

**EMPLOYEE PERCEPTIONS OF DOWNSTREAM OUTCOMES OF HEALTH  
PROMOTION: A CASE STUDY OF THE CLOTHING AND TEXTILES INDUSTRY  
IN SOUTH AFRICA**

by

**RUDI TYRONE DE KOKER**

**Dissertation (course-based degree with 50% dissertation) submitted in partial  
fulfilment of the requirements for the degree**

**Master of Technology: Business Administration**

**in the Faculty of Business and Management Sciences**

**at the Cape Peninsula University of Technology**

**Supervisor: Dr. Bingwen Yan**

**District Six Campus**

**Date submitted: 12 October 2020**

**CPUT copyright information**

The dissertation may not be published either in part (in scholarly, scientific or technical journals), or as a whole (as a monograph), unless permission has been obtained from the University.

## DECLARATION

I, Rudi De Koker, declare that the contents of this dissertation represent my own unaided work, and that the dissertation has not previously been submitted for academic examination towards any qualification. Furthermore, it represents my own opinions and not necessarily those of the Cape Peninsula University of Technology.



---

**Signed**

**12 October 2020**

---

**Date**

## ABSTRACT

Employee perceptions of Workplace Health Promotion (WHP) are pivotal for researchers to ascertain the degree of employee satisfaction and as a quality indicator of such an initiative within an organisation. However, there are considerable challenges faced regarding participation in WHP as employees do not trust the confidentiality of the programme. The problem is further exacerbated in that employees experience the wellness programme as a demand by the employer rather than a beneficial resource to the employee. Thus, this research study aimed to determine the effect of workplace health promotion on downstream outcomes within an organisation. To realise the primary research objective, this study looked into the effect of WHP on clothing and textile employees' (CTE) physical, mental, cognitive and affective outcomes, and social wellbeing. It also explored the effect of the facilitation of preventive interventions.

This study evaluated the perceptions of employees on workplace health promotion in the clothing and textile industry in Cape Town. A combination of both qualitative and quantitative research approaches was followed. Quantitative data were collected from 121 CTEs through a survey questionnaire. The qualitative data were collected via interviews amongst managers, clinical staff and WHP program promoters. SPSS was utilised for analysing the quantitative data, and content analysis was conducted for qualitative data.

The results of the study mostly pointed to the fact that employees in the clothing and textile industry perceived WHP in a very positive light. Most respondents recognised the benefits of WHP to the organisation which includes reduced healthcare costs in the long term and employee satisfaction, among others. The findings further revealed that the majority of CTEs were either unsure or noticed no effect of WHP on their physical health. However, this statement is contradicted in that 84.3% of respondents stated that they feel physically better due to participation in the WHP service offering. A previous study reported disagreement or indecisiveness to this statement amongst WCWs. This study revealed that there had been a positive impact on absenteeism and psychosocial issues. Most of the CTEs perceived that participation in WHP made the prevention of illnesses financially affordable.

**Keywords:** Workplace Health Promotion, Employee perceptions, downstream outcomes, blue-collar workers, Western Cape Province

## **ACKNOWLEDGEMENTS**

This research project would not have been possible without the contribution of so many individuals. During this journey I had to rediscover myself and my perceptions. I had to leave my comfort zone: my job, family and friends, as well as my country to experience new ways of being. In retrospect, each of these steps were critical in shaping my perspective on life and my research project. I have received so much support and encouragement on what I would call an expedition, that it would be nearly impossible to mention each one by name. However, there are those without whom this research project would not have been completed, and I wish to convey my gratitude and acknowledge their contributions.

Firstly, all praise and thanksgiving to God for granting me with strength and knowledge to complete this research project. I thank Him for blessing me with compassion for other humans and guiding me to an area where I could live out this desire.

To my father, Rudolph De Koker, and my mother, Denise De Koker, and my grandmother, Mona De Koker, for their life-long steadfastness, practicality, generous love and continuous reminders to seek happiness and God's will in daily living.

To my brother, Bradley De Koker, his wife, Natalie De Koker, and my sister, Chantal De Koker, thank you for all the assistance, especially during this research project. One page will not do justice for all you have done for me and mean to me.

I also want to express my appreciation for my girlfriend, Nastasha Arendse, for sticking around despite the endless reading, writing, re-reading and re-writing. Thank you for being the voice constantly reminding me to "just write", despite the challenges I faced.

Thank you to all my family and friends (Especially my great uncle, Dennis De Koker and great aunt, Marie De Koker for their contribution, support and love).

To my Research Supervisor, Dr. Bingwen Yan for all your patience, but especially for the caring and support you have provided me. Thank you for keeping me motivated when I wanted to give up.

I wish to thank my former colleagues at Aid for AIDS and all comrades at SACTWU and SACTWU Worker Health Programme – for their support and assistance on this journey.

Special recognition to Comrade Andre Kriel, SACTWU General Secretary, and Comrade Freda Oosthuysen, SACTWU and COSATU National Treasurer, for their guidance, support and encouragement during my research project.

Thank you to the colleagues at the Clothing Industry Health Care Fund in the Western Cape, under the then leadership of Dr. Nabeel Behardien for allowing me to conduct my study in the clinics. My sincere gratitude to Leslin Augustine for all the assistance and planning during the data collection phase of this project – Thank you for making things happen.

Thank you to Paul Moyo and Lusani Malaudzi for assistance with my data analysis.

Lastly, I wish to convey my thanks to all my classmates at both Cape Peninsula University of Technology and Beijing Institute of Technology.

## **DEDICATION**

In loving memory of  
my late grandmother, Kathleen Jurgens  
my late grandfather, Cupido De Koker  
my late great uncle, David Sylvester  
my late great aunt, Delia Sylvester, who worked in the clothing industry in Cape Town

**“TRUST & OBEY”**

## TABLE OF CONTENTS

|   |      |
|---|------|
| DECLARATION .....                                     | i    |
| ABSTRACT.....   | ii   |
| ACKNOWLEDGEMENTS .....                                | iii  |
| DEDICATION.....                                       | v    |
| TABLE OF CONTENTS.....                                | vi   |
| LIST OF FIGURES .....                                 | x    |
| LIST OF TABLES .....                                  | xi   |
| APPENDICES.....                                       | xii  |
| GLOSSARY OF TERMS.....                                | xiii |
| CHAPTER ONE: SCOPE OF THE RESEARCH .....              | 1    |
| 1.1 Introduction .....                                | 1    |
| 1.2 Problem statement.....                            | 2    |
| 1.3 Rationale and significance of the study .....     | 2    |
| 1.4 Aim and objectives of the study.....              | 3    |
| 1.5 Research questions.....                           | 3    |
| 1.6 Research process .....                            | 4    |
| 1.6.1 Paradigm.....                                   | 4    |
| 1.6.2 Research method.....                            | 5    |
| 1.6.2.1 Qualitative Research Approach.....            | 6    |
| 1.6.2.2 Quantitative research approach .....          | 6    |
| 1.7 Research design and methodology .....             | 6    |
| 1.7.1 Research design .....                           | 6    |
| 1.7.2 Demarcation of the study.....                   | 7    |
| 1.7.3 Population .....                                | 7    |
| 1.7.4 Sample method / Technique and sample size ..... | 7    |
| 1.7.5 Data collection instruments .....               | 8    |
| 1.7.6 Data collection.....                            | 8    |
| 1.7.7 Data coding and analysis .....                  | 9    |
| 1.8 Ethical considerations .....                      | 9    |

