

• Breucker and Schröer (1999:7) also state that programmes need to be established in-company as a factor for success.

After an extensive examination of the literature this study argues that one of the success factors of an effective occupational health promotion programme is the careful and thorough design, planning, implementation and evaluation of a programme.

Phases need to include the following:

• obtain management support and commitment
• form an employee committee
• analyse the company and industry including corporate culture assessment
• determine the organisations needs through needs analysis
• develop a health promotion policy
• strategic planning
• implementation of specific programmes
• ongoing evaluation in terms of process, impact and outcome

Grant and Brisbin (1992:18) state that a wellness program must be considered a part of normal business operations. Wellness activities should be viewed with the same importance as any other activity in which the employer and employees would normally participate.

It is evident from the literature that a manager or co-ordinator with a team should manage the occupational health promotion programme. Family of employees should also be
involved as appropriate as is in implied in a social responsibility programme.

In summary Chu et al (2000:155) state that for nations the development of a health promoting workplace will be a prerequisite for sustainable social and economic development.

2.7 NURSING, HEALTH PROMOTION AND TRAINING

Health promotion is not only the domain of nursing, but also a multidisciplinary and intersectoral effort to increase the quality of life and health for all. However, the WHO has called for nurses to be the leaders in the health promotion movement. From the forgoing discussion on health promotion it is evident that nursing needs to incorporate health promotion to be able to keep up with international trends in nursing and contemporary health care delivery.

2.7.1 Role of the nurse in workplace health promotion

The role of the nurse in creating and maintaining the health promoting workplace or learning environment is underpinned in the principles and premises of the Ottawa Charter (WHO 1986) and can and should therefore do the following:

• The nurse fulfils the role of clinician by providing quality health promoting nursing care, medical surveillance, biological and environmental monitoring and first aid.

• The role of advocate for the needs and rights of workers and students is enacted by advocating for a healthy workplace or a health promotion programme by the identification of and the acting on the political, economical, social, environmental, behavioural and biological factors that can be harmful to health (Smith & Maurer 1995:16).

• According to Smith and Maurer (1995:20), the nurse works as a collaborator with employees, students, and other members of the health and safety team, trade unions as well as management towards a common goal namely that of the health
of the worker or student.

- The consultant role entails facilitation of problem-solving, advising management other team members and employees or students.

- The nurse counsels people who are experiencing problems and guides them through the problem-solving process.

- Intrinsic in the role of occupational or campus health nurse is the role of educator or facilitator of learning in health learning as well as educator for students and fellow-workers.

- The nurse manages the health services and the health programme through the principles of management.

- The nurse also conducts and participates in research.

- Assisting individuals, groups or communities to take control over those things that determine their health and to achieve their fullest health potential enacts the role of enabler.

- The nurse also mediates between all sectors and people of a community with differing interest in health like between management and workers or students.

- The nurse uses a caring approach to nursing and therefore role models the requirement for creating supportive environments.

However, to fulfil these roles the nurse needs to be empowered so as to facilitate the process of empowerment that is central to health promotion. To achieve this end nurse need to work more in equal partnership with others rather than do to others or do for others. In addition to working in partnership the nurse also needs to be equipped with the necessary knowledge, skills and attitudes essential in health promotion and health promotion nursing.
Macleod Clark (1993:260) suggests that health promotion is an approach to care for nurses. Health nursing is [thus] the process of promoting health through nursing care and would include features like holism, equity, participation, facilitation, support, negotiation and individuation. The sick nursing approach in contrast, is characterised by dominating, generalised, prescriptive, reassuring and directive interactions.

Similarly Benson and Latter (1998:101) are of the opinion that “health promoting nursing practice is seen as the way forward for the nursing profession”. These authors also argue that all nursing interactions have the potential to be health promoting and that nurses should be trained that health promotion is seen as an integral part of everyday nursing practice rather than a separate activity. Benson and Latter (1998:101) further state that this new paradigm shift has not been incorporated into nurses' ways of thinking or in their practice as been illustrated by the limited empirical evidence available.

Therefore for health promotion to become a feature of nursing and the health promoting nurse a reality there needs to be a shift in nursing from focusing on health problems to health potential and move away from the individualistic approach to health (Robinson & Hill 1998:232-238). The authors are also of the opinion that nurses need to look at health in a collective context as well as an individual one, taking into consideration that societal health has an important influence on the individual's health. In addition nurses should use an approach to nursing practice where the client's own goals of health are taken into consideration, the client has decision making powers, involved in choices and able to express freely their own needs.

A more holistic view of health also needs to be taken by nurses. In assessing the needs of the client, the focus should be on the health needs (normative, felt, expressed and comparative) as opposed to health problems. Through the stages of planning, implementation and evaluation the health promoting nurse will take the principles of individual and multi-disciplinary team involvement into consideration. In addition the health promoting nurse executes nursing at any point on the health-illness continuum and operates within a wider network of health and other professionals to promote the health of the client and the community. Therefore the nurse needs to shift from a knowledgeable doer to a knowledgeable being according to Robinson and Hill (1998:237).
From the literature reviewed it is evident that nursing and health promotion is inextricably linked and that nurses are in a favourable position to promote the health of individuals and communities through health promotion nursing.

2.7.2 Training needs

To enhance professional development and practice nurses need to keep abreast of the latest developments and trends in the field of nursing, occupational and campus health nursing as well as matters pertaining to the workplace and the student community. Therefore to achieve and maintain professional competence and to be part of the global nursing fraternity and village, nurses need to engage lifelong learning.

Similarly Wassel (1994:425) states that “to remain competitive and competent in today’s fast paced, technological society professionals in all areas must devote considerable time and energy to studying and reviewing the latest research and developments”.

To render modern occupational or campus health nursing the nurse needs to have knowledge and skills in health promotion, health education, project management, quality management systems, industrial psychology, health promoting occupational health nursing and research.

Health promotion practice requires knowledge on the context, philosophical and theoretical foundations of health promotion, leading intervention strategies, planning, management and organisation, evaluation of health promotion programmes and research in health promotion. In addition to the knowledge and skills required for health promotion health promoting nursing requires knowledge and skills in empowerment, facilitation, holism, equity, participation and negotiation.

It is evident from the literature reviewed (Latter 1993; Thomson & Dohli 1997) that nurses need to be trained in health promotion and health promoting nursing practice as is supported by the results from the following study done in Scotland. Health promotion training needs analysis was done through a study involving qualified hospital-based nurses in Lanarkshire, Scotland. In summary the study yielded these results: the topics
most discussed with patients by nurses were nutrition/diet followed by smoking and physical activity. The majority nurses agreed that health promotion is an important function of the nurse.

Respondents were asked what they consider they can ultimately contribute (with regard to their health promotion role) in their contact time with patients. The majority of respondents were interested in role development and responses also included that further education and training will facilitate the implementation of health promotion practice (Thomson & Kohli 1997:510-513).

From the above study it is clear that nurses have a need for further education and training and that a need exists for this training so that nurses can integrate health promotion in their nursing practice. The training need is further supported by the findings of a study done in England in 1992 (Latter 1993:75-76). In the study 132 ward sisters in nine health authorities in England were asked whether they perceived a difference between the terms health education and health promotion of which twenty five percent stated that they would use the terms interchangeably.

The understandings of the concepts, without distinguishing between the concepts were found to be characterised by some features namely:

- orientation to illness with emphasis on prevention or coping with illness as opposed to promotion of health
- health education and promotion were seen as consisting of advice giving predominantly on lifestyles around smoking and diet
- respondents perceived health promotion and their role in this as mainly one-to-one nurse patient activities
- responses also lacked any mention of the concepts central to health education and health promotion currently like empowerment, participation, equity and collaboration
- more emphasis was placed on the physical than on the social

A guideline for training in workplace health promotion is provided in the European Foundation’s framework or specification for training. The specification consist of two
structural components namely:

- a seven phased idealised health promotion process consisting of marketing health promotion, setting up structures, assessing needs, developing and implementing a plan, evaluating the initiative and amending the plan
- a set of six roles needed for successful health promotion namely expert, advocate, deliverer, participant, change facilitator and decision maker (Wynne 1999:20-21)

The implication for nursing arising from the above discussion is that nurses have an important role to play in health promotion and that a need exists for training in health promotion and health promoting nursing.

2.8 CONCLUSION

The need then as to why health promotion programme in the workplace and on the campus is clearly substantiated by the above literature review.

Meaning and interpretations were given to the concepts health promotion and occupational health promotion. The Ottawa Charter as point of departure for health promotion and subsequent health promotion developments were discussed. Principles and values underpinning health promotion and the Health Plan of the African National Congress were described. The rationale behind health promotion as well as the contents, organisation and management of a comprehensive occupational health programme were explored and discussed.

Finally, the role of the nurse in health promotion and the training needs for health promotion were reviewed.

In the following chapter the research design and methodology are described.
CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter gives an overview of the research design and methodology that are used in this research.

The constructs emanating from the conceptualisation phase (discussed in chapter 2) will be measured in the operational phase by means of the survey method.

The research methodology facilitates the attainment of the research objectives which are the following:

- The identification and description of the meaning of the concept health promotion according to the literature.
The identification and description of the meaning of the concept health promotion according to occupational and campus health nurses.

The description of the contents, organisation and management of a comprehensive occupational health promotion programme according to the literature.

Description of the contents, organisation and management of a comprehensive occupational health promotion programme according to occupational and campus health nurses.

Identification and description of the rationale behind occupational health promotion.

Exploration and description of the role of the nurse in occupational health promotion.

Exploration and description of the health promotion learning needs of nurses.

Identification and description of the need for occupational health promotion programmes.

3.2 RESEARCH DESIGN

To undertake a scientific study all the components need to fit together in a meaningful whole. To achieve this whole the researcher needs to draw up a design, the strategy for conducting the research or the plan to obtain answers.

Burns and Grove (1999:185) describe research designs as “a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings” and the end-result of a series of decisions of how the research will be implemented.

3.2.1 Selected design

The research design of this research may be described as mainly quantitative, with open-
ended questions interpreted qualitatively, which is exploratory and descriptive and non-experimental in nature so as to understand the phenomenon studied. This research enables respondents to provide personal viewpoints by means of open-ended questions.

This research falls into the category of applied research because the knowledge that is generated can directly influence or improve the practice of health promotion in the workplace.

No hypotheses are formulated in this study because specific outcomes are not predicted and the study is guided by specific research questions.

The following research concepts underpin this research:

+ **Non-experimental**

According to Brink (1996:108), in experimental research there is no manipulation of the independent variable and the setting is not controlled. The research is conducted in a natural setting, the phenomena observed and described and the relationships between variables are explored and explained. In this study the workplace is the setting and the phenomena described according to the selected occupational and campus health nurses.

+ **Quantitative research**

Quantitative research is described as a formal, objective, rigorous, systematic process in which numerical data are utilised to obtain information about the world (Burns & Grove 1999:23). Quantitative research allows the researcher to describe and interpret results from the data collected from the participants. This research describes the need for and content of occupational health promotion programmes according to the data collected from the respondents and is presented in tables, percentages and figures.

+ **Exploratory**

Exploratory research begins with interest in some phenomena and is aimed at investiga-
ting the full nature of the phenomena, its manifestation and other factors with which it is related. Exploratory studies are also conducted when a new area or topic is being investigated (Polit & Hungler 1999:17-18). Health promotion in the workplace is a relative new topic in South Africa and therefore this research is exploratory in nature.

✦ Descriptive

Polit and Hungler (1999:195-196) state that the purpose of descriptive studies is to observe, describe and document aspects of a situation as it naturally occurs. In addition a descriptive design may be used for the purpose of developing theory, identifying problems with current practice, justifying current practice, making judgments, or determining what others in similar situations are doing (Burns & Grove 1999:192). This research has as purpose the identification and description of the need for occupational health promotion programmes, the content, organisation and management of such a programme according to occupational health and campus health nurses. In formation about the current health promotion practice can be obtained.

3.2.2 Rationale for choice of design

The quantitative research design which is exploratory, descriptive and non-experimental in nature was to chosen so as to understand the phenomenon studied, to describe and interpret the research findings, to identify current nursing practice in a natural setting namely the workplace.

In addition validity and reliability can be measured through quantitative research, comparisons made and trends can be detected. The research findings can be generalised to the accessible population in this research.

3.3 RESEARCH METHOD

The survey method is chosen for this study so as to enable the researcher to collect data systematically, in an objective and unprejudiced manner in order to attain answers to the research questions and assumptions as stated in chapter 1. The required data is collected
through self-administered questionnaires, distributed to the respondents selected for this reason.

Polit and Hungler (1997:174) describe a survey as designed "to obtain information regarding the prevalence, distribution, and interrelationships of variables within a population", with no experimental intervention and the people in the sample respond to a series of questions posed by the researcher. Survey studies are concerned with gathering information from a sample of the population. The emphasis in the collection of data in survey studies is on structured indirect observation, questionnaires and interviews. In simple descriptive surveys, the researcher merely searches for accurate information about the characteristics or particular subjects, groups, institutions or situations or about the frequency of a phenomenon's occurrence (Brink 1996:109).

Surveys, however, have certain limitations. Intensive analysis of people's feelings or in depth meaning of circumstances cannot be made. Du Plooy (1996:46) states that one of the major problems with survey research is that of non-response, either as not returning a questionnaire or in the form of item non-response, in which certain questions are not answered.

3.3.1 Motivation for the use of the survey method

An exploratory and descriptive survey can be described as the collection of information from a group of people to describe their knowledge, beliefs, perceptions and opinions regarding a particular topic, event or issue (Polit & Hungler 1997:174). In this research the need for occupational health promotion programmes, the content, organisation and management of such a programme are investigated according to occupational and campus health nurses.

There are certain benefits of using the survey with reference to this study namely:

- Survey research is an economical way of collecting information because it needs less infrastructure and time. This research is limited to occupational and campus health nurses in the Tshwane Metropolitan area, which makes the study affordable.
A survey enables the researcher to obtain extensive information with a broad scope on the subject of occupational health promotion. Extensive analysis rather than intensive analysis are required for the aim of the research.

The researcher wants to know more about the opinion of nurses, working in diverse occupational settings, regarding aspects of occupational health promotion and aspects of their workplace. The survey method facilitates the access to this information.

3.3.2 Population and sample

A description of the population, sample, sampling process and the ethical considerations of the research are provided in this section.

3.3.2.1 Population

Polit and Hungler (1999:278) define a population as “the entire aggregation of cases that meet a designated set of criteria”. The population is the all the persons or objects the researcher is interested in for the purpose of a study.

The main aim of this research is to develop a nursing perspective on occupational health promotion in the workplace. The target population then consists of all occupational and campus health nurses in the Republic of South Africa. However, it is not realistic to include all occupational and campus health nurses and therefore the accessible population is all the registered nurses employed as occupational and campus health nurses in the Greater Pretoria Metropolitan Area (now called the City of Tshwane Metropolitan Municipality).

The criteria for inclusion in this research are:

• The participants are restricted to professional nurses and not other categories of nurses.
• Only nurses whose job description is occupational and campus health nurse is considered.

• The nurses have to be employed in the Greater Pretoria Metropolitan Area (the City of Tshwane Metropolitan Municipality).

The campus health service nurses are included because they render a service to students and staff members.

The Greater Pretoria Metropolitan Area (the City of Tshwane Metropolitan Municipality) is chosen for this study because it is accessible for the researcher, the diversity of occupational settings, identifiable population of professional nurses and economical considerations.

The accessible population was identified as follows:

• The researcher approached the campus health nurses at one tertiary education institution if they are interested in participating in the study. These nurses referred the researcher to other campus health nurses employed in tertiary education institutions in the Greater Pretoria Metropolitan Area (the City of Tshwane Metropolitan Municipality). The Pretoria Society of Occupational Health Nursing Practitioners was contacted and a list with members' names and addresses were obtained. This list served as a guideline for the distribution of the questionnaires.

• The number of participants are 64 occupational health and campus health nurses.

3.3.2.2 The sample

The sample which is defined by Polit and Hungler (1999:279) as the subset of the units that compose the population, was obtained from the accessible population.

3.3.2.3 Sampling process

Burns and Grove (1999:40-41) define sampling as the process of selecting a group of people, events, behaviours or other elements with which to conduct a study.
Purposive sampling combined with networking sampling, also called snowball sampling, are the sampling methods selected for this study while bearing in mind that there is no way to evaluate the precision of the researcher's judgement.

These sampling methods are employed because this research is about a specific topic, in a particular setting and from a specific nurses group perspective.

Purposive sampling is a non-probability sampling method described as "a sampling method based on the judgement of a researcher regarding subjects or objects that are typical or representative of the phenomenon (or topic) being studied, or who are especially knowledgeable about the question at issue" (Brink 1996:141). In this research professional occupational and campus health nurses were selected because they are employed in occupational settings and knowledgeable about health matters at work and in the campus environment.

Networking or snowball sampling is described by Polit and Hungler (1997:227) as a sampling approach in which early sample members are asked to identify and refer other people who meet the eligibility criteria for inclusion in the study. This sampling approach was used because not all occupational health nurses are members of the Pretoria Society for Occupational Health Nurses. The researcher is also not familiar with all campus health nurses and therefore relied on known sample members to refer others.

There are advantages and disadvantages in using purposive and network sampling which include:

- The advantage is that the researcher can determine who is included in the sample.

Disadvantages include:

- The potential for sampling bias.

- The use of a sample that is not representative enough of the population.
• The very limited generalisability of the results (Brink 1996:141).

Burns and Grove (1999:306) state that this approach has been criticised because there is no way to evaluate the precision of the researcher's judgement. Polit and Hungler (1999:284) are also of the opinion that this subjective method of sampling provides no external, objective method for assessing the typicalness of the selected participants. The same authors also maintain that this method can be used to advantage to effectively pretest and evaluate newly developed instruments.

3.3.2.4 Problems encountered in sampling

The following problems were encountered in the sampling process namely:

• Not all members of the accessible population that did not attend the meeting of the Pretoria Society of Occupational Health Nursing Practitioners could be reached telephonically.

• Some addresses and telephone numbers on the membership list of the Pretoria Society of Occupational Health Nursing Practitioners were incorrect.

• Two members of the accessible population were not interested in participating in this research.

3.3.2.5 The setting

According to Polit and Hungler (1999:158), settings are the more specific places where data collection will occur. The authors also states that studies sometimes are conducted in naturalistic settings such as people's homes or places of employment.

The setting for this research is the participant's places of employment.
3.3.2.6 Ethical considerations

According to Polit and Hungler (1999:131) when humans are used as study participants in research care must be taken that the rights of those humans are protected.

The ethical measures pertaining to survey research and this study were implemented as follows:

- **Voluntary participation.** All respondents participated voluntary of their own free will in this study. The participants were not coerced in any way. The principle of respect for human dignity and the self-determination were therefore adhered.

- **Informed consent.** The nature of the study was explained in the cover letter (see addendum B) and by the researcher during the meeting of the Pretoria Professional Society of Occupational Health Nurses on 4 August 1999. During this meeting the researcher had an opportunity to state the aim of the research to the professional nurses and 33 questionnaires were handed out which the respondents took home to complete. The researcher also explained the nature of the study telephonically to prospective participants who did not attend the meeting or were recruited for the research. The nature of the study was also explained in the written permission letters to some of the selected work places (see addenda C, D, E, F and G).

