IDENTIFICATION OF HEALTH NEEDS AND PROBLEMS OF BLACK EMPLOYEES IN THE GERMISTON CITY HEALTH DEPARTMENT

by

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I declare that the **Identification of health needs and problems of black employees in the Germiston City Health Department** is my own work. All the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

Petronella Poho

ABSTRACT

The aim of this study was to identify the health needs and problems of black employees within the Germiston City Health Department in order to indicate a possible relationship between such needs and problems and a high rate of absenteeism.

Although the findings could relate to all employees, this study was limited to black employees only. Data was collected by means of observation, perusal of health records and personal interviews with personnel as well as with the selected sample. The results of the study highlighted the specific health needs and problems of employees as well as factors which could influence their health status and which could contribute to the problem of absenteeism. The main factors identified included interalia poor working conditions and unsatisfactory methods of solving employees problems. Relevant recommendations were made to address the problem of absenteeism in the Germiston City Health Department.

Key terms:

Health need; Health Problem; Violence and health; Absenteeism; Staff turnover; Working conditions; Occupational stress; Occupational safety committees; Injury on duty; Hostel environment

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CHAPTER 1

ORIENTATION TO THE FIELD OF STUDY

1.1 INTRODUCTION

The comprehensive health concept emphasises the prevention of ill-health and the promotion of health of individuals within their work and home situations. Due to factors such as industrialisation and urbanisation, health needs and problems of the communities have changed tremendously. Individuals carry their health needs and problems from the home situation to work. The work situation in turn creates overwhelming demands on employees, hence they experience health problems at home and at work. Ncala (1985: 1) states that *with changes in the social structure such as industrialisation and the resultant influx of people from rural to urban areas, overpopulation in some black areas has put a severe strain on health services.* Social mobility and informal settlements have created increasing demands for health services. Environmental factors such as unemployment, lack of housing, lack of proper water supply and sewerage system, lack

of electricity and other resources have resulted in a growing demand on health services to urgently meet the needs of the community. Factors such as home accidents, gastro-intestinal problems, malnutrition, just to mention a few, pose major problems in these areas. This view is supported by Mamaila who stated in the City Press (1993: 3) that *the impoverished Kliptown squatter community is fighting a war against water-related diseases. Dozens of residents in the informal settlement just outside Soweto, draw their water for house use from the nearby river, not knowing it is infested with filth from an open sewerage system.*

A good basic infrastructure is a vital requirement for an acceptable standard of living. Poor living conditions may lead to high mortality rates and epidemics of communicable diseases such as typhoid, measles and malaria. According to Unicef, WHO and Unesco in Health and Hygiene May/June 1993: 22 *more than half of all illness and death among young children is caused by germs which get into the child's mouth via food and water. In communities without latrines, without safe drinking water and without safe refuse disposal, it is very difficult for families to prevent the spread of disease. It is essential that communities are told the facts about how illness is spread and what they can do to prevent it.*

According to Pearson (1991: 3) *infectious diseases are more easily spread due to inadequate sanitation facilities, lower water usage, lower levels of domestic hygiene, and a lack of waste collection and disposal. The upgrading of these services in particular should receive priority from a health point of view.*

Prinsloo and Prinsloo (1975: 125) also state that *while the provision of shelter is*

important in itself, it must be supplemented by complementary attention to the total environment of the settlement as a whole. A healthy human settlement is one that provides a range of opportunities for the fulfilment of all human needs; that is supportive of each individual's efforts to develop as a self-reliant, responsible, creative human-being; that both facilitates and benefits from the particular cultural context; and ultimately, one that is self-generated and perpetuated, requiring a minimum of input and maintenance from local and other authorities outside the community. It is also clear that in order to achieve a good standard of living, certain basic requirements are necessary. These include interalia adequate housing, sufficient and clean water supply and sanitation measures, storm water drainage, communication systems, schools, shops and clinics.

There is a need for the introduction of a comprehensive health care system, where all aspects of health care, both public and private health care, can be coordinated. Specific emphasis should be on women's health in order to enable women to make informed decisions about their health and that of their families. The comprehensive health care system should include services such as ante- and post-natal care, family planning, cancer prevention, immunisation of children, nutrition, treatment of minor ailments and injuries, and protection against sexual harassment, rape, violence and so on.

Empowerment of women regarding health matters must extend to their parenting role, because women are the pillars of the families. In the work situation women must have assertiveness to negotiate for better working conditions for themselves, including negotiating for maternity leave with benefits. In the community, women must also

have a say about the needs of their families. The African National Congress health policy (1994: 19) supports this approach and points out that *health and health care, like other social services, and particularly where they serve women and children, must not be allowed to suffer as a result of foreign debts or structural adjustment programmes.* In addition, there is an urgent need for health authorities to carefully assess the needs and problems of communities when planning health services. Health services should aim at promoting the individual's physical, social and psychological well-being, and preventing disease, injuries and other health deviations.

The continued existence of human beings depends on the satisfaction of numerous needs, both physical and psychological. The changing life-style that urban employees are exposed to is accompanied by various changes in the health needs of the community. Social mobility due to industrialisation and urbanisation has a tremendous effect on peoples' health needs. Urban life-style tend to increase the need for community resources, such as shelter, employment opportunities, education and adequate health care. Problems experienced by employees in their home and work situations cause stress, disturbing the physical, social and psychological well-being of the entire family.

The health needs and related problems of employees should not only be the concern of the providers of health care services, but is also a matter to be considered by the community as such.

Both employers and employees should look at health holisticly, and should therefore include aspects such as housing, education, employment and so forth, when considering ways to promote the health status of the community.

The high rate of absenteeism amongst the black employees of the Germiston City Health Department motivated the researcher to identify the health needs and problems of these employees. It is recommended that further research will be conducted to also include other departments and ethnic groups in the Germiston City Council. Guidelines for controlling the problem under study should be applicable to all departments.

Birrer (1987: 147) maintains that *many conditions associated with urban living tend to increase the need for community resources as an adjunct to health care. Poverty, which is extensive in urban, especially inner city areas, create stressors. Often patients seen in urban family practice centers expend a great amount of energy trying to meet basic existence needs such as obtaining food, clothing, shelter, heat, electricity.* Urban areas appear to have higher rates of unemployment, overcrowding and inadequate housing. These conditions have been associated with high crime rates. This increases the stress level of people living in these areas which can inhibit people from meeting other needs, including health care.

In the light of the above discussions it can be deduced that the health of employees is influenced by the environment in which they live and work. The health needs and problems that affect their physical, social and emotional well-being, should be identified and a course of action be taken to meet such needs and alleviate the problems. Education, job opportunities, nutrition, housing and so forth are all factors that influence the individual's total well-being. In addition, in the work situation employees are exposed to a number of work related stresses that could adversely affect their health and well-being. These factors should be attended to.

Bernard and Bernard (1988:150) however, state that it is often found that *occupational medicine can only deal with the prevention of recognized hazards directly related to work, and never (or hardly ever) considers the relation between health and working conditions as a whole.*

To be effective workers should be healthy and happy. Not only should the workers be assisted in the promotion of their health status through their active participation, but the importance of worker participation in occupational health must be stressed and serious consideration should be given to the suggestions brought forward by the workers.

Health care and participation are fundamental rights of people who should be taught how to be responsible for their own health and that of their families. This must be taken into consideration when planning health services for employees, and is therefore an aspect which this researcher took particular note of when conducting this study.

1.2 STATEMENT OF THE PROBLEM

Due to a particularly high rate of absenteeism amongst black employees of the Germiston City Health Department, as identified during a previously conducted departmental study (Germiston City Council: 1985) the researcher, on request of the Medical Officer of Health of Germiston, was motivated to initiate this particular research study. The adverse effects of absenteeism on the provision of effective health services, prompted the researcher to identify the health needs and problems of black employees in the Germiston City Council Health Department, in order to indicate a possible relationship between such problems and the high rate of absenteeism which had

been identified. The department under study, currently has no specific guidelines for finding holistic solutions to the identified health needs and problems of employees. Although individual and group counselling is done on a limited basis, this in itself is not enough. One has to identify the specific needs and problems of employees as well as the underlying causes, in order to decide on an effective plan of action to alleviate the problems. There should be effective guidelines for controlling absenteeism and handling the health needs and problems of employees within the department. These guidelines should be meaningful and effective for both employees and employers. They should be developed to control the problem of absenteeism and in the process assist employees to develop an increased sense of responsibility towards their employment.

For the purpose of this study, the following research questions were formulated:

- What are the health needs and problems of black employees within the Germiston City Health Department?

- What are the factors that influence the health status of black employees in the Germiston City Health Department?

- What are the causes of and contributory factors to the high rate of absenteeism identified in the Germiston City Health Department?

- How could the health status of employees in the Germiston City Health Department be improved?

- What recommendations can be made to develop guidelines for attending to identified health needs and problems of employees?

- What recommendations can be made in order to develop guidelines for controlling absenteeism as identified amongst black employees of the Germiston City Health Department?

1.3 OBJECTIVES OF THE STUDY

In conducting this study, the researcher will attempt to

- identify the health needs and problems of black employees within the Germiston City Health Department (hereafter referred to as employees)

- identify factors which influence the health status of employees

- determine the causes of, and contributory factors to the high rate of absenteeism identified in the Germiston City Health Department

- identify measures to promote the health status of employees

- formulate recommendations for the development of guidelines to attend to identified health needs and problems of employees

- formulate recommendations for the development of guidelines to control

absenteeism as identified amongst black employees in the Germiston City Health Department

1.4 SIGNIFICANCE OF THE STUDY

A study such as this, where health needs and problems of employees are identified, can assist health care providers in general with the planning of future health care services and the development of other resources that could contribute to health promotion.

Even though the study is carried out in a specifically demarcated situation, principles underlying health needs and problems remain the same in all situations, and the study therefore has wider implications. The information contained in this study could also be of help to all health care workers who are involved in the continuous assessment of health needs and problems in their particular communities. Although the researcher focused on the needs and problems of black employees in the Germiston City Health Department in particular, solutions that will be suggested can be applied to all work situations.

1.5 ASSUMPTIONS

In line with the specific research questions that have been stated, the following assumptions were formulated:

1.5.1 Assumption 1

Information regarding the nature of the health needs and problems of black employees within the Germiston City Health Department, as well as identification of the factors that influence the health and well-being of workers, will assist in promoting the health status of employees in the Germiston City Health Department as the information could be used in the development of guidelines for attending to identified health needs and problems of employees.

1.5.2 Assumption 2

Information about the factors that influence the health status of employees will assist in identifying the factors that contribute towards the high rate of absenteeism, that had previously been identified in the Germiston City Health Department. This information could assist in the formulation of guidelines to control this high rate of absenteeism.

1.6 LIMITATION OF STUDY AREA

The study is limited to the black employees of the Germiston City Health Department, a subdepartment of the Germiston City Council. Specific attention was given to factors that influence the health and well-being of these employees, and to how these factors contribute towards the high rate of absenteeism that had been identified.

1.7 DEFINITION OF CONCEPTS

The researcher found it necessary to define certain concepts for the purpose of clarification in this study.

1.7.1 Council

The following definition appears in the Germiston City Council's conditions of service: *Council means the Council of Germiston and includes the management committee of the Council, acting by virtue of powers vested in the Council in connection with this agreement and delegated to him in terms of Section 58 of the Local Government (administration and elections) Ordinance, 1960,* (City of Germiston Conditions of Service 1986: 2).

1.7.2 Health

Vlok (1981: 35) refers to the WHO definition of health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

Stanhope and Lancaster (1982: 936) defines health as *a balanced state of well-being resulting from harmonious interaction of body, mind and spirit.*

For the purpose of this study the researcher favours a definition that takes cognisance of health in a broad context, recognising the whole organism and its adaptability to

ecology.

1.7.3 Health need

The Reader's Digest complete word finder Tulloch (1993: 1016), defines a need as *a want or requirement.* If health is defined as a state of physical, social and psychological well-being, it stands to reason therefore that a health need can be interpreted as circumstances or actions that are lacking in fulfilling this complete state of well-being of individuals.

1.7.4 Health problem

The Oxford dictionary defines a problem as a *doubtful or difficult question; thing hard to understand or deal with* (Swannel 1985: 428). In this study a health problem can be defined as any doubtful or difficult challenge which affects the physical, social and psychological well-being of individuals, for which a systematic solution is sought.

1.7.5 Comprehensive health care

Comprehensive health care can be defined as health care for individuals and their families within the community. It is provided from birth throughout all stages of development to advanced old age.

Searle (1986: 16) defines comprehensive health care as *the service that provides for all aspects of health care at the preventive, promotive, curative and rehabilitative levels.*

It is based on progressive patient care concept, referral systems and a team approach in the delivery of health care.

In this study the researcher favours the definition that considers the total health of an individual ie preventive, promotive, curative and rehabilitative levels. The individual's health care is considered within the family in the community, including all environmental factors that affect his total well-being.

1.8 CONCLUSION

In this chapter the researcher attempted to outline and discuss factors that have an influence on the changing health needs and problems of individuals in their home and work situations. These include interalia aspects such as industrialisation and social mobility, unemployment, lack of housing, poor water supply and sanitation and lack of electricity.

The researcher further discussed the statement of the problem under study, the purpose, objectives, assumptions, significance and limitations of the study. Specific concepts referred to in the study were also clarified.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION

In this chapter the researcher will discuss the views and opinions of various authors. Related aspects such as the health of individuals in their work and home situations, health needs and problems as well as factors influencing health care needs and problems will be considered. Since the issue of health needs and problems of employees, as well as the problem of absenteeism are universal concerns, the views of South African as well as international authors will be considered.

Specific attention will be interalia given to the following aspects:

- the nature of health care needs and problems of employees
- factors influencing health care needs and problems
- absenteeism and staff turnover

- occupational health and safety of employees

2.2 HEALTH NEEDS AND PROBLEMS OF EMPLOYEES

The total health of workers should be considered in relation to job demands, the working environment and the overall living conditions of the workers. Employees are faced with a multitude of health problems, some of which are a result of occupational hazards, home and work stresses, physical and psychological agents and so on.

Employees live within the wider social community but also form part of a specific working community. Identification of the needs and problems of the community is one of the basic components of the discipline community health. The concept community diagnosis is very important for effective planning and provision of resources to meet the needs and solve the problems of the community.

Gerber, Nel and Van Dyk (1987: 254) clearly states that *a wide range of human needs is satisfied by working. The most important needs include a need for affiliation, a feeling of competence and success, authority, control, pride and status. Knowing employees' needs, and developing motivation strategies for their employees on the basis of these needs, is a major challenge for management. Therefore it is important for management to be aware of human needs and existing theories of motivation.*

Higgs and Gustafson (1985: 11) explains Maslow's *hierarchy of needs*, and maintains that the basic needs which Maslow identified as being of importance to the individual, also apply to the community as a whole. These needs would therefore also apply to the

individual employee. In order to satisfy individual and community needs, certain human basic needs such as housing, employment, health and recreation facilities should be available to all.

Gerber et al (1987: 254) further states that Maslow's theory has the following two-fold basis:

- *Man is a continuously wanting being. As soon as one need is satisfied, another appears to take its place. A satisfied need cannot act as a motivator of behaviour. Furthermore people can never be fully satisfied, therefore they behave in a particular way to satisfy a need or a combination of needs.*

- *Man's needs are arranged in order of importance, in other words lower - order needs must be satisfied before higher-order needs.*

This implies that people work because of certain needs in their lives. Once the basic needs are satisfied the individual strives to satisfy higher needs. Working for financial gain, makes it possible for employees to satisfy basic needs such as shelter, clothing and food and then strive for higher needs.

Human needs are never static, they change with time, and so are community needs which are dynamic because of continual social change. One has to continuously assess community needs in order to be able to plan effectively and to solve the prevailing problems of the community.

Berns (1982: 28) further elaborates on the theory of needs by stating that *Hertzberg developed a theory of job satisfaction based on Maslow hierarchy and concluded that not all factors increase satisfaction. He views man as having two categories of needs. The hygiene needs (which do not increase satisfaction) include the avoidance of loss of life, hunger, pain, sexual deprivation, and learned fears; the motivators (which do increase satisfaction) include achievement, recognition for achievement, work itself, responsibility, advancement, and psychological growth.*

The views of the above authors are interrelated. Berns agrees with Gerber that a wide range of human needs are satisfied by working. Bern's hygiene needs can be compared to Higg's interpretation of Maslow's basic needs. The fact that once basic needs are satisfied the individual strives for higher needs also applies to the community as a whole. Gerber makes clear that a man is an ever wanting being, striving for higher goals. This also applies to employees who need the motivators which increase job satisfaction. They need competence and success, authority control, pride and status which can be compared to Bern's motivators which include achievement, recognition for achievement, work itself, responsibility, advancement and psychological growth.

Deprivation of these needs may lead to job dissatisfaction, conflict, absenteeism and staff turnover.

2.3 FACTORS THAT COULD INFLUENCE HEALTH NEEDS AND PROBLEMS

There are many factors that influence the health needs of the community. People's health needs are related to the environment in which they live and work. Their health

status is determined by the position they hold in the socio-economic structures within their communities. Lack of education, reduced job opportunities, unemployment, poverty and malnutrition, all affect the physical, social and emotional well-being of individuals, both in the home and in the work situation.

2.3.1 Environmental factors

Although industry created jobs, and jobs provided money to buy food, shelter, clothing, and so forth, it also created many potential health problems. As industrialisation proceeded and technology diversified, occupational health problems followed suit affecting more people and appearing in new forms. Poor working conditions, injuries and stresses assaulted human-beings and produced effects that are detrimental to health. Job related health risks, working conditions, relationship at work, all influence the complete state of well-being of individuals.

Gerber et al (1987: 419) states that *some occupationally related injuries and illnesses are the result of emotional and behavioural factors, but most of them are directly linked with the physical work environment. Those characteristics of the work environment associated with those injuries are called safety risks. Efforts by enterprises to avoid accidents are therefore aimed at removing these safety risks, for example by fitting hazardous machines with protective guards, or by making employees more safety conscious.*

This implies that employees should be educated on safety risks in their work environment and also take precautions to protect themselves against occupational injuries and illness

in their work situation. Authorities have, in terms of legislation, paid much more attention to the safety aspect by setting standards and introducing measures for the protection of employees, while paying relatively little attention to the area of occupational health.