|  |  |    |
|--|--|----|
| 1.9  | Research assumptions.....  | 9  |
| 1.10   | Research constraints.....  | 9  |
| 1.11   | Chapter and content analysis.....                                  | 9  |
| 1.12   | Conclusion .....   | 10 |
| CHAPTER TWO: BACKGROUND AND RESEARCH ENVIRONMENT ..... |  | 12 |
| 2.1  | Introduction .....   | 12 |
| 2.2  | The Clothing and Textiles industry in South Africa .....           | 12 |
| 2.3  | Healthcare in the Clothing and Textiles industry.....              | 17 |
| 2.3.1  | The Health Care Fund.....  | 18 |
| 2.4  | Package of care .....  | 18 |
| 2.4.1  | Employee Health and Wellness Promotion.....                        | 18 |
| 2.4.2  | Acute and Chronic Services .....                                   | 18 |
| 2.4.2  | Psycho-Social Services.....  | 19 |
| 2.4.3  | Oral Health Care .....   | 19 |
| 2.4.4  | Optical Care .....   | 19 |
| 2.4.5  | Physiotherapy and Occupational Therapy.....                        | 19 |
| 2.4.6  | HIV Testing Services.....  | 19 |
| 2.5  | Conclusion .....   | 19 |
| CHAPTER THREE: LITERATURE REVIEW.....                  |  | 21 |
| 3.1  | Introduction .....   | 21 |
| 3.2  | Workplace Health Promotion (WHP) .....                             | 22 |
| 3.3  | Relation between employee wellbeing and the workplace .....        | 26 |
| 3.4  | Effect of working conditions on employee health behaviour.....     | 28 |
| 3.5  | Impact of socioeconomics on WHP .....                              | 29 |
| 3.6  | WHP Stakeholders.....  | 30 |
| 3.6.1  | Employee involvement in WHP .....                                  | 33 |
| 3.6.2  | Employer involvement in WHP .....                                  | 35 |
| 3.7  | Effect of WHP on the facilitation of preventive interventions..... | 38 |
| 3.8  | Effect of WHP on general cognitive and affective outcomes.....     | 40 |
| 3.9  | Effect of WHP on employee’s mental level .....                     | 40 |



|   |   |    |
|---|---|----|
| 3.10  | Cost of Occupational accidents and diseases in South Africa ..... | 41 |
| 3.11  | Conclusion.....   | 42 |
| CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY ..... |   | 43 |
| 4.1   | Introduction .....  | 43 |
| 4.2   | Research design .....   | 43 |
| 4.3   | Research methods .....  | 44 |
| 4.4   | Sampling and data collection.....                                 | 45 |
| 4.4.1   | Quantitative sampling and data collection .....                   | 45 |
| 4.4.2   | Qualitative sampling and data collection.....                     | 46 |
| 4.5   | Data analysis .....   | 46 |
| 4.6   | Trustworthiness .....   | 46 |
| 4.7   | Ethical considerations.....                                       | 47 |
| 4.8   | Conclusion.....   | 47 |
| CHAPTER FIVE: RESULTS .....                         |   | 48 |
| 5.1   | Introduction .....  | 48 |
| 5.2   | Quantitative data analysis .....                                  | 48 |
| 5.2.1   | Descriptive statistics.....                                       | 48 |
| 5.2.1.1   | Interpretation of descriptive statistics .....                    | 50 |
| 5.2.1.2   | Correlation Matrix.....   | 50 |
| 5.2.1.3   | Reliability testing .....   | 53 |
| 5.2.2   | Demographic data analysis and interpretation.....                 | 54 |
| 5.2.3   | Decision-making session data analysis .....                       | 57 |
| 5.2.3.1   | Physical effects .....  | 58 |
| 5.2.3.2   | Mental effects.....   | 58 |
| 5.2.3.3   | Social effects.....   | 58 |
| 5.2.3.4   | Facilitation of Preventative activities.....                      | 59 |
| 5.2.3.5   | General cognitive and affective outcomes .....                    | 59 |
| 5.3   | Qualitative data analysis .....                                   | 60 |
| 5.3.1   | Qualitative content analysis.....                                 | 60 |
| 5.3.1.1   | The main benefits of WHP for the CTEs.....                        | 61 |

|  |  |     |
|--|--|-----|
| 5.3.1.2  | The impact of WHP on CTEs Cape Town .....                          | 62  |
| 5.3.1.3  | The CTEs' perceptions of WHP .....                                 | 63  |
| 5.3.1.4  | Approaches to improve CTEs' participation in WHP.....              | 63  |
| 5.4  | Conclusion .....   | 64  |
| CHAPTER SIX: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS .....       |  | 65  |
| 6.1  | Introduction .....   | 65  |
| 6.2  | Discussion.....  | 65  |
| 6.2.1  | Demographic Data.....  | 65  |
| 6.2.2  | CTEs perception of WHP on their personal health status.....        | 66  |
| 6.2.3  | The impact of WHP on CTE's wellbeing in Cape Town.....             | 67  |
| 6.2.4  | CTEs' perceptions of general cognitive and affective outcomes..... | 68  |
| 6.2.5  | Approach to improve CTEs' participation in WHP .....               | 68  |
| 6.3  | Recommendations .....  | 69  |
| 6.4  | Conclusion .....   | 70  |
| BIBLIOGRAPHY .....   |  | 72  |
| APPENDICES.....  |  | 81  |
| APPENDIX A: ETON Systems - ETON select.....                          |  | 81  |
| APPENDIX B: Clothing Industry Health Care Fund Brochure.....         |  | 84  |
| APPENDIX C: Workplace Health Model.....                              |  | 86  |
| APPENDIX D: Consent letter – Clothing Industry Health Care Fund..... |  | 87  |
| APPENDIX E: Quantitative Research Questionnaire .....                |  | 89  |
| APPENDIX F: Qualitative Interview Schedule .....                     |  | 94  |
| APPENDIX G: SPSS Data Statistics.....                                |  | 96  |
| APPENDIX H: Correlation.....   |  | 117 |
| APPENDIX I: Content Data Analysis.....                               |  | 123 |

## LIST OF FIGURES

|   |    |
|---|----|
| Figure 1.1: Conceptual Map of the Problem-based Research Cycle .....  | 6  |
| Figure 2.1 Number of formal sector employees in the clothing and textiles industry in South Africa .....  | 13 |
| Figure 2.2 Typical machinist stations; (A) operator leaning forward, (B) operator using non-adjustable chair and boxes to support incoming fabric. .... | 15 |
| Figure 2.3 Eton System with pieces clipped on it.....   | 16 |
| Figure 3.1 Taxonomy of WHP Stakeholders .....   | 31 |
| Figure 3.2 Theoretical model linking leadership support, provision of WHP facilities and employee wellbeing .....                                       | 36 |
| Figure 3.3: Reasons for employee non-participation in WHP .....   | 39 |
| Figure 5.1: Gender distribution of respondents .....  | 54 |
| Figure 5.2: Age distribution of respondents.....  | 55 |
| Figure 5.3: Education level of respondents .....  | 56 |
| Figure 5.4: Length of employment with organisation .....  | 56 |
| Figure 5.5: Knowledge of HIV status.....  | 57 |
| Figure 5.6: HIV Status known by age .....   | 57 |
| Figure 5.7: TB testing amongst respondents.....   | 57 |

## LIST OF TABLES

|  |    |
|--|----|
| Table 3.1 Risk factors linked to musculoskeletal injuries and repetitive strain injuries ..... | 25 |
| Table 3.2 Benefits of success WHP interventions.....   | 26 |
| Table 3.3 Employee responses to benefits and barriers to engage with WHP .....                 | 33 |
| Table 3.4 Motivation for employers to carry out WHP .....                                      | 37 |
| Table 5.1 Descriptive Statistics.....  | 49 |
| Table 5.2 Case Processing Summary .....  | 54 |
| Table 5.3 Reliability Statistics .....   | 54 |