- **The right to privacy.** The right to privacy entails that any information collected from the study will be kept in strictest confidence. According to Polit and Hungler (1999:139) anonymity has been achieved when even the researcher cannot link a participant with the information for that person. In this research study no identifying information or numbering were indicated on the questionnaires.

- **Confidentiality,** on the other hand is the management by the researcher of the private information disclosed by the participant (Burns & Grove 1997:204). In this research confidentiality was maintained and confirmed with respondents in writing and verbally. The researcher took measures that no unauthorised person(s) gain access to the raw data of the research. The identities of the respondents were not
revealed during the reporting or publication of the research findings.

3.4 RESUMÉ OF THE STEPS THAT WERE FOLLOWED

This section gives an overview of the steps that were followed to conduct this study:

3.4.1 Conceptual phase

Through experience and a keen interest in health promotion a need was identified for occupational health promotion programmes. The idea then developed to do research on this topic. To facilitate the statement of the research problem a preliminary review of the literature was done. The research problem was stated and research questions, objectives and assumptions formulated to guide the study.

An extensive and focused literature review was then conducted to enhance and broaden the researcher's knowledge and understanding into the field of study and to define the conceptual context on which the study could be based. The literature review also served as a guideline for the development of the measurement instrument.

Polit and Hungler (1999:79-80) identify the following functions of a literature review namely that it can:

- help the researcher to generate ideas or focus on a research topic and aid in the formulation of appropriate research questions
- help the researcher to ascertain what is already known on the topic
- help in the development of a broad conceptual context into which the research topic will fit
- provide information on the research method and approach

3.4.2 Empirical phase

During this phase the required and preferred data-collection instrument was developed. The data-collection instrument was pretested and changes made accordingly. The nature
of the target population for this research was determined and the sample was selected. Permission to conduct the research was obtained from the relevant authorities. The required data was collected from the sample and the collected data was processed, tabulated and interpreted. Conclusions were reached based on the findings of the research and recommendations were made.

An extensive research report was compiled as the last and final step.

3.5  DATA COLLECTION

In this research data is collected by means of a self-administered questionnaire. Burns and Grove (1999:272) describe a questionnaire as a "printed self-report form designed to elicit information that can be obtained through written responses of the subject".

3.5.1 Choice of measurement instrument

The self-administered questionnaire is the choice of measurement instrument for this research for the following reasons:

• Questionnaires are less expensive and require less time and energy to administer.

• Questionnaires offer anonymity, especially in obtaining information about social sensitive issues.

• Bias is reduced because of the absence of an interviewer.

• Data analysis can be relatively easy.

However, there are certain disadvantages to using a self-administered questionnaire. Cormack (2000:302) identifies the following disadvantages of postal questionnaires:

• Low response rate and inability or difficulty in subjects understanding the written language.
• It is not possible to clarify or rephrase questions.
• Forced choice answers not reflecting the individual's experience reduced the willingness to respond.
• Introduction of bias by reading and/or answering questions out of order.
• Lack of personal contact between respondent and researcher.

Burns and Grove (1999:272) also state that if a questionnaire is too long, respondents fail to mark responses to all questions.

3.5.2 Development of the questionnaire

The researcher followed the following steps in the development of the questionnaire:

• Exploratory work was done by means of the analysis of the literature on occupational health promotion. Existing questionnaires in the literature served as a point of departure.

• Discussion with colleagues, friends, professional nurses, experts, and the supervisors of the study yielded ideas for topics included in the questionnaire.

• The desired information was identified after the two above mentioned steps.

• A draft questionnaire was compiled.

• This questionnaire was thereafter discussed with the statisticians of the Department of Statistics at the University of South Africa (Unisa). Their recommendations were implemented. Open-ended questions were deleted and the questionnaire was shortened.

• The questionnaire was thereafter discussed with the supervisors again. Irrelevant questions were deleted.
The questionnaire was pretested with 15 students in occupational health nursing at a tertiary education institution. The purpose of this was to determine the clarity of the questions, the length of time needed to complete the questionnaire and the effectiveness of the instructions. The student's comments and uncertainty about questions were taken into consideration and the questionnaire was adjusted.

The questionnaire was then given to four experts in the field of occupational health and occupational health nursing for a critical evaluation.

Final adjustments were made and the questionnaire discussed with the supervisors, statisticians and an expert on statistical analysis before the final copy was drafted.

A language expert then evaluated the grammar and spelling.

The final copy of the questionnaire was typed and printed for distribution.

An appropriate cover letter was attached to the questionnaires ensuring the anonymity of the subjects and the confidentiality of the information. The cover letter gives an explanation of the aim of the research, the approximate time required to complete the form, the name of the researcher and the organisation supporting the research (see addendum B for a copy of the cover letter).

### 3.5.3 Content of the questionnaire

The questionnaire only contained closed-ended questions with provision on certain questions of adding choices of the respondents' own.

#### ✦ Section 1: Personal information about the respondents

This information is required to know the sample and to determine if any differences in perception between nurses with different qualifications, age groups, place of work and years experience exist.
Section 2: Information relevant to the concept health promotion

The concept "health promotion" is subjected to many different interpretations and is often equated with health education. For the researcher it is necessary to establish what professional nurses understand by the concept health promotion.

Section 3: The content, management and organisation of an occupational health promotion programme

Data is collected in this section so as to gain an understanding of what the respondents' view as important topics/activities for an occupational health promotion programme and the organisation of such a programme from a nursing perspective. Current trends in health promotion practice and occupational health nursing can be identified from this information.

Section 4: Data relevant to health promotion in the workplace of the respondents

Section 5: Data on the disease and sick leave profile in the workplace

One of the research questions is to identify the need for health promotion programmes in the workplace. To enable the researcher to answer this question information had to be obtained from the questions in sections 4 and 5 of the questionnaire.

Section 6: Data pertaining to the role of the nurse in health promotion and nurses health promotion learning needs

See addendum A for a copy of the questionnaire.

The validity of the data-collection instrument was established by the following actions:

- The statisticians in the Department of Statistics assisted with the formation and design of the questionnaire.
• Students in Occupational Health Nursing completed the questionnaires for the pre-testing of the measurement instrument. Students had the opportunity to discuss the problem areas verbally with the researcher. Changes were made subsequently to address the problem areas and to accommodate the recommendations made.

• The questionnaire was given to four experts in Occupational Health and Occupational Health Nursing to evaluate the face validity. Recommendations of these experts were taken into consideration and the questionnaire was adjusted where the researcher was in agreement.

• The Department of Research Support Services at Unisa assisted with the analysis and interpretation of the collected data.

3.5.4 Distribution and collection of the questionnaire

Permission to conduct this research was obtained in writing or telephonically from the tertiary education institutions, local city council, businesses and from industries. The participation of the respondents however remained voluntary, the researcher thus respecting the right to human dignity. This principle is referred to as self-determination which means that prospective subjects have the right to decide voluntarily whether to or not to participate in the research (Polit & Hungler 1993:358). This is evident from the return of 64 completed questionnaires against the 80 that were distributed.

The researcher purchased a list with names of the members of the Professional Society of Occupational Health Nurses. This list served as a guideline for distribution of the questionnaires. The researcher attended the monthly meeting of the Pretoria Professional Society of Occupational Health Nurses on 4 August 1999. During this meeting the researcher had an opportunity to state the aim of the research to the professional nurses and 33 questionnaires were handed out which the respondents took home to complete. The researcher was not present with any of the completion of the questionnaires.

Telephonic contact was made with the prospective respondents that did not attend the meeting to determine their interest in participating in the study. To those that were
interested questionnaires were mailed or delivered by hand.

The researcher also determined telephonically from the members on the list of the society if there were other occupational health nurses employed in their place of work. These nurses then also received questionnaires. So even occupational health nurses that are not members of the society received questionnaires. All questionnaires to tertiary education institutions were delivered by hand after telephonic contact with the participants. Participation was requested telephonically and by the covering letter. The researcher followed up the completion of the questionnaires telephonically and went to collect some of the questionnaires personally.

To facilitate the return of the questionnaires, the researcher included a stamped, self-addressed envelope. In the cover letter a request was made to the participants to return the completed questionnaires as soon as possible, no fixed dated was stipulated. The telephone number of the researcher's supervisor and joint supervisor was also supplied on the covering letter, should any of the participants have any enquiries.

The analyses of these questionnaires are discussed in chapter 4 of this report.

3.5.5 Responses to the measurement instrument

Sixty-four of 80 questionnaires that were distributed were returned, where after the data was analysed. A total response rate of 80% was achieved which is a high response for questionnaires. It is stated by Burns (1999:272) that the response rate for mailed questionnaires is usually small (25% to 30%) which results in the sample not being representative of the population.

As the questionnaires were not numbered, it was not possible to identify the workplaces relevant to this research. What is known, however, is that all the questionnaires distributed to tertiary education institutions were returned.

Constraints experienced in the collection of the data included the following:
73

- Incomplete questionnaires in terms of item non-response. In one questionnaire one whole page was not answered.

- Rank order questions not answered correctly for example in items 23 and 24 one respondent entered a ranking of one against two alternatives and no other rankings.

- Not all questionnaires distributed were returned resulting in a 20% non-return.

- One questionnaire contained long descriptions of the Occupational Health and Safety Act, problems at work were discussed, problems with occupational health nursing being seen as primary health care and a section of the questionnaire was described as industrial psychology. Ten sections of this questionnaire were not answered.

3.6 DATA ANALYSIS

The returned questionnaires were coded and numbered to facilitate data capturing and the auditing of the captured data.

The researcher with the assistance of a statistician of the Department of Research Assistance Services analysed the captured data through the Statistical Package for the Social Sciences (SPSS) program, a statistical software package. By means of statistical procedures the quantitative data was analysed and presented in a meaningful way.

The qualitative data, from the sections, which had the option of providing own opinions, was recorded by hand under each item and paraphrased or quoted verbatim.

As this research is descriptive the research findings of the analysed data are presented mainly in frequency tables and different charts.

3.7 VALIDITY AND RELIABILITY

To make a research study meaningful the measurement instrument needs to be the
reliable and valid.

**Validity**

The validity of the data collection instrument was checked for face and content validity by supervisors, three lecturers in occupational health nursing and occupational health and hygiene as well as an occupational health nursing practitioner not included in the study. These experts with research experience and subject knowledge were asked to give feedback on the content, relevance of questions and any ambiguities in the wording of the items.

To establish logical or sampling validity items supported in the literature were included in the questionnaire and experts from the Department of Statistics and Research Support Services of Unisa was used to evaluate the items used in the measurement instrument. The statisticians also evaluated the measurement instrument in terms of the comprehensiveness to draw conclusions, appropriateness of questions, length of questionnaire and the suitability for data analysis.

**Reliability**

The internal consistency or homogeneity of reliability of the research instrument was established by means of the Cronbach's alpha (coefficient alpha) method.

### 3.8 Conclusion

This chapter provided an overview of the research methodology with a description of the target and accessible population and the research design. The sampling procedure and the development of the questionnaire plus the procedure followed to collect, analyse and interpret the data were described.

The next chapter provides an analysis and presentation of the research findings.
CHAPTER 4

Analysis and presentation of research findings

4.1 INTRODUCTION

In the preceding chapter all aspects relevant to the research methodology, design and the research procedure was discussed.

This chapter has as focus the analysis and discussion of data collected from occupational health and campus health nursing practitioners in diverse occupational settings. The findings are presented in tabular, graphic and written form. In addition an analysis of the validity and reliability of the measurement instrument is described.

The results of the research are discussed according to the sections of the questionnaire, namely:

- personal information of the sample
- the meaning of the concept health promotion
the contents, organisation and management of an occupational health promotion programme

• general information about health promotion and the data on the disease and sick leave profile of the workplaces where respondents work

• the role of the nurse in health promotion and health promotion learning needs of occupational health and campus health nurses

4.2 EVALUATION OF DATA QUALITY

Evaluation of the data quality is important in any research study. Polit and Hungler (1999:407) state that “an ideal data collection procedure is one that measures or captures the constructs in a way that is relevant, credible, accurate, unbiased and sensitive”.

Central to the evaluation of the quality of data are the reliability and the validity of the measurement instrument. If constructs have a low validity and reliability, the findings will be questionable.

4.2.1 Validity

The validity of this research was determined by the statistical procedure named factor analysis. By making use of factors, which are groups of variables that have certain characteristics in common, the need to separately compute statistics for individual variables is reduced. Burns and Grove (1999:325) describe that factor analysis sorts the variables into categories according to how closely related they are to the other variables and the closely related variables are grouped together into a “factor”. According to Burns and Grove (1997:495-496), factor analysis has the following uses, namely to:

• aid in the identification of theoretical constructs
• confirm the accuracy of a theoretically developed construct
• assist in the development of measurement instruments
• function as a data reduction strategy
The researcher carries out a factor analysis by examining the Eigenvalues to decide how many factors will be included in the factor analysis. According to Burns and Grove (1997:496), Eigenvalues are the sum of the square weights for each factor. The minimal amount of variance that must be explained by the factor to add significant meaning can be determined by making use of the scree test. The scree test is one of the strategies that may be used to decide on the number of factors to include in the factor analysis and this test is considered by some to be the most reliable. It requires that the Eigenvalues be graphed.

Figure 4.1 illustrates the scree plot from the factor analysis.

![Factor Scree Plot](image)

**Figure 4.1**  
*Scree Plot from the factor analysis*

A factor analysis for section 3 of the questionnaire was performed by means of the SPSS program and with the assistance of a statistician of the Department of Research Support
Services, at the University of South Africa.

Figure 4.2 illustrates the percentages of the factors.

![Factor Analysis Diagram]

**Figure 4.2**

*Factor analysis of the findings*

The findings of the factor analysis reflected in figure 4.2 with regards to the topics and activities reveals that factor one (occupational health) scores a percentage of 56.4. Factor 2 (mental health), scored a percentage of 7.4 and factor 3 (family health) 4.6%. In addition factor 4 (abuse/violence) obtained a score of 3.6%, factor 5 (lifestyle change programmes) 2.9% and factor 6 (socio-physical environment) scored a percentage of 2.8.

The lower importance attached to factors 5 and 6 indicates that there is not an holistic approach to the promotion of employees' health.

The factors are formulated as listed in table 4.1.
Table 4.1: Content of an occupational health promotion programme

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational hygiene</td>
<td>1 Occupational health</td>
</tr>
<tr>
<td>Workplace safety</td>
<td></td>
</tr>
<tr>
<td>Noise pollution</td>
<td></td>
</tr>
<tr>
<td>Healthy back education</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Air pollution</td>
<td>1 Occupational health (cont.)</td>
</tr>
<tr>
<td>First aid (physical)</td>
<td></td>
</tr>
<tr>
<td>Responsible use of medicines</td>
<td></td>
</tr>
<tr>
<td>Prevention of sexually transmitted diseases</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Water pollution</td>
<td></td>
</tr>
<tr>
<td>Physical fitness</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
</tr>
<tr>
<td>Abuse of alcohol</td>
<td></td>
</tr>
<tr>
<td>Personal hygiene</td>
<td></td>
</tr>
<tr>
<td>Water safety</td>
<td></td>
</tr>
<tr>
<td>Abuse of drugs</td>
<td></td>
</tr>
<tr>
<td>Healthy eating behaviour</td>
<td></td>
</tr>
<tr>
<td>Employee assistance programme</td>
<td></td>
</tr>
<tr>
<td>Lifestyle assessment</td>
<td>2 Mental health</td>
</tr>
<tr>
<td>Dealing with difficult people</td>
<td></td>
</tr>
<tr>
<td>Emotional first aid</td>
<td></td>
</tr>
<tr>
<td>Healthy lifestyle education</td>
<td></td>
</tr>
<tr>
<td>Healthy interpersonal relations</td>
<td></td>
</tr>
<tr>
<td>Stress management</td>
<td></td>
</tr>
<tr>
<td>Emotional health (mental health)</td>
<td></td>
</tr>
<tr>
<td>Cancer risk reduction</td>
<td></td>
</tr>
<tr>
<td>Physical fitness programme</td>
<td></td>
</tr>
<tr>
<td>Weight management programme</td>
<td></td>
</tr>
<tr>
<td>Personal health risk appraisal</td>
<td></td>
</tr>
<tr>
<td>Circulatory disease prevention</td>
<td></td>
</tr>
<tr>
<td>Men's health issues</td>
<td>3 Family health</td>
</tr>
<tr>
<td>Reproductive health</td>
<td></td>
</tr>
<tr>
<td>Road safety</td>
<td></td>
</tr>
<tr>
<td>Women's health issues</td>
<td></td>
</tr>
<tr>
<td>Responsible sexual behaviour</td>
<td></td>
</tr>
<tr>
<td>Constructive leisure time activities</td>
<td></td>
</tr>
<tr>
<td>Understanding ageing people</td>
<td></td>
</tr>
<tr>
<td>Safety in the home</td>
<td></td>
</tr>
<tr>
<td>Recreation</td>
<td></td>
</tr>
<tr>
<td>Spouse abuse</td>
<td>4 Abuse / violence</td>
</tr>
<tr>
<td>Prevention of violence</td>
<td></td>
</tr>
<tr>
<td>Child abuse</td>
<td></td>
</tr>
<tr>
<td>Healthy parenting</td>
<td></td>
</tr>
<tr>
<td>Dental disease prevention</td>
<td></td>
</tr>
<tr>
<td>Stop smoking programme</td>
<td></td>
</tr>
<tr>
<td>Alcohol control programme</td>
<td>5 Lifestyle – change programmes</td>
</tr>
<tr>
<td>Healthy intake of alcohol</td>
<td></td>
</tr>
<tr>
<td>Drug intake control programme</td>
<td></td>
</tr>
<tr>
<td>Financial management</td>
<td></td>
</tr>
<tr>
<td>Retirement planning</td>
<td>6 Socio-physical environment</td>
</tr>
<tr>
<td>Land pollution</td>
<td></td>
</tr>
<tr>
<td>Environmental education</td>
<td></td>
</tr>
<tr>
<td>Transcultural communication</td>
<td></td>
</tr>
</tbody>
</table>
Factor 1: Occupational health

In the analysis of the factor 1 it is evident that most topics are associated with traditional occupational health related issues and health problems that are most frequently treated in the workplace. Noise, air pollution and injuries are health hazards in most workplaces and, therefore, safety and occupational hygiene are attributed by the respondents as important in the workplace. First aid is rendered in case of injuries in the workplace and healthy back education is important to prevent back injuries.

HIV/AIDS and tuberculosis associated with this infection, other sexually transmitted diseases, diabetes, hypertension, abuse of alcohol and drugs are diseases with a high incidence in South Africa and are therefore frequently treated and managed health problems in the workplace. An employee assistance programme is a necessity for employees with alcohol and drug abuse problems, people who are HIV positive or suffering from AIDS, and workers with personal problems need to be counselled.

Personal hygiene education is important, especially in the food industry, because it is a requirement for maintaining health, and the lack thereof is often encountered in workplaces. In certain occupations physical fitness is a prerequisite like in the building industry, and in general, physical fitness is a component of a healthy lifestyle and assists with sustaining productivity. Healthy eating behaviour is important for providing the body and mind with the necessary nutrients to function effectively and build up the immune system.

Responsible use of medicines and education is essential for the prevention of misuse and abuse and protecting health care systems of over use. For medicines to be effective they need to be taken as prescribed and only if indicated.