The environmental stresses that could exist in the work situation include the following:

- Physical stresses such as temperature, light, noise and radiation. For instance heat has certain effects on the individual's health such as dehydration, thirst and heat exhaustion, fatigue and so on. Cold often causes metabolic disturbances; disfunctioning of hypothalamus; poor concentration and productivity. Faulty activities can cause fires which can cause damages. Noise interferes with communication and can lead to deafness.

- Chemical stresses such as dusts, fumes, gases, vapour causing lung problems.

Today South Africans who live in and around the towns and large cities are faced with poor living conditions. Environmental problems such as squatting, poor refuse removal, poor sanitation and water supply, all affect the health of workers both at home and at work. In their desperate search for job opportunities, they have streamed to towns and cities, hence the increase in environmental problems, caused largely by the increasing incidence of squatting. These new urbanised communities do not always have means to pay for refuse removal, let alone housing and effective sanitation and water supply.

It is difficult to promote a healthy life-style of employees living in such poor circumstances. However, a comprehensive and multidisciplinary approach could be established to improve their living and working conditions. Politicians, medical personnel, industrial hygienists as well as individual members of the community should stand together and improve the employees' living and working conditions.

2.3.2 Psychosocial factors related to the work environment

Gerber et al (1987: 124) points out that *a person joins, and enters into a psychological contract with an enterprise, on the basis of his personal needs and goals. Both the individual employee and the enterprise have certain expectations which must be met in order to uphold this contract. The integration of personal goals with the goals of the enterprise seems to be the best way to uphold this contract. This provides the basis for motivated employee behaviour which is essential for the success of the enterprise.*

Both the employees and employers must recognise the importance of communication in the work situation, in order to achieve the goals of the organisation as well as the goals of employees. Job satisfaction of employees and the success of the organisation depends on this relationship.

According to the WHO (1978: 318) *the psychosocial work environment depends upon working relationships, security of employment, degree of responsibility, and task factors such as repetitiveness, speed, alternation shifts, overload and underload, and in the case of certain occupations (like seafaring and underground mining) the strain of isolation. The capacity to adapt to different working environments is influenced by many factors*

including education, cultural background, family life, social habits, and what the worker expects from employment.

The work environment should be conducive to both employees and employers. People should be allocated to jobs according to their skills for effective productivity. Factors that contribute to better adaptation of employees in the work environment should be taken into account in order to avoid unnecessary stresses and strains.

Occupational stress can have a positive or negative effect on the well-being of employees. Psycho-social factors such as the work environment, job tasks, multiple roles of employees, work policies and so forth, can all affect the employees health.

Under certain conditions, working women, rural workers entering industrial employment for the first time, and adolescents may be particularly vulnerable to psychological stresses.

The different types of stress in the work situation include interalia the following:

- Ergonomic stresses such as body position, fatigue and disorganisation of work.

- Psychosocial stresses, such as conflict, worry, social isolation and aggression.

Stresses and strains in the work environment affect the physical, social and psychological well-being of individuals. Behavioural changes such as irritability, conflict, absenteeism and staff turnover can be experienced. These lead to the disorganisation

of the enterprise and decreased productivity.

2.3.3 Political factors

Health needs of individuals cannot be met by any single organisation. A multidisciplinary team approach which include members from non-governmental, and governmental officials should be followed. This is confirmed by Hammond and Gear (1986/2: 219) who asks *if we can separate environmental health issues from political-economic issues. If we pollute the environment it pollutes us. It is the individuals in rural areas who relieve themselves in "the bush", it is policy makers who decide to resettle people into overcrowded areas with inadequate infrastructures and resources, it is health inspectors who do not enforce statutory limits, it is the villagers who wash and bath in rivers and it is the government officials who fail to allocate resources for protected water supplies for all South Africans.*

Community health will never improve until all South Africans have access to adequate housing, have adequate sanitation and water supply, sufficient food, accessible and acceptable health services as well as a healthy working environment. Politicians need to take cognisance of this. However, with the population growth in South Africa, this may be a far reached goal.

Participants at a Primary Health Care Conference which was held at the Institute of Child Health, University of London in 1987, stressed the importance of political commitment in primary health care to achieve health for all. It became clear that people's participation in political processes can result in more equitable distribution of

land, income, and public services including health and education. People should be better educated, live a healthy life-style, live longer, enjoy higher average incomes, be more secure in their jobs, and have access to available resources. Politicians should look at the satisfaction of community needs rather than satisfying their political demands.

The health plan for South Africa, produced by the African National Congress (hereafter referred to as ANC) (1994: 20) also stresses the importance of political commitment in primary health care. According to the health plan, *the PHC approach requires political will on the part of the government, and commitment from communities, health and allied workers, health policy makers, health service managers and the broad range of health-related sectors (education, sanitation, water supply, electrification, finance, agriculture, small business development, etc). The government will formulate national policies, strategies and plans of action to launch and sustain PHC as part of the Comprehensive National Health System and in coordination with other sectors.*

Coovadia (1991:20) maintains that *once the foundation of a democratic state have been established, health for all South Africans by the year 2000 will require a staggering investment in human, economic, technological and social resources.* Coovadia continues by stating that *the first requirement is political stability and peace throughout the country, whereafter, attempts to ensure an acceptable health service should be integrated into overall members for social reconstruction.*

Ryder (1991: 2) stated that *with the social and political changes in South Africa, we as community workers are facing the most dramatic and demanding challenges of all times. The multiplicity of cultures, religious beliefs and the diversity background of the*

people of South Africa which together form the community with which we must, through our best endeavours, take through these troubled times. The health attitudes of people is interwoven with their culture and perhaps this should be our point of departure.

In the past health authorities could not take into consideration the culture of people when planning health services. However, changes in health care delivery demanded recognition of people's cultures and religious beliefs in planning health services which will meet the needs of the communities. It is important to know and understand all these aspects in order to promote the employees' life-style.

2.3.4 Violence and health

Violence affects the physical, social and psychological well-being of individuals within the community as well as in the work situation. A desire for democracy and liberation from the previous political rule in South Africa brought misery and conflict within communities. Violence, in particular black on black violence has been the scourge of South African townships for many years. Although one tends to stress the political nature of the conflict, there is no doubt that socio-economic factors such as lack of housing, unemployment and others are also major determinants which must be taken into consideration when examining the issue of violence.

The scrapping of influx control laws brought about freedom of movement to many black communities. People were free to seek work in big cities, with big industries, but the unavailability of jobs due to many factors such as lack of skills, economic constrains in the country, and so on, led to further unemployment and the development of more

squatter camps.

The overall crucial socio-economic and other accompanying political factors such as political rivalry, resistance to change by the apartheid regime, political intolerance and so on, worsened the situation. Violence became endemic in South Africa and many people lost their lives and properties were destroyed.

The Medical Association of South Africa expressed its concern about the escalating violence and its effect on health care delivery. The Association feared that violence might jeopardise overstressed health services even further. Staude, Rissik, Marshall and Gale (1993: 4) refer to the concern of Doctor Bernand Mandell, chairman of MASA's Federal Council, who stated that *we need our doctors and health personnel to help build a healthy nation ... to care for the sick. They must be available to serve the community in a safe and protected environment. The sad fact is that health personnel are human too and if fear and anxiety were to override their calling, communities could be deprived of health services where they are needed most.*

Various community leaders, such as the Reverend Mvume Dandala, King Zwelithini and Chief Ndamase made a great effort to stop violence, especially black on black violence. Due to continued violence many employees could not go to work and this continued to disturb their total well-being. The continuous social upheaval that people in certain townships experienced extensive loss of property, deaths, loss of jobs and so forth, severely affected the social and psychological well-being of individuals. The need for peace has been emphasised by the ANC health policy (1994: 56) in which it is stated that *the promotion of peace and security for all people is not only a pre requisite for health*

development but is also vital to the overall process of reconstruction and socio-economic development.

Violence has a disastrous effect on the lives of all individuals. Not only does it affect the physical and mental health of the people, but is also influences factors such as education and socio-economic well-being of the community.

Indeed, violence has disturbed the total well-being of individuals within their communities. In many instances the provision of effective health care has become virtually impossible. Home visits, district nursing services and health education within communities have largely been suspended. Health personnel are exposed to insults and harassment by criminals who have taken an advantage of the situation. Their cars are being hijacked, stolen and stoned. This does not only cause fear, but also causes stress in health workers seriously affecting their health and well-being. The psychological trauma caused by seeing dead bodies lying around the clinics, hearing gunshots, seeing groups of people running around and others standing at street corners, can not be overlooked.

If the providers of health care are mentally, socially and physically disturbed, then meeting the health care needs of the communities will become impossible. It is often found that the health care personnel who work within their own communities, providing community based primary health care, are affected the most seriously by the violence.

In addition, the lack of housing experienced by the sufferers of violence led to a further increase in squatter camps, where there is little or no basic services such as electricity

and water. This also affects the total well-being of people, who are unable to meet their basic needs.

Violence also have a major effect on the education of the community. Many schools and other institutions of education have been either destroyed or severely disrupted. Employees work to meet their needs and those of their families. Education of their children for better employment opportunities is one of their main objectives. Without a good basic education, it is not possible to earn a good living wage, which is necessary to meet the basic needs of the worker and his family.

2.3.5 Housing

Housing has for many years been a matter of great concern to the government. More than twenty years ago Prinsloo and Prinsloo (1975: 125) stated that the *"housing-problem" in South Africa, along with "health" and "employment", is currently the focus of much attention by National and Local Government, private institutions and the general public.*

Housing as one of the major influences on the total health of individuals, is also greatly affected by issues such as migrant labour and social mobility. Accommodation generally provided for migrant workers is simply not designed to house families. Many migrant workers live in single quarters in hostels, whilst others establish a home in one of the squatter areas for the accommodation of their family members who visit them from time to time.

Ellis, Hendrie, Kooy and Maree (1977: 35) maintain that *living conditions in the Ciskei and Transkei are characterised by extensive poverty, high rates of unemployment, widespread undernutrition and malnutrition resulting in high infant mortality rates, social disruption due to the absence of men from the regions and a shortage of urban housing.* Industrialisation and urbanisation is said to be the main cause of the housing shortage and ultimately lead to squatting. The problems is going to remain for many years to come, unless job opportunities are also made available in smaller towns and in rural areas.

Squatting is a serious socio-economic problem. Even if the influx of people to the cities should stop, there will still be a squatting problem because families move into squatter areas for various other reasons such as population increase, unemployment followed by failure to pay for essential services, and so forth.

One agrees with Prinsloo (1977: 34) who emphasise the fact that *surely a worthy goal for all of us is to live in settlements that are healthy and humane*? The living conditions of people should enable them to fulfill their basic needs. They should be empowered with health information that will develop them as self-reliant, responsible and creative human beings within their communities. All human beings,irrespective of colour, creed and race, have a right to live in enviroments, which are condusive to a healthy life style.

Tobias (1975: 127), in discussing squatting in Cape Town, points out that *as far as education and more specifically as far as schooling is concerned the squatters share much in common with people from working class townships throughout the Cape Peninsula. All are members of exploited and oppressed groups and all are victims of a*

system which denies them equal access to the resources of society. The problems of the seventees to which Tobias referred, is still with us today.

Pieterse (1992: 18) pointed out that *urbanisation, however, has not only involved a movement of population from the rural to urban areas, but it has at the same time re-organised the economic, social and political structures of every nation state.* These changes have not taken into consideration the health needs and problems of communities in rural areas, and has resulted in the uneven distribution of health services.

Squatting is accompanied by poor sanitation, overcrowding, high crime rate and increase in diseases. Therefore the approach to health care must be done according to the needs of the squatter community. It must take into account all factors that have an impact on health such as housing, provision of basic facilities such as water, sanitation and sewerage, employment and education.

Pieterse (1992: 18) also state that *there is a critical need to have a regionalised and more appropriate metropolitan approach to the financing and planning of all aspects of health services and those factors impacting on health.*

Pearson (1991: 3) adds to the debate by pointing out that *the problem with squatters cannot be solved by one singe body corporate. With informal settlements on both proclaimed land becoming an everyday occurrence, something must be done. We cannot wish these people away; nor is law enforcement the answer. Whilst they are squatting, the health authorities must take responsibility.*

The views of the above authors imply that whether squatting is formal or informal, it needs minimum basic services such as roads, water, sanitation, schools and clinics. Failure to look at the basic infrastructure could lead to health problems. Lack of housing leads to squatting and in order to enable citizens to have proper housing compulsory education for better job skills is a necessity. These are all factors that employers should keep in mind when considering the effect of poor living conditions on the health and well-being of their employees.

2.3.6 Migrant labour

The number of migrant workers employed in urban areas has increased tremendously over the past number of years. Endemic and acquired diseases from the workers' countries of origin include a number of parasitic diseases such as malaria, communicable and noncommunicable diseases such as cholera, sexually transmitted diseases and tuberculosis just to mention a few.

In many instances a migrant worker has to adjust to a wide variety of new conditions in a new environment. These may include differences in eating habits, utilisation of health services, social customs, the cost of living, housing facilities, the type of work and the working environment. The worker may be handicapped in dealing with these changes due to inexperience regarding urban lifestyle and due to communication problems, differences in cultural background, customs and traditions. Such factors have an influence on the migrant worker's needs.

Migrant workers should be provided with occupational health services including pre-

employment and regular periodic medical examinations. Additional preventive and promotive health measures such as health education on nutrition, oral hygiene, eye care, cancer prevention and X-ray tests should be provided. It would also assist migrant workers with adjustment in their work environment, if language training courses could be available to them.

2.3.7 Nutrition

The nutrition of employees should be a concern of all employers, and should receive particular attention in the relevant occupational health programmes. Employees should be nourished adequately to be able to meet their total health needs, including any special demands placed on them by their work environment. Employees should receive sufficient renumeration to enable them to purchase adequate food for themselves and their families. However, this does not always happen due to economic impediments when wages are low, educational impediments when food habits are hygienically unsound, and geographical constraints when a worker's place of employment is far from home and transport is inadequate.

Employers can play a positive role by providing health education to employees regarding planning of well-balanced diets, correct cooking habits and so forth and by provision of meals for employees during working hours. It should however, be borne in mind that educational programmes on nutrition cannot be nationally uniform, because of varying customs and cultures of employees.

Canteens provided by employers are sometimes not used by employees. It is a good

principle to encourage employee representatives to participate in the planning and routine management of canteens, to ensure better utilisation thereof.

Searle (1977-79: 49 states that *the design of canteens and eating facilities should be geared to cultural preferences of the workers. Industry can often be assisted by the consultant services of trained nutritionists. These consultants can advise on ways of satisfying nutritional needs within the general framework of the workers' traditional eating habits.*

This emphasises the fact that authorities can provide canteens for their employees, but if the food provided in these canteens is not what the employees want, then the nutritional goals of both the employers and employees will not be achieved. A person's culture determines his or her eating habits. Employers should bear this in mind.

2.3.8 Alcoholism

Alcoholism may be regarded as a social pathology by reason of its frequency and the severity of its effects on the individuals both in the working and non-working situations.

Everly and Feldman (1985: 147) states that *when an employee is troubled by personal problems involving marital, financial concerns, worries, depression or lowered self-esteem, alcohol abuse, and so on, it is less likely that the employee will contact an employer as a comforting listening ear for assistance in the mitigation or resolution of these problems. More specifically, employees who suffer from alcohol abuse and its related problems more consistently than not shy away from personal contact with a*

supervisor or employer lest the employer jeopardizes his or her employment.

The employee will usually deny that alcohol abuse interferes with his work performance and productivity, because of fear of dismissal. Ultimately the masking of the employee's personal problem will cause a communication breakdown between the employer and the employee and more problems will begin to appear.

It is obvious that an employee's personal problems, and specifically those problems caused by alcoholism, could exact a great toll on the work-place. Where alcoholics however, form part of the working community, early identification of alcohol abuse and early intervention will assist in curbing the problem. Delayed intervention could lead to prolonged poor performance by the employee and repeated absenteeism, and will finally result in dismissal. Indeed, alcoholism could severely impair the physical, social and psychological well-being of an employee, and employers should therefore take note of factors that could contribute to the development thereof.

2.3.9 Smoking

Smoking can be regarded as an environmental health hazard, because it is not only the smoker that is being affected, but also other employees whom the smoker comes in contact with in offices and other work situations.

Everly and Feldman (1985: 93) refers to a WHO study which maintains that *smokers of all ages demonstrate higher death rates, for both sexes, compared to non-smokers.*

Legator (1990: 12) points out that *there is now an increasing concern about the harmful effects of tobacco smoke in the environment which is inhaled by non-smokers, making them, in effect, passive smokers. The tobacco smoke in the environment comes from smoke exhaled by the smokers and sidestream smoke produced by the burning end of the cigarette. Almost two-thirds of the labour force are exposed to tobacco smoke in the working environment. Many people are exposed to additional passive smoke in their homes and/or general environment. It has been estimated that the average non-smoking adult over 35 years of age inhales 1,46 mg of cigarette tar per day in the work and home environments. In more practical terms, this exposure is equivalent to the amount of tar a smoker inhales from one to three cigarettes per day.*

When considering the views of the above authors, it is obvious that cigarette smoking should be taken seriously in the work-place. A number of anti-smoking interventions can be recommended in the work-place such as anti-smoking days that should be celebrated more than once a year in the work-place, counselling programmes to assist smokers to stop smoking, restricting smoking in work-places and separating canteens and restrooms for nonsmokers from that of smokers.

Rorke (1991: 129) supports this view by emphasising that *much evidence exists that smoking is detrimental to health. The resultant economic burden to South Africa is enormous, particularly in the light of escalating health care costs. This suggests that comprehensive anti-smoking measures are needed to counter the problem.*

It is clear that definite measures must be taken to curb smoking and the detrimental effects thereof, in the work-place. A number of comprehensive anti-smoking measures

can be recommended, the most pertinent for the work situation being that of restricting smoking whilst on duty, promotion of the rights of nonsmokers and assisting smokers to stop smoking.