## **APPENDICES**

|   |     |
|---|-----|
| <a href="#">APPENDIX A: ETON Systems - ETON select</a> .....                          | 81  |
| <a href="#">APPENDIX B: Clothing Industry Health Care Fund Brochure</a> .....         | 84  |
| <a href="#">APPENDIX C: Workplace Health Model</a> .....                              | 86  |
| <a href="#">APPENDIX D: Consent letter – Clothing Industry Health Care Fund</a> ..... | 87  |
| <a href="#">APPENDIX E: Quantitative Research Questionnaire</a> .....                 | 89  |
| <a href="#">APPENDIX F: Qualitative Interview Schedule</a> .....                      | 94  |
| <a href="#">APPENDIX G: SPSS Data Statistics</a> .....                                | 96  |
| <a href="#">APPENDIX H: Correlation</a> .....   | 117 |
| <a href="#">APPENDIX I: Content Data Analysis</a> .....                               | 123 |

## GLOSSARY OF TERMS

| <b>Terms / Acronyms / Abbreviations</b>         | <b>Definition / Explanation</b>   |
|---|---|
| <b>Health Self-efficacy</b>                     | The belief in one's own capacity to improve and maintain health.  |
| <b>Workplace Health Promotion</b>               | The combined efforts of employers, employees, and society to improve the mental and physical health and well-being of people at work.   |
| <b>Blue Collar Workers</b>                      | A working-class person who performs manual labour.  |
| <b>Clothing Workers</b>                         | Employees who cut and sew fabric and other materials into clothing, performing one task in the production of many garments, rather than performing all the tasks required to produce an item of clothing.   |
| <b>Textile Workers</b>                          | Employees who prepare natural and synthetic fibres for spinning into yarn and manufacture yarn into textile products that are used in clothing, in household goods, as well as many industrial purposes.  |
| <b>Clothing &amp; Textiles Employees (CTEs)</b> | The grouping of Clothing and Textiles Workers.  |
| <b>Non-Communicable diseases</b>                | A disease that is not transmissible directly from one person to another, i.e., Heart disease and Diabetes.  |
| <b>CUT, MAKE &amp; TRIM (CMT)</b>               | Cut means cutting of garment patterns from fabric roll. Make is stitching the complete garment with necessary trims. Trim means trimming of uncut threads tails, cleaning loose thread from the garment after stitching and doing the checking, finishing and packing the garment |

# CHAPTER ONE: SCOPE OF THE RESEARCH

## 1.1 Introduction

This section is an orientation to the study, which includes a brief introduction, background to the research problem, problem statement, and research question. It further explains the research objective, ethical considerations, research assumptions, research constraints, and the significance of the study.

The Luxembourg Declaration of 1997 describes Workplace Health Promotion (WHP) as the combined efforts of employers, employees, and society to improve the health and wellbeing of persons at work (European Network for Workplace Health Promotion, 2012).

Improvement in health and wellbeing can be achieved by:

- a) improving the work organisation and the work environment; and
- b) promoting the active participation of all stakeholders in the process; and
- c) encouraging personal development.

(European Agency for Safety and Health at Work, 2012; Currás, 2017)

Furthermore, WHP does not substitute workplace risk management but is a supplementary service, and proper risk management is the basis for an effective WHP programme (European Agency for Safety and Health at Work, 2012).

Limitations in the research by Nöhammer, Schusterschitz, and Stummer (2013) indicate that the focus of the study was on the outcomes perceived by employees on WHP and excluded medical parameters and absenteeism. The outcomes in the study reflects on WHP which have the highest impact on the employee benefits that can be grouped as cognitive, emotional, convenience/pleasure, and social issues (Nöhammer *et al.*, 2013). Furthermore, WHP programmes encapsulate many more effects that are beneficial to employees. Nöhammer *et al.* (2013) further postulate that research limitations in the study require further testing amongst blue-collar workers and physical benefits. This study focused on Clothing & Textile employees (CTEs) in an organisation in Cape Town in the Western Cape Province. Participants were selected from the organisation's clinics in Salt River, Athlone, Elsie's River, Delft, Grassy Park, and Mitchell's Plain. Management team members interviewed included managers, clinical staff and workplace health promoters from the health care organisation.

## 1.2 Problem statement

WHP benefits the improvement of the well-being of employees (Nöhammer et al., 2013). However, only a section of the workforce sampled by Nöhammer et al. (2013) experienced a sense of improvement in their well-being. The research found that 40.1 percent of the sample provided feedback that they were willing to try the WHP. According to Myers (1984), Taute and Manzini (2014) cited by Sieberhagen, Pienaar, and Els (2011), there are challenges regarding participation in Employee Wellness Programmes (EWP). One such challenge is that employees do not trust the confidentiality of the programme.

The problem is further exacerbated in that employees experience the EWP as a demand by the employer rather than a beneficial resource to the employee. Should employee participation in WHP be increased, it may result in more employees completing the programme (Terry *et al.* 2008). Zungu and Setswe (2007) postulate that there are better working conditions at organisations where WHP programmes are established. Subsequently, the participation rate was low (average 50 percent), and those who participated were healthy managers and white-collar workers. Where organisations have healthier employees, the ratings for psychosocial work conditions are also more favourable (Ljungblad *et al.* 2014).

The Clothing and Textiles industry offers WHP to blue-collar workers, however despite targets being managed the perceptions of employees are not evaluated. Such evaluation will guide the quality of the interventions, increase participation and improve working conditions which in turn results in healthier employees.

## 1.3 Rationale and significance of the study

Occupational Health and Safety cover Health and Safety, but no legislation exists regarding employee wellness (Sieberhagen, Rothmann, and Pienaar, 2009). Developing countries face issues mainly with regards to dangerous occupations and heavy physical work, while in industrialised countries, the focus is on psychosocial stressors. WHP is not compulsory in South Africa, as per Occupational Health and Safety (OH&S) legislation, yet it is stipulated that the workplace should be safe as well as healthy (Zungu and Setswe, 2007; Mchunu, 2012; Tshoose, 2014; Hampson *et al.* 2016). WHP focuses on awareness creation, facilitating change, managing health, and promoting a healthy and supportive workplace (Sieberhagen, Pienaar, and Els, 2011). According to the Human Sciences Research Council, Non-Communicable Diseases



(NCDs) are caused to a large extent by tobacco use, unhealthy diet, insufficient physical activity, and the harmful use of alcohol (HSRC, 2013).

According to Dickson-Swift *et al.* (2014), health in the workplace focused on OH&S measures to reduce physical risks and injury to employees. In many instances, employers maintain that upholding OH&S legislation forms part of their role or responsibility in their employees' health and wellness (Dickson-Swift *et al.*, 2014). The value of supporting employee health results in positive outcomes for the entire organisation with reported increases in productivity and reduced absenteeism. Despite research indicating positive results from implementing WHP, limited data exist regarding employee perceptions of such interventions (Harbin, 2017). Therefore, the scope of this research problem reads as follows: Clothing & Textiles Employee (CTE) perceptions of WHP outcomes have a direct impact on CTE participation in WHP and its success.

#### **1.4 Aim and objectives of the study**

The primary research objective of this study is to determine the effect of workplace health promotion on clothing & textiles employees' perceptions of downstream outcomes within the organisation. The secondary research objectives are:

- To explore the main benefits of WHP for Clothing and Textiles employees (CTEs).
- To determine the effect of the WHP on CTE's physical, mental, and social wellbeing in Cape Town.
- To find out the CTEs' perceptions of general cognitive and affective outcomes.
- To determine an effective way of improving CTEs' participation in WHP.

#### **1.5 Research questions**

The primary research question is as follows: Do Clothing and Textile employees (CTEs) perceive WHP as beneficial to their health status? The following investigative questions were researched to inform the primary research question:

- What are the main benefits of WHP for Clothing and Textiles employees (CTEs)?
- How does WHP affect CTE's physical, mental, and social wellbeing in Cape Town?
- What are the CTEs' perceptions of general cognitive and affective outcomes?