Water safety can be seen in terms of not polluting water, of prevention of drowning and as the consumption of clean and safe water. Industries also often pollute nearby dams, rivers and streams with their effluent waste.
Factor 1 is associated with prevention of diseases and injuries, specific risk reduction and ill-health orientated with elements of health potential enhancement.

**Factor 2: Mental health**

Factor 2 can best be described as concerning mental and interpersonal health and lifestyle associated issues. Emotional (mental) health, emotional first aid, healthy interpersonal relations, stress management and dealing with difficult people are all issues of mental and social health. Stress is a psycho-social threat in the workplace particularly now in South African workplaces because of transformation, globalization and pressure for production and competition. Stress does not only manifests in physical symptoms but also manifests through emotional and behavioural features which can contribute to injuries, accidents, conflict and lowered productivity.

Physical fitness and weight management programmes can contribute to the prevention of diseases and act as stress management techniques. Lifestyle factors such as smoking, obesity, eating and emotional factors can be associated with cancer and circulatory diseases. Personal health risk appraisal and lifestyle assessments provide people with a risk profile for certain diseases and an indication of lifestyle matters that need attention. Many people are subjected to traumatic events in South Africa in the form of vehicle accidents, hijackings, theft, homicide, retrenchments and rape and are therefore in need of emotional first aid.

**Factor 3: Family health**

Central to the family health factor are mostly issues to do with people in their home environment. The themes emerging from this factor are men's and women's health issues, sexual issues, safety matters, recreation and leisure time activities. Parents and grandparents are part of families and can therefore explain the inclusion of understanding of ageing people in this factor.
Factor 4: Abuse/violence

It is evident in the factor abuse/violence that three topics have to do with violence and abuse, namely spouse and child abuse and prevention of violence. Healthy parenting can be a preventative measure for child abuse. However, dental disease prevention appears to be the topic that is not compatible with the theme violence.

Prevention of violence, healthy parenting and dental disease prevention are topics that are concerned with primary prevention. Spouse and child abuse are concerned with tertiary prevention.

Factor 5: Lifestyle-change programmes

The three programmes contained in this factor are programmes that are normally offered outside the workplace by other agencies. Programmes need a multi-disciplinary approach, are time intensive and would therefore not be seen as suitable to offer in the workplace.

However, if the workplace collaborates with outside agencies, the workplace can be an ideal venue for such programmes because programmes are available that do not need in-residence treatment. There are financial implications for using alcohol, drugs and smoking and often families are affected financially because of these habits. Healthy intake of alcohol is also an approach to the control of alcohol abuse. Knowledge about healthy intake of alcohol can possibly prevent the abuse of alcohol.

Factor 6: Social and physical environment

Two of the themes in this factor, namely land pollution and environmental education are to do with protecting and caring for the environment.

Retirement planning and transcultural communication may be perceived as belonging to an environment outside the workplace and has to do with social relations.
4.2.2 Reliability

To ensure the quality and adequacy, a measuring instrument needs to be reliable. In essence, the reliability of a measurement instrument is the degree of consistency with which it measures the attribute it is suppose to measure. Polit and Hungler (1999a:411) state to this effect that a reliable measure is one that maximises the true score component and minimises the error component. The greater the error, the lower the reliability.

Methods used to estimate reliability rely on the calculation of a reliability coefficient, a numeric index that reflects the proportion of true variability in a set of scores to the total obtained variability. The value of the reliability coefficient normally ranges between 0,00 and 1,00 indicating a perfect reliability and 0,00 indicating no reliability. A reliability of 0,70 for a newly developed instrument is considered acceptable (Burns & Grove1997:327).

The extent to which all the items of a measurement instrument measure the same attribute is the internal consistency or homogeneity aspect of reliability. In this study the Cronbach's alpha method (coefficient alpha) was used to evaluate the internal consistency of section 3 of the questionnaire. Cronbach's alpha yielded a 0,9845 value that is seen as highly reliable.

4.3 ANALYSIS AND PRESENTATION OF DATA GENERATED BY THE QUESTIONNAIRE

The research findings obtained from the questionnaires are analysed, presented and discussed in this section.

To organise the data the researcher used ungrouped frequency distributions to present the categorical variables by means of tables. The tables and figures reflect the numerical values obtained on a particular value as well as the percentage of the sample.

4.3.1 Section 1: The sample

To contextualise the research, it is important for the researcher to have knowledge of the
demographic and other relevant information about the sample. Items 1 to 12 on the questionnaire dealt with personal information and demographic characteristics of the sample.

The purpose of this section of the questionnaire was to obtain demographic and other personal information on the respondents who make up the sample. This information will also serve as a basis for analysis of other sections of the questionnaire.

**Item 1: Place of work**

In figure 4.3 the occupational settings of the respondents are depicted.

![Bar chart showing occupational settings of respondents](image)

**Figure 4.3**

*Occupational settings of the respondents (N=63)*

From figure 4.3 it is evident that the majority (46,0%) of the respondents work in the manufacturing industry, 6,3% at technikons, 11,1% at universities, 12,7% are private practitioners, 6,3% work in business and 17,5% in local authorities.
Item 2: Highest qualification

In figure 4.4 a record of the highest qualification of the respondents is represented.

![Figure 4.4](image)

**Figure 4.4**

*Highest qualification (N=64)*

From figure 4.4 it is clear that the majority (53.1%) of respondents have a diploma as highest qualification, 10.9% have a higher or advanced diploma, 25.0% with a bachelors degree, 9.4% with honours degrees and 1.6% (one respondent) with a masters degree. These findings demonstrate that less than half of the respondents have engaged in advanced postbasic education.

Items 3 to 9: Additional qualifications

Figure 4.5 presents an overview of the additional qualifications of the respondents.
Figure 4.5 demonstrates that 91.7% of the respondents have a midwifery qualification, 44.0% have psychiatric nursing qualifications, 87.3% have community health nursing qualifications, 90.0% have occupational health nursing qualifications, 40.4% have nursing administration qualifications with 20.9% of the respondents have a nursing education qualification.

The qualifications with the lowest percentages are also those answered by the least respondents, namely 50 psychiatric nursing, 47 nursing administration and 43 nursing education respectively. The researcher surmises that these findings are due to the fact that the respondents do not have the qualifications and therefore did not answer the items.

The most respondents, namely 60, each answered the items on midwifery and occupational health nursing. Twenty-one respondents indicated other qualifications additional to the above, of which those with the highest frequency is reflected in table 4.2.
Table 4.2: Other qualifications (N=21)

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samtrac occupational health and safety management</td>
<td>7</td>
</tr>
<tr>
<td>Diploma in PHC clinical diagnosis, and treatment and care</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacology for nurses</td>
<td>3</td>
</tr>
<tr>
<td>Business management and MDP</td>
<td>3</td>
</tr>
<tr>
<td>BA in psychology</td>
<td>2</td>
</tr>
</tbody>
</table>

As is reflected in table 4.2, seven respondents have a qualification in occupational health and safety management and four respondents have a qualification in clinical diagnosis, treatment and care. Three respondents indicated a qualification in pharmacology for nurses and business management with two respondents indicated that they have a bachelors of arts degree in psychology.

The following qualifications were all indicated by individual respondents: advanced nursing dynamics, paramedic, first aid, audiometry, marriage guidance and counselling, HIV/AIDS training, family planning, risk management and rheumatology nursing.

* Item 10: Gender

Figure 4.6 reflects the gender distribution.

![Gender distribution](image)
Of the 62 respondents who answered this question, 58 (93.0%) were female and 4 (6.5%) were males.

It is evident from this data that relatively few males are employed as occupational health or campus health nurses.

✦ Item 11: Age

Figure 4.7 reflects an analysis of the age groups of the respondents.

![Figure 4.7](image)

*Figure 4.7*

*Age (N=64)*

The results indicate that 4.7% of the respondents fall into the 20-29 year old category, 26.6% into the 30-39 year, the majority (45.3%) falling into the age category of 40 to 49 years and 23.4% into the 50-59 years of age. It is evident from the data that relatively few young adults are employed in the occupational and campus health nursing field.
Item 12: Years of experience in occupational or campus health nursing

The purpose of this section was to explore the years of experience the respondents have so as to draw comparisons between experience and responses.

Figure 4.8 reflects the years of experience of the respondents.

**Sixty-four respondents of whom 6.3% have less than one-year experience answered this item, 26.6% have 1-5 years, 18.8% have 6-10 years and the majority, namely 48.8% has more than 10 years experience.**

The findings in section 1 of the questionnaire demonstrate that less than half of the respondents have engaged in advanced postbasic education. Relatively few respondents have psychiatric nursing, nursing administration and nursing education. The respondents
only include four males. The majority falls into the 40-49 years old category and have 10 years and more experience in occupational health or campus health nursing. These aspects may be regarded as limitations to this research.

4.3.2 Section 2: The meaning of the concept health promotion

The purpose of section 2 of the questionnaire was the evaluation of the perception or meaning, occupational and campus health nursing practitioners attach to the concept health promotion. This aspect was important to this study because health promotion can be interpreted from different perspectives and from a nursing perspective it is equated with health education as is evident from the literature reviewed.

This section also deals with research question 2, namely what do nurses understand by the concept health promotion?

Table 4.3 represents the outcome of item 13.

Table 4.3: Meaning of the concept health promotion (N=63)

<table>
<thead>
<tr>
<th>Meanings</th>
<th>N=63</th>
<th>Yes %</th>
<th>No %</th>
<th>Unsure %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education?</td>
<td>63</td>
<td>96.8</td>
<td>3.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Prevention of disease?</td>
<td>60</td>
<td>96.7</td>
<td>3.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Decreasing health hazards?</td>
<td>59</td>
<td>96.6</td>
<td>0.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Enabling people to take control over their health?</td>
<td>61</td>
<td>95.1</td>
<td>4.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Nursing embraces health promotion?</td>
<td>55</td>
<td>90.9</td>
<td>7.3</td>
<td>1.8</td>
</tr>
<tr>
<td>Increasing health potential?</td>
<td>56</td>
<td>89.2</td>
<td>5.4</td>
<td>5.4</td>
</tr>
<tr>
<td>More than prevention of disease?</td>
<td>56</td>
<td>69.6</td>
<td>14.3</td>
<td>16.1</td>
</tr>
<tr>
<td>Advocacy for people's health rights?</td>
<td>55</td>
<td>67.3</td>
<td>18.2</td>
<td>14.5</td>
</tr>
</tbody>
</table>

The above table gives an overview of the meanings the respondents attach to health promotion:

• Health education meant health promotion to 96.8% respondents as against 3.2% who did not share that perception.
The majority of the respondents (96.7%) were of the opinion that prevention of disease meant health promotion as against only 3.3% that did not agree with this statement. None of the respondents were unsure on this item.

Decreasing health hazards were seen by 96.6% of the respondents as health promotion, whereas none indicated that it did not mean health promotion and 3.4% were unsure.

The majority of the respondents (95.1%) indicated that enabling people to take control over their health meant health promotion whereas 4.9% did not agree.

Nursing embraces health promotion were answered positively by 90.9% of the respondents, with 7.3% answered negatively and 1.8% were unsure.

The respondents had to indicate if increasing health potential meant health promotion to which 89.2% answered positively, 5.4% answered negatively and 5.4% were unsure.

More than prevention of disease denoted health promotion to 69.6% of the respondents whereas 14.3% were not of the opinion and 16.1% were unsure.

For 67.3% of the respondents advocacy for people's health rights denoted health promotion, against 18.2% who answered negatively and 14.5% were unsure.

The highest response rates were on the items, prevention of disease, health education and enabling people to take control over their health, which the majority of respondents indicated that those concepts mean health promotion. A higher response rate on these three statements may be explained in terms of the familiarity of those statements as against the other statements. The findings from item 13 are supported in the literature as is evident from the health promotion description of Maben and Macleod Clark (1995:1163), namely health promotion attempts to improve the health of an individual or community and is concerned with the prevention of disease. Health education through information-giving, advice, support
and skills training is a necessary prerequisite to health promotion. According to the Ottawa Charter (WHO 1986:1), health promotion is defined as "the process of enabling people to increase control over, and to improve their health".

The findings from the item that deals with health education can also be interpreted that nurses equate health education with health promotion. If so, then the findings of a study conducted in England in 1992 would support this, in which 132 ward sisters in nine health authorities were asked whether they perceived a difference between the terms health education and health promotion of which 25.0% stated that they would use the terms interchangeably (Latter 1993:75-76).

As is illustrated in table 4.3, 90.9% of the respondents indicated that nursing embraces health promotion, only 55 of the respondents answered the item. The lowest response rates, although they were 67.3% and 69.6%, were attached to the statements of that health promotion is advocacy for health rights and more than prevention. The highest percentages for negative and unsure responses were also indicated for these two statements.

A possible reason for this may be that nurses are not yet ready to enter the so-called political arena or might not be familiar with the concepts. In addition a possible explanation can be that the majority of the respondents fall into the age group 40-59 years and might not have had any training in health promotion or engaged in lifelong learning.

Additional meanings were attributed to the concept health promotion by nine respondents, which include the following quoted verbatim:

- The identification of health and safety hazards and trends.
- Prevention and reduction of accidents at home and work.
- Assists in detection of disease in early stages.
Maintain health through empowering with information and people take responsibility for their health.

People given knowledge about diseases and the optimisation of health.

Provision of basic needs to the needy by the government and the general improvement in adult literacy.

The last three verbatim statements of the respondents indicate thinking that is in line with the contemporary view of health promotion with its focus on more than health and disease as is supported in the literature. Maben and Macleod Clark (1995:1163) state that empowerment, equity, collaboration and participation are the means or methods of achieving health promotion and health promotion also fosters an ability to cope with illness or disease. These authors, in addition, also state that at a wider and broader level, health promotion is concerned with the wider influences on health, on legislation and the desire to effect social change to improve health.

In conclusion, health promotion means the prevention of disease, advocacy for health rights, decreasing health hazards, more than prevention of disease, health education, and increasing health potential as well enabling people to take control over their health. Health promotion also refers to the maintenance of health through empowerment, provision of basic needs and improvement in adult literacy. Health promotion is also inherent in nursing practice.

A wide range of meanings were attached to the concept health promotion. The more familiar concepts such as health education were answered by more respondents than the less known concepts, namely advocacy for people's health rights. However, all 64 respondents did not answer this section. A possible reason for this is that the concept health promotion is an unfamiliar and difficult concept to describe.
4.3.3 Section 3: The contents, organisation and management of a comprehensive occupational health promotion programme

The purpose of this section of the questionnaire was to determine the content (topics/activities), organisation and management of an occupational health promotion programme from a nursing perspective. This section relates to research question 4: What should the content, organisation and management of a comprehensive occupational health promotion programme (OHPP) consist of from a nursing perspective?

♦ Items 14 and 15: Occupational health promotion programme

The SPSS program used to analyse the findings, by means of calculating the mean and the standard deviation determined these rankings in ascending order of importance.

• Workplace safety was seen as very important by 89.1% respondents and as not important by 6.3%. Supporting evidence is provided by Saphire (1995:572) who proposes high risk reduction programmes such as hazard communication, safety, use of seat belts and ergonomics as part of a comprehensive programme.

• Occupational hygiene was rated as very important by 76.6% and as not important by 3.1% of the respondents. Supporting evidence is provided by Saphire (1995:572) who proposes high risk reduction programmes such as hazard communication, safety, use of seat belts and ergonomics as part of a comprehensive programme.

• First aid (physical) was rated as very important by 69.8% and as not important by 1.6% of the respondents. Wachs (1997:479-482) includes first aid as a topic in a comprehensive programme.

• Healthy back education was rated by 75.0% as very important and as not important by 4.7% of the respondents. Self-care programmes such as education that empowers self-health management, for example, on posture, are proposed by Saphire (1995:572).
• **Noise pollution** was perceived as very important by 71,9% and as not important by 3,1% of the respondents. This topic is entrenched in the informed choice programmes such as rationales for the use of personal protective equipment proposed by Saphire (1995:572).

• **Stress management** was rated as very important by 65,1% of the respondents and as not important by 4,8%. From the literature it is clear that stress management is an important topic in a health promotion programme as is supported by the opinion of Wachs (1997:479-482). In addition supporting evidence is also provided by O'Donnell (1994:XI) who states that emotional health is the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. Similarly to the above Zuma (1995:47) maintains that many important health activities can be accomplished at the workplace such as handling of managerial and poverty-related stress.

• **Prevention of sexually transmitted diseases** was perceived as very important by 65,6% and as not important by 6,3% of the respondents. Wachs (1997:479-482) is of the opinion that the reduction of communicable diseases like HIV/AIDS and the importance of immunisations should be addressed in an OHPP.

• **Abuse of alcohol** was rated as very important by 64,1% and 4,7% as not important. Alcohol and drug education is proposed by Wachs (1997:479-482) as part of a comprehensive OHPP.

• **Personal hygiene** was rated by 60,3% as very important and by 3,2% of the respondents as not important. Supporting evidence is provided by Zuma (1995:47) who maintains that many important health activities can be accomplished at the workplace such as basic hygiene including the prevention of pink eye.

• **Physical fitness** was perceived as very important by 65,1% of the respondents and as not important by 6,3%. Exercise, fitness or walking clubs, aerobics, team sports and hiking are activities that should be part of an OHPP according to Wachs.
Table 4.4 provides a summary of the ten most important topics determined by calculating the mean and the standard deviation.

Table 4.4: Ten most important topics/activities in the content of an OHPP (N=64)

<table>
<thead>
<tr>
<th>Topic/activity</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Workplace safety</td>
<td>1,33</td>
<td>1,02</td>
</tr>
<tr>
<td>2. Occupational hygiene</td>
<td>1,45</td>
<td>0,97</td>
</tr>
<tr>
<td>3. First aid</td>
<td>1,46</td>
<td>0,86</td>
</tr>
<tr>
<td>4. Healthy back</td>
<td>1,53</td>
<td>1,10</td>
</tr>
<tr>
<td>5. Noise pollution</td>
<td>1,55</td>
<td>1,02</td>
</tr>
<tr>
<td>6. Stress management</td>
<td>1,59</td>
<td>1,03</td>
</tr>
<tr>
<td>7. Prevention of sexually transmitted diseases</td>
<td>1,67</td>
<td>1,14</td>
</tr>
<tr>
<td>8. Abuse of alcohol</td>
<td>1,69</td>
<td>1,11</td>
</tr>
<tr>
<td>9. Personal hygiene</td>
<td>1,70</td>
<td>1,06</td>
</tr>
<tr>
<td>10. Physical fitness</td>
<td>1,70</td>
<td>1,16</td>
</tr>
</tbody>
</table>

- **Tuberculosis** was rated as very important by 64,1% and as not important by 6,3% of the respondents. Wachs (1997:479-482) is also of the opinion that the reduction of communicable diseases is an important aspect of an OHPP. In addition within the envisaged ANC’s National Health System (1994:20) priority will also be given to the prevention and control of major risk factors and diseases such as AIDS, tuberculosis, heart disease, common cancers and trauma.