The world *no-tobacco day* was celebrated on 31 May 1994, where the World Health Organisation appealed to everyone to stop smoking. Hiroshi (1994: 43) stated that *this year, World No-Tobacco Day is focusing on the media, in an effort to encourage them to commit themselves fully to this battle for healthy living and pure air unspoiled by tobacco smoke. As providers of information to millions of readers, listeners or viewers, the media can form a most effective channel for making everyone aware of the harmful effects of tobacco and encouraging smokers to give up their habit.*

There is a clear challenge to all leaders in all social sectors including the work situation, to cooperate towards reducing this harmful habit. Smoking is indeed a health hazard. The medical association of South Africa in the Sowetan (21 June 1994: 2) made an urgent appeal to the government and all political parties to support Health Minister doctor Nkosazana Zuma in her efforts to curtail smoking.

2.4 ABSENTEEISM AND STAFF TURNOVER

Absenteeism is a problem which has a significant impact on the productivity of any organisation. It is the duty of management to identify factors which could contribute to absenteeism and finally to staff turnover.

Price (1986: 1) states that *absenteeism has been viewed as a form of*

"withdrawal" from unsatisfactory conditions of the work. It can be defined as a "non-attendance" for scheduled work. The idea of "scheduled work" is the core of the definition. An employee does not report for work when he/she is supposed to be there.

Arranged non-attendances such as vacation leave, maternity and study leave are not considered as absenteeism, nor are incidences of unexpected absence due to illness or family crises. It is however, essential for employers to keep accurate records of employees' work attendance and to look at all possible causes of absenteeism.

Roberts (1982: 979) maintains that *over one million people are absent from work every day because of sickness or other unanticipated causes.* A recent report by the Office of Health Economics states that *sickness is still the most significant cause of lost working time. It accounts for 25 times as many days lost as industrial injuries, and almost 40 times as many days lost through strikes.* Employees stay away from work for various reasons, and give many excuses for being absent from work. Both management and representatives of employees, such as unions, should look at the causes of absenteeism and its impact on the specific organisation. Absenteeism should be controlled through communication between management and employees to avoid unnecessary staff turnover and low morale amongst employees.

The reasons that have been cited for absenteeism from work are numerous. There is a belief that absenteeism can be caused by unsatisfactory renumeration, lack of promotion opportunities, role overload, working under stress conditions, for example, doing district work on foot under bad geographic conditions and unsatisfactory conditions of service.

McDonald and Shaver (1981: 13) points out that *in identifying the various causes of absenteeism among nursing staff, it is important to distinguish between those that are beyond the control of nursing administrators and those over which some control can be exercised.*

The causes of absenteeism among nursing staff, as suggested by McDonald and Shaver can also be applied to other workers, and are summarised as follows:

- **Uncontrolled causes**

  These causes include employee and family illnesses, personal problems that are not job related, non-work related injuries, inclement weather, funerals, appearances in court and emergencies which occasionally arise.

- **Controllable causes**

  These are causes of absenteeism that can be partially and sometimes wholly controlled by management and include the following:

  - **Intrinsic causes**

    * the job itself, boredom, and a belief that a particular activity is not critically needed
    * ineffective supervision
    * poor intragroup and intergroup work relations

* lack of control over the decisions affecting one's work
* overwork and physical exhaustion

- **Extrinsic causes**

These causes stem mainly from the environment surrounding the employee, and include factors such as pay, policies, or the physical work setting.

- **Personality causes**

These causes can be traced to the employee's behaviour and refer interalia to personality related absences such as hypochondriac behaviour absences, poorly motivated individuals, alcoholism and drug abuse.

Absenteeism is a problem which affects management as well as employees themselves. It impinges on productivity in various ways and it is time consuming, because of the work performance of short-staffed personnel, redelegation of duties, counselling of employees to avoid a conflict situation, and so forth.

There are various types of chronic absentees and these can be summarised as follows:

- the hypochondriac absentee, who reports various types of pain and sickness incidences in order to stay away from work, and who seeks sympathy from the supervisor to justify her pain and subsequent absenteeism

- the immature absentee who is easily influenced by other workers to stay away from work, and who abuses sick leave because it is there

- the escapist absentee who stays away from work because of boredom in the work environment, caused by various factors such as poor supervision or incorrect job allocation

- the abusive absentee who is a difficult person to deal with as she takes sick leave simply because others do so, and then becomes hostile and resentful when questioned about her frequent absences

- poorly motivated absentee who is on the job for financial reward only, and who does not participate actively in the work situation

- the *burned-out* absentee, who used to be a highly motivated employee, but who, due to certain factors such as overwork, poor communication and so on, gradually lost enthusiasm and zeal for the job

Early identification of all types of absentees is essential for effective counselling and support. Managers and supervisors should deal with all these types of absentees if they wish to successfully promote productivity in the work situation.

Individuals within the communities are increasingly becoming aware of their rights in health care provision. The trend towards greater professional accountability and public scrunity of professional practice, coupled with changing and conflicting professional,

personal, and cultural expectations of the work force create numerous stresses that accompany the employee to the work-place.

Many aspects of the internal organisational environment can also contribute to absenteeism. Vaguely defined attendance policies, deficient work group cohesiveness, and ineffective supervision are examples. Even management styles which convey indifferent attitudes or lack of leadership can contribute to absenteeism within an organisation.

Price and Mueller (1986: 3) in discussing the impact of absenteeism and turnover on the functioning of the organisation implies that absenteeism homeostasis in the work situation, is time consuming, increases costs without corresponding increase in output or production. When an employee absents herself or himself unexpectedly, supervisors spend valuable time re-allocating other employees and delegation becomes very difficult due to staff shortage and at times available employees are unable to perform the delegated duties effectively.

A basic principle of delegation implies that delegation should be done according to the level of knowledge of a person, and the person to whom the job is delegated must be able and willing to perform it according to his/her knowledge. If this does not happen, the financial implications are immense.

The costs of absenteeism and turnover involve not only replacement of personnel, but also paper work which is time consuming. Turnover also labels the organisation

negatively, whether causes are known or unknown. Once the problem occurs it needs to be investigated, causes identified and removed. All these increased costs are accompanied by reduced productivity.

One must also consider the impact of absenteeism and turnover on effectiveness. Health personnel in hospitals, health care centres and clinics are striving at achieving effective quality patient care. It is therefore diffucult for them to provide effective quality care when absenteeism and staff turnover is high. The impact of the two on effectiveness vary among organisations, probably being more severe where work performance requires certain specialised skills and knowledge.

Hasiuk (1987: 4) further states that *absenteeism is a particularly significant problem that can dramatically have impact upon an organization's productivity and costs.* The author points out that absenteeism is an issue which impacts on the management of human resources, and which demands insightful awareness of many complex issues, all of them in-extricably linked to the cost and quality of care.

Excessive turnover and absenteeism are expensive to both employer and worker in terms of money, morale and wasted manpower. A certain degree of turnover and absenteeism can be expected but excessive rates should be reduced by sound personnel policies in which management and labour work close together.

Longo and Uranker (1987: 78) agrees that absenteeism and turnover are costly and time consuming by stating that *a nurse retained is a nurse recruited. Retention of a nurse means that a hospital has been protecting its investment. Since job satisfaction and*

longetivity have tended to be related, nursing administrators must be aware that satisfiers today can vary from money, to working conditions, to autonomy, to self-actualization, and they must recognise and capitalise on the satisfiers which predominate in their organization. If the satisfiers which are most likely to cause nurses to remain employed in their organization can be identified, then retention is a real possibility.

2.4.1 Control of absenteeism and staff turnover

There is no single effective method to control absenteeism. One should look at various aspects such as organisational policies and different strategies to reduce absenteeism.

Various steps could be followed when conducting a discipline attendance policy. These include a documented oral warning followed by a written warning, then suspension without pay for a certain period of time and finally dismissal.

Roberts (1982: 979) warns that *management must maintain a continuous fight against absence as all policies have a habit of petering out after some time.* The author suggests a written policy that will cover aspects such as

- the level of absenteeism that will be tolerated
- the type of action to be taken to achieve and maintain that level
- who is responsible for the action to be taken
- the absence rules to be applied, and the method of communicating the policy to employees

In general, it is agreed that employees should have a clear absence policy from their particular employing authority. It should state how absence is to be notified, the time allowed to do so, the person to notify, and the sick pay entitlement. The employer should be informed of the progress of an employee towards recovery and the likely date of return to work in order to keep sick leave records up to date.

Kuzmits (1981: 388) states that *some absenteeism policies - particularly those that include provisions for excused and unexcused absences - often force the supervisor to judge the legitimacy of whatever excuse the employee offers for not showing up for work.*

In adequate absenteeism control guidelines cause failure to effective employee, counselling. Managers often blame an employee for excessive absenteeism, instead of looking at the factors in the work situation that could contribute to a high rate of absenteeism such as poor policies, lack of counselling and lack of a reward for good attendance.

Rowland and Rowland (1985: 373) are of the opinion that *looking at the reduction strategies in both absenteeism and turnover various organizations react in various ways, because the causes as well as contributory factors differ with each organization.*

It is pointed out by these authors that there are various steps to be followed when controlling absenteeism, ie

- the collection of data

- consideration of financial implications
- consideration of contributing variables that affect absenteeism
- finding solutions to the problem of absenteeism

2.5 OCCUPATIONAL HEALTH AND SAFETY

Occupational health care services are being developed throughout the country to serve people at work, not only in the narrow sense of industry, but in commerce and all public services. The services should be comprehensive and aim at the promotion and maintenance of the highest degree of the physical, mental and social well-being of workers, prevention of health problems caused by their working environment, protection from health hazards and risks, resulting from adverse factors to health, and placing an employee in an occupational environment adapted to his physical and psychological well-being. The interaction of the employee, working environment and work should be the main consideration.

The health and well-being of employees is important for effective productivity in the work situation. Employers should have a vested interest in the promotion of the life-style of employees by providing effective occupational health services to meet their health needs.

According to the Occupational Health and Safety Act (1993: 12) *every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees.*

The act also requires appointment of health and safety representatives, at least one representative for every hundred employees or part thereof in case of shops and offices, and at least one representative for every fifty employees or part thereof, in case of all other work-places.

The functions of health and safety representatives can be summarised as follows:

- identification and reporting of health hazards in the work-place

- inspection of health and safety measures in the work-place and inspection of the work-place in consultation with the health and safety inspectors

- investigation of employees complaints relating to health and safety, as well as the examination of causes of incidents at the work-place

- representation of employees in health and safety committee meetings

- making recommendations to employers on matters affecting health and safety of employees

Health and safety representatives are required to form health and safety committees, which will develop, promote, maintain and review measures to ensure the health and safety of employees.

Every employee should take reasonable care for his/her health and safety in the work-

place, to avoid accupational illness and injuries. To be able to do so effectively, employees should receive relevant traning and supervision at the work-place.

Everley and Feldman (1985: 5) emphasise the fact that *the work-place, where most individuals spend at least one third of their life, is considered to be the ideal place to promote health behaviour. Occupational health promotion offers the potential of affecting not only the health of the individual worker, but the health of the organization and the community as a whole.*

Safety in the work situation is a major factor in the promotion of the well-being. Sugden (1980: 126) states that *the protectors of health and safety of persons in the work environment is an important part of the overall health protection of the population.*

Spicer (1991: 7) adds to the debate by stressing that *employers must take work-place safety seriously.*

Occupational health and safety involves a team approach to be truly effective. Occupational nurses, doctors, industrial hygienists, occupational physicians, psychologists, health educators, nutritionist, and so forth, all have a role to play in reducing injuries and illnesses in the work-place. In addition, employees must be educated on health and safety in the work environment, to prevent the occurrence of occupational injuries and illnesses. Workers must also accept a certain degree of responsibility for their own safety.

In this regard Ingram (1985: 2) stated that *each and every employee must ensure that*

he/she is conversant with company safety policies and rules and regulations. They must learn to accept safety, not as an additional burden, but as an essential integral part of their daily routine. Supervisory personnel in particular must set an example and also continually strive to promote safety consciousness amongst their colleagues and subordinates.

Occupational health services should be comprehensive and extended to the community, working with hospitals, health care centres, doctors as well as available social agencies in the community. Knowledge of the working environment is of paramount importance in interpreting the health needs of people at work. The scope of occupational health extends not only to the requirements of people while at work, but also to their domestic and social situations. The responsibility for this health service can be shared by all members of the multidisciplinary team, including doctors, paramedics, nurses, management and employees themselves.

2.6 CONCLUSION

In this chapter the views of various authors regarding the health needs and problems of employees, factors that could influence health needs and problems, absenteeism and staff turnover, as well as occupational health and safety, were considered. The information collected provided the researcher with adequate guidelines to embark on the proposed study.

The literature study also assisted the researcher in formulating the assumptions for this study namely that

- information regarding the nature of the health needs and problems of black employees within the Germiston City Health Department, as well as identification of the factors that influence the health and well-being of workers, will assist in promoting the health status of employees in the Germiston City Health Department, as the information could be used in the development of guidelines for attending to identified needs and problems of employees

- information about the factors that influence the health status of employees will assist in identifying the factors that contribute towards the high rate of absenteeism, that had previously been identified in the Germiston City Health Department. This information could assist in the formulation of guidelines to control this high rate of absenteeism.

CHAPTER 3

DESIGN, METHODOLOGY AND CONDUCT OF STUDY

3.1 INTRODUCTION

The aim of this chapter is to present an outline of the scope and limitation of this research project, as well as to describe the conduct and methodology of the study. As the main objective of the study was to identify the health needs and problems of black employees in the Germiston City Health Department, in order to identify the possible relationship between such problems and the high rate of absenteeism which had primarily been identified in the Department, the researcher deemed it necessary, before commencing with the main research project, to obtain a general understanding of the nature of the population that would be included in the study. The information that was collected for this purpose included interalia the following:

- A brief analysis of the various subdepartments of the Germiston City Health Department.

- A description of the area of residence of black employees, as well as their area of recruitment.

- An outline of the educational standard of black employees, their cultural background and the transport facilities available to them.

3.2 SCOPE AND LIMITATION OF THE STUDY

The study was limited to include only black employees of the Germiston City Health Department. Although the researcher recognises that there is a need for the study to be extended to other departments, and to employees of other ethnic groups, it was not possible to do so in this study, as permission was only granted to include black employees of the Germiston City Health Department, when conducting this study.

3.3 BRIEF DESCRIPTION OF THE POPULATION UNDER STUDY

To produce a meaningful identification of health needs and problems of black employees in the Germiston City Health Department, the researcher found it necessary to include a brief description of the population under study.

3.3.1 Analysis of the number of employees in each subdepartment

The Health Department is one of the largest subdepartments within the Germiston City Council. It is composed of four subdepartments, that is the cleansing department, city black clinics, Tembisa and Katlehong clinics. In each subdepartment there are male and female employees, both skilled and unskilled. Each subdepartment has a code number for reference during departmental communication within the Germiston City Council. The number of employees in the various subdepartments, according to 1991 statistics of the Health Department is outlined in Table 3.1.

Table 3.1. Number of employees in the various subdepartments of the Germiston City Health Department.

SUBDEPARTMENT	CODE NUMBER	NUMBER OF EMPLOYEES
Cleansing department	76	356
Katlehong clinics	69	44
Tembisa clinics	90	45
City black clinics	77	54
	n =	499

3.3.2 Area of residence of employees

A small number of the employees that were included in the study reside in one of the following areas: Soweto, Vosloorus, Thokoza, Tembisa, Alexandra and Katlehong. The majority of the population under study, however, reside in the Robert Strachan men's hostel which is situated near Kutalo railway station in Germiston, and which belongs to

the Germiston City Council.

Although the immediate environment of employees in these townships at first glance appears to be of a satisfactory nature, the overall socio-economic environment leaves much to be desired. Problems relating to violence, political instability and overcrowding are rife in the townships, and have led to the development of squatter areas. All these factors could have an adverse influence on the health and well-being of residents.

3.3.3 Area of recruitment of employees

Some of the employees are recruited from Lebowa, Transkei, Ciskei and KwaZulu and are employed on an annual contract basis. However, certain of the cleaners, clerks and drivers are recruited from the residential areas that surround Germiston. Health personnel, including nurses, health inspectors and doctors, are generally also recruited from the surrounding residential areas.

3.3.4 Educational standard of employees

The standard of education of many of the employees is found to be generally unsatisfactory. Although there are various skilled and professional employees, like nurses, doctors, health inspectors, clerks and health educators, Germiston City Council Research Study (1985: 3) revealed that *about 40% of black employees within the Germiston City Council, had no formal education at all, whilst 49% had undergone secondary and high school education.* The minimum standard of education required for professional and skilled personnel is laid down according to availability and level of

posts, and is reflected in Table 3.2. The required standard of education for unskilled employees such as cleaners, is not specified. As long as prospective employees in this category are physically well and can communicate in English and Afrikaans, he/she will qualify for employment. However, some of the employees do attend adult education centres in various areas to improve their literacy level. Study leave, as well as study loans, are made available to allow professional and skilled employees to upgrade themselves.

3.3.5 Cultural background of employees

Black employees within the Germiston City Health Department belong to various ethnic groups such as Zulus, Xhosas, Sothos and Shangaans. It is therefore obvious that cultural differences will be noted. In this regard it is often seen that although the use of modern medicine has been accepted to a certain degree by most employees, the majority still continue to make use of traditional medicine in addition to western medicine. It is also found that there is strong adherence to certain customs, especially amongst employees that belong to extended families. In such families it is for instance common for the elders to decide when and where the sick or injured family member should seek medical care and whether he or she should first go to the traditional healer and then to the medical doctor or vice-versa. This became evident following a previous departmental research study (Germiston City Council research: 1985) and during interviews conducted with employees in various subdepartments of the Germiston City Health Department.

Table 3.2. Minimum qualifications/experience required from professional and skilled personnel according to the Germiston City Health Department.

DESIGNATION	QUALIFICATIONS	MINIMUM EXPERIENCE
Senior Community Health Nurse in Charge	B Degree in Nursing Community Health Nursing Medical Surgical and Midwifery	5 years
Senior Community Health Nurse	Community Health Nursing Medical Surgical and Midwifery	3 years
Community Health Nurse (Grd I)	Community Health Nursing Medical Surgical and Midwifery	2 years
Community Health Nurse	Community Health Nursing Medical Surgical and Midwifery	-
General Nurse	Medical Surgical and Midwifery	-
Midwife	Registered Midwife	2 years
Clinic Assistant	Midwife Enrolled Nurse	-
Health Educator	Diploma in Health Education	-
Combi Driver	Standard 6	3 years
Clerks	Standard 8	3 years

3.3.6 Transport facilities available to employees

Bus and taxi services are utilised by most employees to transport them to and from their places of employment. There are also local trains operating at specified times to and

from Germiston, Kempton Park, Katlehong and Johannesburg. Some employees walk from Robert Strachan hostel to their places of employment and a few have their own transport.