- Which approach can be used to improve CTEs' participation in WHP effectively?

## 1.6 Research process

### 1.6.1 Paradigm

Much research has been conducted on WHP with the outcome being to improve the health of the employee. Punnett *et al.* (2009) illustrates the association of socio-economic status, working conditions and health behaviours on health outcomes of mental health, cardiovascular health and musculoskeletal health. The process can extend to include the perceptions of employees on their health outcomes and WHP. In addition, activity to evaluate employee perceptions may be extended on the WHP strategies suggested by Pauncu (2012) cited as:

- Providing incentives for participation
- Establishing a wellness informational campaign
- Scheduling wellness seminars on diabetes, nutrition, physical fitness and cholesterol, etc.
- Establishing initiatives such as fitness, sleep diary, tobacco use cessation and injury prevention
- Providing onsite chair massages or simple stretching exercises to do at the desk
- Changing vending machine options to offer healthier, low-fat snacks and drinks
- Actively promoting employee participation in all Workplace Health Promotion Programs

In the European context, the quality of WHP programs are measured by, amongst others, the employees' participation in planning of WHP programmes and the evaluation of WHP programs (European Network for Workplace Health Promotion, 2012). It is however not clear on who should conduct the evaluation and whether employees' perceptions will be accounted for.

Goetzel *et al.* (2014) postulates that the measurement of WHP can be broadly categorised into: program structure, delivery process, and expected clinical, health care utilisation/cost, and productivity outcomes. The researcher notes the absence of evaluating employee perceptions of WHP.

In a study by Dickson-Swift *et al.* (2014) it is asserted that despite numerous studies worldwide on the successes of WHP programmes, not much evidence existed for

companies in Australia. An objective of the study conducted was to explore employees' understanding of work place health, which concluded that employees' expectations are that WHP extends further than physical wellness, but to instil an organisational culture to provide the most benefits to individual employees.

With the objectives of the research in mind, it is thus imperative to determine the effect of WHP on employees' perceptions, in addition to the secondary research objectives: exploring the main benefits of WHP for employees; determining the effect of the WHP on employees' physical, mental, and social wellbeing; realising the employees' perceptions of general cognitive and affective outcomes; and determining an effective way of improving employees' participation in WHP.

The mixed-methods approach was selected for the research questions as the required data is both numerical and contextual (Williams, 2007). The quantitative method used for data collection was a survey containing closed-ended questions to collect the numerical data. The researcher conducted interviews using open-ended questions to collect the narrative data, which constituted the qualitative method (Williams, 2007). Managers, clinical staff, and workplace health promoters from the health care organisation participated in the qualitative data collection.

### **1.6.2 Research method**

Ellis and Levy (2008) assert that the structure of a research undertaking comprises individual yet related elements. The elements are the research problem, which directs the investigation, research objectives, research questions, literature review, methodology, results, and conclusions. Furthermore, Leedy and Ormond, as cited by Ellis and Levy (2008), propose that the research problem initiates the research and limits the scope of the research undertaking, as it amalgamates all aspects of the research as shown in Figure 1.1.

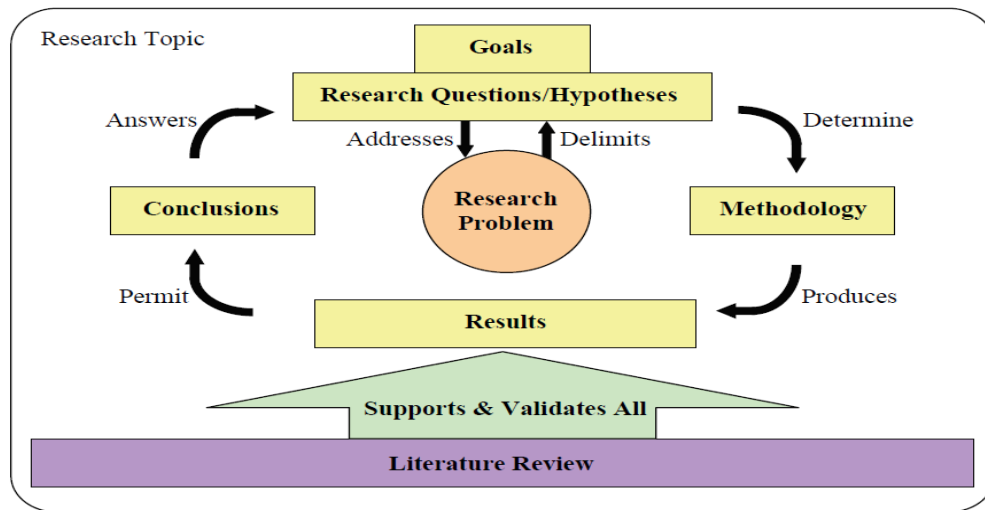


Figure 1.1: Conceptual Map of the Problem-based Research Cycle

A combination of both qualitative and quantitative research approaches was therefore followed in this current study.

### 1.6.2.1 Qualitative Research Approach

The researcher made use of a qualitative research method, namely, interviews to augment the research findings amongst the respondents who underwent the WHP sessions.

### 1.6.2.2 Quantitative research approach

A questionnaire was designed containing two sections. Section 1 elicited demographic data, which included age, gender, years with the organization, and geographic location of respondents. Section 2 required sub-sections relating to the themes of physical effects, mental effects, social effects, facilitation of preventative activities, general cognitive and affective outcomes.

## 1.7 Research design and methodology

### 1.7.1 Research design

Research design is the overall strategy implemented to solve the research problem (Leedy and Ormrod, 2015). Furthermore, the research design provides the order which the researcher follows, the data the researcher collects, and the data analyses the researcher conducts.

This section elaborates on the research design and methodology employed in this research undertaking. The research was conducted as a case study to understand the

dynamics and complexities of WHP within the Clothing and Textiles industry and to identify recurring patterns and consistent regularities in the findings (Welman et al., 2005). Case study research scientifically examines a real-life phenomenon comprehensively and within its environmental setting (Ridder, 2017).

### **1.7.2 Demarcation of the study**

Struwig and Stead (2001) described demarcation of study as the scope of the research project, what is included and what is excluded. This study was thus conducted in the Clothing and Textiles manufacturing industry in Cape Town to evaluate perceptions of employees on WHP. Further information is contained in the section on research constraints.

### **1.7.3 Population**

From a data collection perspective, the population includes individuals who possess the information the researcher wishes to acquire in order to address the research question (Ragab and Arisha, 2017).

The study object or population of the study consisted of factory employees in Cape Town within a Clothing and Textiles manufacturing organisation. The population size of clothing workers in Cape Town as of June 2018 was 17447 (Jeftha, 2018). In addition population for managers, clinical staff, and workplace health promoters from the health care organisation which totalled 25.

### **1.7.4 Sample method / Technique and sample size**

According to Malhotra *et al.* as cited by Ragab and Arisha (2017) the sampling design process is usually outlined in the following five steps: (1) Define the population, (2) Determine the sampling frame, (3) Select the sampling technique, (4) Determine the sample size, and (5) Execute the sampling process.

The two main sampling techniques are probabilistic and non-probabilistic sampling (Ragab and Arisha, 2017). Greener, as cited by Ragab and Arisha (2017) asserts that within probability sampling, each individual in the population has an equal chance (or probability) of being randomly selected in order to produce a sample that is statistically representative of the population. However, in non-probability sampling techniques the selection of individuals from the population is not random and is determined by the researcher.

Quota sampling ensures that a certain characteristic of a population sample will be represented to the exact extent that the investigator desires (Acharya *et al.*, 2013).