- **Healthy interpersonal relations** were rated by 54,7% as very important and by 3,1% of the respondents as not important. This aspect is supported by O'Donnell (1994:xi-xii) who is of the opinion that social health refers to the ability to form healthy relationships with friends, family, neighbours and colleagues. This aspect may be addressed by child and frail parent care programmes, support groups, group recreation and sports teams. The author also believes that incorporating social health programmes into occupational health promotion programmes may represent the greatest opportunity available for improving the impact of health promoters.
Air pollution was perceived by 64.1% as very important and as not important by 3.1% of the respondents. The Ottawa Charter (1986:1) supports this topic or activity in that health cannot be separated from the other goals of living and people and their environments are inextricably linked. Creating supportive environments through caring for each other, our communities and the natural environment are the guiding principle for all nations, regions, communities and the world. In the ANC’s National Health Plan for South Africa (1994:20) priority will be given to the protection of the environment.

Responsible use of medicines was rated as by 62.5% as very important and by 6.3% of the respondents as not important. This item can be seen as part of alcohol and drug education as proposed by Wachs (1997:479-482).

Abuse of drugs was rated as very important by 62.5% and as not important by 6.3% of the respondents. The supporting evidence is supported by Saphire (1995:572) who proposes lifestyle change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise.

Figure 4.9 illustrates the next five most important topics/activities.

![Figure 4.9](image)

*The next five most important topics/activities*
The research findings from figure 4.9 reflect the following:

- **Emotional health** was rated by 60.3% as very important and by 4.8% of the respondents as not important. Emotional health is according to O'Donnell (1994:xii), the mental state of being of the individual and includes the stresses in a person’s life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure programmes. Wachs (1997:479-482) is also of the opinion that effective and assertive communication, as topics under mental health, should be addressed.

- **Healthy lifestyle education** was rated by 55.6% as very important and as not important by 4.8% of the respondents. Saphire (1995:572) proposes lifestyle-change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise. According to Wachs (1997:479-482), coping enhancement, time management, balancing home/work, sleeping well and travel seminars should be part of a comprehensive OHPP these aspects are included in a healthy lifestyle.

- **Physical fitness programme** was seen as very important by 57.1% and as not important by 3.2% of the respondents. O'Donnell (1994:xii) states that lifestyle-change programmes have as desired outcome lifestyle-related behaviour change, like quitting smoking, managing stress more effectively or exercising on a regular basis. Exercise, fitness or walking clubs, aerobics, team sports and hiking are activities that should be part of an OHPP according to Wachs (1997:479-482).

- **Employee assistance programme** (EAP) was rated as very important by 52.4% and not important by 3.2% of the respondents. A comprehensive health promotion programme also caters for employees with personal problems such as family problems, ageing or emotional difficulties. Sherman (1990:62-65) defines employee assistance programmes a core wellness activity in the workplace. EAP is seen as a health promotion essential although it focusses on existing problems instead of
on prevention. Emotional health is according to O'Donnell (1994:xi), the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure programmes.

- **Diabetes** was perceived by 54,0% as very important and by 3,2% of the respondents as not important. Saphire (1995:572) states that chronic disease management programmes such as diabetes and high blood pressure should be contained in a comprehensive OHPP.

A discussion of the remaining findings follows:

- **Alcohol control programme** was perceived by 57,1% of the respondents as very important and by 4,8% as not important. Saphire (1995:572) proposes lifestyle-change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise as part of a comprehensive OHPP.

- **Hypertension** was seen as very important by 54,0% and not important by 3,2% of the respondents. This aspect is supported by Saphire (1995:572) who is of the opinion that chronic disease management programmes such as diabetes and high blood pressure should be contained in a comprehensive OHPP.

- **Stop smoking programme** was seen as very important by 58,7% and as not important by 3,2% of the respondents. O'Donnell (1994:xi) states that lifestyle-change programmes have as desired outcome lifestyle-related behaviour change, like quitting smoking, managing stress more effectively or exercising on a regular basis. Successful lifestyle-change programmes use a combination of health education, behaviour modification, and experiential practice and feedback opportunities. Similarly to the above Zuma (1995:47) maintains that many important health activities can be accomplished at the workplace such as smoking cessation.
Environmental education was rated as very important by 54.0% and by 3.2% of the respondents as not important. The Ottawa Charter (WHO 1986:1) supports this topic or activity in that health cannot be separated from the other goals of living and people and their environments are inextricably linked. Creating supportive environments through caring for each other, our communities and the natural environment are the guiding principle for all nations, regions, communities and the world.

Personal health risk appraisal was rated as very important by 51.6% and as not important by 4.8% of the respondents. According to Wachs (1997:479-482), health risk appraisal is an aspect to be dealt with in an OHPP.

Land pollution was rated as very important by 50.0% and as not important by 3.2% of the respondents. The Ottawa Charter (WHO 1986:1) supports this topic or activity in that health cannot be separated from the other goals of living and people and their environments are inextricably linked. Creating supportive environments through caring for each other, our communities and the natural environment are the guiding principle for all nations, regions, communities and the world.

Drug intake control programme was seen as very important by 51.6% and as not important by 6.5% of the respondents. The supporting evidence is provided by Saphire (1995:572) who proposes lifestyle-change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise as part of a comprehensive OHPP.

Healthy eating behaviour was seen as very important by 48.4% and by 4.7% as not important. The supporting evidence is provided by Wachs (1997:479-482) who is of the opinion that nutrition related topics include low fat/high fibre, cooking classes, shopping classes and dental health should be addressed in a comprehensive OHPP.

Weight management programme was perceived by 46.0% of the respondents as very important and by 4.8% as not important. Saphire (1995:572) proposes
lifestyle-change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise as components of an OHPP.

- **Water pollution** was seen by 50,8% as very important and as not important by 6,3%. The supporting evidence is provided by The Ottawa Charter (WHO 1986:1) in which it is stated that health cannot be separated from the other goals of living and people and their environments are inextricably linked. Creating supportive environments through caring for each other, our communities and the natural environment are the guiding principle for all nations, regions, communities and the world.

- **Healthy intake of alcohol** was rated as very important by 49,2% and as not important by 3,2% of the respondents. The supporting evidence is provided by Saphire (1995:572) who proposes lifestyle-change programmes such as smoking cessation, weight loss, alcohol and drug abuse prevention and exercise as components of an OHPP. Healthy intake of alcohol is part of an alcohol abuse prevention programme.

- **Circulatory disease prevention** was rated as very important by 40,3% and as not important by 4,8%. Within the ANC’s National Health Plan priority be given to the prevention and control of major risk factors and diseases such as Aids, tuberculosis, heart disease, common cancers and trauma (ANC 1994:20).

- **Water safety** was ranked by 50,0% of the respondents as very important and by 4,7% as not important. No supporting evidence was found in the literature. However Wachs (1997:479-482) is of the opinion that home and car safety should be included in a OHPP and water safety can be seen as part of safety in the home.

- **Responsible sexual behaviour** was perceived by 47,6% of the respondents as important and as not important by 9,5%. Included in the ANC’s vision for health is the promotion of health with attention to health education on sexuality, child spacing, oral health, substance abuse, environmental and occupational health (ANC 1994:19-20).
• **Emotional first aid** was seen by 39.7% as very important and by 3.2% as not important. **Emotional health** is according to O'Donnell (1994:xi), the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure programmes.

• **Transcultural communication** was seen as very important by 40.6% and as not important by 4.7% of the respondents. The supporting evidence is provided by Wachs (1997:479-482) who states that effective and assertive communication as topics should be included under mental health.

• **Men's health issues** were rated as very important by 40.3% and as not important by 3.2%. No evidence was found in the literature to support this item.

• **Cancer risk reduction** was viewed by 42.9% as very important and by 4.8% as not important. Wachs (1997:479-482) is of the opinion that cancer prevention should be part of a comprehensive OHPP.

• **Lifestyle assessment** was seen as very important by 33.3% and by 3.2% of the respondents as not important. No supporting evidence found in the literature.

• **Dealing with difficult people** was perceived by 35.9% as very important and by 3.1% as not important. The supporting evidence is provided by Wachs (1997:479-482) who states that effective and assertive communication as topics should be included under mental health.

• **Recreation** was rated as very important by 31.3% and not important by 4.7% of the respondents. The inclusion of this item is supported by O'Donnell (1994:xi) who is of the opinion that emotional health is the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This
area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure programmes.

- **Women's health issues** were perceived as very important by 35.9% and as not important by 7.8% of the respondents. Women's health issues should be included because more women are in the labour market and estimated 70.0% of those women are in child bearing years. Health concerns to be addressed are breast examination, prenatal and postnatal care, breastfeeding, reproductive health and violence/abuse. The Adelaide Conference in 1988 identified the promotion of women's health as a priority. According to Saphire (1995:572), prenatal and postnatal programmes should be offered. Within the envisaged National Health System priority will be given to women's health issues, protection of the environment, maternal and child care, rural health services and health care of the disabled (ANC 1994: 19-20).

- **Financial management** was rated by 31.3% as very important and by 4.7% as not important. No evidence found in the literature to support this item.

- **Spouse abuse** was rated by 38.1% as very important and not important by 7.9% of the respondents. No evidence found in the literature to support this topic.

- **Reproductive health** was seen as very important by 38.1% and as not important by 11.1% of the respondents. Included in the ANC's National Health Plan is the promotion of health with attention to health education on sexuality, child spacing, oral health, substance abuse, environmental and occupational health (ANC 1994:19-20).

- **Prevention of violence** was seen by 39.7% as very important and by 9.5% of the respondents as not important. No specific evidence from the literature to support this topic was found.

- **Dental disease** prevention was rated by 30.6% as very important and as not important by 6.5% of the respondents. Wachs (1997:479-482) includes dental
health in a comprehensive programme.

- **Retirement planning** was rated by 33.3% respondents as very important and by 6.3% as not important. No supporting evidence was found in the literature although Wachs (1997:479-482) includes ageing well in a comprehensive OHPP.

- **Safety in the home** was rated as very important by 35.9% and not important by 9.4%. This topic is supported by Wachs (1997:479-482) who is of the opinion that home and car safety, first aid, and self-defence should be part of an OHPP.

- **Road safety** was rated as very important by 31.3% and as not important by 6.3% of the respondents. This topic is supported by Wachs (1997:479-482) who is of the opinion that home and car safety, first aid, and self-defence should be part of an OHPP.

- **Child abuse** was seen as very important by 38.1% and not important by 14.3%. No supporting evidence was found in the literature.

- **Healthy parenting** was perceived as very important by 30.2% and as not important by 12.7% of the respondents. Wachs (1997:479-482) is of the opinion that family health aspects such as raising healthy children, ageing parents, effective and assertive communication as topics under mental health should be included in an OHPP. Frye and Veatch (1989:423-424) are also of the opinion that a parent education programme in the workplace not only benefits the individual parent but also the employee.

- **Constructive leisure time** was rated by 14.5% as very important and by 11.3% as not important. Emotional health is according to O'Donnell (1994:xi), the mental state of being of the individual and includes the stresses in a person's life, the reaction of the individual to these stresses as well as the ability to relax and devote time to leisure activities. This area is addressed in workplace health promotion programmes by stress management, employee assistance and recreation and leisure.
Understanding aging people was rated as very important by 21.0% and as not important by 9.7% of the respondents. Wachs (1997:479-482) is of the opinion that family health aspects such as raising healthy children, ageing parents, effective and assertive communication as topics under mental health should be included in an OHPP.

One respondent listed workplace conflict management as an additional topic for an OHPP.

In order to make the list of topics/activities more comprehensible a table was compiled to present the ten least important topics/activities. To determine these rankings the mean and standard deviation were calculated.

Table 4.5 an overview of the 10 least important topics/activities in the content of an OHPP.

Table 4.5 The ten least important topics/activities in an OHPP (N=64)

<table>
<thead>
<tr>
<th>Topic/activity</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Reproductive health</td>
<td>2.35</td>
<td>1.37</td>
</tr>
<tr>
<td>2 Prevention of violence</td>
<td>2.37</td>
<td>1.38</td>
</tr>
<tr>
<td>3 Dental disease prevention</td>
<td>2.37</td>
<td>1.22</td>
</tr>
<tr>
<td>4 Retirement planning</td>
<td>2.38</td>
<td>1.21</td>
</tr>
<tr>
<td>5 Safety in the home</td>
<td>2.39</td>
<td>1.32</td>
</tr>
<tr>
<td>6 Road safety</td>
<td>2.41</td>
<td>1.23</td>
</tr>
<tr>
<td>7 Child abuse</td>
<td>2.41</td>
<td>1.43</td>
</tr>
<tr>
<td>8 Healthy parenting</td>
<td>2.65</td>
<td>1.39</td>
</tr>
<tr>
<td>9 Constructive leisure time activities</td>
<td>2.74</td>
<td>1.21</td>
</tr>
<tr>
<td>10 Understanding aging people</td>
<td>2.84</td>
<td>1.28</td>
</tr>
</tbody>
</table>

It can be concluded from these findings that:

- The ten most important topics/activities are traditional occupational health and safety related issues, with workplace safety ranked number 1 and physical fitness ranked number 10, are depicted in table 4.4.
- The unhealthy was seen as more important than the healthy, focus on sickness
more than health as illustrated by the fact that abuse of alcohol is rated more important than healthy intake of alcohol (see the discussion of these two subitems of item 14 and 15).

- Topics/activities of a physical nature are ranked as more important than those topics of a psycho-social nature like physical first aid is rated as more important than emotional first aid (see table 4.4 and paragraph 35). Six of the least preferred topics are psycho-social in nature. Only two of the most important topics/activities are psycho-social in nature like abuse of alcohol and stress management (see tables 4.4 and 4.5).

- The topics that are related to family and employees life outside the workplace is rated as less important such as healthy parenting, child abuse, understanding ageing people, retirement planning and constructive leisure time activities. These topics are also more of a psycho-social nature (see table 4.5).

- It is worth taking note that the following topics, namely child abuse (14,3%), healthy parenting (12,7%), constructive leisure time activities (11,3%) and reproductive health (11,1%) were perceived by the respondents as not important. Transcultural communication, violence and child abuse are examples of problem areas in South Africa though they are possibly perceived as something that belongs to life outside the workplace. No reason or explanation can be provided by this research for these findings. Constructive leisure time is important for self-esteem, enjoyment, vital in a healthy lifestyle and can possible lead to the prevention of frustrations that can lead to abuse of alcohol and violence.

✦ Item 16: Do you think that aspects of all employees' health should be evaluated as part of an OHPP?

The purpose of this section of the measuring instrument was to determine whether the respondents thought that special investigations pertaining to employees' health should be evaluated as part of an occupational health promotion programme.
Table 4.6 provides an overview of the special investigations.

Table 4.6: Special investigations (N=62)

<table>
<thead>
<tr>
<th>Special investigations</th>
<th>N=64</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyesight and vision</td>
<td>62</td>
<td>98.4</td>
<td>0.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>61</td>
<td>95.1</td>
<td>3.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Hearing</td>
<td>62</td>
<td>90.4</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Back problems</td>
<td>61</td>
<td>85.2</td>
<td>11.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Urine analysis</td>
<td>61</td>
<td>83.6</td>
<td>9.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Lung function</td>
<td>55</td>
<td>78.2</td>
<td>14.5</td>
<td>7.3</td>
</tr>
<tr>
<td>Personal risk for certain diseases</td>
<td>60</td>
<td>77.0</td>
<td>11.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>60</td>
<td>65.0</td>
<td>26.7</td>
<td>8.3</td>
</tr>
</tbody>
</table>

As can be seen from table 4.6, 98.4% of the 62 respondents was of the opinion that eyesight and vision should be tested whereas 0.0% indicated negatively and 1.6% were unsure.

Of the 61 respondents 95.1% indicated that blood pressure should be evaluated with 3.3% of the respondents indicating negatively and 1.6% were unsure.

Hearing should be investigated according to 90.4% of the 62 respondents in contrast to 4.8% that indicated negatively and 4.8% that were unsure.

Of the 61 respondents 85.2% indicated that employees should be evaluated for back problems with 11.5% did not share this viewpoint and 3.3% were unsure.

Urine analysis should be done according to 83.6% as against 9.8% who answered negatively and 6.6% were unsure.

Of the 55 respondents 78.2% was of the opinion that lung function should be evaluated with 14.5% who answered negatively. The lower item response rate, namely 55 can possibly be attributed to the fact that some of the respondents work in settings such as a business where air pollution is not a hazard.
Of the 60 respondents who answered the item on the evaluation for personal risks for diseases 77.0% answered positively, 11.5% answered negatively and 11.5% were unsure.

Cholesterol should be evaluated according to 65.0% of the 60 respondents with 26.7% who indicated it should not be evaluated. The relatively high percentage, namely 26.7% that answered negatively to the analysis of cholesterol levels can be due to the fact that it is costly to take blood samples and have them evaluated.

Eight respondents made additional comments and also identified other aspects of employee's health that should be evaluated as quoted verbatim:

- The above aspects depends on the type of industry and the job people do like vision screening if the job requires driving.
- Lung function will depend on the job and if indicated.
- First do a screening, then continue with special examinations.
- You can include any topic, but I think you should identify the promotion programme after you have done your occupational health risk assessment per plant as well as your periodical medical evaluations.
- Occupational history – very important link into the above on individual basis and occupational risk basis. Back problem screening only if the employee is subjected to ergonomic stress.
- Weight and body fat.
- Tuberculosis and cannabis use screening.
- Stress profile.
- Previous medical, surgical and employment history.
Blood tests though not specified for what except one respondent indicated the blood glucose levels should be measured.

Physical assessment at commencement, periodically and exit.

Alcohol consumption.

"As I understand, according to the ACT this can only be done in the job performed has an inherent hazard which include 16.1 – 16.9. If the job therefore requires it – the answer would be yes. If not, it will be illegal to do it".

"All depends on where the person is working – will also determine the information that they will need in such a programme".

Ergonomics.

At this point it is worth noting that according to Wachs (1997:479-482), the screening of vision, hearing, cholesterol, pulmonary function and blood pressure should be part of a comprehensive programme.

Item 17: Presentation methods of a health promotion programme

The reason for this section of the measuring instrument was to enable the researcher to determine the methods the respondents thought should be employed to offer an occupational health promotion programme. These methods are presented in table 4.7.

An overview of the findings of item 17 are presented in table 4.7.
Table 4.7: Presentation methods (N=64)

<table>
<thead>
<tr>
<th>Methods</th>
<th>N=64</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education talks</td>
<td>63</td>
<td>92.1</td>
<td>6.3</td>
<td>1.6</td>
</tr>
<tr>
<td>Posters</td>
<td>64</td>
<td>90.6</td>
<td>4.7</td>
<td>4.7</td>
</tr>
<tr>
<td>Video programmes</td>
<td>62</td>
<td>90.3</td>
<td>6.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Pamphlets</td>
<td>63</td>
<td>88.9</td>
<td>6.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Monthly newsletter</td>
<td>63</td>
<td>87.3</td>
<td>7.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Group information sessions</td>
<td>63</td>
<td>81.0</td>
<td>11.1</td>
<td>7.9</td>
</tr>
<tr>
<td>Workshops</td>
<td>63</td>
<td>79.4</td>
<td>15.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Discussion groups</td>
<td>63</td>
<td>77.8</td>
<td>15.9</td>
<td>6.3</td>
</tr>
<tr>
<td>Individual information sessions</td>
<td>64</td>
<td>75.0</td>
<td>21.9</td>
<td>3.1</td>
</tr>
<tr>
<td>Bulletin board</td>
<td>63</td>
<td>74.6</td>
<td>19.1</td>
<td>6.3</td>
</tr>
<tr>
<td>Theatre presentations</td>
<td>61</td>
<td>63.9</td>
<td>21.3</td>
<td>14.8</td>
</tr>
<tr>
<td>Lectures</td>
<td>63</td>
<td>61.9</td>
<td>33.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Payroll inserts</td>
<td>61</td>
<td>57.4</td>
<td>32.8</td>
<td>9.8</td>
</tr>
</tbody>
</table>

It is evident from the above table that 90.0% and more of the respondents favoured health education (92.1%), posters (90.6%) and video programmes (90.3%). These three methods need fewer interactions from the nurses unless health education talks and video programmes are presented in a participative manner. A possible explanation for this is that posters and video programmes are readily available and health education talks can be presented in a short period of time.