3.4 THE MODUS OPERANDI THAT WAS FOLLOWED

The steps which were followed in order to conduct this study were as follows:

3.4.1 Literature study

A detailed literature study as discussed in chapter 2, was done in order to collect valuable information with regard to the aspects relevant to this study. This enabled the researcher to proceed with the required research with more insight to its objectives.

3.4.2 Permission to conduct the study

Permission to conduct the study within the Germiston City Health Department was obtained from the Germiston Medical Officer of Health. (Letter attached as Addendum 1).

The persons in charge in all subdepartments of the Germiston City Health Department were visited before commencing with the study. The study and its objectives were briefly explained to them. In all instances where observation, perusal of health records, and interviews were done, permission to do so was obtained, and the cooperation of the

persons in charge of subdepartments was secured before hand.

3.4.3 Identification of boundaries

The boundaries of the areas to be investigated in the study were identified, i.e. the four subdepartments of the Germiston City Health Department as analysed in Table 3.1.

3.4.4 Data collection methods

The necessary information required for this study was collected by means of observation done by the researcher, perusal of health records and interviews held with personnel in charge of the various subdepartments, as well as with employees who formed part of the selected sample. (Refer to Addendum 2 and 3.)

3.4.4.1 Observation checklist

The researcher developed an observation checklist in order to collect relevant data from the various subdepartments. The checklist was compiled after an initial visit to the subdepartments.

A list of aspects regarded by the researcher to be of importance and relevant to the research study, was listed to facilitate the recording of information collected during the observation. (See Addendum 2).

Information collected was rated as follows:

Good = 2 points (aspects that comply with expected norm)

Satisfactory = 1 point (areas in need of improvement)

Poor = 0 point (aspects that do not comply with expected norm)

The checklist was pre-tested in one of the subdepartments before commencing with the main research study.

The researcher found it difficult to observe all aspects listed on the checklist in the cleaning department, due to the fact that employees do not remain at this particular department during the day, but merely report there in the morning whereafter they work in outlying areas for the rest of the day.

Although the researcher used the same checklist for all subdepartments, the uniqueness of each subdepartment was taken into account as mentioned above, with regard to the cleaning department, and data from each subdepartment was subsequently tabulated as discussed in chapter 4.

3.4.4.2 Perusal of health records

At the Robert Strachan hostel clinic where health services are offered to the residents, the researcher perused relevant health records. Specific note was taken of injuries on duty which occurred during the period from 1987 to 1991, as well as of chronic and communicable diseases reported during 1990 and 1991 (previous records in this category were not available). The incidence of minor ailments was also noted.

3.3.4.3 Preparation of an interview schedule

An interview schedule was designed for use during the collection of data from the selected sample. The schedule was prepared according to the literature study that was undertaken, and the analysis of the population under study. The aim of the interview schedule was to obtain

- personal data pertaining to employees in general as well as to their families
- data about the health status of employees and their families
- information about the health and safety of employees in the work situation

A total of 79 questions were included in the interview schedule with possible responses numbered from 1 to 79 (V1 to V82). The majority of the questions were constructed as close-ended questions with 1 to 7 alternatives being available to select an answer from. Where necessary, extra space was provided to fill in the general opinions of respondents where further elaboration on specific aspects were required (for example refer to question (6), question (16) and question (26)). A few open-ended questions were included in order to allow the respondents an opportunity to express their opinions and add further comments. (Refer to question (25), question (23) and question (30)).

Although the interview schedule was prepared in English, the researcher and her assistant discussed questions in languages best understood by each respondent, in order to ensure that they understood the meaning of the questions. This assisted the

researcher in obtaining valuable information, which would not have been achieved if questionnaires has been posted to the respondents to complete on their own. The fact that the interviews were personally conducted by the researcher and the research assistant, ensured that all applicable questions were put to the respondents and their answers and reactions were noted. The researcher pretested the interview schedule on some employees in one of the subdepartments of the Germiston City Health Department, in order to identify problems relating to the understanding and answering of questions as well as completing and tabulating data.

The interview schedule consisted of three sections. The first section dealt with the personal and general data of respondents and their families (Items 1 to 20) (V1 to V19) (personal and general data of respondents and their families). The second section dealt with the health status of respondents and their families (Items 21-57) (V20 to V61). The third section required information about the health and safety of respondents, in the work situation, their social status and the availability of recreational facilities (Items 58 to 79) (V62 to V82) (health and safety of respondents in their work situation). In this last section respondents were asked to comment on how they perceive their health to be affected by their safety and social needs.

In designing the interview schedule, the researcher wanted to ensure that it would be free from bias, be appropriate to answer the questions formulated in this study and not influence the respondent's response. It was also constructed in a way that would make it easier for the researcher to analyse and interpret the collected data.

The interview schedule was divided into three sections as follows:

- personal and general data of respondents and their families
- health status of respondents and their families and
- the health and safety of respondents in the work situation

to enable the researcher to analyse and interpret data systematically.

3.4.5 Sampling

As it was not possible to include the entire population of the Germiston City Health Department, a stratified random sample was obtained in order to carry out this study. All four subdepartments of the Germiston City Health Department were included (refer to Table 3.1).

Treece and Treece (1986: 216) states that *stratified random sampling involves taking certain areas of the population, dividing the areas into sections, and then taking a random sample from each section.*

The researcher used such a stratified random sampling technique in each department so that the units in the sample are similar to the units in the population as a whole, and thereby ensures that the sample obtained is not a nontypical sample.

The researcher used the individual pay-numbers of employees in each subdepartment to select respondents forming part of the sample. Pay-numbers were put in a container in each subdepartment and selected numbers were pulled out at random. A total of 100 respondents were selected to form part of the sample. The result of the sampling

procedure is outlined in Table 3.3.

The sample which was selected included approximately twenty percent of employees in each subdepartment. The researcher considered factors such as time available to conduct the study, costs as well as the employees cultural and education background, to determine the size of the sample. Interviews were conducted during lunch periods and after working hours. Time was also needed for interpretation of questions according to languages understood by employees for clarification.

Table 3.3. Analysis of sample selection.

SUBDEPARTMENT	NUMBER OF EMPLOYEES	SAMPLE
Cleansing department	356	72
Katlehong clinics	44	8
Tembisa clinics	45	10
City black clinics	54	10
$\tilde{n}$ =	499	100

3.4.6 Pilot study

Treece and Treece (1986: 42) states that *the pilot study is actually a mini study, so it includes all the steps of data collection and analysis except that the number of subjects are on a smaller scale.*

In preparation for this research project, the researcher conducted a pilot study from 1

to 6 May 1992. The pilot study gave the researcher an opportunity to have a trial run of the methodology envisaged for the research project. It also gave the researcher an opportunity to pretest the interview schedule and to measure the respondents' understanding of questions, as well as whether they gave complete and pertinent answers. Where necessary changes were made to the interview schedule in order to eliminate irrelevant questions, to clarify unclear questions and to make the instrument generally more effective.

During the pilot study it was possible for the researcher to identify the best opportunities to meet subdepartmental supervisors as well as respondents in their work situation, without disturbing the various subdepartments. It also gave the researcher an opportunity of arranging a place where the respondents could be interviewed in private to maintain confidentiality. The various languages used by respondents could also be identified for future communication purposes. The pilot study also gave the researcher an opportunity to advise the research assistant regarding the correct use of the interview schedule, as well as to provide guidance about different interviewing techniques that could be used. Findings collected during the pilot study provided the researcher with a good background on hwich to base the main research project.

3.4.7 Research assistant

Time to conduct interviews was limited, as most of the interviews with respondents had to be held during the designated lunch periods, or after working hours. The researcher therefore found it necessary to make use of an assistant to conduct the interviews. Although the researcher could speak most of the languages used by the respondents, it

was useful to engage the assistance of a research assistant, a professional nurse, who was fluent in Sotho, Shangaan, Zulu and English, to make communication with respondents easier. The necessary training was given to the research assistant before and during the pilot study. Constant communication between the researcher and the assistant was maintained throughout the period when interviews were being conducted, to ensure continuous guidance and advice as required.

3.4.8 Collection of data

Clear communication channels were established with all concerned, and the most convenient means of collecting the required data was discussed during a preliminary visit to the following persons:

- the supervisor of the cleansing department
- the community health nurse in charge of the Robert Strachan hostel clinic
- a professional nurse at the City black clinic
- a senior community health nurse in charge of Tembisa clinics
- a senior community health nurse at Katlehong clinics
- two senior clerks at Robert Strachan Hostel control office

The researcher met with the Germiston Medical Officer of Health on a regular basis to discuss the progress of the data collection.

The following methods of data collection, as referred to in paragraph 3.4.4. were carried out:

3.4.8.1 Observation

Observation was done throughout the various stages of the research process. Firstly, during the preliminary study and secondly during the visits to the subdepartments of the Germiston City Health Department and the Robert Strachan hostel where the majority of the employees reside. Attention was interalia given to the following aspects in the various subdepartments.

- The external and internal environment of the subdepartments as well as of the Robert Strachan hostel.

- Interpersonal relationship between employees in the work situation, between fellow hostel dwellers and between employees and people in authority.

- Factors relating to the nutrition of employees, such as food preparation, food hygiene, cleanliness of dining halls as well as eating habits of employees.

- Health and safety of employees in the work situation, with specific reference to safety equipment, first-aid boxes and availability of first-aiders in the various subdepartments.

3.4.8.2 Perusal of records

Relevant statistics records available in the subdepartments were perused, as well as those kept at the Robert Strachan control offices and the Robert Strachan clinic. This

was done to identify common illnesses or diseases amongst employees, as well as to determine the number of injuries on duty in each of the subdepartment included in the study.

3.4.8.3 Conducting interviews

A total of 100 employees from the subdepartments under study were interviewed. Random sample from each subdepartment was obtained (refer to Table 3.3).

All interviews were carried out during the period of 12 to 27 May 1992. Each interview lasted an average of 30 minutes and most of the interviews with the respondents were done after work or during their lunch hour.

All appointments with the respondents were arranged in person or telephonically with the supervisors of various subdepartments, who then stipulated the time for interviews.

The researcher and her assistant commenced each interview by introducing themselves, followed by a brief explanation of the purpose of the research project. Each respondent was respectfully handled and assured that confidentiality would be maintained and that their identities would not be revealed at any stage.

Rapport was established by being friendly, considerate, patient and by reacting diplomatically to nonverbal cues from respondents. Time was also spent discussing the personal aspects of the respondent's health related problems which cropped up spontaneously during the interview. Advice was given on the course of action to be

taken in regard to such problems.

3.4.9 Analysis of data

All data collected was analysed systematically. The results are discussed in chapter 4 of the study.

3.4.10 Interpretation of findings

The results of the analysed data were interpreted and certain health needs and problems were identified, as outlined in chapter 5.

3.4.11 Recommendations

Finally, recommendations were made in regard to meeting the health needs of employees, in order to control the rate of absenteeism and to promote the health status of black employees within the Germiston City Health Department. These recommendations are listed in chapter 5 of this study.

3.5 CONCLUSION

In this chapter the framework of this research, i.e. the design, methodology and conduct of the study was discussed. This involves all the steps of the research project and provides an overview of the entire study.

The scope and limitation of the study were outlined, and a brief description of the population under study was provided. The modus operandi that was followed included the literature study, sampling procedure, the pilot study, collection of data, analysis of data, interpretation of the findings and finally recommendations which were made.

CHAPTER 4

ANALYSIS OF DATA

4.1 INTRODUCTION

This chapter consists of a summary of data collected during the research process. Certain aspects of the analysed data are presented in the form of figures, checklists and tables.

In order to identify the health needs and problems of black employees in the Germiston City Health Department, the researcher systematically analysed data collected by means of observation, through the perusal of health records, as well as through interviews held with various sample participants.

4.2 DATA COLLECTED BY MEANS OF OBSERVATION

Information collected by using an observation checklist was analysed for each

subdepartment as follows:

4.2.1 Robert Strachan hostel and cleansing department

- **External environment**

The general impression which the researcher had of the Robert Strachan hostel is that it is a well built face brick structure with a well painted corrugated roof. The building is situated in a well kept garden with lawns, flower beds, trees and hedges. The hostel is well secured with a high fence and security gates. Security guards patrol the property on a twenty four hour basis. The cleansing department is situated in a clean building which is well secured with a high fence and security gates. This department is also supplied with security guards on a twenty four hour basis.

- **Internal environment**

Both the cleansing department and the Robert Strachan hostel appears to be very clean and tidy with well painted offices. However, the living quarters and ablution blocks of the Robert Strachan hostel are not at all satisfactory. Sleeping quarters are congested with an average of five beds with mattresses as well as a steel locker for each employee in each of the rooms. Walls are dirty and the ablution blocks lack privacy in the shower areas as some of the doors are broken. Most of the toilet seats were broken and needed replacement. It was however, found that hot and cold water is freely available. Although the walls of the

dining hall needed painting, the area was clean.

- **Interpersonal relationships**

The relationship between roommates and colleagues appear to be satisfactory. Communication in the work-place also appears to be satisfactory, and respondents reported that they are able to communicate with people in authority through their supervisors, who always appear to be available during working hours. However, respondents expressed concern about the apparent lack of direct communication with people in authority, as they feel such communication to be essential at times, but that supervisors sometime fail to take their complaints to management.

- **Nutrition**

The researcher observed that in general the methods of food preparation used by the employees, as well as their eating habits are very poor. The diet of most employees consist of cooked porridge and meat or tinned beans or fish, with little or no vegetables and fruit. Employees reported that they only cooked when they had a craving for home made food such as porridge, but would otherwise buy food such as bread, potato chips, tinned fish, tinned beans and cold drinks.

- **Health and safety**

It was noted that first aid boxes with the necessary equipment were available at

the cleansing department as well as at the Robert Strachan hostel. First aiders were also available at the work situation.

4.2.2 Katlehong clinics

- **External environment**

The external environment of all clinics appears not satisfactory, with poorly maintained gardens. However, the general appearance of the buildings appears satisfactory with security fence and security gates, but with no security guards on twenty four hour basis. Areas around the clinics have long grass and stagnant water on rainy days.

- **Internal environment**

The internal environment of all clinics appears to be satisfactory. Toilets and hand wash basins appeared to be clean, although some toilets need repair of toilet seat covers.

- **Interpersonal relationship**

Interpersonal relationship in the work-place appeared to be good. The general impression which the researcher had is that there is open communication and team work amongst employees in all clinics. However, respondents reported that interpersonal relationship with people in authority should be improved. People

in authority have no direct communication with all employees, but with senior personnel only.

- **Nutrition**

Food preparation and eating habits and cleanliness of employees appears generally good. Employees bring their own lunch boxes to work.

- **Health and safety**

The researcher observed that first aid boxes with the necessary equipment were available as well as first aiders in all clinics.

4.2.3 Tembisa clinics

- **External environment**

The external environment of all clinics appears to be satisfactory. The clinics are situated in clean areas with security fence and gates, but with no security guards on twenty four hour basis. However, gardens with vegetables, lawn and trees, need maintenance.

- **Internal environment**

The internal environment of all clinics also appears to be satisfactory. It was

found that although the toilets and hand wash basins are clean, some were in need of repair.

- **Interpersonal relationship**

Interpersonal relationship amongst employees appeared to be good. Respondents reported that there is team work and sharing of ideas amongst employees in the work situation. However, communication with people in authority was reported as unsatisfactory, because only supervisors meet with the people in authority regularly, and there are no periodic meetings with all employees.

- **Nutrition**

Food preparation, personal hygiene and eating habits of employees appeared to be good. Employees bring their own lunch boxes to work, with well prepared diet, sandwiches and fruit.

- **Health and safety**

It was noted that first aid boxes with the necessary equipment as well as first aiders were available in all clinics.

4.2.4 City black clinic

- **External environment**

The general appearance of the clinic appears to be good. The building is situated in a well kept garden with flower beds, security fence and gates with security guards on a twenty four hour basis.

- **Internal environment**

The internal environment appears to be good, with clean walls, ceilings and tiled floors. Toilets and hand wash basins appeared to be very clean.

- **Interpersonal relationship**

The interpersonal relationship in the work-place appears to be good. Respondents reported that they communicate with people in authority whenever there is a need and that they work as a team, as this clinic is situated within the Germiston City Health Department.

- **Nutrition**

Food preparation and eating habits of employees appears to be good. Some employees bring their lunch boxes to work and some have their meals at the Germistonian canteen which belongs to the Germiston City Council. A well

balanced diet is sold at the canteen at R4,50 a plate from Monday to Friday each week, excluding public holidays.

- **Health and safety**

First aid boxes with all necessary equipment as well as first aiders with first aid certificates were available in the department.

4.3 DATA COLLECTED BY MEANS OF PERUSAL OF HEALTH RECORDS

Although occupational health services for black employees are provided at the Robert Strachan hostel clinic, most employees in the Katlehong clinics, Tembisa clinics and City black clinics use their medical aid schemes when sick or injured, and therefore consult their private doctors. These employees only utilise the departmental clinic at the Robert Strachan hostel to report injuries sustained whilst on duty, or to receive treatment for chronic illnesses such as pulmonary tuberculosis. Pre-employment medical examinations are also done at the Robert Strachan hostel clinic. The health records perused at the Robert Strachan hostel clinic indicated that the majority of employees utilising this clinic are employed in the cleansing department.

The Robert Strachan hostel clinic is managed by a community health nurse and a medical practitioner on a daily basis, excluding week-ends and holidays. The records revealed that the services provided include preventive and promotive aspects such as

- pre-employment examinations

- health education (individual and group)
- periodic physical examinations including chest X-rays
- treatment of minor ailments and injuries
- referrals to hospital and other available resources where necessary
- communicable disease control

4.3.1 Common ailments

According to the health records which were perused, it was identified that the following common ailments occur most frequently amongst the employees:

- gastro-intestinal conditions such as diarrhoea, gastritis and vomiting
- respiratory conditions such as pneumonia and bronchitis
- ear, nose and throat conditions such as tonsillitis and otitis media
- communicable diseases such as pulmonary tuberculosis, sexually transmitted diseases including gonorrhoea en syphilis. No AIDS or HIV positive cases have as yet been recorded

Table 4.1 gives as indication of the incidence of certain communicable and chronic diseases during the period 1990 to 1991.