The sample size selected through non-probabilistic sampling was based on the population comprising of the organisation's membership who have participated in WHP. Qualitative data were collected from managers, clinical staff, and workplace health promoters from the health care organisation. The researcher conducted in-depth interviews with these managers within the organization for insight into the strategic intent of the WHP, as well as to gather information regarding the operational processes within the organization about WHP. Quantitative data were collected from 121 respondents through self-administered questionnaires. The researcher endeavoured to match the cohorts of both the qualitative and quantitative approaches.

### **1.7.5 Data collection instruments**

Rating scales are commonly used in the social sciences and to test perceptions. Such instruments often use a Likert-type scale, which requires the respondent to answer a series of statements by marking whether they strongly agree, agree, unsure, disagree, or strongly disagree (Croasmun and Ostrom, 2011).

All responses to the questionnaire were on a Likert-type scale ranging from 1-5. This approach had been selected as it saved time when conducting the survey. The survey was directed at blue-collar workers. Due to the unknown literacy level of the respondents, this simplified approach allowed respondents to articulate themselves easily.

A pilot study was conducted to ensure data validity. The pilot study consisted of a sample of 20 respondents. Cronbach's alpha was used to test the reliability of the dataset.

### **1.7.6 Data collection**

The organisation granted access to the researcher to research within its facilities. Furthermore, the data collected may be used and kept for future studies. The researcher conducted the interviews; however, assistance was sought from shop stewards to create awareness of the study amongst employees, and surveys were disseminated and collated with the assistance of fieldworkers.

### **1.7.7 Data coding and analysis**

Due to the mixed methods approach adopted, both IBM SPSS and MS Excel were used for data coding and analysis. The quantitative survey was coded in IBM SPSS. IBM SPSS was selected as it presents a multi-feature system for statistical processing and analysis of diverse empiric data. The software allowed the researcher to perform high-speed data processing. The researcher carried out descriptive procedures such as frequencies, correlations, and reliability analyses. Also, the software provided tables, diagrams, and charts (Sadchikova and Rodin, 2017). The qualitative survey was analysed following the four stages of content analysis as described by Bengtsson (2016): de-contextualisation, re-contextualisation, categorisation, and compilation.

### **1.8 Ethical considerations**

Strict ethical considerations were applied to this study:

- The researcher obtained ethical clearance from the organisation within which the study was conducted;
- Respondents were informed of the purpose of the survey and that all information was used anonymously and with strict confidentiality.

### **1.9 Research assumptions**

It was assumed that:

- The data would be easily accessible;
- The organisation will benefit from the research outcomes;
- This research will inform future strategic and policy decisions relating to WHP.

### **1.10 Research constraints**

The following limitations of this research are:

- The study was conducted in a South African organisation within the Clothing and Textiles industry in Cape Town and excluded all other areas and sectors.
- The study was focused on the perceptions of CTEs and did not consider health metrics such as Cholesterol, Blood pressure, Blood Glucose, HIV Viral Load, TB cure rate, amongst others.
- The study did not include absenteeism data.

### **1.11 Chapter and content analysis**

The chapter and content analysis applicable to this dissertation is the following:

### **Chapter 1 – Scope of the research:**

This chapter discussed the scope of the research, specifically about the clothing and textile industry. In addition, this chapter elaborates on the structure which has been employed for this research, introducing the research topic, the background of the research, problem statement, objectives of the study, research design, and research methodology.

### **Chapter 2 – Background to the research environment:**

This section provided insight on where the clothing and textiles industry originated in South Africa, how it grew and the demographics within the industry. Furthermore, the chapter introduces the challenges with regard to working conditions, as well as technology aimed at negating such challenges. A holistic perspective of health promotion in the clothing and textile industry is provided. This chapter provides a South African perspective as a particular focus.

### **Chapter 3 – Literature review**

This chapter explored relevant studies in the field of WHP, which comprehensively reviewed the findings of authors across the world.

### **Chapter 4 – Research approach and research methodology:**

This section presents the research design and methodology, comprising comprehensive information on data design, collection, analyses, and ethics.

### **Chapter 5- Presentation of Results**

The chapter focuses on the presentation of results from the surveys and interviews.

### **Chapter 6 – Discussion, recommendations and conclusion:**

This is the final chapter. It concludes the key aspects of the research findings. The research results are interpreted with a detailed discussion. Recommendations for policy, further studies, and WHP, in general, are suggested.

## **1.12 Conclusion**

This study aimed to determine the perceived effect of workplace health promotion on downstream outcomes within the Clothing and Textiles industry. According to the extant literature, the value of supporting employee health results in positive outcomes for the entire organisation with reported increases in productivity and reduced absenteeism. Therefore, the scope of this research reads as follows: Clothing and



Textiles Employee (CTE) perceptions of WHP outcomes have a direct impact on employee participation in WHP and its success.

## **CHAPTER TWO: BACKGROUND AND RESEARCH ENVIRONMENT**

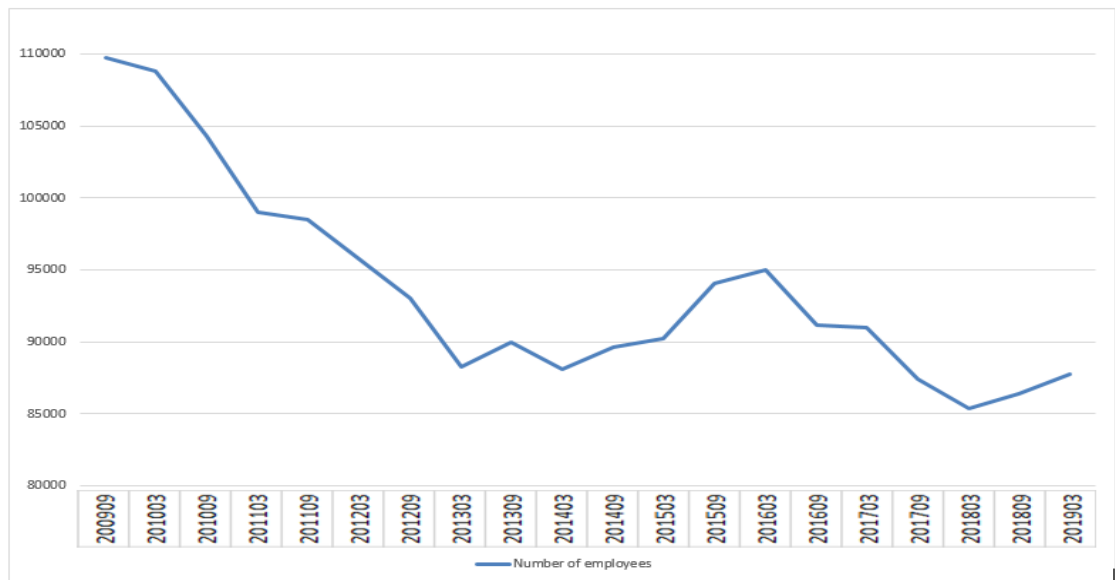
### **2.1 Introduction**

This section provides an overview of how WHP is practiced within the clothing and textiles industry. This chapter will elaborate on the demographics and working conditions within this industry both locally and internationally, as well as the Health Care Fund in the Western Cape.