More than 80.0% of the respondents favoured pamphlets (88.9%), monthly newsletter (87.3%) and group information sessions (81.0%). A possible explanation for this preference is that pamphlets and monthly newsletters are one way health communication methods and easy to administer. Group information sessions can also be less interactive depending on the presentation manner.

The following presentation methods, namely workshops (79.4%), discussion groups (77.8%), individual information sessions (75.0%), bulletin board (74.6%), were favoured by 70% and more of the respondents. Workshops, discussion groups and individual information sessions are more interactive methods and time consuming for nurses and workers. The bulletin board is also a one-way and a less interactive communication method, however a bulletin board needs updating and ordering.
The least preferred methods are theatre presentations (63.9%), lectures (61.9%) and payroll inserts (57.4%). The reason for the relatively lower percentages in these methods might be attributed to the fact that theatre presentations and payroll inserts are not so common and familiar methods. A lecture is time consuming, needs a suitable venue and is not so effective in facilitating learning and may therefore have been preferred by less of the respondents. However, larger audiences can be reached through lectures. Despite the gaining in popularity of industrial theatre presentations as a training method in organisations and corporations, 14.8% of the respondents were unsure of this method.

Relatively high percentages of the respondents answered negatively to the following methods, namely:

- Group information sessions (11.1%), workshops (15.9%), discussion groups (15.9%).
- Individual information sessions (21.9%), bulletin board (19.1%), theatre presentations (21.3%), lectures (33.3%) and payroll inserts (32.8%). These findings can maybe be attributed to the fact that these methods are time consuming, can be disruptive to production or that nurses are not skilled in the necessary presentation and facilitation skills.

Additional methods identified by three respondents include the following: competitions, on the spot health education, and health and promotional days like fun runs. In addition four respondents indicated the use of the Internet and e-mail.

One respondent is of the opinion that all can work (quoted verbatim).

Items 18 and 19: Potential benefits of an occupational health promotion programme for employees and employers

The aim of this section of the measuring instrument was to explore the respondent's
perception of the potential benefits of an occupational health promotion programme for employees and employers.

The findings of item 18 are illustrated in table 4.8.

Table 4.8: Potential benefits of an OHPP for employees (N=64)

<table>
<thead>
<tr>
<th>Potential benefits</th>
<th>N= 64</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved health status</td>
<td>63</td>
<td>95.2</td>
<td>1.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Improved morale</td>
<td>63</td>
<td>92.1</td>
<td>3.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Increased motivation</td>
<td>64</td>
<td>89.1</td>
<td>4.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Enhanced organisational commitment</td>
<td>64</td>
<td>89.1</td>
<td>4.7</td>
<td>6.3</td>
</tr>
<tr>
<td>Feeling cared for</td>
<td>63</td>
<td>88.9</td>
<td>6.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Decreased stress</td>
<td>63</td>
<td>88.9</td>
<td>6.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Enhanced job satisfaction</td>
<td>64</td>
<td>87.4</td>
<td>6.3</td>
<td>6.3</td>
</tr>
</tbody>
</table>

As can be seen from table 4.8, 80.0% and more of the respondents answered positively to all the potential benefits listed. The percentage respondents who answered negatively or were unsure were very low.

All 64 respondents indicated increased motivation, organisational commitment and enhanced job satisfaction as potential benefits.

Additional benefits identified by 10 respondents as quoted verbatim include:

- Assertiveness and self-reliance.

- Healthy and happy family/ society.

- "On condition that there is no uncertain working conditions, because job security or uncertain job conditions will not contribute to the above".
• Decrease in health expenditure and expenses/ reduced medical costs.

• Early detection of disease and occupational disease.

• Increased productivity, motivation and self acceptance.

• Improved sense of security and improved family commitments.

• Increased societal commitments.

• More clarity on health issues.

• Fewer accidents.

✦ Findings of item 19

Table 4.9 gives a presentation of the potential benefits of an occupational health promotion programme for employers.

Table 4.9: Potential benefits of an OHPP for employers (N=64)

<table>
<thead>
<tr>
<th>Potential benefits</th>
<th>N=64</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity improvement</td>
<td>64</td>
<td>95,3</td>
<td>0,0</td>
<td>4,7</td>
</tr>
<tr>
<td>Reduced absenteeism</td>
<td>63</td>
<td>93,7</td>
<td>1,6</td>
<td>4,7</td>
</tr>
<tr>
<td>Decrease in accidents</td>
<td>62</td>
<td>92,0</td>
<td>3,2</td>
<td>4,8</td>
</tr>
<tr>
<td>Reduced health care costs</td>
<td>64</td>
<td>90,6</td>
<td>6,3</td>
<td>3,1</td>
</tr>
<tr>
<td>Product quality enhancement</td>
<td>63</td>
<td>82,5</td>
<td>9,5</td>
<td>8,0</td>
</tr>
<tr>
<td>Reduced staff turnover</td>
<td>63</td>
<td>76,2</td>
<td>14,3</td>
<td>9,5</td>
</tr>
<tr>
<td>Improvement in community image</td>
<td>63</td>
<td>66,7</td>
<td>20,6</td>
<td>12,7</td>
</tr>
</tbody>
</table>

It is evident from table 4.9 that 80,0% and more of the respondents perceived the following as potential benefits, namely productivity improvement, reduced absenteeism, decreased accidents, reduced health care costs and product quality enhancement.
Reduced staff turnover was perceived by 76.2% of the respondents as a potential benefit as against 14.3% who answered negatively.

Improvement in community image was perceived by 66.7% as a potential benefit, whereas 20.6% answered negatively and 12.7% were unsure. A possible reason for the relatively high negative and unsure response on improvement in community image can be that it is a fairly lateral and unfamiliar perception.

All 64 respondents indicated productivity improvement and reduced health care costs as potential benefits.

Four respondents identified additional benefits for employers quoted verbatim, namely:

- Ownership.
- Early identification of disease happening.
- Early detection of disease and occupational disease.
- Prevention of occupational disease.

An example of such a verbatim response includes the following:

- *Ja bydraend maar tersiër redeneer glad nie so nie/bedryf sielkunde vir bestuur om werkers se houdings vir produktiwiteit te verhoog.* (Yes contributory, but tertiary do not reason so/industrial psychology for management to change the attitudes of workers towards increased productivity).

These findings are supported by Lusk (1992:417) and Breucker and Schröer (1999:7) who reflect that various researchers found positive outcomes regarding absenteeism, health
care costs, reduction of accidents, observed possible overall improvement in productivity, cost savings in current health care costs and improvement in employees attitudes and morale.

✦ **Item 20: Financial contribution of employees**

The respondents were asked whether they think employees should contribute financially towards an occupational health promotion programme.

Sixty-one of the respondents answered item 20 with the majority of the respondents (48.8%) of the opinion that employees should not contribute financially and 25 (39.1%) answered positively. Five respondents (7.8%) were unsure.

✦ **Item 21: Workplace as a suitable venue**

Respondents' evaluation of the workplace as a suitable venue was extremely positive, as is evident from 96.8% of 63 respondents that answered positively and 3.2% were unsure.

The finding is supported Girdano (1986:12) who states that research has demonstrated that people tend to make better use of programmes offered at work than they do of similar programmes offered in other settings.

One respondent commented as quoted verbatim the following:

"As the only place, but no time".
Item 21: Family participation

Sixty-two respondents, of whom 61.3% were of the opinion that family should participate, while 27.4% were of the opinion that family should not participate and 11.3% were unsure, answered this item.

One respondent was of the opinion that “family can participate on condition that the occupational health programme for the employees is up to date”.

Items 22 and 23

The purpose of items 22 and 23 were to identify the preferred structure under which an OHPP should resort and who is the preferred person to manage such a programme according to occupational and campus health nurses.

Item 22: Preferred structure (department) under which an OHPP should resort

The most preferred structure, under which an OHPP should fall, by 38 of the respondents, is the occupational health and safety department. The second most preferred structure is the human resources department with the least preferred structure as a private organisation (3 respondents). No evidence was found in the literature to support these findings.

Item 23: Preferred person to manage an OHPP

Of the 48 respondents who answered the rank order question correctly, 31 respondents rank the occupational health nurse as the most preferred person to manage an OHPP.
The second most preferred person is a health promotion coordinator with 22 respondents who indicated this preference. The trade union is the least preferred manager of an OHPP with 41 respondents indicating this ranking.

For the purpose of analysing the data of item 23, 16 questionnaires could not be considered because they were incomplete or incorrectly ranked.

Item 25: Levels of intervention

Figure 4.10 depicts the responses to item 25.

![Levels of intervention graph](image)

**Figure 4.10**

*Levels of intervention (N=64)*

The findings as illustrated in figure 4.10 reveals that 90.0% and more of the respondents are of the opinion that all three levels of intervention should be used.
Item 26: The inclusion of an EAP in an OHPP

Of the 62 respondents who answered this item 90.3% are of the opinion that an employee assistance programme should be part of an occupational health promotion programme, 6.5% answered negatively and 3.2% were unsure. This finding is supported by Sherman (1990:62-65) who states that employee assistance programmes is a core wellness activity in the workplace and is seen as a health promotion essential although it focusses on existing problems instead of on prevention.

Item 27: Early learning centre for children

Of the 63 respondents who answered this item 85.7% are of the opinion that an early learning centre for employee's children should be part of an occupational health promotion programme with 3.2% and 11.1% felt unsure. No evidence was found in the literature to support the finding that on-site childcare facility is preferred above off-site facilities. Nevertheless Coulson, Goldstein and Ntuli (1998:154) are of the opinion that such a facility would be beneficial.

An extensive overview was provided of the topics/activities that should be included in an OHPP with the more traditional occupational health and safety issues as the most important.

The respondents in general were in favour of special investigations of employees' health as part of a comprehensive OHPP, particularly vision, hearing and blood pressure control.

The less interactive and time-consuming methods are the most preferred methods of presentation. Due to workload, time pressure and the focussed practice on occupational health and related issues, nurses might choose the less interactive and time-consuming methods. However, all listed methods were answered by more than 50.0% of the respondents. The respondents identified a range of benefits of an OHPP for employees and employers. The majority of the respondents were of the opinion that employees
should not contribute financially and that the family should participate in an OHPP. The majority of the respondents were also of the opinion that the workplace is a suitable venue for an OHPP.

The occupational health and safety department was the preferred structure under which an OHPP should resort and the occupational health nurse as the preferred manager. The majority of the respondents felt that all three levels of intervention, namely awareness campaigns, lifestyle behavioural change programmes and supportive environments should be included in an OHPP. According to the majority of the respondents, an OHPP should also include an EAP and an early learning centre for children.

4.3.4 Section 4: General data about health promotion in the respondent's place of work

The purpose of this section of the measuring instrument was to collect data about the respondents' perceptions of health promotion related issues in their workplaces. This section of the measurement instrument relates to research question 8: Is there a need for occupational health promotion programmes in selected occupational settings?

Item 28: The presence of a health promotion programme in the workplaces

Figure 4.11 provides an overview of the presence of health promotion programmes in the places of work of the respondents.
From the above figure only 24 (37,5%) of the 61 respondents indicated that a health promotion programme exist in their workplaces. Twenty-three (37,7%) respondents answered negatively and 23,0% were unsure. No explanation can be given for the finding that 23,0% of the respondents were unsure if an OHPP exists in their workplace.

**Item 29: Presence of an employee assistance programme in workplaces**

The majority of the respondents 69,8% of the 63 who answered this item indicated that there is an employee assistance programme in their workplace with 22,2% indicating there is no programme and 7,9% of the respondents were unsure.
Item 30: Identification of the need for an occupational health promotion programme

In figure 4.12 the responses of item 30 are reflected.

Figure 4.12
Need for an occupational health promotion programme at workplace (N=61)

Figure 4.12 clearly illustrates that 57.1% respondents answered positively, 36.5% answered negatively and 6.3% were unsure. According to the Occupational Health and Safety Act No of 1993 (South Africa 1993), workplaces are required to have a health programme. This legal requirement can possibly explain why 36.5% of the respondents felt that there is no need for an OHPP. In addition an existing health education programme in the workplace can maybe be seen as an OHPP.
Item 31: Working conditions conducive to all aspects of health

Of the 61 respondents who answered this question 93.4% answered positively, 3.3% answered negatively and 3.3% were unsure.

Item 32: The workplace as a healthy organisation

Of the 63 respondents who answered this question 46.0% (29) are of the opinion that their workplaces are healthy organisations, 44.4% answered negatively and 9.5% were unsure.

Item 33: Prevalence of a quality of work life

Of the 63 respondents who answered item 33, 37 (58.7%) answered positively, 15 (23.8%) answered negatively and 17.5% were unsure.

The findings between items 31, 32 and 33 are contradictory. Possible reasons for this are that the meanings of the concepts, working conditions, healthy organisation and quality of work life, could have been misinterpreted or not understood.

The findings of this section of the measurement instrument are contradictory. However, more than half of the respondents (57.1%) stated that there is a need for an occupational health promotion programme despite 39.3% that indicated that there is an OHPP in their places of work.

4.3.5 Section 5: Data on the disease and sick leave profile in the respondent's place of work

The purpose of this section of the questionnaire was to obtain information on the number of employees suffering from ill-health, number of employees absent due to sick leave, number of lost working days and the number of hours nurses spend on the different levels
of nursing care. This section of the questionnaire pertains to research question 8.

Item 34: The adverse influence of the place of work on employees' health

Figure 4.13 depicts the findings of item 34.

![Figure 4.13: Adverse influence of workplace (N=61)](image)

Of the 63 respondents who answered this item, 52.4% of the respondents answered positively, 27.0% answered negatively and 20.6% were unsure.

If these findings are compared with the findings in item 31 a discrepancy is found. When the respondents were asked if working conditions are conducive to health 93.4% answered positively.

Item 35: Incidence of employees' suffering of ill-health

Of the 61 respondents who answered this item 29.5% answered positively, 49.2%
answered negatively and 21,3% were unsure. A possible reason for 21,3% of the respondents being unsure is that they do not have the statistics or they might be campus health nurses who do not see that many employees.

♦ **Item 36: Incidence of employees with injuries**

Of the 61 respondents who answered this item 29,5% answered positively, 60,7% answered negatively and 9,8% were unsure.

♦ **Item 37: Number of employees in workplace**

Of the 62 respondents who answered this item 19,3% (12) work in a workplace with 0-399 employees, 24,2% (15) work in workplaces with 400-799 employees. The majority 35 (56,5%) of the respondents work in workplaces with 800 to 1000 and more employees.

♦ **Item 38: Indicate the amount of time you as an occupational health practitioner spend on average per day on preventive, promotive, curative and rehabilitative aspects of health care**

### Table 4.10: Responses per hour per level of care (N=41)

<table>
<thead>
<tr>
<th>Level of health care</th>
<th>Hours</th>
<th>Number of respondents</th>
<th>N=64</th>
<th>% respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative</td>
<td>≥6</td>
<td>41</td>
<td>62</td>
<td>66,2</td>
</tr>
<tr>
<td>Promotive</td>
<td>0-2</td>
<td>38</td>
<td>58</td>
<td>65,5</td>
</tr>
<tr>
<td>Curative</td>
<td>0-2</td>
<td>36</td>
<td>58</td>
<td>62,1</td>
</tr>
<tr>
<td>Rehabilitative</td>
<td>0-2</td>
<td>28</td>
<td>59</td>
<td>47,5</td>
</tr>
</tbody>
</table>

Table 4.10 reflects a summary of the findings of item 38 indicating the most responses per hour(s) per level of nursing care. It is evident that the most time is spend on preventative care as indicated by 41 (66,2%) spend more than 6 hours per day on preventive care.
The most responses were recorded in the 0-2 hour category for the promotive, curative and rehabilitative levels of care.

This research examined the relation between the findings of item 37 and 38 to establish if there is any correlation or pattern. The findings are presented in table 4.11.

Table 4.11: Responses: level of care per size of workplace (N=59)

<table>
<thead>
<tr>
<th>Most hours per level of care</th>
<th>L N=35</th>
<th>M N=15</th>
<th>S N=12</th>
<th>Total N</th>
<th>% N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Preventive</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>7</td>
<td>12.0</td>
</tr>
<tr>
<td>2 Promotive</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>5.0</td>
</tr>
<tr>
<td>3 Equal time preventive and promotive</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td>4 Curative</td>
<td>10</td>
<td>4</td>
<td>7</td>
<td>21</td>
<td>35.5</td>
</tr>
<tr>
<td>5 Equal amounts on all 4 levels</td>
<td>10</td>
<td>7</td>
<td>0</td>
<td>17</td>
<td>29.0</td>
</tr>
<tr>
<td>6 Equal time on preventive or promotive and curative</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>13.5</td>
</tr>
<tr>
<td>7 Rehabilitative</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Key:
L = 800 and more employees
M = 400-799 employees
S = 0-399 employees

Table 4.11 reveals that 7 (12,0%) of the respondents spend most of their time on preventive care, 5,0% on promotive care, 3,4% on the most time equally between preventive and promotive, 35,0% of the respondents spend the most time on curative care and 1,6% on rehabilitative care. Of the respondents 29,0% indicated that they spend equal time on all levels of care. However, the time spent on rehabilitation is less. Equal time spent on preventive/promotive and curative care was indicated by 13,5% of the respondents.

♦ Item 39: Number of employees ill during 1998

Of the 49 respondents who answered this item 8,0% indicated that 0-49 employees were ill during 1998, 6,0% indicated 50-99 employees ill and 29,0% indicated 100-199
employees being ill during 1998. The majority of the respondents (57.0%) indicated that 200 and more employees were ill during 1998.

Three of the respondents indicated that they do not have access to this information because human resources have the information.

To determine if there is any relation between item 37 and 39 table 4.12 presents a summary between items 37 and 39.

Table 4.12: Number of employees ill during 1998 per workplace size (N=49)

<table>
<thead>
<tr>
<th>Number of employees ill during 1998</th>
<th>L N=35</th>
<th>M N=15</th>
<th>S N=12</th>
<th>Total N</th>
<th>% N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-49</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>8.0</td>
</tr>
<tr>
<td>50-99</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6.0</td>
</tr>
<tr>
<td>100-199</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>14</td>
<td>29.0</td>
</tr>
<tr>
<td>200 and more</td>
<td>18</td>
<td>7</td>
<td>3</td>
<td>28</td>
<td>57.0</td>
</tr>
</tbody>
</table>

Table 4.12 reveals that 51.0% (18) respondents who work in the larger workplaces indicated 200 and more employees ill. This finding can certainly be explained in terms of size. However 7 (47.0%) respondents who work in a medium sized organisation indicated this number and 3 (25.0%) respondents in a small workplace also indicated this number. If these findings are a true reflection than the number for medium and small enterprises are relatively high. These findings also contradict the findings from item 35 in which 49.2% of 61 respondents indicated that there is not a high incidence of illness in their places of work.