Table 4.1. Incidence of communicable and chronic diseases 1990 to 1991.

CONDITIONS	1990	1991
Pulmonary tuberculosis	19	16
Sexually transmitted conditions	14	19
Hypertension	5	9
Anaemia	4	3
Alcoholism	-	3

4.3.2 Injuries on duty

The employee records which were studied revealed the occurrence of the following injuries sustained whilst on duty:

- road accidents involving municipal waste collectors whilst running after the waste truck, or falling from the fast moving vehicle
- dog bites sustained when collecting refuse from resident's yards
- cut wounds due to handling broken glass articles whilst collecting refuse bags

Table 4.2 reflects injuries sustained whilst on duty from 1987 to 1991, that occurred in the various subdepartments.

Table 4.2. Injuries on duty from 1987 to 1991.

PERIOD	SUBDEPARTMENTS			
PERIOD IN YEARS	69	76	90	77
1991	2	56	0	1
1990	0	60	1	0
1989	0	46	0	1
1988	0	39	0	2
1987	0	25	2	1
n =	2	226	3	5

Key:

Subdepartment	Code
Cleansing department	76
Katlehong clinics	69
Tembisa clinics	90
City black clinics	77

4.4 DATA COLLECTED DURING PERSONAL INTERVIEWS WITH RESPONDENTS

Personal interviews were conducted with the sample of the population under study. An interview schedule was used (see Addendum 3) and the following data was collected:

4.4.1 Section 1: Personal data of respondents and their families

- **Age and sex distribution of respondents (Items 1 and 2)**

These items were included in order to enable the researcher to identify the age and sex distribution of all respondents, and also to develop a clear picture of the population under study. Of the 100 respondents, twenty four were female and seventy six were male. The age distribution of respondents is outlined in Table 4.3.

Table 4.3. Age distribution of respondents.

AGE GROUPS	FREQUENCY
18 to 25 years	7
26 to 33 years	27
34 to 41 years	31
42 to 49 years	20
50 to 57 years	11
58 to 65 years	4
66 and over	0
n =	100

- **Home language of respondents and languages in which interviews were conducted, where respondents could not understand English (Item 3)**

It was necessary to obtain an analysis of the language used by respondents in

order to identify significant communication problems which could be encountered during interviews. However, the researcher and her assistant experienced no problems as they were both able to communicate well in most all black languages used by respondents including Xhosa, Sotho, Zulu, Shangaan and so forth. Where difficulties occurred in understanding the questionnaires the home language of respondents was used for effective interpretation. Fifty five respondents spoke both North and South Sotho and forty five respondents spoke Nquni languages such as Zulu, Xhosa and Shangaan.

- **Marital and religious status of respondence (Items 4 and 5)**

The data collected through these items provided the researcher with information regarding the religion of the respondents. It was found that seventy of the respondents were Christians and thirty were non-Christians. The marital status of respondents is outlined in Table 4.4.

Table 4.4. Marital status of respondents.

MARITAL STATUS	NUMBER OF RESPONDENTS
Single	22
Married	70
Divorced	6
Separated	0
Widowed	1
n =	100

- **Standard of education of respondents (Item 6)**

In order to gain the holistic view of the health needs and problems of employees, the researcher found it necessary to look at the educational standards of the respondents so as to identify their educational needs and the potential influence thereof on their health status. According to Table 4.5 it would appear that the education standard of respondents vary greatly.

Table 4.5. Educational standard of respondents.

STANDARD OF EDUCATION	NUMBER OF RESPONDENTS
No formal education	22
1 to 4 years education	18
Standard 3 to standard 4	12
Standard 5 to standard 6	20
Standard 7 to standard 8	16
Standard 9 to standard 10	8
Post-matric diplomas and degrees	4
n =	100

- **Adult education programmes (Item 7)**

The information gathered revealed that ninety of all respondents are not involved in any form of adult education or in programmes to further their education by attending courses at an adult education centre. Ten are furthering their education by attending adult education centres such as technikons or universities.

- **Category of work (Item 8)**

Out of one hundred respondents sixty four are labourers, twelve are doing clerical work, twelve are drivers and twelve are professionals like nurses and health educators.

- **Length of service in the Germiston City Health Department (Item 9)**

The length of service of respondents vary greatly and is outlined in Table 4.6.

Table 4.6. Length of service of respondents in the Germiston City Health Department.

PERIODS	NUMBER OF RESPONDENTS
Less than 1 year	2
1 to 3 years	15
4 to 6 years	25
7 to 9 years	12
10 to 11 years	6
more than 11 years	40
n =	100

- **Opinions of respondents about their income (Item 10)**

Despite the fact that most of the respondents had a long service, twenty of them reported their income as satisfactory, and eighty as poor. Comments given by respondents include the lack of considering the length of service, the high cost

of living, education of their children and planning for retirement, when people in authority determine employees' salary scales.

- **Additional source of income of respondents (Item 11)**

Ninety of the respondents reported no other source of income apart from their salaries, and ten reported that they are involved in selling soft goods and some stated that they do part-time gardening jobs over week-ends.

- **Accommodation (Items 12 to 16)**

The researcher wanted to obtain information regarding the area of residence of respondents and their families, the type of housing and basic needs and facilities such as water supply, toilet and bathroom facilities available in their houses.

Information gathered revealed that seventy four of the respondents reside at the Robert Strachan hostel and twenty six in local residential areas including Katlehong, Tembisa, Vosloorus and Alexander Townships. Out of the seventy four respondents who reside at the Robert Strachan hostel, forty four also have a family home in the Transkei, twenty in Lebowa and ten in KwaZulu. According to these respondents, their family homes are usually self-built houses, either made of mud or bricks with thatched or corrugated iron roofs. Those who reside in local residential areas live either in municipal houses or self-built houses similar to other houses in municipal areas.

- **Family responsibilities**

  - **Number of individuals in each family**

The researcher wanted to identify the number of individuals in each family. The information would assist them in assessing the living conditions of respondents, as well as to identify the nature of the families, whether extended families or nuclear families (Item 17). Table 4.7 shows the number of family members living with each respondent.

Table 4.7. Number of individuals in each family.

GROUP OF MEMBERS	NUMBER OF RESPONDENTS
1 to 2 members	2
3 to 4 members	20
5 to 6 members	24
7 to 8 members	36
9 to 10 members	14
more than 10 members	4
n =	100

  - **Care of the under 5 years (Item 18)**

Information from sixty six respondents revealed that the children who are younger than five years are looked after either by their mothers or their grandmothers. Thirty respondents stated that these children are cared for at a variety, or are looked after by child minders.

- **Number of unemployed adult members in the family (Item 19)**

In assessing the number of unemployed adult family members, housewives, pensioners and the handicapped were excluded. Eighty respondents reported adult unemployment in their families. Reasons given for their unemployment included retrenchment, lack of jobs and lack of education for better jobs.

- **Old age pensions for people over the age of sixty (Item 20)**

Twenty five of the respondents reported that their family members who were eligible for an old age pension, received such a pension. Four respondents stated that they have applied for a pension but have not yet received it.

4.4.2 Section 2: Health status of respondents and their families

In this section the researcher want to assess the health status of respondents and their family members, as well as their health care utilisation. This was done in order to identify factors that influence the health status of the respondents and their families, and to suggest measures that could be implemented to improve their health status.

- **Medical aid schemes (Items 21 and 22)**

Out of one hundred respondents only twenty eight belong to a medical aid

scheme. Reason given for not belonging to the medical aid schemes, included the following comments:

- medical aid schemes are very expensive
- *we seldom get sick or injured, so we cannot pre-pay for illness or injuries*
- family members are too far away to benefit from using the medical aid scheme
- lack of knowledge about medical aid schemes

Twenty five of the twenty eight respondents who belong to a medical aid scheme, reported that all their family members enjoy benefits of the medical aid scheme and the remaining three reported that only certain of their family members enjoy the benefits of their medical aid scheme.

General health status of family members (Items 23 and 24)

Most respondents reported that the general health status of the family members is good. Seventeen respondents reported health problems in their families. These health problems are outlined in Table 4.8.

Table 4.8. Health problems of family members and place of treatment.

FAMILY MEMBER	PROBLEM	PLACE OF TREATMENT
Father	Hypertension	Local hospital
Father	Hypertension	Local clinic
Mother	Mental health problem (epilepsy)	Local hospital
Mother	Diabetes/cataract	Local hospital
Mother	Mental health problem	Local clinic
Mother	Asthma	Local hospital
Mother	Hypertension	Local hospital
Mother	Hypertension	Local clinic
Mother	Chronic fracture right leg	Local hospital
Mother	PTB	Local clinic
Brother	Chronic fracture right leg	Local Hospital
Brother	CCF	Local hospital - private doctors
Wife	Hypertension	Local hospital
Wife	CCF	Local hospital
Sister	Back ache after fall from horse	Local hospital
Wife	Stroke	Local hospital
Daughter	Epilepsy	Local clinic

PTB = Pulmonary tuberculosis

CCF = Congestive cardiac failure

Handicapped members in the family (Items 25 and 25.1)

Looking at health as a complete state of physical, social and mental well-being, the researcher found it necessary to identify the physically or mentally handicapped members within the families and their impact on other family members. Eight respondents reported that there are handicapped members in their families. Three of the individuals are mentally handicapped and five physically handicapped, receiving regular treatment either at a local clinic or hospital.

Most pressing social needs in the respondent's families (Items 26 to 28)

The majority of respondents said that their most pressing social needs were related to finance. Some of the problems included:

- lack of finance to purchase essential equipment for home use
- lack of finance to build homes for their families, near their place of employment
- financial burden to provide for the education of their children
- difficulty in obtaining drivers licences
- financial difficulty to pay lobola and to get married

Most respondents mentioned banks and building societies as support systems to be utilised to meet their pressing social needs.

- **Decision-making on health matters within the family units (Item 29)**

Most respondents reported that decision-making on health matters within their families, are done by paternal grandparents. In the absence of paternal grandparents mothers of main family units make decisions, because fathers and sons of main family units are always away at work. The males should however, be notified about any decisions made by the mother.

- Health status of respondents

The work-place where employees spend at least one third of their life, is considered to be the best place to promote and prevent deviations from health. The researcher therefore found it necessary to look at the health status of respondents, including injuries on duty and the investigation and treatment thereof, as well as minor ailments, chronic conditions, communicable diseases and so forth.

- Injuries on duty (Items 30 and 30.1)

Out of hundred respondents thirty six reported injuries on duty whilst employed by the Germiston City Health Department. Most injuries reported were dislocations and fractures of the limbs, head injuries, sprains, car accidents and lacerations which occurred due to cuts from broken bottles and other sharp instruments found in refuse bins.

- **Investigation of injuries on duty (Items 31, 31.1 and 31.2)**

Of thirty six respondents who reported injuries on duty whilst being employed by the Germiston City Health Department, six reported that their injuries were investigated and that they were told that their papers were been sent to Pretoria however, nothing more was heard about the matter. Thirty respondents did not know whether their injuries were investigated or not. When they sustained injuries, they were however, referred either to the Robert Strachan hostel clinic or to the local hospital (Item 32).

- **Absenteeism of employees at work (Items 33 and 33.1)**

This research study was initiated because of a high rate of absenteeism amongst black employees within the Germiston City Health Department. It was thus necessary to assess the absenteeism rate of all respondents and the reasons therefor. Eighty six respondents reported to have been absent from work either due to illness or injury at some stage whilst being employed by the Germiston City Health Department. Various reasons for the absenteeism were given by respondents, including minor ailments such as upper respiratory tract infections, gastro-intestinal problems, chronic conditions like tuberculosis, injuries on duty and so on. Respondents either attended the Robert Strachan hostel clinic and referrals to hospital were done, or respondents were put off sick whilst receiving treatment prescribed at the clinic.

- **Treatment of conditions that caused absenteeism amongst respondents (Item 34)**

Most respondents received treatment at the Robert Strachan hostel clinic and some were referred to one of the local hospitals. However, certain respondents reported that they also received treatment from a traditional doctor, in addition to seeing a medical doctor at the clinic or hospital.

- **Medical examination of respondents (Item 35)**

Periodic medical examination of employees is very important for the early detection of health deviations and prompt treatment. Two respondents reported that they were medically examined within the past six months, eighteen between six to twelve months ago, ten between one year to three years ago, twenty more than three years ago and fifty cannot remember when they were last medically examined.

- **Chest X-Rays done (Items 36 and 37)**

All respondents reported that they had chest X-Rays done. Fifty six reported to have been X-rayed in 1991, thirty in 1990, six in 1989, four in 1987 and four could not remember when.

- **Communicable diseases (Item 38)**

Of the hundred respondents interviewed, only thirty six reported that they have

previously suffered from sexually transmitted diseases such as gonorrhoea and syphilis. No HIV infected individual was identified. According to the information it came to light that two of the respondents previously suffered from typhoid, two from cholera and four from bilharzia.

Treatment of communicable diseases (Item 39)

Most cases of sexually transmitted diseases were treated at Robert Strachan hostel clinic and private doctors. Typhoid, cholera and bilharzia cases were been treated at the local clinics and hospitals.

Chronic conditions (Item 40)

Information about the incidence of chronic conditions such as tuberculosis, diabetes, cancer, heart conditions and epilepsy was collected. It was found that only two respondents suffered from hypertension and four from pulmonary tuberculosis.

The above-mentioned pulmonary tuberculosis cases receive regular treatment at the Robert Strachan hostel clinic and hypertension cases at the local hospital (Items 41 and 42).

Smoking habits of respondents (Items 43 and 43.1)

Smoking is a precursor of cancer, and it is not only smokers that are affected but

also non-smokers. It was therefore essential to assess whether respondents are smokers or not, as smokers could affect their own health as well as that of other employees. It was discovered that eighty respondents are smokers using either cigarettes or pipes. Cigarette smokers reported to be smoking an average of one packet of cigarettes a day whilst most of the pipe smokers said that they use one packet of BB best blend per day.

Alcohol consumption (Items 44 and 44.1)

Eighty respondents consume liquor, mostly over week-ends and in the evenings. It would appear that most of the liquor consumers are also smokers.

Health status of female employees (Items 45 to 50)

Antenatal clinics and deliveries

Since industrialisation and urbanisation many women have dual roles. They have responsibilities as employees and also take care of the members of their families. They are the mechanism of promoting health and better life-style within the families. It was thus necessary to specifically assess the health status of women. Of the twenty four female employees fourteen were married and have children and ten were single with no children. The married women reported that they received their ante-natal care at a local clinic or at provincial or private hospitals, but also visited private doctors with other ailments related to pregnancy, such as back

ache. Three of the respondents reported receiving traditional medicine *Isihlambezo*, during pregnancy. Eight women had their deliveries at the provincial hospital, two at the local authority clinic and four at private hospitals.

- **Post-natal care (Item 47)**

The respondents who have children reported that they received their post-natal care after six weeks, in provincial and private hospitals or at the local authority clinics where they had their deliveries.

- **Pap smears (Item 48)**

Of the twenty four women, six reported that they had their pap smears taken two years ago and one a year ago. The remaining women reported that they never took any pap smears at all.

- **Family planning methods (Items 49 and 50)**

Of the twenty four female respondents, twenty were on a family planning method and only four were no longer using any family planning methods as they have reached menopausal stage. Eight respondents use Depo Provera and eleven use Nu-Isterate and only one use an oral contraceptive. Respondents reported that they receive their contraception from the local authority clinics.

- **Dental care (Items 51 to 53.1)**

Fifty four respondents receive dental care from private dentists, sixteen from provincial hospitals, whilst four reported that they use medicine received from traditional healers. Twenty six have never received any dental care. The reasons given were that they had never experienced toothache or any other dental problems.

Various reasons were given regarding the use of a particular dental service. These include the following:

- *the dental care service is the only one known to the respondents*
- *the dental care service is the nearest available*
- *the dental care service is the cheapest and most reliable*
- *the dental care service keeps my teeth strong en healthy*

Seventy respondents reported that they visit a dentist only when experiencing dental problems, and four reported that they use traditional medicine once a year to keep their teeth strong and healthy.

- **Eye care (Items 54 to 55.1)**

Eighty six of the respondents have never experienced any eye problems. Only fourteen have experienced eye problems which vary greatly, such as short sightedness or swollen eyelids, especially in the mornings. Fifty of

the respondents know where to have their eyes tested. Places mentioned include the local optician and out-patient departments at provincial hospitals and local authority clinics.

- **Nutrition (Items 56 and 57)**

Most of the respondents buy meals during working hours from the nearby shops, whilst others bring their own lunch-boxes and only buy cold drinks from local shops. Fifty four of the respondents reported that they have two meals per day, one during working hours and one in the evenings, sixteen have meals three times a day, and thirty reported having meals more than three times a day, that is in the morning, during tea break, lunch break and in the evenings.

4.4.3 Section 3: Health and safety of respondents in their work situation

In this section the researcher wanted to assess the health and safety of respondents in the work situation, their active involvement in health and safety through education, representation in safety committees, their right to belong to trade unions for better communication, as well as the recreation facilities available to them.

The health and safety of employees in the work situation is very important. However, it cannot be left to authorities to pursue alone. Employees should be taught about the importance of their health and safety in the work situation and be actively involved in safety committees. Increased employee awareness on health and safety would be useful

in increasing protective behaviour against work hazards.

- **Health education in the work-place (Items 58 and 59)**

Information from most respondents reveal that health education within their departments is given by the nursing sister and/or health educator. Health education is given as the occasion arises according to the needs of the group concerned.

- **The most valuable health education topics (Items 60 to 62)**

Respondents gave various topics that are valuable to them and the following list reflect some of the topics, as stated by the respondents:

- aids prevention and counselling
- treatment of aids by traditional healers
- human anatomy and physiology (*tell us about our bodies when injured or sick*)
- teenage pregnancy
- aids in pregnant women
- sex education to adolescents
- epilepsy
- tuberculosis and nutrition
- any health related matters
- any new diseases

Most respondents reported that topics of value to them are related to their needs and those of their families. They need to know more about health related topics in order to be responsible for their own health and that of their families. Health education topics that should be included in the programme during 1993 are the following: aids, treatment by medical and traditional healers, tuberculosis - prevention and treatment, cancer prevention, and sexually transmitted diseases.