*Employment in the garment industry rose worldwide in the late 1990s to approximately 11 million workers in 1998. Generally, sewing machine operators have little control over their workload, work pace and work schedule. Employment is unstable and often involves a tight delivery schedule so that the work pace is fast, time for rest breaks is limited and working hours may be long. Thus, in this population, work-organisation might be an important contributor to musculoskeletal disorders. [In America] Garment workers are a vulnerable working population, since they are primarily immigrants of low socio-economic status, low educational level, and without union representation (Wang et al., 2007).*

### **2.2 The Clothing and Textiles industry in South Africa**

The Clothing Industry in South Africa traces back to Cape Town (predominantly coloured female workers), with expansion later in Witwatersrand (primarily white female workers) during the 1920s to 1930s and an estimated workforce of about 50 000 by the late 1950s (Nattrass and Seekings, 2012; Matsoma and Ambe, 2017). Matsoma and Ambe (2017) summarise the employment figures for the Clothing Industry as follows: In the 1980s, 170 000; 1996, the highest employment was recorded at 228 053; after that, a decline in 2005 to 142 865; and 2013 only 80 000 employees. Figure 2.1 illustrates the decline in jobs within the formal sector of the clothing and textiles industry from 2009 to 2019.



**Figure 2.1 Number of formal sector employees in the clothing and textiles industry in South Africa**

Source: (South African Market Insights, 2019)

This downward trend in employment is attributed to clothing manufacturers seeking less costly locations due to intense local competition and the global economic downturn (Matsoma and Ambe, 2017). When there are job losses in the formal sector, similar jobs are created in the informal sector. The informal sector is considered to be non-compliant businesses, thus indicating that a gap exists in the actual employment data (Nattrass and Seekings, 2012).

The South African clothing and textile industry's goal is to grow into a globally preferred provider of textiles and apparel. It is focused on employing all opportunities at its disposal, namely, natural, human, and technological resources. Despite a decline in employment figures in the Clothing, Textiles, Footwear, and Leather (CTFL) industries, the industry accounted for approximately 14% of manufacturing employment and represented South Africa's second-largest source of tax revenue. Furthermore, the industry contributes roughly 8% of the country's Gross Domestic Product (GDP) (Business/Partners, 2014).

The domestic industry is predominantly situated in the Western Cape and KwaZulu-Natal (KZN), with a smaller footprint in Gauteng. The sector varies per region; the Cape Metropolitan Area is well-known for the high fashion orientation of its industry, whereas KZN concentrates on mass-market production (Business/Partners, 2014). According to Tilly *et al.* (2013), there are also demographic differences amongst the regions, for example:

- Durban (KZN) has predominantly South African Black and Indian women employees and the employers are mostly White and Indian men (owners of Cut, Make and Trim (CMTs))
- Cape Town (the Western Cape) where the majority of the employees are South African Black and Coloured women, with the same profile for employers, as seen in KZN, mostly White and Indian men (CMTs) and again the same demographic for the design houses
- Johannesburg (Gauteng) where CMTs ownership lies with South Africans or foreigners and employment, is split between South African women and Malawian, Zimbabwean and Mozambican men (Tilly *et al.*, 2013).

The Clothing and Textiles industries consist of a large group of women employed as machinists who sit in a constant stationary position due to sight requirements at the machine. This precipitates a static burden that jeopardises the wellbeing of the employee (Gahlot, Mehta, and Singh, 2017). The seated position is preferred to standing in sewing, as it provides added support and assists with accuracy, however sitting is associated with one-sided strain and restricted movement (Rossinen, 2018).

A typical sewing workstation, as seen in Figure 2.2, consists of a sewing table with a built-in electric sewing machine, a non-adjustable household chair, and cardboard boxes/cart to hold incoming fabrics and sewn products (Wang *et al.*, 2007). The use of boxes or trays for holding fabric has been negated by the implementation of Flexible material handling systems (FMHS) for apparel industries (Dai, Lee and Cheung, 2009). Not many studies have focused on machinists, despite the fact that in the United States of America (USA), machinists are in the top 20 employments (out of 841) with the highest rate of lost time due to over-use injuries (Wang *et al.*, 2007).



Figure 2.2 Typical machinist stations; (A) operator leaning forward, (B) operator using non-adjustable chair and boxes to support incoming fabric.

(Source: Wang *et al.*, 2007)

Clothes hangers to conveyor belts are used to move pieces from one stage to another during production. Clothes hangers and boxes can be used on its own or in conjunction with larger transportation devices (Rossinen, 2018). Larger factories utilise more sophisticated computerised systems, as shown in Figure 2.2, to which clips are installed to transport the pieces from the cutting area to the finishing station and thus

negating the requirement of moving large boxes (Eton Systems, 2012, 2019; Rossinen, 2018). The Eton select was carefully designed to help management control and plan production, maximize your output, and minimize waste, as outlined in Appendix A.



**Figure 2.3 Eton System with pieces clipped on it**

Source: (Eton Systems, 2019)

From a socioeconomic perspective, according to Vlok, as cited by Natrass and Seekings (2012), it is imperative to note that for many, the clothing industry is “the only source of formal employment and very many families are dependent on it for their survival”. This is echoed by Van der Westhuizen, as cited by Natrass and Seekings (2012). Clothing workers are, for families, the primary breadwinner, and the loss of even a low-wage job will plummet families into poverty.

A study conducted within the clothing manufacturing industry in the Western Cape identified the Employee Wellness Programme (EWP) as beneficial in improving health-related behaviours and perception of health-related quality of life (HRQoL) of the employees (Edries, Jelsma and Maart, 2013). In the study conducted in 2005 the improvements in perception of HRQoL was ascribed to physical workouts at the workplace including the perceived knowledge gained through workplace education sessions (Edries, 2005).

### 2.3 Healthcare in the Clothing and Textiles industry

In South Africa, an employee's health and wellness are protected and directed by:

- the Constitution of the Republic of South Africa;
- the Occupational Health and Safety Act;
- the Labour Relations Act;
- the Basic Conditions of Employment Act;
- the Compensation for Occupational Diseases and Injuries Act;
- the Unemployment Insurance Act;
- the Employment Equity Act; and
- the Skills Development Act.

(Pienaar, et al., 2009)

Textile manufacturers identified that increasing absenteeism and lower productivity was related to HIV/AIDS. The disease negatively impacted skills development and productivity and raised concerns for the future growth of the industry. At the time, the government's response to HIV/AIDS was limited, and it was thus in the best interest of the industry to address the challenge. The textile industry developed an HIV/AIDS policy through bargaining councils (tripartite regulation), and the employers' associations are obligated to contribute to a bargaining council healthcare fund. Textile companies pay approximately ZAR 0.30 per employee per week towards an HIV/AIDS levy, and employees also contribute. The service is only available to paid-up employees. Eight clinics were set up, and 80-100 staff were employed –ranging from doctors, dentists, oral hygienists, social workers, peer educators, and nursing staff. HIV/AIDS-related services at the clinics involve prevention initiatives, HIV Testing Services, and ARV treatment. ARV treatment is provided through a partnership with the provincial government (Müller-Debus, Thauer and Boerzel, 2009; Setswe, 2009).

The Southern African Clothing & Textile Workers' Union (SACTWU) is the most influential union in the fashion manufacturing industry and organises employees in the clothing, textiles, leather, footwear and allied distribution industries (Tilly *et al.*, 2013).

SACTWU has the largest membership (105 000 members) in the clothing, textile, leather, and footwear industry locally and internationally as at the end of August 2017 (SACTWU, 2019). In addition to organising employees and negotiating terms and conditions of employment, SACTWU affords its members' various social benefits, namely, educational bursary scheme and in 1998 established a Worker Health Programme. SACTWU's activism ensured that HIV/AIDS be incorporated in the health service offering of the Bargaining Councils (Müller-Debus, Thauer and Boerzel, 2009).

The Worker Health Programme is an HIV and AIDS worker education, awareness, prevention, treatment, and support programme (Tilly *et al.*, 2013). According to trade union officials, in SACTWU, healthcare service is one of the critical components which potential members find attractive (Otoo, 2017). The report furthermore asserts that, while other unions focus their education and training towards shop stewards, National Office Bearers and Trade Union officials, SACTWU has been found to be the exception. This is supported by data that highlights that amongst others, that SACTWU has facilitated HIV/AIDS training to 155 284 members (some attended more than once), 15 leaders, three officials, and 1214 shop stewards (Otoo, 2017).