Item 40: Lost working days

Of the 47 respondents who answered item 40, 10.6% indicated that 0-49 working days were lost, and 10.6% also indicated 50-99 lost working days and 21.0% indicated 100-199
lost working days. The majority of the respondents, namely 57.6% indicated 200 and more lost working days.

Table 4.13 provides an overview of the lost working days per workplace size.

Table 4.13: Number of lost working days per size of workplace (N=47)

<table>
<thead>
<tr>
<th>Number of lost working days during 1998</th>
<th>L N=35</th>
<th>M N=15</th>
<th>S N=12</th>
<th>Total N</th>
<th>%N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-49</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>50-99</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>10.6</td>
</tr>
<tr>
<td>100-199</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>10</td>
<td>21.2</td>
</tr>
<tr>
<td>200 and more</td>
<td>17</td>
<td>5</td>
<td>5</td>
<td>27</td>
<td>57.6</td>
</tr>
</tbody>
</table>

It is evident from table 4.13 that 0-49 lost working days is reported by 10.6% of the respondents who work in medium and small workplaces. In the category 50-99 lost working days 6.3% are reported from the medium size workplace and 2.1% from the large and small workplaces.

The table also reveals that 78.8% of the reported lost working days fall into the categories 100-199 and 200 and more. It is worth noting that five respondents from medium and five respondents from the small workplaces reported 200 and more lost working days.

A possible explanation for this can be that the smaller workplaces may have less occupational health and safety personnel and services.

From the findings of section 4.3.5 of the measurement instrument the following conclusions are drawn:

- More than 50.0% of the respondents indicated that their workplace has an adverse influence on employee's health. If these findings are compared with the findings in item 30 a discrepancy is found. When the respondents were asked if working conditions are conducive to health 93.4% answered positively. A relative high
percentage (20.6%) of the respondents was unsure if their workplaces have an adverse influence on health.

- Only 29.5% of the respondents were of the opinion that there is a high incidence of ill-health and injuries in their workplaces.

- Nurses spend more time on curative services, especially in the larger workplaces than on the preventive or promotive services. Almost a third (29.0%) of the respondents spend equal time on preventive, promotive, curative and rehabilitative care during their working days.

- Low item response rates were encountered in items 39 and 40. A possible reason for this may be that nurses do not have these statistics.

- There is a relative high incidence of absenteeism due to ill-health. A relative high number of lost working days were also reported.

4.3.6: Section 6: Role of the nurse in health promotion and health promotion learning needs

The purpose of this section of the measuring instrument was to explore and describe the role of the occupational and campus health nurse in health promotion and their health promotion learning needs. This aspect of the questionnaire concerns research questions 6 and 7.

Item 41: Role of the nurse in health promotion

Table 4.14 provides an overview of the findings of item 41.
Table 4.14: Roles of the nurse in health promotion in the workplace (N=60)

<table>
<thead>
<tr>
<th>Roles</th>
<th>N=60</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>facilitator</td>
<td>60</td>
<td>92,0</td>
<td>6,7</td>
<td>1,3</td>
</tr>
<tr>
<td>researcher</td>
<td>59</td>
<td>89,8</td>
<td>3,4</td>
<td>6,8</td>
</tr>
<tr>
<td>presenter</td>
<td>59</td>
<td>86,4</td>
<td>10,2</td>
<td>3,4</td>
</tr>
<tr>
<td>initiator</td>
<td>58</td>
<td>86,3</td>
<td>8,6</td>
<td>5,1</td>
</tr>
<tr>
<td>coordinator</td>
<td>57</td>
<td>86,0</td>
<td>8,8</td>
<td>5,2</td>
</tr>
<tr>
<td>consultant</td>
<td>58</td>
<td>79,3</td>
<td>10,3</td>
<td>10,4</td>
</tr>
<tr>
<td>counsellor</td>
<td>56</td>
<td>71,4</td>
<td>19,6</td>
<td>9,0</td>
</tr>
</tbody>
</table>

Of the 60 respondents 92,0% are of the opinion that the nurse should fulfil the role of facilitator, 6,7% answered negatively and 1,3% were unsure.

More than 85,0% of the respondents were of the opinion that the nurse should fulfil the roles of researcher, presenter, initiator and coordinator. However, 10,2% of the respondents were of the opinion that the nurse should not be a presenter. This viewpoint can possibly be explained in terms of time constraints.

Of the 58 respondents who answered the item on consultant, 79,3% answered positively, 10,3% answered negatively and 10,4% were unsure.

Of the 56 respondents who answered the alternative on the role of counsellor 71,4% answered positively, 19,6% answered negatively and 9,0% were unsure.

After reviewing the 18 questionnaires on which negative or unsure answers were recorded, the following findings are recorded:

- Of the 18 respondents, five have only general nursing and occupational health nursing qualifications.
- One respondent is not in possession of an occupational health nursing qualification.
Three respondents are registered in general nursing, midwifery, community health nursing and occupational health nursing.

Five respondents obtained qualifications in general nursing, midwifery, community health nursing, psychiatric nursing and occupational health nursing.

One respondent is registered in general nursing, midwifery, nursing administration, nursing education and occupational health nursing and a bachelor's degree as highest qualification.

One respondent has a bachelors degree with general nursing, midwifery, psychiatric nursing and community health nursing.

One respondent was of the opinion that the role of initiator, presenter, researcher and consultant should be optional. In addition, the respondent was also of the opinion that the role of facilitator should be full-time and that it was more important to have the right personality profile than job qualifications. This respondent has a masters degree as highest qualification.

One respondent has a honours degree in psychology, general nursing, psychiatric nursing, occupational health nursing and nursing education as qualifications. This respondent answered unsure on the items presenter, counsellor and consultant.

The majority of the respondents are in the 30-49 years old age group, with one respondent being in the 20-29 year-old group and one in the 50-59 years old.

Most of the respondents who answered negatively or unsure only have a diploma as highest qualification. A possible reason for some respondents answering negatively or unsure on the alternatives of facilitator, researcher, counsellor and consultant may be a lack of training in these areas.
Additional information

- One of the respondents who only answered two items, namely coordinator and counsellor work at a university and has a diploma in general nursing.

- One respondent who did not answer this section has a bachelor's degree as highest qualification and works at a university.

- The three other respondents who did not answer this section have a diploma or advanced diploma as highest qualification and work in industry.

This study has no explanation why four respondents did not answer this section.

Item 42: Training in health promotion

In figure 4.14 an analysis of the training of the respondents in health promotion is reflected.

Figure 4.14

Training in health promotion (N=63)
As is depicted in figure 4.14 it is evident that the majority of respondent's have training in health promotion as 83.1% of the 59 respondents answered positively, 8.5% answered negatively and 8.5% were unsure.

Item 43: Training in health education

Of the 63 respondents who answered this item 69.8% answered positively, 27.0% answered negatively and 3.2% felt unsure. At this point it is worth noting that only 59 respondents answered item 42 as against 63 who answered item 43. A possible explanation is that the concept health education is more familiar than health promotion and that the respondents are not clear about the meaning of the concept health promotion. Of the respondents 8.5% were also unsure if they have had training in health promotion and 3.2% were not sure about training in health education.

Figure 4.15 reflects the need to learn more about health promotion.

![Figure 4.15](image)

*Figure 4.15*

*Need to learn more about health promotion (N=63)*
It is evident from figure 4.15 that 79,4% (50) of the respondents want to learn more about health promotion whereas 19,0% do not want to learn more about health promotion and 1,6% were unsure.

The respondents who answered positively to item 44 were requested to answer items 45-47.

Item 45: Learning needs

The purpose of this section of the measurement instrument was to identify the health promotion leaning needs of the professional. This item will provide answers to the research question 7.

Table 4.15 presents an overview of the aspects of health promotion that the respondents want to learn about.

Table 4.15: Health promotion learning needs (N=59)

<table>
<thead>
<tr>
<th>Aspects</th>
<th>N=59</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education</td>
<td>38</td>
<td>100,0</td>
<td>0,0</td>
<td>0,0</td>
</tr>
<tr>
<td>Occupational Health Promotion</td>
<td>42</td>
<td>95,2</td>
<td>4,8</td>
<td>0,0</td>
</tr>
<tr>
<td>Health Promotion theories/models</td>
<td>38</td>
<td>86,8</td>
<td>10,6</td>
<td>2,6</td>
</tr>
<tr>
<td>Health Promotion nursing</td>
<td>41</td>
<td>85,4</td>
<td>9,8</td>
<td>4,8</td>
</tr>
<tr>
<td>Evaluation of Health Promotion</td>
<td>40</td>
<td>85,0</td>
<td>15,0</td>
<td>0,0</td>
</tr>
<tr>
<td>Philosophy and Ethos of Health Promotion</td>
<td>59</td>
<td>66,1</td>
<td>33,9</td>
<td>0,0</td>
</tr>
<tr>
<td>Health Risk Assessment</td>
<td>35</td>
<td>57,1</td>
<td>34,3</td>
<td>8,6</td>
</tr>
</tbody>
</table>

Table 4.15 clearly illustrates that:

Of the 38 respondents who answered the item on health education, 100,0% want to learn about health education.
The need to learn about the occupational health promotion process was expressed by 95.2% of the 42 respondents who answered this item with 4.8% who answered negatively. Of the 38 respondents 86.8% indicated a need to learn about health promotion theories and models with 10.6% indicating no such need and 2.6% were unsure.

Health promotion nursing is indicated, as a need by 85.4% of the 41 respondents with 9.8% of the respondents who answered negatively and 4.8% were unsure. Interest to learn about evaluation of health promotion was expressed by 85.0% of the respondents and 15.0% demonstrated no interest.

Of the 59 respondents who answered the item on philosophy and ethos of health promotion, 66.1% wants to learn about this and 33.9% do not. It is worth noting that 59 respondents answered this item despite the fact that only 50 answered positively to item 44.

Of the 35 respondents who answered the question on health risk assessment only 57.1% want to learn about this aspect and 34.3% expressing no need to learn about health risk assessment with 8.6% unsure.

The other learning needs identified by three respondents are facilitation, motivation, presentation and negotiation skills as well as risk management and physical assessment and examination.

The total number of respondents for items 45-47 should have been 50. However, it is noteworthy that the response rates vary between 35 and 59.

**Item 48: Preferred methods of learning**

Figure 4.16 presents an overview of the methods by which respondents want to learn about health promotion.
It is evident from figure 4.16 that 94.9% of the respondents want to learn through seminars. Of the 38 respondents who answered the item on theatre presentations, 89.5% wants to learn by this method.

Discussion groups as a learning method is favoured by 85.4% of the 41 respondents who answered this item.

Of the 39 respondents who answered the item on workshops 64.1% want to learn through workshops. However, it is noteworthy that 30.8% of the respondents answered negatively and 5.1% were unsure on learning through workshops. A possible reason for the high negative response of 30.8% on the workshops method is that workshops normally take a whole day or more than one day. It can be a problem for occupational and campus health nurses to get time off.

Only one respondent wants to learn by means of lectures.
Two respondents identified the following additional methods, namely:

- Combination of lectures and workshops.

- Syndicate projects

**Item 47: Motivations for wanting to learn more about health promotion**

Table 4.16 presents the findings of the motivations for wanting to learn more about health promotion.

Table 4.16: Motivations for wanting to learn about health promotion (N=43)

<table>
<thead>
<tr>
<th>Motivations</th>
<th>N=43</th>
<th>% Yes</th>
<th>% No</th>
<th>% Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>For personal development</td>
<td>40</td>
<td>100,0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>I want to know more about health promotion</td>
<td>43</td>
<td>86,0</td>
<td>12,0</td>
<td>2,0</td>
</tr>
<tr>
<td>Because I want to implement a health promotion programme</td>
<td>39</td>
<td>84,6</td>
<td>7,7</td>
<td>7,7</td>
</tr>
<tr>
<td>For professional development</td>
<td>36</td>
<td>78,0</td>
<td>17,0</td>
<td>5,0</td>
</tr>
<tr>
<td>Because it is part of primary health care</td>
<td>7</td>
<td>14,0</td>
<td>43,0</td>
<td>43,0</td>
</tr>
</tbody>
</table>

The findings as presented in table 4.16 illustrate that 80,0% and more of the respondents want to learn about health promotion because they want to know more about health promotion, for personal development and because they want to implement a health promotion programme. Of the 40 respondents who answered the item on personal development, 100,0% cited personal development as a motivation. Professional development as a motivation was cited as by 78,0% of the 36 respondents as against 17,0% who answered negatively to this motivation.

Only one respondent answered positively to the item because it is part of primary health care and 43,0% answered negatively and 43,0% were unsure. A possible explanation for the high negative and unsure items on primary health care is that occupational health and health promotion is not perceived as part of primary health care. Primary health care and
occupational health are possibly seen as two separate services.

This research finds it difficult to explain or provide reasons for the 12.0% who answered negatively to the motivation that they want to know more about health promotion. Similarly it is difficult to explain why 22.0% answered negatively and were unsure to the motivation for professional development.

Additional reasons supplied by two respondents are reflected in these two verbatim statements:

*Previous training in today's workplace not adequate any longer.*

"Om toegevoegde waarde te wees vir die maatskappye wat ek bedien" (to be value added to the businesses which I serve).

It is noteworthy to add this verbatim comment of one of the respondents', namely self-development and professional development is self-centred.

In conclusion the answering of section 4.3.6 was in general characterised by a low item response rate.

The roles with the highest positive response rate were those of facilitator and researcher and roles with the highest percentage negative and unsure answers were presenter, counsellor and consultant.

Although 83.1% of the 59 respondents indicated that they have had training in health promotion, 79.4% of the 63 respondents indicated that they want to learn about health promotion. Despite the fact that only 50 respondents indicated in item 44 that they want to learn more about health promotion, items 45-47 were answered by 7-59 respondents.
Possible reasons for this can be that the instruction on the questionnaire were not clear enough or the questionnaire was too lengthy resulting in the respondents losing interest, or the fatigue factor.

4.4 CONCLUSION

This chapter has analysed the data collected from the questionnaires answered by occupational health and campus health nursing practitioners in diverse occupational settings. The data was discussed and presented through tables and figures.

In addition this chapter also explored the validity and reliability of section three of the measurement instrument. Validity and reliability were confirmed.

The findings of the study were discussed and reported according to the personal information of the participants/respondents, the meaning of the concept “health promotion”, the contents, organisation and management of an occupational health promotion programme.

General information about health promotion and data regarding disease and injury incidence and the sick leave profile of the workplaces where respondents work were discussed and reported. In addition, the role of the nurse in health promotion, and the health promotion learning needs of occupational health and campus health nurses were also reported and discussed.

The next chapter covers the conclusions, limitations of the research, recommendations and concrete proposals made by the researcher.
CHAPTER 5

Conclusions, limitations, recommendations and concrete proposals

5.1 INTRODUCTION

In chapter 4 a presentation, analysis and discussion of the data was given. The aim of the research was to identify the need for occupational health promotion programmes in selected occupational settings from a nursing perspective.

In this chapter the conclusions are presented by being linked to the research objectives and questions. The limitations that were experienced in this study are listed and discussed.

In light of the findings and conclusions reached by the researcher specific recommendations are made with regard to nursing practice, education and research. Recommendations for future research are also suggested.
A conclusion ends this chapter.

5.2 CONCLUSIONS

This research contributed to the development of health promotion within occupational health and campus health nursing practice.

The conclusions are based on the objectives of this research (see section 1.6) and the research questions (see section 1.7) are answered.

5.2.1 Research objectives 1 and 2: The meaning of the concept health promotion

According to the literature health promotion can be described as structured activities and interventions to enhance the health of individuals and communities through their own efforts and in partnership with professionals, in a holistic manner by means of health education, healthy public policies and specific preventive measures. Central to health promotion are the values of empowerment, equity and collaboration and the focus on positive health even in disease and illness taking into consideration the wider social influences on health. All the interpretations of the concept health promotion provide evidence of the move away from the individual lifestyle behaviour as focus to that of embracing aspects of the social model of health. In addition the descriptions of health promotion also have the imperatives of empowerment, prevention of disease, holistic health and social actions as central to the definitions.

Assumption 1

Health promotion means to enhance health through various activities is partly proven correct. However, as is evident from the above conclusion health promotion means more than only the enhancement of health through activities.

According to occupational and campus health nurses health promotion means the prevention of disease, advocacy for health rights, decreasing health hazards, more than prevention of disease, health education, and increasing health potential as well enabling
people to take control over their health. Health promotion also refers to the maintenance of health through empowerment, provision of basic needs and improvement in adult literacy and embraces nursing practice. Some of the modern attributes namely empowerment, health education, prevention of disease and social actions are contained within the meanings and interpretations of the respondents given to the concept health promotion.

Assumption 2

Nurses perceive health promotion as health education and prevention of disease. This assumption is partly proven correct because the majority and the highest percentage of respondents indicated health education and prevention of disease as meaning health promotion. However, other meanings were also attributed to the concept health promotion.

5.2.2 Research objectives 3 and 4: The contents, organisation and management of a comprehensive occupational health promotion programme

A comprehensive occupational health promotion programme caters for the holistic health needs of individuals and for employees with personal problems such as family problems, ageing or emotional difficulties. Diverse and comprehensive programmes offerings are a feature of occupational health promotion programmes such as lifestyle change and self-care programmes, chronic disease management and informed choice programmes, pre-natal and post natal and high risk reduction and immunisation programmes.

An occupational health and safety programme is included in an OHPP and reciprocally health promotion is part of an occupational health and safety programme. Therefore prevention has to become part of the entire corporate strategy. Health promoting environmental and organisational design should be taken into consideration in occupational health and safety practice.

An affirmative action and social responsibility policy and programme are part of the health promoting workplace in South Africa. A comprehensive OHHP addresses the identified employee health needs through raising awareness levels, providing support services,
promoting lifestyle behaviour changes and supporting work cultural enhancement programmes and policies.

A successful programme should be organised and managed through participation of all employees in all stages, by using a project management approach, be comprehensive and integrated into the management of the organisation with management firmly committed to the OHPP and programmes must include individual-directed and environmental-directed measures from various fields. It is evident from the literature that a manager or coordinator with a team from the organisation itself should manage the occupational health promotion programme. A comprehensive OHPP is a team effort and involves not only the offering of health education.

Assumption 3

Health promotion in the workplace focusses primarily on lifestyle and behaviour change aspects. This assumption is proven incorrect because entails other aspects as well as is evident from the above conclusion.

From the professional nurses viewpoint the traditional occupational health related issues are considered the most important topics/activities for a comprehensive OHPP that focus mostly on prevention and the physical aspects of health. In addition the answers reflect a tendency to focus more on disease than health. The topics/activities that involve aspects of the employee's life other than worker is perceived as less important. Special investigations such as vision testing are also included. The less time consuming, interactive and participative presentation methods are preferred. The nurse is the preferred manager of an OHPP that should resort under the occupational health and safety department. Employees should not contribute financially and their families should participate. An early learning centre for children and an EAP programme should be part of the programme. In addition an OHPP should include multi-level offerings such as awareness campaigns, lifestyle change programmes and supportive environments.