Aids counselling centre in the department (Items 63 and 64)

Seventy two of the respondents reported that they did not know whether there is an AIDS counselling centre in the department. Twenty eight said that there is no such centre in their department, but added that respondents were told by the nursing sisters or health educators about AIDS and its prevention in family planning clinics, sexually transmitted disease clinics, and at the Robert Strachan hostel clinic.

Health and safety committees and representation of employees (Items 65 and 66)

Seventy one respondents had no knowledge about health and safety representatives and safety committees in their departments, eighteen answered that there were no health and safety committees in the departments and eleven reported that they were aware of health and safety committees in their departments, but that they were not represented on the committees. They reported that their supervisors always inform them about health and safety in the work situation.

- **Inservice training on health and safety (Item 67)**

Ninety respondents reported that they attended a once off meeting on health and safety at the city hall and ten have never attended any meeting on health and safety.

- **Health and safety equipment used by respondents (Items 68 and 69)**

Respondents listed the following health and safety equipment as being available to them at work:

- overalls
- rubber gloves
- gumboots
- fire-extinguishers
- waste containers for used needles and syringes
- uniforms
- spectacles
- plastic bags and trolley for refuse collection
- gowns

All the above equipment is provided free of charge.

Health hazards as perceived by respondents in the work situations (Item 70)

Most respondents saw car accidents as the greatest health hazard followed by bottle cuts, injuries by sharp objects, dust inhalation, dog bites and painful feet due to wearing gumboots. Some mentioned environmental factors such as poor sanitation at the work-place or poor lighting in the work-place which affected their eyesight. Employees doing home visits expressed concern about violence and intimidation, and felt that was the greatest risk to their health.

Problems that have been experienced by respondents in their work situation (Item 71)

The problems that occurred most regularly, as reported by respondents are discrepancies in their salaries (referred to as *short pays* by respondents), poor communication with heads of departments, poor working conditions, poor salary scales, staff shortage and high workload, lack of transport and a lack of opportunity for promotion. With regard to the *short pays* in salaries received, the researcher was informed that a delay in processing sick leave forms, fluctuating tax deductions from salaries are the main causes of the problem.

Violence and intimidation (Items 72 to 73)

Factors such as violence and intimidation, whether politically motivated or due to labour disputes, affect the health of employees as well as that of their families. It was necessary to assess whether respondents were influenced by such

factors in their work situation. All respondents reported that they have been affected by factors such as violence and intimidation which are politically related. This often resulted in stay always, mass actions, labour disputes and violence in local residential areas. Various respondents said that going on duty was accompanied by intimidation and fear of coming back home after work. Labour disputes were accompanied by mass actions and forced staying away from work. Fear of loss of work or loss of income, adversely affected the mental, physical and social health of respondents as well as that of their families.

Trade union membership (Items 74 and 74.1)

All respondents reported that they belonged to a trade union such as South African Municipal Workers' Union, South African Black Municipal and Allied Workers' Union.

Solution of personal problems of respondents in the work situation (Items 75 and 76)

Personal problems of respondents discussed in Item 71 were attended to mostly by supervisors within their subdepartments, however, eight respondents mentioned that shop-stewards attended to their personal problems.

Most respondents felt that personal problems of employees should be solved by their supervisors, but if these problems occur regularly, the heads of the subdepartments should be notified and finally the head of the department. If

these problems cannot be solved by the head of the health department, shop-stewards should be notified to take the matter to the trade unions concerned for negotiation.

- **Recreational facilities available at work (Items 77 and 78)**

Respondents reported that there are no recreational facilities available to employees but there is a soccer team based at the Robert Strachan men's hostel. Only ten respondents reported that they were actively involved in soccer.

- **Relationship at work (Item 79)**

Sixty six respondents reported that their relationship to each other at work is very good and thirty four said that it is satisfactory. Comments given were that respondents come from far to work for their families and agreed that is their common goal. Others reported that men fight today and laugh tomorrow and that only females bare grudges. Most respondents mentioned that even if they are from different homelands and residential areas with differing social and cultural backgrounds, the work situation is very important to their lives as they spend most of their time in it. Good relationships were therefore seen as being of great importance.

4.5 CONCLUSION

In order to identify the health needs and problems of employees within the Germiston

City Health Department, it was necessary for the researcher to analyse the data which have been collected by means of observation. This assisted her to develop a better understanding of the workers in the various subdepartments included in the study.

Perusal of health records helped the researcher to identify conditions such as minor ailments and injuries, communicable and chronic diseases that affect the health of employees.

Data about respondents, such as information about their families and their health and safety was collected by means of the interview schedule. This information will assist the researcher to get a clearer picture of the health needs and problems of employees.

CHAPTER 5

DISCUSSION OF INTERPRETATIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

A high rate of absenteeism amongst black employees in the Germiston City Health Department, motivated the researcher to initiate this research study.

Specific health needs and problems of employees as well as factors which could influence their health status and which could contribute to the high rate of absenteeism were highlighted. Ultimately, the researcher found that there was a relationship between identified health needs and problems, and a high rate of absenteeism. Measures that could be implemented to promote the health status of employees were suggested and recommendations for the development of guidelines to attend to the identified health needs and problems were formulated.

In this chapter the researcher also presents a summary of the identified health needs and problems of employees, and suggests certain recommendations to address the identified needs and problems.

5.2 HEALTH NEEDS AND PROBLEMS AS IDENTIFIED BY THE RESEARCHER

From the interpretation of data collected by means of observation, perusal of health records and personal interviews with respondents, the researcher identified the following health needs and problems as being the most prominent factors which could contribute to the high rate of absenteeism amongst black employees of the Germiston City Health Department. The identified health needs and problems that are presented reflect the comments of the respondents interviewed during the research study.

5.2.1 Personal and general data of respondents and their families

The data collected in this section revealed certain common factors that could influence the health and well-being of respondents and their families, and could subsequently influence the rate of absenteeism amongst employees.

- **Educational support available to employees**

  There appears to be a lack of accessible educational centres for employees, especially for labourers residing at the Robert Strachan men's hostel. It was also indicated that there is a lack of financial support in the form of bursaries or study loans to assist children of employees. It must be remembered that

education is an individual right and not a privilege. The success of each organisation depends on the skills and knowledge of employees, and employers should therefore look at the educational upliftment of the underprivileged, the labourers and their family members, particularly children. Educated and skilled personnel could better understand the impact of absenteeism on the organisation, and would therefore become more productive workers. Adult education centres should be established to uplift the educational standard of employees. This is supported by the fact that most of the employees residing in the hostel are labourers, some without any formal education at all, and others with only primary school education. (See Table 4.5).

Salaries and salary discrepancies

From the information discussed in chapter 4, it can be deduced that the socio-economic status of most employees is generally poor. Factors such as poor standard of education could lead to poor salaries. Social needs reported by respondents indicate that most employees need additional finance to solve some of their most pressing needs such as the education of their children, building of proper houses, and so forth. Salary discrepancies is another issue that disturbs the well-being of employees. Most employees expressed their dissatisfaction with their salaries, and viewed discrepancies in salaries as a negative reward for hard work done. This lowers their morale and affects work production and finally leads to high rate of absenteeism and turnover.

Living conditions of employees and their families

The following factors which were identified in this study, highlight the poor living conditions of employees included in the study:

- inadequate sleeping arrangements at the Robert Strachan hostel
- lack of safe water supply especially in the rural areas
- poor refuse disposal and sanitation, particularly noted in rural areas
- lack of proper housing facilities and electricity especially in rural areas and in the informal settlements

It is well documented that inadequate living conditions, as identified in chapter 4, can have an adverse influence on the health and well-being of the individual.

The study indicates that hostel residents are living apart from their families, and are only able to visit their families periodically over week-ends and during their vacation leave. According to the information outlined in chapter 4, it would appear that the living conditions of employees and their families in rural areas are of a very poor standard. Communities in rural areas contribute to the wealth of the country, but their basic needs such as shelter are often not cared for. Rural families have a right to live in properly built houses within the environment that will promote their total well-being. It is important to note that the Minister of housing announced recently that attention must be given to the housing problem experienced by rural communities, particularly farm workers, and plans are being identified to attend to this matter. The importance of such action is

highlighted by Prinsloo and Prinsloo (1975: 125) who points out that *while the provision of shelter is clearly only one facet of the creation of a successful human settlement, housing programmes should facilitate and lead directly to healthy settlements.*

Water supply and sanitation

The data collected during interviews with the respondents indicates that there are definite areas in need of improvement regarding the water supply and sanitation available to employees. Pearson (1993: 25) in his project on the kwaHlope water supply at Ndwedwe, points out that *one of the most important basic needs of rural people is access to a supply of safe water for drinking, washing and household cleanliness. A major challenge associated with the upgrading of rural water supplies is an accurate assessment of the needs of the specific community, the effective transfer of information to the community and the acceptance by the community of the upgraded system.* Unsafe and inadequate or insufficient water supply is a health hazard, especially if the number of family members in each household, as well as their ages, are taken into consideration. Communicable diseases such as typhoid and cholera are more prevalent in areas where water supply is unsafe and inadequate. Illness of any one member of the family affects the whole family, as well as work attendance of employees. It is also evident that employees residing in local residential areas have adequate water supply and toilet facilities, but very few bathrooms, which pose a problem to the personal hygiene of the employees. However, their families in rural areas are largely deprived of all these essential services. The

poor facilities, such as inadequate pit-privy toilets, could lower the health status of employees and their family members at their family homes.

5.2.2 Health status of respondents and their families

Various factors that could influence the health status of employees and their families were identified and presented in chapter 4. The adverse affects of such factors should be considered and attended to in order to improve the health and well-being of the employees referred to in this study.

- **Lack of knowledge about medical aid schemes**

  The fact that most employees are not on medical aid schemes need to be investigated. This might be due to lack of knowledge about medical aid schemes, or due to the fact that membership of the schemes is not compulsory. Some respondents and their family members have very specific health problems, and could therefore benefit from membership of a medical aid scheme. The value of belonging to such a scheme or even the importance of regular medical examinations, is not acknowledged by employees.

- **Poor nutrition and poor eating habits**

  Observation done by the researcher on food preparation and eating habits of employees at the Robert Strachan hostel indicated that most employees do not consume a well-balanced diet on a daily basis. Poor eating habits and inadequate

diet could lower the body's resistance to disease, especially to infectious and communicable diseases, and ultimately could lead to a poor health status. The health status of employees could be promoted by educating them on proper food preparation and proper eating habits, without alienating them from their traditional nutritional customs.

- **Lack of comprehensive health care**

The data collected and analysed with regard to specific aspects of a comprehensive health care system available to the respondents, indicated that there are areas in need of urgent attention.

- **Dental health care**

It would appear that most of the respondents receive dental care services from private dentists, provincial hospitals and from traditional healers as these services are utilised only when employees experience dental problems such as toothache and gingivitis, it is evident that a prophylactic approach is non-existent. It is therefore clear that respondents lack knowledge of preventive dentistry, and attention should be given to this matter.

- **Eye care**

Most respondents reported that they seek eye care from private doctors, opticians and local hospitals, only when experiencing problems. This indicates

that there is also a lack of preventive eye care available to the respondents.

- **Family planning services**

Information collected from female employees reveal that family planning services are utilised satisfactorily, but that this is not the case with regard to cancer prevention services, as was indicated by the lack of use of pap smear facilities.

- **Communicable and chronic conditions**

Most cases of communicable and chronic conditions such as tuberculosis, hypertension or sexually transmitted diseases, are treated at the Robert Strachan hostel clinic, or at a local clinic, or provincial hospital. Treatment is usually given by private doctors, as well as traditional healers. With regard to injuries sustained, it was alarming to note that most respondents did not know whether an injury which they sustained whilst on duty was being investigated or not.

- **Ante- and post-natal care**

Although ante- and post-natal care services are mostly obtained at provincial or private hospitals, general practitioners are also visited when ailments related to pregnancy such as backache are experienced. Traditional medicine called *isihlambezo* is also used during pregnancy by most female employees with the belief that labour problems will be minimised. It is obvious that employees continue to make use of traditional medicine and attention should therefore be

given to incorporating such services into the comprehensive health care system.

Ntshalintshali (1993: 20), a marketing consultant with affiliated medical administrators (AMA), stated the following:

There's no bones about it - traditional healers, that is inyangas, isangomas, diviners and the likes, are here to stay. But on what terms?

It is evident from the above information that employees utilise both modern and traditional medicine for treatment of illness and injuries. The need to do research into the effectiveness and influence of traditional medicine in the instances referred to is apparent, but fall outside the scope of this research study.

Smoking and alcoholism

The excessive use of alcohol and tobacco which appears to be evident amongst the respondents, is an area of concern that should be investigated. The situation of alcohol abuse and smoking amongst respondents may be related to the lack of recreational facilities or to loneliness as a result of being away from their families. Separation of employees from their families is another issue that could lead to social pathologies, such as loneliness, alcoholism and family disorganisation. Both smoking and alcoholism affect the total well-being of employees. Smoking is a health hazard and a precursor of lung cancer. The dangers of smoking on the health of individuals is emphasised by Rorke (1991:

129) who states that *the review of South African and international literature provides overwhelming evidence that smoking, both active and passive forms, is detrimental to health. Studies have shown that smokers are more likely than non-smokers to suffer and die from ischaemic heart disease, chronic obstructive lung disease, lung and oesophageal cancer, and other smoking-related diseases.* It should therefore be a matter of concern that so many respondents are regular smokers and consumers of liquor.

5.2.3 Health and safety in the work situation

Information from most respondents indicate that employees are not well-informed about the importance of health and safety in the work situation. The factors that could influence the health and safely of employees in the work situation, as highlighted during the interviews, are discussed under the following headings:

- **Health and safety representatives and committees**

The lack of knowledge about health and safety matters were quite evident, as can be seen in the types of injuries which occur on duty, as well as according to complaints received about interalia the occurrence of painful feet due to the wearing of gumboots.

It must be remembered that the employer is responsible for ensuring as far as possible the safety of employees in the work situation. The establishment of health and safety representatives is therefore of vital importance in order to

carry out the employers obligation. Employees should be informed about the need for, and responsibilities of health and safety representatives and safety committees. Matthysen (1985: 75) emphasises the importance of health and safety representatives by stating that *the safety representative is really another pair of eyes to assist the employer in creating a safe work-place or recognising hazards. In other words, they are health and safety watchdogs.*

It is evident, when considering the information collected during the study, that health and safety committees should be established in the work-place, and safety representatives should be members of that committee. Employers should therefore take the health and safety of employees in the work situation more seriously to prevent injuries on duty and occupational health diseases. This is a matter that deserves attention in the Germiston City Health Department.

Inservice training on health and safety

There is a clear indication from the information received from respondents, that inservice training on health and safety in the work-place in the Germiston City Health Department is inadequate. It is the duty of employers to update employees on matters relevant to health and safety in the work-place. This can be achieved by integrating relevant programmes with other inservice training programmes. It would also appear that health and safety equipment used by employees are not inspected regularly. This is supported by the example previously referred to regarding the situation of painful feet developing due to the wearing of gumboots. Middel (1992: 18) supports the importance of workers'

safety by stating that *the protection of the workers is normally the most difficult aspect, as one has to rely on their co-operation in wearing protective gear, etc. This is often a question of an attitude problem.* Employers should therefore give serious consideration to the education of employees on health and safety.

- **Health education in the work-place**

The information received from most respondents indicates that there is inadequate health education input in the work-place. Employees should be empowered with knowledge regarding health matters, in order to enable them to take responsibility for their own health and that of their families. Health education, both individual and in group form, should be done regularly. Health education programmes should include topics that are related to the identified needs and problems of employees and their families, as well as to worker participation programmes. Worker participation could empower employees with health information that will help them to make proper decisions regarding matters that affect their health and that of their family members. It is through participation in matters that affect the employee's well-being, that the physical, mental and social upliftment of the working community can be achieved.

- **AIDS counselling centres**

The information from most respondents indicated that there is a lack of AIDS counselling centres in the subdepartments. Employers must bear in mind that all employees, not only those who are AIDS or HIV positive, need counselling.

Employees need to have access to an AIDS counselling centre where they will be able to talk to someone who can be trusted, in order to obtain valid information. In a trusting and understanding relationship, employees can express their feelings, explore new ideas and develop a change in behaviour without feeling threatened. Counselling services should be extended to family members of employees.

Evian and Crewe (1993: 2) emphasise the importance of education with regard to AIDS prevention by stating that *it is **TIME TO ACT** to get politicians and influential leaders to give public commitment to the education of the public about the disease and to the provision of care and social protection. Political commitment and political will are essential to a comprehensive and meaningful national AIDS programme. This means that our leaders and politicians need to use their voices, their resources, their influence and their budget to help in the struggle against AIDS.* This warning should also be noted by employers. Smart (1992: 19) supports the above statement by stating that: *Besides those who are infected or who have AIDS, other people in need of counselling include firstly, the worried well, those who have a morbid pre-occupation with AIDS, which may generate many anxiety symptoms which in fact mimic the symptoms of AIDS. Secondly, family and friends, the significant others, who may have higher and more chronic levels of stress and emotional vulnerability than the person with AIDS.*

Recreation facilities

It would appear from comments of the respondents interviewed, that recreational

facilities for employees are inadequate. Recreation is generally recognised as a basic human need, because it contributes to the physical, mental and social well-being of individuals. Employees need to be exposed to more recreational activities which could promote a better life style.

Guidelines for solving employees' problems

As is evident from the respondents interviewed it is clear that there is a lack of guidelines for solving the problems experienced by employees. This could lead to labour unrest. A problem-solving process, which will allow communication to flow from bottom upwards and visa versa, in order to identify whether management or supervisors are responsible for solving the problems or if participative problem-solving is necessary, should be introduced. A written policy should be developed in this regard. Stumbling blocks relevant to the personality of managers or inflexible management style, should be identified and rectified. Problems of employees should be identified by immediate supervisors who should be approachable and must apply their own problem-solving methods. If this fails the problem must be referred to the head of the subdeparmtent and finally to the head of the health department. Suppressing employees problems through rigidity and an autocratic approach, is detrimental to the organisation, and can lead to employee dissatisfaction, absenteeism and finally an abnormally high staff turnover.