### **2.3.1 The Health Care Fund**

The Clothing Industry Health Care Fund (CIHCF) is a non-profit organisation funded through contributions by employees and employers in the clothing sector. The CIHCF offers its members primary healthcare services at fixed-site facilities across the Cape Town Metro. Through partnerships with universities in and around Cape Town, the services to members are extended to include physiotherapy, occupational therapy, as well as psychological services (see Appendix B). All these services are available without a limit to employees and their dependents at fixed sites. General Practitioners situated in the community are contracted to offer health care services to members. These visits are, however, limited to the principal member and seven visits within a twelve-month period.

## **2.4 Package of care**

### **2.4.1 Employee Health and Wellness Promotion**

Interactive talks are facilitated at fixed sites and factories on a range of topics. These topics include mental health, cancer awareness, substance abuse, stress management, and teenage pregnancy. Additional topics are added as requested by the employees. The Health and Wellness Coordinator engages the factories to plan the Employee Health and Wellness Promotion programme to be congruent with the health needs of the employees.

### **2.4.2 Acute and Chronic Services**

Employees have access to Family Planning Methods, PAP smears, Hormone Replacement Therapy. The latter service is not directly offered by the CIHCF, however via a partnership and there might be a minimal cost to the employee. Other gynaecological conditions and counselling services are offered as well. Minor ailments



are treated, such as coughs, colds, bumps, boils, and bruising caused by accidents. Both adults and children receive treatment for diabetes, hypertension, asthma, epilepsy and other chronic conditions. The CIHCF assists in facilitating the application of disability grants.

#### **2.4.2 Psycho-Social Services**

Support is offered through counselling sessions to assist employees in dealing with challenges such as anxiety, work and home stress, death, domestic violence, and substance abuse.

#### **2.4.3 Oral Health Care**

Oral health services include cleaning and polishing of teeth, construction of dentures, fillings, dental extractions, and limited orthodontics (braces).

#### **2.4.4 Optical Care**

Free eye examinations and lenses are offered at the fixed sites.

#### **2.4.5 Physiotherapy and Occupational Therapy**

- Physiotherapy facilitates the diagnosis, assessment, treatment, and prevention of human movement disorders, restoring normal function and manages pain in adults and children.
- Occupational Therapy includes work assessments, functional capacity evaluation, return-to-work programmes, and supported employment.

#### **2.4.6 HIV Testing Services**

HIV testing takes place at all fixed facilities and factories. Counselling and support are offered, as well as linkage to care.

### **2.5 Conclusion**

Against the background and demographics of the Clothing and Textiles industry, it is evident that due to the nature of work, employees within the Clothing and Textiles industry's health and wellbeing are at risk, especially those who are employed as machinists who sit in mainly in a stationery position for most of the working day. In addition, some factories requires the manual movement of boxes which places strain on the employees' body.

The CIHCF was established to render primary healthcare services and extended to include physiotherapy, occupational therapy, as well as psychological services.

The SACTWU Worker Health Programme came into existence due to absenteeism and lower productivity at factories, as a consequence of HIV/AIDS in the industry. The SACTWU Worker Health Programme manages HIV/AIDS through education/training, testing and treatment. This programme was developed in a time when government's response to HIV/AIDS was limited.

These responses thus aims to improve employee wellbeing, increasing productivity, and decreasing absenteeism of vulnerable employees who are for many families the sole breadwinner. The following chapter will discuss health concerns affecting employees in general.

## CHAPTER THREE: LITERATURE REVIEW

### 3.1 Introduction

It is important to note that poor health and unhealthy lifestyle impacts negatively on workforce and productivity (Rongen *et al.*, 2014; Hampson *et al.*, 2016). Therefore workplaces are best suited for health promotion because the targeted audience spends most of their time proportionally there (Person *et al.*, 2010; Edries, Jelsma, and Maart, 2013; Rongen *et al.*, 2014). As a result, WHP programmes can gain access to employees aged 18 to 64, who requires assistance with lifestyle adjustments (Rongen *et al.*, 2014). The WHO identified the workplace as a priority setting for health promotion in the 21<sup>st</sup> century (Hampson *et al.*, 2016). However, the workplace may only be a suitable setting for health promotion under good work environment conditions (Jørgensen *et al.*, 2016).

South Africa is experiencing an escalation of NCDs in rural and urban settings. Isaacs *et al.* (2014) identify risk factors that exacerbate this health concern as:

- An aging population who are more vulnerable to developing NCDs;
- A smoking, sedentary lifestyle and unhealthy diets;
- Dietary changes, i.e., consumption of foods high in refined sugar and flour; and
- Genetic disposition (Isaacs *et al.*, 2014)

The Western Cape Burden of Disease Study indicates that in 2004, diabetes, stroke, and ischaemic heart disease were among the primary causes of premature death. Strokes were identified as a major cause of death. Cardiovascular disease (CVD) was the leading cause of death (25% of all deaths) in both men and women in the Western Cape. The prevalence for persons in the province, with a BMI greater than 25.0 and 30.0 was high; in women, it is 57.1% and men 38.4% (ranked highest in all provinces) (Isaacs *et al.* 2014).

Hampson *et al.* (2016) postulates that WHP can increase productivity by 20% of GDP in some countries. Paradoxically, should an employee be involved in a severe injury on duty, the site will shut down until a root-cause analysis has been finalised. However, should an employee succumb to a heart attack on the job due to high cholesterol, the work continues without a stoppage. Due to OHAS and WHP not being integrated into the workplace, it restricts the effectiveness and cost-efficiency of both initiatives.

### 3.2 Workplace Health Promotion (WHP)

“Workplace health promotion is a coordinated set of programs, policies, benefits, and environmental supports designed to keep all employees healthy and safe. This comprehensive approach addresses multiple risk factors and health conditions at the same time and influences both employees and the overall organization or worksite” (CDC, 2016).

Cancelliere *et al.* (2011) cites that, “Health promotion in the workplace is defined as preventing, minimizing and eliminating health hazards, and maintaining and promoting work ability. Worker health and wellness is maintaining a balance of the physical, mental, and social ingredients, as well as health habits associated with good physical condition, energy, and vitality”.

The common practice is that WHP concentrated on personal health behaviour modification, namely, activity, inappropriate diet, smoking, and stress prevention, which are proven contributors to chronic disorders such as obesity, hypertension, CVD, and diabetes. However, WHP is a more wide-ranging public health intervention than the prevention of specific diseases at a personal level. Advancements, in its implementation, have addressed environmental influences on health behaviours in the community and work surroundings (Punnett *et al.*, 2009). The WHO’s Ottawa Charter for Health Promotion (1986), as cited by Punnett *et al.* (2009) emphasised the effect of working and living conditions on socio-economic health disparities:

*Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health.*

In a study conducted by Leslie *et al.* (2013), the results indicated that amongst the blue-collar workers (BCW), 38% of the participants reported high blood pressure and 27% high cholesterol. Furthermore, BCW suggested that employers can measure whether workplaces are healthier by tracking clinical tests and blood pressure results (77%), additional health education sessions and topics offered by the worksite (42%), and healthier food options offered at the canteen (36%).

WHP programmes' objective is to improve personal behaviour, improve health, work competence, and work productivity (Rongen *et al.*, 2013). A study conducted in Bangladesh postulates that health awareness programmes bring value to a manufacturing organisation and directly increases productivity by reducing absenteeism and staff turnover. A nominal investment in training and health-related preventative costs (that is, feminine hygiene products) translates into a significant return on investment (ROI). In addition, happy and healthy employees will convey lessons learned through health awareness in their respective communities, which has a social impact (Tareque and Efron, 2018). Hymel *et al.* (2011) cite a study conducted in 2001, where the annual health expenditure for persons with five or more health risks was twice that of persons who are considered healthier (two or fewer health risks).