The most important potential benefits of an OHPP for employees were indicated as improved health status and morale. Potential benefits of an OHPP for employers are the
following namely: productivity improvement, reduced absenteeism, decreased accidents, reduced health care costs and product quality.

✦ Assumption 4

The contents of an occupational health promotion programme focus primarily on the traditional occupational health and safety aspects from a nursing perspective. This assumption is proven correct although other topics/activities are also contained in an OHPP according to occupational and campus health nurses although to a lesser extent.

5.2.3 Research objective 5: Identification and description of the rationale behind occupational health promotion

Health promotion in the workplace is supported by international trends and strategies such as the Settings for Health approach of which the workplace is viewed as one of the most important settings for the new century. In addition to the settings approach the global strategy on occupational health for all supports health promotion in the workplace. One of the objectives of this global strategy has as aim the development of healthy work practices and promotion of health at work.

It is evident from the literature that the workplace is seen as an effective setting for health promotion for economical, population and other reasons. Health promotion is as an integral part of health care in South Africa through primary health care which include health education, health promotion and prevention of disease.

Primary health care and occupational health is contained within the new public health approach that uses health promotion as the point of departure. In the Occupational Health and Safety Act 85 of 1993 (South Africa 1993) no specific mention is made of occupational health promotion programmes, the Act , however, states that employers are responsible for creating a healthy and safe environment through a health and safety programme.

The literature further reveals that a health promotion programme can assist in helping employees cope with transformation and for organisations to become competitive global
forces. A comprehensive occupational health promotion programme makes good business sense and health is an investment for both employees and employers. Healthy and safe workplaces contribute to quality of life, which is the goal of the RDP (ANC 1994b).

Assumption 5: The rationale behind occupational health promotion is that the workplace is a suitable venue for health promotion initiatives. The rationale behind occupational health promotion is more than the workplace as a suitable venue. Therefore the assumption is proven partly true.

5.2.4 Research objective 6: Exploration and description of the role of the nurse in occupational health promotion

The roles of the professional nurse in health promotion are varied and encompass that of facilitator, researcher, presenter, initiator, coordinator, consultant and counsellor.

The assumption that nurses view their roles in health promotion as that of coordinator and facilitator is partly correct. Other roles are also included as is evident from the above conclusion.

5.2.5 Research objective 7: Exploration and description of the health promotion learning needs of nurses

The findings clearly state that occupational and campus health nursing practitioners want to learn more about health promotion despite the fact that the majority indicated that they have had training in health promotion and education. Health education and the occupational health promotion process are indicated as the most important learning needs. The respondents indicated that they want to learn about health promotion through seminars, theatre presentations, discussion groups, workshops. The need to want to know more about health promotion is indicated as the prime motivation.

It is evident that health promotion and occupational health are not perceived as part of primary health care and the culture of lifelong learning has not been internalised. To assist the process of empowerment of individuals or communities, professionals in the field
of health promotion need to be empowered facilitators themselves.

Assumption 7

Occupational and campus health nurses have a need for training in health promotion and occupational health promotion. This assumption is proven correct.

5.2.6 Research objective 8: Identification and description of the need for occupational health promotion programmes

The answer to research question 8 is that a need for occupational health promotion programmes exist in selected occupational settings. This is clear from the findings that more than half of the respondents indicated that there is no OHPP in their workplaces and expressed a positive need for such a programme. More than half of the respondents indicated that their workplace has an adverse influence on employee's health and nurses spend a lot of time on curative services, especially in the larger and smaller workplaces. The need is also supported by international and national trends and by the potential benefits of such a programme as discussed in section 2.5.

Assumption 8

A need for occupational health promotion programmes exists in occupational settings is proven correct.

5.3 LIMITATIONS OF THE RESEARCH

- Not all the distributed questionnaires were completed and returned resulting in a sample of 64 respondents instead of 80. The smaller sample can have an influence on the factor analysis of section 3 of the questionnaire because section 3 consisted of 54 items.

- Many of the questionnaires, namely 27.0% were returned incomplete. Certain sections, particularly section 6 of the questionnaire and items were not answered
and rank order questions were completed incorrectly (6.0%) with the result that the validity of the findings can be compromised. Three respondents did not answer section 6 of the questionnaire.

- The questionnaire was too long. The length of the questionnaire might have had an influence on the item response rate.

- This study was restricted to the Greater Pretoria Metropolitan Area (now called City of Tshwane Metropolitan Municipality). This meant that the viewpoints of occupational and campus health nurses in other regions were not included which can have an influence on the generalisability of the findings.

- The findings in section 1 of the questionnaire demonstrated that less than half of the respondents have engaged in advanced post-basic education. Relatively few respondents have psychiatric nursing, nursing administration and nursing education. The respondents only include four males. The majority falls into the 40-49 years old category and have 10 years and more experience in occupational health or campus health nursing. These aspects may be regarded as limitations to this research.

- Health promotion is a multi-disciplinary effort and although this study was from a nursing perspective the other health team members were not included in the study. This meant that only the viewpoints of the professional nurses were considered.

- A theoretical limitation experienced was the limited South African literature available on the topic. This meant that the literature review was done mainly from an European and American perspective.

### 5.4 RECOMMENDATIONS

The following recommendations are made on the basis of the findings and conclusions of this research:
5.4.1 Recommendations regarding a paradigm shift in occupational health nursing

The primary focus in health promotion from a nursing perspective presently is on those topics/activities contained in traditional occupational health and safety. This focus needs to be broadened to promote the health of employees in an holistic and equitable manner.

Figure 5.1 depicts a visual presentation for the proposed holistic approach to OHPP.

![Holistic Approach Diagram]

**Figure 5.1**

*A proposed holistic approach to an occupational health promotion programme*

The proposed approach as depicted in figure 5.1 illustrates the broadening and extension of topics and activities from the traditional ones to those that involve emotional and family health, abuse/violence, lifestyle change programmes and socio-environmental aspects. A gradual and evolutionary extension and inclusion based on the needs of employees, the organisation and country, is recommended. The eventual outcome will be a comprehensive, holistic approach in line with the literature, national and international trends. The
circle represents one whole with continuous input on all levels.

5.4.2 A proposed empowerment approach

In addition to the holistic approach and empowerment approach is also recommended.

Table 5.1 illustrates the potential empowerment effects of health promotion actions and workplace actions using an empowerment approach.

Table 5.1: A proposed framework for an empowerment occupational health promotion approach

<table>
<thead>
<tr>
<th>Health promotion actions</th>
<th>Workplace actions</th>
<th>Potential positive impact on empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness campaign</td>
<td>Through newsletters, health education, payroll inserts and videos</td>
<td>Awareness of health needs/problems to serve as catalyst for action</td>
</tr>
<tr>
<td>Healthy company policy:</td>
<td>• Health promotion policy development and implementation</td>
<td>• Participation of employees in policy development</td>
</tr>
<tr>
<td>• Health promotion policy</td>
<td>• Training and skills development programme</td>
<td>• participation in health programme design, planning</td>
</tr>
<tr>
<td>development and implement-</td>
<td>• Employment equity programme</td>
<td>• implementation and evaluation</td>
</tr>
<tr>
<td>ation</td>
<td>• Sound &amp; healthy labour relations through the Labour Relation Act (South Africa</td>
<td>• Participate in action research</td>
</tr>
<tr>
<td>• Best practice</td>
<td>1995) implementation</td>
<td>• Self-esteem enhancement through training, job placement</td>
</tr>
<tr>
<td>• Evidence based</td>
<td>• Basic Conditions of Service Act implementation</td>
<td>• Work collaboratively with stakeholders to achieve goals</td>
</tr>
<tr>
<td>• Bench marking</td>
<td>• Humanistic approach to management of employees</td>
<td>• Platform for needs expression and acting upon those needs</td>
</tr>
<tr>
<td>• Bottom up approach</td>
<td></td>
<td>• Respect, dignity, valued</td>
</tr>
</tbody>
</table>

<p>| Health education             | • Comprehensive and holistic topics and activities                                  | Information                                                                    |
|                              | • Participative learning approach                                                  | knowledge to make informed choices                                            |
|                              |                                                                                 | Responsibility for actions emphasised                                          |
|                              |                                                                                 | Equity                                                                        |
|                              |                                                                                 | Life long learning                                                             |
|                              |                                                                                 | Contribution of own experience and knowledge                                   |</p>
<table>
<thead>
<tr>
<th>Health promotion actions</th>
<th>Workplace actions</th>
<th>Potential positive impact on empowerment</th>
</tr>
</thead>
</table>
| **Supportive environment** | Culture of caring:  
  - Physically, mentally, socially safe and healthy environment  
  - Career development programme | To be cared for enables to care for others |
| **Employee assistance programme (EAP)** | Implement EAP based on the humanistic approach  
  - Alcohol, drug and HIV/AIDS policy | Assistance with problem-solving  
  - Independence  
  - Control over own decisions  
  - Self-esteem enhancement through own problem-solving |
| **Social responsibility programme and quality of work life programme** | Policy development and implementation  
  - Recognition of human rights  
  - Small business development in community  
  - Organisational development through quality circles, management by objectives, job enrichment and participative management  
  - Alternative work arrangements | Community empowerment  
  - Community empowerment leads to person empowerment and vice versa  
  - Increased participation  
  - Sustainable partnership, ownership and stewardship  
  - Multi-skilled, competent in different skills |
| **Prevention and risk reduction** | Occupational health and safety Act 85 of 1993 as amended by Act 181 of 1993 compliance and implementation  
  - Education  
  - Protective clothing and devices  
  - Ergonomics: Work, workstations and procedures redesign | Knowledge of Act  
  - Self-awareness and self-esteem enhancement  
  - Self-care actions |
| **Organisational culture and development** | Participatory democracy based on the values of respect, dignity, equality and freedom  
  - Equity and social justice  
  - Tolerance and acceptance  
  - Humans valued  
  - Person and organisation centred  
  - Investment enterprise for health | Participation  
  - Experience of health communications |

The above table clearly illustrates the health promotion and workplace actions needed to facilitate empowerment in employees or students.
5.4.3 Recommended guidelines for the development and implementation of an occupational health promotion programme

It is recommended that occupational health and campus health nurses initiate and facilitate the development, planning, implementation and evaluation of workplace and student health promotion programmes in partnership with other professionals and the employees or students.

Recommended steps for development as follows:

- The professional nurses firstly need to become empowered themselves and knowledgeable beings.
- Create awareness: employees, students, other professionals and management.
- Obtain management support and commitment.
- Form a health committee representative of all stakeholders.
- Analyse the company and industry including corporate culture assessment.
- Determine the organisations needs through needs analysis.

Research and in particular action research is essential for conducting an organisational analysis as well as determining the health needs of the employees. Evidence based health promotion and best practice can only be determined by extensive research. Through action research the employees are involved and participate in all the stages of an OHPP that leads to empowerment. Research is also stressed in the Ottawa Charter (1986) that states the need for health services to move in the health promotion direction with a stronger attention to health research and effect changes in the education and training of professionals.

- Develop a health promotion policy with all stakeholders.
- Strategic planning.
- Implementation of specific programmes.
- Ongoing evaluation in terms of process, impact and outcome.
By facilitation, making a process available, the nurse will heed the call for nurses to take the lead in health promotion.

5.4.4 Training

It is recommended that a health promotion, health promoting nursing and research training programme be developed and offered to occupational and campus health nurses. The researcher recommends that health promotion nursing should also be included in all nursing and nurse training curricula.

5.4.5 A proposed framework for health promoting nursing

Figure 5.2 illustrates a proposed framework for the actualisation of health promoting nursing in a workplace or campus.

Health promoting nursing requires that the nurse has a positive self-esteem, a strong sense of self-efficacy and self-reliance. In order to enact health promoting nursing, the nurses need to be empowered themselves based on the required skills, knowledge and attitudes conducive to health promotion. The skills required for health promoting nursing are: healthy communication, counselling, listening, facilitation, mediation, decision-making, advocacy and conflict management. Knowledge of health promotion, communication, industrial psychology, nursing, project management, participative health education, human behaviour, life skills and the meanings and perceptions that employees and students attach to health and health behaviour. The health promoting nurse will therefore clarify these meanings and perceptions so as to establish a frame of reference for health promoting and empowering engagement.
Essential attitudes that underlie health promoting nursing are caring, tolerance for cultural diversity, empathy and congruence. These skills, knowledge and attitudes will have a positive influence on the self-esteem and self awareness of the nurse and enable the nurse to be a knowledgeable being who works in partnership with individuals, groups or communities to achieve their health goals through the use of the therapeutic or health-promoting self.
promoting self. In health promoting nursing the focus is on holistic health needs at all levels of intervention and with all stakeholders. The proposed approaches in health promoting nursing are humanistic, whole person and whole workplace or campus centred, collaborative, professional and competent and empowering. Health promoting nursing approaches nursing and health promotion within the medical, salutogenic and social models of health. An approach that utilises a bottom up strategy, in other words starting with the individuals, groups or community themselves instead of a top to bottom approach is advocated so as to enhance ownership and empowerment.

The theory and practice of health promotion, and the concepts and attitudes underlying empowerment, are implemented by means of reflective practice in the extended roles of the nurse.

Health promoting nursing is applicable at all levels of nursing interventions and focus on holistic health needs and not on health problems and utilises the various approaches as illustrated in the framework. Inherent in health promoting nursing is the involvement of all stakeholders and a participatory approach.

From the literature reviewed it is evident that nursing and health promotion is inextricably linked and that nurses are in a favourable position to promote the health of individuals and communities through health promotion nursing.

5.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations for further research emanates from this research namely:

• Establish the current status of health promotion in South African work places so as to determine the extent to which health promotion is implemented.

• Research regarding the health promoting workplace and tertiary education institutions that involves all stakeholders be undertaken.
Health promotion training of health professionals should be evaluated so as to determine to what extent the training meet the international trends and standards.

It is recommended that similar research in other parts of Gauteng and the country is undertaken.

The division of occupational health and primary health care should be investigated and a conclusion reached as to the position of these two services. Is it feasible to have two separate services or is it more cost effective to have one service and in the best interest of employees and workplaces?

5.6 CONCRETE PROPOSALS

As a result of this study the following proposals are put forward:

- The founding of a national workplace health promotion association.
- The appointment of workplace health promotion facilitators in workplaces.
- Feedback by means of a workshop or seminar to all interested stakeholders, namely the government, trade unions, employee associations, health professionals and the private sector.
- Update training programme for occupational and campus health nurses which include health promotion.

5.7 COMMENTS

The comments that were received from two respondents is worth noting because it supports recommendation five (see section 5.5).
The following comments were all received by one respondent:

- *That there should be a definite line between primary health care and occupational health, although the two link with each other (quoted verbatim).*

- *The title of this research was Occupational Health Promotion Programme, this was queried and the researcher quotes verbatim: “The Act do not say promotion, it does say Occupational Health Programme”.*

- *Enhance wellness in the definition of occupational health promotion was queried and the respondent stated that enhance the wellness is part of the nurses job description and primary function so he/she is doing it.*

- *Campus health nursing was perceived as part of primary health care.*

- Comments on sections 17, 18 and 19 of the questionnaire as follows:
  - “Industriële sielkunde vir bestuur- vir werkers se houding om produktiwiteit te verhoog”.

- Sections 20, 21 and 22 of the questionnaire were perceived as PHC and was thus not answered by the respondent.
  - *Under employee assistance programme there was a question from the respondent: “Is dit sielkundiges”?*

- The question in the content of the programme that deals with the prevention of sexually transmitted diseases was also queried in terms of the policy of the workplace.

- The meaning of the concept health promotion was queried in terms of primary or occupational health.
  - “Het gevind dat skoonmaak kontrakte as occupational hygiene gesien word, byvoorbeeld, die toilette en kleedkamers- OH dit is mos geraas en dampe”.
• The item on the hours of health care was not answered because it was perceived as primary health care.

  "Dit het my 6 maande geneem om bestuur te laat verstaan dat OH en PHC geskei moet wees" (quoted verbatim).

  "OH is 'n aspek van verpleegkunde in die volkereg en moet nie as 'n sous gesien word nie bo-op roomys nie" (quoted verbatim).

Respondent two provided this comment as quoted verbatim:

"Die algemene tema van die navorsing het twee vlakke in beroepsgesondheid aangeraak. Daar was nie 'n duidelike skeidslyn tussen daadwerklike beroepsgesondheid en primêre gesondheidsorg. Beroeps le meer klem op in die werksituasie, terwyl daar gevoel word dat die navorsingstuk 'n kombinasie is van beroeps en primêr."

From these comments it is clear that primary health care and occupational health care is seen as two separate entities. The question the researcher then ask is: occupational health care and nursing not health promoting?

5.8 CONCLUSION

An enquiry into the need for occupational health promotion programmes in selected occupational settings: a nursing perspective was implemented to establish whether there is a need for occupational health promotion programmes in selected occupational settings from a nursing perspective.

The frame of reference for this study was the acknowledgement by the researcher of the importance of health promotion in the workplace as a means of developing and achieving a healthy nation and Health for All (WHO 1998). The benefits for employers and employees are clearly demonstrated, as does the contribution of health promotion to the achievement of South African health goals contained within the White Paper for the Transformation of the Health System (South Africa 1997b).
The overall outcome of this research demonstrates clearly the need for health promotion programmes and the health promoting workplace. Health promotion in the workplace is gaining momentum internationally and is one of the cornerstone of health care delivery in South Africa. However, the potential for health promotion in the South Africa workplaces has not yet been fully realised. Health promotion can contribute to improvement of the quality of life, enhance health and well-being prevent diseases and contain health care costs.
LIST OF SOURCES


ANC – see African National Congress.


Addendum A

Questionnaire
Addendum A: Questionnaire

Please enter your response to the following questions by marking the answer/code of your choice with an “X”.

SECTION 1: PERSONAL INFORMATION

1. Please indicate your place of work

<table>
<thead>
<tr>
<th>Industry</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technikon</td>
<td>2</td>
</tr>
<tr>
<td>University</td>
<td>3</td>
</tr>
<tr>
<td>Private occupational health nursing practitioner</td>
<td>4</td>
</tr>
<tr>
<td>Business</td>
<td>5</td>
</tr>
<tr>
<td>Local authority</td>
<td>6</td>
</tr>
</tbody>
</table>

2. Please indicate your highest academic qualification

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>1</td>
</tr>
<tr>
<td>Higher / Advanced diploma</td>
<td>2</td>
</tr>
<tr>
<td>Bachelors degree</td>
<td>3</td>
</tr>
<tr>
<td>Honours degree</td>
<td>4</td>
</tr>
<tr>
<td>Masters degree</td>
<td>5</td>
</tr>
<tr>
<td>Doctoral degree</td>
<td>6</td>
</tr>
</tbody>
</table>

Please indicate your additional professional qualifications by answering the following six questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Midwifery</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4 Psychiatric Nursing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5 Community Health Nursing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6 Occupational Health Nursing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7 Nursing Administration</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8 Nursing Education</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

9. Other (please specify)

10. Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
</tr>
</tbody>
</table>

11. Which age category do you belong to?

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29 years</td>
<td>1</td>
</tr>
<tr>
<td>30 to 39 years</td>
<td>2</td>
</tr>
<tr>
<td>40 to 49 years</td>
<td>3</td>
</tr>
<tr>
<td>50 to 59 years</td>
<td>4</td>
</tr>
<tr>
<td>60 and older</td>
<td>5</td>
</tr>
</tbody>
</table>

12. How many years of occupational / campus health nursing experience do you have?

<table>
<thead>
<tr>
<th>Experience</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>1</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>2</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>3</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>4</td>
</tr>
</tbody>
</table>
SECTION 2: WHAT IS HEALTH PROMOTION?