- **Lack of absence control guidelines**

The fact that the researcher was unable to identify any departmental guidelines for control of absenteeism, indicates that there are possibly no such written guidelines in the various subdepartments. This is a matter of concern as the majority of respondents reported that they have been absent form work at one stage or another. The difficulty experienced by supervisors to verify the reasons for absenteeism, is a further matter of concern. To overcome this problem well-defined policy guidelines should be developed for control of absenteeism.

- **Absence policies**

The need to develop a clearly defined personnel policy regarding acceptable and unacceptable behaviour is obvious, and should be introduced to minimise the potential for excessive absenteeism. It would appear that there is currently no relevant policy available in the Department in question to attend to interalia the following matters:

* the level of absence that will be tolerated in the work situation
* the action plan that must be taken to achieve and maintain that level
* the absence rules to be applied and the method of communicating the policy to all employees
* an agreement with recognised trade unions regarding the absence policy

- **Record-keeping**

A comprehensive system of record keeping regarding absenteeism is important, in order to understand the nature and extent of the problem. No evidence could be found during this study that a record system exists which will adequately attend to matters such as the following:

* Where does absenteeism occur in the department?
* How many employees are involved?
* The identities of employees involved
* Number of days lost by each absentee per annum
* Reasons given for absenteeism
* Certified and uncertified sick leave certificates

The results of absenteeism in each subdepartment should be recorded clearly. These findings should be discussed at departmental meetings and ideas shared on how to solve the problem. Incentives for individuals who maintain a low absenteeism rate, should be considered. Clearly defined, written policies to control the incidence of absenteeism should be developed. These policies should refer to all types of absenteeism as well as to the effect thereof on salaries/wages. Refer to Addendum 4 and Addendum 5 for examples of policy documents that could be used in the control of absenteeism in the various subdepartments of the health department.

Employee counselling

Employees who are absent from work frequently, should be counselled on the effects and consequence of absenteeism. Through effective counselling, managers and supervisors will be able to assist employees with their problems.

Roberts (1982: 979) in discussing absenteeism in the hospital environment agrees with the above by stating that *sickness represents only the tip of the iceberg of time lost by employees staying away from work. People stay away from work for dozens of reasons -even for the reasons they give as excuses when they come back. Persistent widespread absenteeism in a hospital, or by one employee, should never be tolerated with long-suffering resignation.* Employees should be made to understand the nature and consequences of absenteeism, as well as relevant facts about the absence policy and rules of the organisation. Employees returning after being absent from work should report to their supervisors, stating the reasons for their absence in writing and signing the relevant sick note. If abuse of leave of any kind is identified, the employee should be made aware of the problem by means of a verbal warning. If abuse continues, a written warning should be issued, and if the problem gets worse, further disciplinary measures, such as change of department should be introduced. However, managers and supervisors should have a listening ear for the problems of employees in order to assist them in utilising available resources to solve their problems. A continuous support system is

therefore necessary.

- **Identification of employees' problems**

The large number of problems identified by respondents, as outlined in chapter 4, indicates that there is a definite need for a system in which employee problems could be identified and attended to. A plan of action to assist them in solving these problems should be developed.

- **Working conditions**

Information collected by the researcher indicates that the working conditions of the respondent are not satisfactory in all respects. Conditions such as inadequate salaries and salary discrepancies unconducive external and internal environments of the clinics, staff shortage and high work load are clear indications of poor working conditions. This is also emphasised by Van Tonder (1992: 46) who states that *nurses have a right to a safe working environment without any preventable risks to the health or safety of employees.* This should be a matter of concern to all employers. Problems such as lack of promotion opportunities also make it clear that there is lack of good communication within the department as well as a lack of recognition of employees by people in authority. The importance of due recognition of workers (in this case nurses) is pointed out by Berns (1982: 31) who states that *I believe nursing has historically satisfied the lower level needs and goals of nurses, namely the basic physiological needs of safety and security. The social needs are presently being addressed with increased salary, job security,*

better working conditions, and improved relations with superiors and peers. However, nurses are now looking for employment settings which will meet much higher needs including recognition, achievement, responsibility, and or job potential for growth. These principles should also apply to all other workers in industry and elsewhere. In addition, the nature of the problems identified in the study indicates that there is a lack of clearly defined policies with regard to promotion opportunities, staff establishment and transport facilities.

5.3 SUMMARY OF RECOMMENDATIONS

The researcher acknowledges the fact that not all of the health needs and problems as discussed, are applicable to all subdepartments of the Germiston City Health Department. However, it must be kept in mind that similar problems could exist in all the departments, and should be attended to. The researcher concentrated on areas of where improvements can be implemented to solve the problems and meet the health needs of employees. Specific recommendations have been made by the researcher concerning the most important areas in need of attention, in order to ensure that the health needs and problems of black employees within the Germiston City Health Department will be adequately catered for. Some of these recommendations have already been discussed earlier in this chapter, and the researcher found it useful to summarise the most pertinent recommendations in the following discussion.

5.3.1 Personal and general aspects concerning employees and their families

- Adult education centres, that are accessible to all employees, to uplift their

standard of education, must be established.

- Bursaries and study loan facilities to assist children of employees, especially with high school, college, technikon and university education, should be available.

- The salaries and wages of employees, should be improved according to their job description. Better compensation for higher skilled jobs should be introduced in order to eliminate inequalities. Employees should be paid salaries that have a predetermined relationship to salaries paid in similar jobs by competitive employers, as shown in salary surveys.

- Living conditions of employees and their families should be improved, with specific reference to the following:

  * Sleeping arrangements at the Robert Strachan men's hostel could be improved by accommodating not more than two to three persons in each room.

  * Part of the Robert Strachan men's hostel could be developed into family units for married employees who would prefer to live with their families.

  * The Robert Strachan hostel should be painted and floors should be tiled.

  * Renovation of the ablution block at the hostel, should be done, privacy and cleanliness should be maintained.

* A quarterly health inspection of the Robert Strachan hostel should be introduced to ensure that a satisfactory state of cleanliness is maintained.

* Employees should be empowered to provide safe water supply and satisfactory sanitation method for their families in rural areas.

* Employees should be educated regarding proper refuse disposal and sanitation, especially as it applies to rural areas. Aspects such as building and maintaining pit-privy toilets, digging of holes for refuse disposal, recycling of paper, plastics and bottles, storage of drinking water and so forth, should be highlighted.

* Assistance should be given to employees with regard to housing loans, to enable them to buy or build better houses for their families, whether in urban or rural areas.

5.3.2 Health status of employees and their families

- Information centres, that will deal with all health matters relevant to the employees such as medical aid schemes, smoking, alcoholism and so forth, should be established within all subdepartment of the Germiston City Health Department.

- Canteens should be available in all subdepartments. A well-balanced diet should be available to all employees in the form of affordable meals that can be

purchased at the various canteens.

- An AIDS counselling centre, which forms part of the health information centre, should be established.

- Comprehensive health care services preventive and promoted should be available to all employees, including those who reside at the Robert Strachan men's hostel. In addition to the existing health services, preventive dental care services, eye care services, services for cancer prevention, treatment of communicable and chronic conditions, ante- and post-natal care and so forth, should be introduced.

- No smoking areas in canteens, dining-halls, conference rooms and offices should be established. Anti-smoking days should be celebrated to create an awareness of the health hazard that smoking poses to all employees.

- Counselling services regarding alcoholism should be developed. Employee participation in Alcoholic Anonymous (AA), should be encouraged, as well as regular visits by support agencies, such as the South African National Council for Alcoholism, to reinforce rehabilitation and support services for alcoholics and their family members.

5.3.3 Health and safety in the work situation

- Health and safety representatives should be appointed in each subdepartment.

- Health and safety inspections should be carried out in the work-place, particularly with regard to the use of health and safety equipment.

- Health and safety committees, should be formed with two or more representative employees from each subdeparmtent, as well as members representing management.

- Recreation facilities should be created in the work-place, as well as at the Robert Strachan men's hostel. Recreation programmes should be adapted to the needs of employees and should include activities as identified by the employees and the residents of the hostel.

- Guidelines for solving employees' problems should be developed in each subdepartment, and these should be communicated to all employees.

- Clearly defined promotional policies should be developed which will indicate how positions which become vacant within the department will be filled.

- Inservice training programmes regarding health and safety in the work-place should be developed. These should form part of the existing inservice education programme.

- Exit interview committees should establish the reasons why employees leave the organisation, and should suggest measures to eliminate factors leading to dissatisfaction and subsequent resignation.

- Guidelines for control of absenteeism should be developed. Such guidelines should clearly spell out the extent of absenteeism that will be tolerated in the work-place as well as the impact of absenteeism on productivity.

5.4 LIMITATIONS OF THE STUDY

Although this research study was limited to black employees in the Germiston City Health Department, the researcher acknowledges that the identified health needs and problems, as well as recommendations that were made, could be applicable to other departments of the Germiston City Council.

A similar research study could also be carried out amongst other racial groups working in the Germiston City Council.

5.5 CONCLUSION

It was stated in chapter 1 that employees carry their health needs and problems from the home situation to work, and the work situation in turn creates overwhelming demands on employees, who must be mentally, physically and socially well to meet these demands. Absenteeism is viewed as a reaction to unsatisfactory working conditions, therefore health needs and problems of employees should be continuously identified and a course of action taken to meet such needs and solve related problems. The health of employees is related to environmental factors that influence their lifestyle, such as working conditions, renumeration, recreation, sickness, as well as political factors especially violence and labour unrests. These problems are usually accompanied by

salary discrepancies, absenteeism and so forth, and finally adversely affect turnover. Poor living conditions such as lack of proper housing, poor water supply and sanitation, all affect the health status of employees and their family members.

The health status of employees and their family members could also contribute to absenteeism, and the importance of health education and inservice training to address these issues must be recognised by all concerned health care workers. Employees should be empowered with health care knowledge and be guided towards the understanding of their own health needs and problems as well as those of their families. Lack of worker participation in health matters affects the employees' responsibility for their own health and that of their family members. Participation could assist employees to make decisions about their health problems, and also help in breaking a total dependence of employees on health authorities to cater for their health needs and problems. Lack of accessible comprehensive health care services to employees should be a matter of great concern to employers and health care planners. Unavailability of health services such as ante- and post-natal services, preventive dentistry, taking of pap smears, is time consuming when needed by employees and could contribute to a high rate of absenteeism. Poor nutrition and poor eating habits undermine the health status of employees and their families, whilst their resistance to diseases is lowered and they therefore frequently become ill and absent themselves from work. Lack of recreation facilities affect the total well-being of employees who turn to negative activities like liquor consumption for recreation.

Unsatisfactory methods of solving employees' problems and lack of absence policies could also contribute to a high rate of absenteeism. Poor working conditions such as

dirty internal and external environment of the work-place, poor salaries and salary discrepancies, lack of promotion opportunities and high workload could also contribute to the high rate of absenteeism at work.

The information included in this chapter gives an overview of the researcher's interpretation of the health needs and problems of black employees within the Germiston City Health Department, based on information outlined in chapter 4 of this study.

The researcher attempted to identify the health needs and problems of black employees, and how these could influence the high rate of absenteeism in the Germiston City Health Department. Specific recommendations to attend to these problems, were suggested. The researcher is of the opinion that the high rate of absenteeism identified amongst employees in the Germiston City Health Department, will be reduced if adequate measure are taken to attend to the issues highlighted in this study.

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ADDENDUM 1

GERMISTON

✉ 145

GERMISTON

1400

☎871-7911

NAVRAE/ENQUIRIES: MRS L FOURIE - 51-0287

ONS VERW./OUR REF.: 4/2/2/11

18 -06- 1990

Mrs P T Poho
Katlehong Health
Care Centre
310 Goba Section
KATLEHONG
1832

Madam

APPLICATION FOR A MASTERS DEGREE

Your letter dated 04 December 1989 in the above regard, refers.

Pleae accept my apologies for the delay in replying to your request. Due to an administrative oversight the matter has only very recently come to my attention.

The Council has pleasure in granting your request to undertake further studies towards obtaining a masters degree subject to the undertakings mentioned in your letter and further subject to the specific condition that you confer with the Medical Officer of Health at regualr intervals to discuss your progress. It is further a condition of the said approval, that the Medical Officer of Health will consider each request for your access to information on merit. You will undoubtedly realise the sensitivity of the matter and will obviously treat any information with integrity and confidentiality.

You are further wished every success with your undertaking.

Yours faithfully

TOWN CLERK

/mz

elike versoek gerig binne sewe dae na die datum wat op rief verskyn, kan 'n soortgelyke brief in die ander ampte- indien dit verlang word, aangestuur word.

Upon a written request made within seven days after date appearing on this letter, a similar letter will be forwarded in the other official language, if so desired.

ADDENDUM 2

OBSERVATION CHECKLIST

1 GOOD = 2 2 SATISFACTORY = 1 3 POOR = 0

n = 32

	1	2	3
External environment:			
■ general appearance			
■ security			
■ plantation			
Internal environment:			
■ living rooms			
■ ablution block			
■ dining-hall			
■ administration offices			
Communication:			
■ roommates			
■ work-place			
■ authorities			
Nutrition:			
■ food preparation			
■ personal hygiene			
■ eating habits			
Health and safety:			
■ first-aid boxes			
■ safety equipment			
■ first-aid certificates			
n = 32			

ADDENDUM 3

INTERVIEW SCHEDULE

SECTION 1

PERSONAL AND GENERAL DATA OF RESPONDENTS AND THEIR FAMILIES

(1) **AGE GROUP**

18-25 YEARS	1
26-33 YEARS	2
34-41 YEARS	3
42-49 YEARS	4
50-57 YEARS	5
58-65 YEARS	6
66 AND OVER	7

[ ] V1

(2) **SEX**

MALE	1
FEMALE	2

[ ] V2

(3) **HOME LANGUAGE**

S SOTHO	1
N SOTHO	2
ZULU	3
XHOSA	4
SHANGAAN	5
OTHER	6

SPECIFY _____ [ ] V3

(4) MARITAL STATUS

SINGLE	1
MARRIED	2
DIVORCED	3
SEPARATED	4
WIDOWED	5

☐ V4

(5) RELIGION

NONE	1
CHRISTIAN	2
MOSLEM	3
OTHER	4

SPECIFY _____ ☐ V5

(6) WHAT IS YOUR STANDARD OF EDUCATION?

NO FORMAL EDUCATION	1
1-4 YEARS SCHOOLING	2
STANDARD 3 TO STANDARD 4	3
STANDARD 5 TO STANDARD 6	4
STANDARD 7 TO STANDARD 8	5
STANDARD 9 TO STANDARD 10	6
POST MATRIC DIPLOMAS AND DEGREES	7

SPECIFY _____ ☐ V6

(7) ARE YOU ATTENDING ANY ADULT EDUCATION PROGRAMMES?

YES	1
NO	2

☐ V7

(8) CATEGORY OF WORK

LABOURER	1
CLERICAL WORK	2
DRIVER	3
SECURITY	4
PROFESSIONAL	5
SPECIFY _____	
OTHER	6
SPECIFY _____	V8

(9) HOW LONG HAVE YOU BEEN EMPLOYED IN THIS DEPARTMENT?

LESS THAN 1 YEAR	1
1-3 YEARS	2
4-6 YEARS	3
7-9 YEARS	4
10-11 YEARS	5
MORE THAN 11 YEARS	6
	V9

(10) IN YOUR OPINION IS YOUR INCOME

GOOD	1
SATISFACTORY	2
POOR	3
FURTHER COMMENTS _____	V10

(11) DO YOU RECEIVE ANY OTHER SOURCE OF INCOME APART FROM YOUR SALARY?

YES	1
NO	2

FURTHER COMMENTS _____ [ ] V11

ACCOMMODATION AND FAMILY DATA

(12) AREA OF RESIDENCE _____

(13) TYPE OF DWELLING

HOUSE	1
FLAT	2
HOSTEL	3
ROOM	4
OTHER	5

SPECIFY _____ [ ] V12

(14) IS THERE ANY RUNNING WATER IN YOUR HOUSE?

YES	1
NO	2

FURTHER COMMENTS _____ [ ] V13

(15) HOW MANY BATHROOMS/SHOWERS?

NONE	1
ONE	2
TWO	3
MORE THAN TWO	4

[ ] V14

(16) WHAT TOILET FACILITIES ARE AVAILABLE?

ONE TOILET IN THE HOUSE	1
MORE THAN ONE TOILET IN THE HOUSE	2
ONE TOILET OUTSIDE	3
OTHER ARRANGEMENTS	4

SPECIFY _____ ☐ V15

FAMILY RESPONSIBILITIES

(17) HOW MANY MEMBERS OF THE FAMILY ARE LIVING WITH YOU?

1-2 MEMBERS	1
3-4 MEMBERS	2
5-6 MEMBERS	3
7-8 MEMBERS	4
9-10 MEMBERS	5
MORE THAN 10 MEMBERS	6

☐ V16

(18) WHO TAKES CARE OF THE UNDER 5 YEARS OLD WHEN YOU ARE AT WORK?

GRANDMOTHER	1
CHILDMINDER	2
CRECHE	3
OTHER	4

SPECIFY _____

NOT APPLICABLE	5

☐ V17

(19) ARE ANY OF THE ADULT MEMBERS OF YOUR HOUSEHOLD UNEMPLOYED?

YES	1
NO	2

☐ V18

19.1 IF "YES", STATE REASONS

_____

_____

(20) ARE THE HOUSEHOLD MEMBERS OVER 60 YEARS RECEIVING OLD AGE PENSION?

YES	1
NO	2
DO NOT KNOW	3

FURTHER COMMENTS _____ ☐ V19

_____

SECTION 2

HEALTH STATUS OF RESPONDENTS AND THEIR FAMILIES

(21) DO YOU BELONG TO A MEDICAL AID SCHEME?

YES	1
NO	2

FURTHER COMMENTS _____ [ ] V20

(22) WHICH MEMBERS OF THE FAMILY ENJOY THE BENEFITS OF YOUR MEDICAL AID SCHEME?

ALL	1
SOME	2
NOT APPLICABLE	3

FURTHER COMMENTS _____ [ ] V21

(23) WHAT IS THE GENERAL HEALTH STATUS OF FAMILY MEMBERS?

ALL ARE WELL	1
ALL ARE ILL	2
SOME MEMBERS ARE ILL	3

FURTHER COMMENTS _____ [ ] V22

_____

_____

(24) IF ANY MEMBERS OF THE HOUSEHOLD ARE ILL, PLEASE SUPPLY THE FOLLOWING INFORMATION ABOUT EACH MEMBER:

MEMBER	PROBLEM	HEALTH CARE RECEIVED
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		

(25) ARE ANY HOUSEHOLD MEMBERS MENTALLY OR PHYSICALLY HANDICAPPED?