<table>
<thead>
<tr>
<th></th>
<th>In your opinion, do the following statements describe health promotion?</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1</td>
<td>Prevention of disease?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.2</td>
<td>Advocacy for peoples health rights?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.3</td>
<td>Decreasing health hazards?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.4</td>
<td>More than prevention of disease?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.5</td>
<td>Health education?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.6</td>
<td>Increasing health potential?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.7</td>
<td>Nursing embraces health promotion?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.8</td>
<td>Enabling people to take control over their health?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.9</td>
<td>Other, please specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 3: OCCUPATIONAL HEALTH PROMOTION PROGRAMME

<table>
<thead>
<tr>
<th></th>
<th>How important do you think the following topics/activities are in an occupational health promotion programme? On a scale of 1-5 please rate each topic/activity with 1 being very important and 5 not important at all.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1</td>
<td>Workplace safety</td>
<td>1</td>
</tr>
<tr>
<td>14.2</td>
<td>Road safety</td>
<td>2</td>
</tr>
<tr>
<td>14.3</td>
<td>Safety in the home</td>
<td>3</td>
</tr>
<tr>
<td>14.4</td>
<td>Water safety</td>
<td>4</td>
</tr>
<tr>
<td>14.5</td>
<td>Healthy eating behaviour</td>
<td>5</td>
</tr>
<tr>
<td>14.6</td>
<td>Physical fitness</td>
<td>1</td>
</tr>
<tr>
<td>14.7</td>
<td>Recreation</td>
<td>2</td>
</tr>
<tr>
<td>14.8</td>
<td>Women’s health issues</td>
<td>3</td>
</tr>
<tr>
<td>14.9</td>
<td>Reproductive health</td>
<td>4</td>
</tr>
<tr>
<td>14.10</td>
<td>Men’s health issues</td>
<td>5</td>
</tr>
<tr>
<td>14.11</td>
<td>Responsible sexual behaviour</td>
<td>1</td>
</tr>
<tr>
<td>14.12</td>
<td>Healthy back (spinal column)</td>
<td>2</td>
</tr>
<tr>
<td>14.13</td>
<td>Water pollution</td>
<td>3</td>
</tr>
<tr>
<td>15</td>
<td>How important do you think the following topics/activities are in an occupational health promotion programme? On a scale of 1-5 please rate each topic/activity with 1 being very important and 5 not important at all.</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>15.1</td>
<td>Land pollution</td>
<td>1</td>
</tr>
<tr>
<td>15.2</td>
<td>Noise pollution</td>
<td>1</td>
</tr>
<tr>
<td>15.3</td>
<td>Air pollution</td>
<td>1</td>
</tr>
<tr>
<td>15.4</td>
<td>Dental disease prevention</td>
<td>1</td>
</tr>
<tr>
<td>15.5</td>
<td>Circulatory disease prevention</td>
<td>1</td>
</tr>
<tr>
<td>15.6</td>
<td>Healthy parenting</td>
<td>1</td>
</tr>
<tr>
<td>15.7</td>
<td>Understanding ageing people</td>
<td>1</td>
</tr>
<tr>
<td>15.8</td>
<td>Healthy interpersonal relationships</td>
<td>1</td>
</tr>
<tr>
<td>15.9</td>
<td>Prevention of violence</td>
<td>1</td>
</tr>
<tr>
<td>15.10</td>
<td>Dealing with difficult people</td>
<td>1</td>
</tr>
<tr>
<td>15.11</td>
<td>Occupational hygiene</td>
<td>1</td>
</tr>
<tr>
<td>15.12</td>
<td>Emotional health (mental health)</td>
<td>1</td>
</tr>
<tr>
<td>15.13</td>
<td>Trans-cultural communication</td>
<td>1</td>
</tr>
<tr>
<td>15.14</td>
<td>Emotional first aid</td>
<td>1</td>
</tr>
<tr>
<td>15.15</td>
<td>Responsible use of medicines</td>
<td>1</td>
</tr>
<tr>
<td>15.16</td>
<td>Cancer risk reduction</td>
<td>1</td>
</tr>
<tr>
<td>15.17</td>
<td>Healthy lifestyle education</td>
<td>1</td>
</tr>
<tr>
<td>15.18</td>
<td>Tuberculosis</td>
<td>1</td>
</tr>
<tr>
<td>15.19</td>
<td>Prevention of sexually transmitted diseases</td>
<td>1</td>
</tr>
<tr>
<td>15.20</td>
<td>Constructive leisure time activities</td>
<td>1</td>
</tr>
<tr>
<td>15.21</td>
<td>Personal hygiene</td>
<td>1</td>
</tr>
<tr>
<td>15.22</td>
<td>Hypertension</td>
<td>1</td>
</tr>
<tr>
<td>15.23</td>
<td>Diabetes</td>
<td>1</td>
</tr>
<tr>
<td>15.24</td>
<td>Abuse of alcohol</td>
<td>1</td>
</tr>
<tr>
<td>15.25</td>
<td>Abuse of drugs</td>
<td>1</td>
</tr>
<tr>
<td>15.26</td>
<td>Child abuse</td>
<td>1</td>
</tr>
<tr>
<td>15.27</td>
<td>Spouse abuse</td>
<td>1</td>
</tr>
<tr>
<td>15.28</td>
<td>Healthy intake of alcohol</td>
<td>1</td>
</tr>
<tr>
<td>15.29</td>
<td>Financial management</td>
<td>1</td>
</tr>
<tr>
<td>15.30</td>
<td>Retirement planning</td>
<td>1</td>
</tr>
<tr>
<td>15.31</td>
<td>Stop-smoking programme</td>
<td>1</td>
</tr>
</tbody>
</table>
15 (Cont) How important do you think the following topics/activities are in an occupational health promotion programme? On a scale of 1-5 please rate each topic/activity with 1 being very important and 5 not important at all.

<table>
<thead>
<tr>
<th>15.32</th>
<th>Weight-management programme</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>68</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.33</td>
<td>Stress management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>69</td>
</tr>
<tr>
<td>15.34</td>
<td>Drug intake control programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>70</td>
</tr>
<tr>
<td>15.35</td>
<td>Physical fitness programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>71</td>
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<tr>
<td>15.36</td>
<td>Alcohol control programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>15.37</td>
<td>Environmental education</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>15.38</td>
<td>Personal health risk appraisal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>74</td>
</tr>
<tr>
<td>15.39</td>
<td>Lifestyle assessment</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>75</td>
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<tr>
<td>15.40</td>
<td>Employee assistance programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>76</td>
</tr>
<tr>
<td>15.41</td>
<td>First aid (physical)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>77</td>
</tr>
<tr>
<td>15.42</td>
<td>Other, please specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>78</td>
</tr>
</tbody>
</table>

16 Do you think the following aspects of all employees' health should be evaluated in the workplace as part of an occupational health promotion programme?

<table>
<thead>
<tr>
<th>16.1</th>
<th>Blood pressure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>79</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.2</td>
<td>Cholesterol</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>80</td>
</tr>
<tr>
<td>16.3</td>
<td>Back problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>81</td>
</tr>
<tr>
<td>16.4</td>
<td>Urine analysis</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>82</td>
</tr>
<tr>
<td>16.5</td>
<td>Eyesight and vision</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>83</td>
</tr>
<tr>
<td>16.6</td>
<td>Hearing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>84</td>
</tr>
<tr>
<td>16.7</td>
<td>Personal risk for certain diseases</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>85</td>
</tr>
<tr>
<td>16.8</td>
<td>Lung function</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>86</td>
</tr>
<tr>
<td>16.9</td>
<td>Other: (please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>87</td>
</tr>
</tbody>
</table>
In your opinion which methods should be employed to present the health promotion programme?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.1 Monthly newsletter</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.2 Bulletin board</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.3 Posters</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.4 Group information sessions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.5 Payroll inserts</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.6 Individual information sessions</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.7 Video programmes</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.8 Health education talks</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.9 Workshops</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.10 Lectures</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.11 Theatre presentations</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.12 Pamphlets</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.13 Discussion groups</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17.14 Other, please specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

In your opinion, which of the following are potential benefits of an Occupational Health Promotion Programme in the workplace for employees?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• improved health status</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• improved morale</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• feeling cared for</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• enhanced job satisfaction</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• enhanced organisational commitment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• increased motivation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>• decreased stress</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
19 In your opinion, which of the following are potential benefits of an Occupational Health Promotion Programme in the workplace for employers?

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity improvement</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Reduced absenteeism</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Reduced health care costs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Improvement in community image</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Reduced staff turnover</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Product quality enhancement</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Decrease in accidents</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other, please specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

20 Do you think employees should contribute financially to a Health Promotion Programme?

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

21 In your opinion, is the workplace a suitable venue for a Health Promotion Programme?

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

22 Do you think employees' family should participate in an Occupational Health Promotion Programme?

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

23 In your opinion, under which structure (department) in the workplace should an Occupational Health Promotion Programme resort? Rank your referred structure, with number 1 being your most preferred choice to number 5 being your least preferred choice of structure:

<table>
<thead>
<tr>
<th>Rank order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resources Department</td>
</tr>
<tr>
<td>Employee Association</td>
</tr>
<tr>
<td>Private organisations</td>
</tr>
<tr>
<td>Autonomous department</td>
</tr>
<tr>
<td>Occupational Health and Safety Department</td>
</tr>
</tbody>
</table>
In your opinion, who should manage the Occupational Health Promotion Programme at your workplace? Rank your preferred programme manager, with number 1 being your most preferred choice to number 5 being your least preferred choice.

<table>
<thead>
<tr>
<th>Rank order</th>
<th>126</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promotion Programme Coordinator</td>
<td>127</td>
</tr>
<tr>
<td>Occupational Health Nursing Practitioner</td>
<td>128</td>
</tr>
<tr>
<td>Human Resources Officer</td>
<td>129</td>
</tr>
<tr>
<td>Trade Union</td>
<td>130</td>
</tr>
<tr>
<td>Health Committee</td>
<td>131</td>
</tr>
</tbody>
</table>

In your opinion, should an Occupational Health Promotion Programme include the following levels of intervention?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>awareness campaigns</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>lifestyle behavioural change campaigns</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>supportive environments</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

In your opinion, should an Occupational Health Promotion Programme include an Employee Assistance Programme?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>135</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In your opinion, should an Occupational Health Promotion Programme include an early learning centre for the employees' children?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>136</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION 4: GENERAL DATA ABOUT HEALTH PROMOTION IN YOUR PLACE OF WORK

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an Occupational Health Promotion Programme in your workplace?</td>
<td>127</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an Employee Assistance Programme in your workplace?</td>
<td>128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think there is a need for an Occupational Health Promotion Programme in your workplace?</td>
<td>129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are working conditions in your workplace conducive to all aspects of health?</td>
<td>130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your opinion, is your workplace is a healthy organisation?</td>
<td>131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does a quality of work life prevail at your workplace?</td>
<td>132</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION 5: DATA ON THE DISEASE AND SICKLEAVE PROFILE IN YOUR WORKPLACE

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Does your workplace have an adverse influence on employees' health?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>35</td>
<td>Is there a high incidence of employees suffering from ill-health in your workplace?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>36</td>
<td>Is there a high incidence of employees with injuries in your workplace?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>37</td>
<td>Indicate the number of employees in your workplace</td>
<td>0 - 199</td>
<td>200 - 399</td>
</tr>
<tr>
<td>38</td>
<td>Indicate the amount of time you as an Occupational Health Nursing practitioner spend on average per day on</td>
<td>Hours</td>
<td></td>
</tr>
<tr>
<td>38.1</td>
<td>Preventive aspects of health care</td>
<td>&lt;2</td>
<td>2</td>
</tr>
<tr>
<td>38.2</td>
<td>Promotive aspects of health care</td>
<td>&lt;2</td>
<td>2</td>
</tr>
<tr>
<td>38.3</td>
<td>Curative aspects of health care</td>
<td>&lt;2</td>
<td>2</td>
</tr>
<tr>
<td>38.4</td>
<td>Rehabilitative aspects of health care</td>
<td>&lt;2</td>
<td>2</td>
</tr>
<tr>
<td>39</td>
<td>Please indicate how many employees were absent due to illness in 1998</td>
<td>0 - 49</td>
<td>50 - 99</td>
</tr>
<tr>
<td>40</td>
<td>Indicate the number of working days lost due to ill health for the calendar year 1998</td>
<td>0 - 49</td>
<td>50 - 99</td>
</tr>
</tbody>
</table>

SECTION 6: ROLE OF THE NURSE AND LEARNING NEEDS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>In your opinion, should the roles of the Occupational Health nursing practitioner for Health Promotion in the workplace, be one of:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>41.1</td>
<td>• initiator</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.2</td>
<td>• co-ordinator</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.3</td>
<td>• facilitator</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.4</td>
<td>• presenter</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.5</td>
<td>• counsellor</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.6</td>
<td>• researcher</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>41.7</td>
<td>• consultant</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### Questionnaire on Health Promotion and Education

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 Please indicate whether you have had any training in Health Promotion.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>43 Please indicate whether you have had any training in Health Education.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>44 Do you want to learn about Health Promotion?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you answered yes to question 44 please complete questions 45 to 47

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>45 Please indicate what you want to learn.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45.1 Philosophy and Ethos of Health Promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.2 Health Risk Assessment</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.3 Occupational Health Promotion process</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.4 Health Education</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.5 Health Promotion nursing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.6 Evaluation of Health Promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.7 Health Promotion theories/models</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>45.8 Other, please specify</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>46 Please indicate how you want to learn.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46.1 Lectures</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.2 Workshops</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.3 Seminars</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.4 Discussion groups</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.5 Theatre presentations</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46.6 Other, please specify</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>47 Why do you want learn more about Health Promotion?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47.1 Because it is part of primary health care</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.2 I want to know more about Health Promotion</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.3 For personal development</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.4 Because I want to implement a Health Promotion Programme</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.5 For professional development</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>47.6 Other ( please specify)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Thank you for your time
Addendum B

Cover letter to the questionnaire
Addendum B: Cover letter to the questionnaire

AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL SETTINGS: A NURSING PERSPECTIVE

Dear colleague

I am a student at Unisa busy with my masters' degree in community health nursing and my research involves the identification of the need for occupational health promotion programmes in selected occupational settings.

Professor L King or Ms SP Hattingh can be contacted at 012-4296131 should you have any enquiries.

Health promotion is the process of enabling people to increase control over, and to improve their health.

An occupational health promotion programme can be seen as the systematic efforts of an organisation to enhance the wellness of its members through education, behavioural change and cultural support.

The researcher needs your response to determine the need for such a programme, to decide on the type of activities that should be included in an occupational health promotion programme as well as to determine the occupational health promotion learning needs of nursing practitioners.

It is estimated that it will take you ± 20 minutes to complete this questionnaire.

All information is confidential.

Will you please return the completed questionnaire in the addressed envelope as soon as possible.

Your time and cooperation is greatly appreciated.

Thank you.

Agnes Huiskamp
Addendum C

Letter of request for permission to undertake the study
Addendum C: Letter of request for permission to undertake the study

TO:  
Address:  
Pretoria

Dear

I am a student at Unisa busy with a masters degree in Community Health Nursing and my research involves the identification of the need for Occupational Health Promotion Programmes in selected occupational settings. Professor L King or Ms SP Hattingh can be contacted at (012) 429-6131 should you have any enquiries.

The title of my research study is AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL SETTINGS: A NURSING PERSPECTIVE.

My target group is occupational and campus health nursing practitioners in tertiary education institutions, organisations and industries in The Greater Pretoria Metropolitan Area and involves 80 professional nurses.

I hereby ask your permission to give my questionnaires to be completed, to the campus health nursing practitioners in your organisation.

Attached please find a copy of my questionnaire.

I will appreciate it if you can give me permission in writing.

I will send the questionnaires to the campus health nurses as soon as I gain permission from you.

May this request meet with your favourable consideration and approval.

Thank you.

Ms A A Huiskamp  
1999/08/11  
Tel/Fax: (012) 343-9589
Addendum D

Letter of permission from the City Council of Pretoria
PERMISSION FOR RESEARCH STUDY

Permission has been granted for you to conduct the research study on "An inquiry into the need for occupational health promotion programmes in selected occupational settings: A nursing perspective."

We wish you all the best during your research.

Dr E Oosthuizen
DIRECTOR PHC 2

23 August 1999
Addendum E

Letter of permission from Nampak Paper
Addendum E: Letter of permission from Nampak Paper

10 August 1999

Ms Agneta Huiskamp
133 High Street
Sunnyside
PRETORIA 0002

Dear Ms Huiskamp,

Permission is hereby granted to have your questionnaires completed by our Occupational Health Nurse.

The questionnaires have been passed to Sister Amanda Segal, and should you have any queries, please contact her directly.

Yours sincerely,

[Signature]

AVAN DER TOUW
GENERAL MANAGER
Addendum F

Letter of permission from
Technikon Northern Gauteng
Addendum F: Letter of permission from Technikon Northern Gauteng

To: Professor L van Staden  Acting Principal  
From: A A Huskamp  Senior lecturer - Nursing

DATA COLLECTION FOR RESEARCH PROJECT.

I am a student at Unisa busy with a masters' degree in Community Health Nursing and my research involves the identification of the need for Occupational Health Promotion Programmes in selected occupational settings. Professor L King or Ms S P Hattingh can be contacted at 012- 4296131 should you have any enquiries.

The title of my research study is AN ENQUIRY INTO THE NEED FOR OCCUPATIONAL HEALTH PROMOTION PROGRAMMES IN SELECTED OCCUPATIONAL SETTINGS: A NURSING.

My target group is occupational and campus health nursing practitioners in tertiary education institutions and industries.

I hereby ask your permission to give my questionnaires to the two campus health nurses to complete.

The questionnaire contains questions on nurses' viewpoint on the content of such a program, the disease and sick leave profile of their place of work, and nurses health promotion learning needs and their role in health promotion.

Please find attached the section of the questionnaire pertaining to their places of work.

I do not ask on the questionnaire for the institution or organization's name.

May this request meet with your favorable consideration and approval?

Thank you

Ms A A Huskamp
1999/08/02

8/18/99

Mr Muller
Approved. If you agree with me please notify Mr Huskamp accordingly.

Mr Huskamp
You may proceed with your study as approved by the committee.

Best wishes

4/18/99
Addendum G

Letter of permission from the University of Pretoria
1999-08-23

Ms Agnes Hulskamp
183 High Street
Sunnyside
PRETORIA
0002

Dear Ms Hulskamp,

PERMISSION FOR RESEARCH STUDY

I acknowledge receipt of your fax dated 19-08-91. I wish to apologize for the delayed written response.

I wish to inform you that you are permitted to go ahead with your research in Student Health division.

Yours sincerely,

[Signature]

M R E Morelo
HEAD STUDENT SUPPORT