YES	1
NO	2

[ ] V23

(25.1) IF YOU ANSWERED "YES" TO THE PREVIOUS QUESTION, WHAT SOCIAL/HEALTH ASSISTANCE DO THEY RECEIVE? BRIEFLY DISCUSS:

_____

_____

_____

(26) BRIEFLY LIST THE MOST PRESSING SOCIAL NEEDS IN YOUR HOUSEHOLD.

_____

_____

_____

_____

(27) DO YOU KNOW OF ANY SUPPORT SYSTEM THAT CAN BE UTILISED TO MEET THE ABOVE MENTIONED NEEDS?

YES	1
NO	2

☐ V24

(27.1) IF YOU ANSWERED "YES" TO QUESTION (27), DISCUSS BRIEFLY:

_____

_____

_____

_____

_____

(28) DO YOU OR ANY OF YOUR HOUSEHOLD MEMBERS UTILISE ANY OF THE RESOURCES REFERRED TO IN QUESTION?

YES	1
NO	2

☐ V25

(28.1) IF YOU ANSWERED "YES" TO QUESTION (28), PLEASE SPECIFY:

_____

_____

_____

_____

_____

(29) WHO MAKES THE DECISIONS ON HEALTH MATTERS WITHIN THE FAMILY UNIT?

FATHER (OF MAIN FAMILY UNIT)	1
MOTHER (OF MAIN FAMILY UNIT)	2
DAUGHTER (OF MAIN FAMILY UNIT)	3
SON (OF MAIN FAMILY UNIT)	4
PATERNAL GRANDPARENTS	5
MATERNAL GRANDPARENTS	6
OTHER	7

SPECIFY _____ ☐ V26

HEALTH STATUS OF RESPONDENTS

(30) HAVE YOU EVER SUSTAINED ANY INJURY WHILST IN THE EMPLOYMENT OF THE GERMISTON CITY HEALTH DEPARTMENT?

YES	1
NO	2

☐ V27

(30.1) IF YOU ANSWERED "YES" TO QUESTION (30) PLEASE GIVE DETAILS:

_____

(31) WAS THE INJURY INVESTIGATED?

YES	1
NO	2
DO NOT KNOW	3
NOT APPLICABLE	4

☐ V28

(31.1) **IF YOU ANSWERED "YES" TO QUESTION (31) WHAT WAS THE OUTCOME OF THE INVESTIGATION?**

_____

_____

_____

(31.2) **IF YOU ANSWERED "NO" TO QUESTION (34), WHAT WAS THE REASON?**

_____

_____

(32) **WHERE DID YOU RECEIVE TREATMENT FOR THE INJURY REFERRED TO IN QUESTION (30)?**

DEPARTMENT FIRST AID STATION	1
HOSPITAL	2
PRIVATE DOCTOR	3
LOCAL AUTHORITY CLINIC	4
TRADITIONAL HEALER	5
OTHER	6

SPECIFY _____

NOT APPLICABLE	7

☐ V29

FURTHER COMMENTS _____

_____

_____

(33) **HAVE YOU EVER BEEN ABSENT FROM WORK DUE TO ILLNESS OR INJURY WHILST BEING EMPLOYED BY THE GERMISTON CITY HEALTH DEPARTMENT?**

YES	1
NO	2

[ ] V30

(33.1) **IF "YES" GIVE DETAILS** _____

_____

_____

(34) **WHERE DID YOU RECEIVE TREATMENT FOR THE CONDITION REFERRED TO IN QUESTION (33)?**

DEPARTMENT FIRST AID STATION	1
HOSPITAL	2
PRIVATE DOCTOR	3
LOCAL AUTHORITY CLINIC	4
ELSEWHERE	5
SPECIFY _____	
NOWHERE	6

[ ] V31

FURTHER COMMENTS _____

_____

(35) WHEN LAST WERE YOU MEDICALLY EXAMINED?

WITHIN THE PAST 6 MONTHS	1
6-12 MONTHS AGO	2
1-3 YEARS AGO	3
MORE THAN 3 YEARS AGO	4
NEVER	5
CANNOT REMEMBER	6

V32

(36) HAVE YOU EVER HAD A CHEST X-RAY DONE?

YES	1
NO	2
DO NOT KNOW	3

V33

(37) IF YOU ANSWERED "YES" TO QUESTION (36), WHEN WERE YOU LAST X-RAYED?

1991	1
1990	2
1989	3
1988	4
1987	5
BEFORE 1987	6
DO NOT KNOW	7

V34

(38) HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?

SEXUALLY TRANSMITTED DISEASES (INCLUDING AIDS)

YES [1] NO [2] DO NOT KNOW [3] [ ] V35

TYPHOID

YES [1] NO [2] DO NOT KNOW [3] [ ] V36

CHOLERA

YES [1] NO [2] DO NOT KNOW [3] [ ] V37

OTHER

YES [1] NO [2] DO NOT KNOW [3] [ ] V38

SPECIFY _____

(39) WHERE DID YOU RECEIVE TREATMENT FOR THE CONDITION REFERRED TO IN QUESTION (38)?

HOSPITAL [1]

PRIVATE DOCTOR [2]

LOCAL AUTHORITY CLINIC [3]

GERMISTON CITY HEALTH CLINIC [4]

ELSEWHERE [5]

SPECIFY _____

NOWHERE [6]

[ ] V39

(40) HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

HEART CONDITION

YES [1] NO [2] DO NOT KNOW [3] [ ] V40

DIABETES

YES [1] NO [2] DO NOT KNOW [3] [ ] V41

TUBERCULOSIS

YES [1] NO [2] DO NOT KNOW [3] [ ] V42

EPILEPSY

YES [1] NO [2] DO NOT KNOW [3] [ ] V43

CANCER

YES [1] NO [2] DO NOT KNOW [3] [ ] V44

(41) DO YOU RECEIVE REGULAR TREATMENT FOR THE HEALTH PROBLEM/S REFERRED TO IN QUESTION (40)?

YES [1]

NO [2]

[ ] V45

(42) IF YOU ANSWERED "YES" TO QUESTION (41) WHERE DO YOU RECEIVE SUCH TREATMENT?

HOSPITAL [1]

PRIVATE DOCTOR [2]

LOCAL AUTHORITY CLINIC [3]

GERMISTON CITY HEALTH CLINIC [4]

TRADITIONAL HEALER [5]

OTHER [6]

SPECIFY _____

NOT APPLICABLE [7]

[ ] V46

(43) DO YOU SMOKE CIGARETTES?

YES	1
NO	2

[ ] V47

(43.1) IF YOU ANSWERED "YES" TO QUESTION (43), HOW MANY CIGARETTES PER DAY?

_____

(44) DO YOU CONSUME ANY LIQUOR?

YES	1
NO	2

[ ] V48

(44.1) IF YOU ANSWERED "YES" TO QUESTION (44), HOW OFTEN DO YOU CONSUME LIQUOR? BRIEFLY EXPLAIN.

_____

QUESTIONS 45 TO 48 TO BE ANSWERED BY FEMALE EMPLOYEES

(45) WHERE DO YOU GO WHEN YHOU REQUIRE ANTE-NATAL CARE?

PROVINCIAL HOSPITAL	1
PRIVATE DOCTOR	2
GERMISTON CITY HEALTH CLINIC	3
NOWHERE	4
ELSEWHERE	5

SPECIFY _____

[ ] V49

(46) WHERE DID YOU DELIVER YOUR BABIES?

AT HOME	1
LOCAL AUTHORITY CLINIC	2
PROVINCIAL HOSPITAL	3
PRIVATE HOSPITAL	4
HAVE NEVER BEEN PREGNANT	5
ELSEWHERE	6

SPECIFY _____

☐ V50

(47) WHERE DID YOU IN THE PAST RECEIVE POST-NATAL CARE?

PROVINCIAL HOSPITAL	1
PRIVATE HOSPITAL	2
LOCAL AUTHORITY CLINIC	3
PRIVATE DOCTOR	4
ELSEWHERE	5

SPECIFY _____

HAVE NEVER BEEN PREGNANT	6

☐ V51

(48) **WHEN LAST DID YOU HAVE A PAP SMEAR DONE?**

LESS THAN 6 MONTHS AGO	1
6-12 MONTHS AGO	2
MORE THAN A YEAR AGO	3
MORE THAN TWO YEARS AGO	4
NEVER	5
DO NOT KNOW	6

☐ V52

(49) **ARE YOU USING A FAMILY PLANNING METHOD?**

YES	1
NO	2

☐ V53

(49.1) **IF YOU ANSWERED "YES" TO QUESTION (49), WHAT FAMILY PLANNING METHOD ARE YOU USING?**

_____

(50) **WHERE DO YOU RECEIVE FAMILY PLANNING SERVICES**

PROVINCIAL HOSPITAL	1
LOCAL AUTHORITY CLINIC	2
PRIVATE DOCTOR	3
PRIVATE HOSPITAL	4
OTHER	5
SPECIFY _____	
NOT APPLICABLE	6

☐ V54

DENTAL CARE

(51) WHERE DO YOU NORMALLY RECEIVE DENTAL CARE?

GERMISTON CITY HEALTH CLINIC	1
LOCAL AUTHORITY CLINIC	2
PRIVATE DENTIST	3
NOWHERE	4
ELSEWHERE	5

SPECIFY _____

[ ] V55

(52) WHY DO YOU MAKE USE OF THAT PARTICULAR DENTAL SERVICE?

IT IS THE NEAREST AVAILABLE	1
IT IS THE CHEAPEST	2
IT IS THE BEST	3
IT IS THE ONLY ONE I KNOW OF	4
OTHER REASONS	5
NOT APPLICABLE	6

SPECIFY _____

[ ] V56

(53) HOW OFTEN DO YOU VISIT A DENTIST?

EVERY 6 MONTHS	1
ONCE A YEAR	2
ONCE EVERY TWO YEARS	3
ONCE EVERY THREE YEARS	4
ONLY WHEN EXPERIENCING PROBLEMS	5
NEVER	6

[ ] V57

(53.1) IF NEVER PLEASE EXPLAIN WHY?

_____

_____

EYE CARE

(54) HAVE YOU EVER EXPERIENCED EYE PROBLEMS?

YES	1
NO	2

[ ] V58

(54.1) IF "YES" SPECIFY _____

_____

(55) DO YOU KNOW WHERE THE NEAREST FACILITY IS TO HAVE YOUR EYES TESTED?

YES	1
NO	2

[ ] V59

(55.1) IF YOU ANSWERED "YES" TO THE ABOVE QUESTION, WHERE IS IT SITUATED?

_____

_____

NUTRITION

(56) WHERE DO YOU OBTAIN YOUR MEALS DURING WORK TIME?

DEPARTMENT CANTEEN	1
SELF PREPARED FOOD	2
BUY FOOD FROM SHOPS	3
OTHER	4

SPECIFY _____

☐ V60

(57) HOW MANY MEALS DO YOU HAVE A DAY?

ONE	1
TWO	2
THREE	3
MORE THAN THREE	4

☐ V61

SECTION 3

HEALTH AND SAFETY OF RESPONDENTS IN THE WORK SITUATION

HEALTH EDUCATION

(58) WHO PRESENTS HEALTH EDUCATION SESSIONS IN YOUR DEPARTMENT?

NURSING SISTER	1
HEALTH EDUCATOR	2
INDUSTRIAL HYGIENIST	3
SOCIAL WORKER	4
DOCTOR	5
OTHER	6

SPECIFY _____

[ ] V62

(59) HOW OFTEN DO YOU RECEIVE HEALTH EDUCATION TALKS IN YOUR DEPARTMENT?

DAILY	1
ONCE A WEEK	2
ONCE A MONTH	3
OTHER	4

SPECIFY _____

NEVER	5

[ ] V63

(60) IN YOUR OPINION WHAT ARE THE MOST VALUABLE HEALTH EDUCATION TOPICS THAT WERE PRESENTED TO YOU IN 1990/1991?

_____

_____

_____

_____

(61) BRIEFLY EXPLAIN WHY YOU FOUND THE ABOVEMENTIONED HEALTH EDUCATION TOPICS TO BE OF VALUE/INTEREST.

_____

_____

_____

_____

(62) WHAT OTHER HEALTH EDUCATION TOPICS WOULD YOU LIKE TO BE INCLUDED IN THE 1992/1993 PROGRAMME?

_____

_____

_____

_____

(63) IS THERE ANY HIV/AIDS COUNSELLING CENTRE IN YOUR DEPARTMENT?

YES	1
NO	2
DO NOT KNOW	3

[ ] V64

(64) IF YOU ANSWERED "YES" IN QUESTION (63), WHO DOES THE AIDS COUNSELLING?

DOCTOR	1
NURSING SISTER	2
SOCIAL WORKER	3
HEALTH EDUCATOR	4
OTHER	5
SPECIFY _____	
NOT APPLICABLE	6

[ ] V65

(65) IS THERE ANY HEALTH AND SAFETY COMMITTEE IN THE GERMISTON CITY HEALTH DEPARTMENT?

YES	1
NO	2
DO NOT KNOW	3

☐ V66

(66) IF YOU ANSWERED "YES" IN QUESTION (65), ARE YOU REPRESENTED ON THE COMMITTEE?

YES	1
NO	2
DO NOT KNOW	3

FURTHER COMMENTS _____

☐ V67

(67) HOW OFTEN DO YOU RECEIVE INSERVICE TRAINING REGARDING HEALTH AND SAFETY IN YOUR WORK ENVIRONMENT?

DAILY	1
ONCE A WEEK	2
ONCE A MONTH	3
ONCE A YEAR	4
OTHER	5

SPECIFY _____

NEVER	6

☐ V68

(68) WHAT HEALTH AND SAFETY EQUIPMENT DO YOU USE AT WORK?

_____

_____

_____

(69) IS THE HEALTH AND SAFETY EQUIPMENT MENTIONED IN QUESTION (68) PROVIDED FREE OF CHARGE?

YES	1
NO	2
DO NOT KNOW	3

☐ V69

(70) WHAT DO YOU PERCEIVE AS HEALTH HAZARDS IN YOUR WORK ENVIRONMENT? BRIEFLY DISCUSS:

_____

_____

_____

_____

(71) BRIEFLY DISCUSS ANY PROBLEMS WHICH YOU HAVE EXPERIENCED AT WORK:

_____

_____

_____

_____

(72) HAVE YOU EVER BEEN INFLUENCED BY FACTORS SUCH AS VIOLENCE OR INTIMIDATION WHICH IS POLITICALLY RELATED IN YOUR WORK?

YES	1
NO	2

☐ V70

(72.1) IF YOU ANSWERED "YES" TO QUESTION (72), BRIEFLY DISCUSS

_____

_____

(73) HOW DID/DOES THE CURRENT STATE OF VIOLENCE AFFECT YOU OR YOUR FAMILY'S HEALTH? BRIEFLY EXPLAIN

_____

_____

(74) DO YOU BELONG TO ANY TRADE UNION?

YES [1]

NO [2]

[ ] V71

(74.1) IF YOU HAVE ANSWERED "NO" TO QUESTION (74), KINDLY EXPLAIN WHY?

_____

_____

(75) WERE THE PROBLEMS MENTIONED IN QUESTION (71) ATTENDED TO BY:

SOCIAL WORKER	YES	[1]	NO	[2]	[ ]	V72
SUPERVISOR	YES	[1]	NO	[2]	[ ]	V73
SHOP STEWARD	YES	[1]	NO	[2]	[ ]	V74
OTHER	YES	[1]	NO	[2]	[ ]	V75

SPECIFY _____

(76) IN YOUR OPINION, HOW SHOULD THESE PROBLEMS HAVE BEEN HANDLED?

_____

_____

_____

(77) WHAT RECREATIONAL FACILITIES ARE AVAILABLE AT WORK?

SOCCER FIELDS	YES	1	NO	2		V76
NETBALL FIELDS	YES	1	NO	2		V77
TENNIS COURTS	YES	1	NO	2		V78
RECREATION HALLS	YES	1	NO	2		V79
SWIMMING POOLS	YES	1	NO	2		V80

(78) ARE YOU ACTIVELY INVOLVED IN ANY OF THE ABOVEMENTIONED RECREATION ACTIVITIES?

YES	1	
NO	2	
		V81

(79) HOW DO YOU RELATE TO OTHERS AT WORK?

POORLY	1	
FAIRLY	2	
SATISFACTORILY	3	
VERY WELL	4	
		V82

FURTHER COMMENTS:

_____

_____

_____

_____

_____

ADDENDUM 4

SAMPLE OF A SELF-CERTIFICATION FORM

SECTION 1: TO BE COMPLETED BY EMPLOYEE

SURNAME: ..... FORENAMES: .....
(Mr/Mrs/Miss)

SUB-DEPARTMENT: ..... PAY NUMBER: .....

PERIOD OF SICKNESS ABSENCE WAS FROM ..... TO .....

I certify that I was unable to attend work for the above period and the reason for my absence was:

.....

.....

SIGNATURE _____ DATE: _____

- -

SECTION 2: TO BE COMPLETED BY IMMEDIATE SUPERVISOR OR DEPUTY

ARE YOU SATISFIED THAT THE INFORMATION GIVEN ABOVE IS CORRECT?
YES/NO

DID THE EMPLOYEE CONTACT YOU TO INFORM YOU OF THE ABSENCE?
YES/NO

ARE YOU CONCERNED ABOUT THE EMPLOYEE'S LEVEL OF ABSENTEEISM?
YES/NO

SIGNATURE: _____ DATE: _____

A copy of this form to be given to the Head of the Department, Personnel, and the last one to be filled in by the immediate supervisor.

ADDENDUM 5

SAMPLE OF AN INDIVIDUAL ABSENCE AND SICK RECORD

NAME: _____ SUB-DEPARTMENT: _____

PAY NUMBER: _____ DATE: _____

MONTH	DAYS
JANUARY	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	

ABSENCE DAYS TO BE CLEARLY MARKED

KEY:

Certified sickness	=	S
Uncertified sickness	=	US
Authorised absence	=	A
Unauthorised absence	=	UA
Lateness (in minutes)	=	L
Holidays	=	H

TOTAL:

S =
US =
A =
UA =
L =
H =