In organisations where there has been an investment in employee wellbeing, the results show that absenteeism decreased by 40%, staff turnover by 25%, and occupational accidents and injuries by 50%. Also, employees in good health are up to 20% more productive than those in poor health (Silcox, 2016).

Despite an overlap, industrialised countries have a more comprehensive approach to employee safety, health, and wellness, as opposed to developing countries. This approach could be due to the shortfall of employee wellness legislation. Psycho-social stressors take precedence in industrialised countries while developing countries concentrate on hazardous occupations and labour intensive work. Thus for employee safety, health, and wellness to be adequately implemented, it may need to be legislated. Alternatively, infrastructure might be provided to support a management standards approach (Sieberhagen, Rothmann, and Pienaar, 2009).

WHP differs from OH&S in that WHP is not a legislated requirement; it is voluntary for both employees and employers. It is an initiative based on risks, requirements, and preferences, and is guided by OH&S principles. However, the scope can be expanded (Pauncu, 2012).

WHP broadly involves (ENWHP, 2012):

- Having an organisational commitment to improving the health of the workforce.
- Providing employees with appropriate information and establishing comprehensive communication strategies
- Involving employees in decision-making processes
- Developing a working culture that is based on partnership

- Organising work tasks and processes so that they contribute to, rather than damage, health
- Implementing policies and practices that enhance employee health by making healthy choices the easy choices
- Recognising that organisations can have both a positive and a negative impact on workers' health and wellbeing.

Summarily, the expected outcomes of an ideal WHP program were described by Goetzel *et al.* (2014) as the following:

- Make workers aware of their health and how being in good health improves the quality of life
- Workers should take 'ownership' of their behaviours and be accountable for health and cost outcomes
- High participation and active involvement in these programs. People should take advantage of the many programs offered
- Employees should lose weight, stop smoking, exercise more often, eat a healthy diet, better manage their stress levels, and generally adopt healthy habits
- Medical claims costs should go down. The company should experience a lower incidence of certain diseases linked to behaviours like diabetes, heart disease, cancer, chronic obstructive pulmonary disease (COPD), musculoskeletal disorders, and stroke
- Workers will be absent less often, disability costs will be controlled, accidents avoided, and injury rates should drop sharply
- These programs will attract the best talent—and turnover rates will be reduced because we are the employer of choice in the community
- Workers will perform at higher levels—they will be happier, have more energy, and produce better results for our company
- Establish a culture of health and well-being, where every worker feels valued and vital to the enterprise—this will inspire greater loyalty and a high level of engagement
- The program will produce a positive return-on-investment (ROI) for the company—for every dollar spent, two or three will be saved (Goetzel *et al.*, 2014).

It is imperative to note that within the Clothing and Textiles industry, the most prevalent conditions are musculoskeletal injuries such as lower back pain and repetitive strain

injuries. These can result in lengthy absenteeism and increased utilisation of health services (Edries, Jelsma, and Maart, 2013). These conditions are linked to the following occupational and behavioural factors:

Table 3.1 Risk factors linked to musculoskeletal injuries and repetitive strain injuries

| <b>Occupational risk factors</b>  | <b>Behavioural risk factors</b> |
|-----------------------------------|---------------------------------|
| Exposure to repetitive work tasks | Obesity                         |
| Prolonged sedentary postures      | Physical inactivity             |
| Heavy lifting                     | Poor diet                       |
| Intensive-physical labour         | Substance abuse                 |
| Long working hours                |                                 |

(Edries, Jelsma and Maart, 2013)

According to (Fox et al., 2018), roles and responsibilities of both employers and workers are anticipated to change with potential for a greater burden of responsibility on workers to address risk factors both inside and outside the workplace that affect health at work. Apart from the above mentioned risk factors, (Dollard et al., 2007) discussed the importance of monitoring and managing psychosocial risk factors in the workplace. The authors indicate that job conditions are changing in terms of key psychosocial risk factors such as job security, work intensity, violence and bullying, albeit in different patterns across diverse countries and labour markets (Dollard et al., 2007).

Furthermore, (McLellan, 2017) explores the relationship between health and work, outlines opportunities for employers to make this relationship health promoting, and identifies areas needing further exploration. The author concluded that work, health, and employee well-being are inextricably linked (McLellan, 2017).

The CDC Workplace Health Model is a process that follows a four-step methodology to create a WHP programme. The steps, as illustrated in Appendix C, are:

- 1) To assess employee health and safety challenges and to stipulate current WHP actions, capabilities, requirements, and obstacles.
- 2) To plan and define the WHP work-packages, to include milestones, priorities, and infrastructure.
- 3) To implement the initiative in a manner that incorporates all WHP strategies and interventions and creating access to WHP for all employees.
- 4) To evaluate the WHP initiative to measure its quality, efficacy, and its perceived importance.

(Dombrowski, Snelling and Kalicki, 2014; CDC, 2016)

WHP is beneficial to employees and employers, which offers security to both parties, as stipulated in Table 3.1.

Table 3.2 Benefits of success WHP interventions

| <b>For Employees</b>  | <b>For Employers</b>                    |
|---|---|
| Reduced risk for premature death  | Reduced productivity loss               |
| Reduced risk for cardiovascular disease, diabetes, cancers, back pain, and high cholesterol | Reduced risk for short- term disability |
| Higher job satisfaction   | Enhanced mood                           |
| Increased worker income   | Enhanced work performance               |
| Lower debt  | Reduced health-care spending            |
| Lower long-term unemployment  | Lower employee turnover rates           |

(Pronk, 2015; Arnett, 2016)

Despite limited literature available on the effects of WHP implemented in Africa, a study conducted in an electricity supply company reported results of a positive effect of WHP. In developing countries, benefits have been reported in WHP programmes, such as web-based counselling, printed materials, group activities, and supervised exercise classes. Furthermore, the success of WHP is subject to employer commitment and motivation of employees to participate (Edries, Jelsma, and Maart, 2013).

### **3.3 Relation between employee wellbeing and the workplace**

As healthcare expenditure is increasing, policymakers, insurers, and employers are seeking ways to improve health, yet limit their financial burden (Baicker, Cutler and Song, 2010). Employers are being pressured by policymakers and economists to prioritise employee wellbeing as it is regarded as a business metric that impacts the bottom line (Silcox, 2016). Silcox (2016) further asserts that many employers and trade unions now look beyond workplace conditions, to the impact of work on employee wellbeing. In this regard, they are tackling organisational factors affecting employee wellbeing like long working hours. Other measures include: building individual and organisational resilience during periods of organisational change, fostering a mentally healthy workplace, implementing strategies to reduce work-related stress, violence, and bullying and harassment. Employee wellbeing surpasses compliance with legislation and areas of good practice, as it includes non-occupational factors such as a healthy lifestyle, family welfare, and commuting conditions.

Traditional economics associated productivity with the production rate, technology, and training, yet omitting the circumstances of the employee. Recent studies of the apparel industry in developing countries suggests:



- Absenteeism is influenced by chronic illness;
- Low labour productivity in the apparel industry is a result of widespread and chronic absenteeism; and
- Absenteeism can be reduced, and productivity increased through WHP.

(Tareque and Effron, 2018)

The workplace is well-positioned as an environment where health behaviour change can be effected, as initial and follow-up contact with employees is more likely at the workplace. Communication can be structured accordingly (Robroek *et al.*, 2009; Person *et al.*, 2010). Utilising the organisation's culture and dynamics, along with addressing barriers to participation, is likely to ensure improved health and wellbeing. WHP is generally centred on utilising individual behaviour change interventions and group activities to improve health. This has progressed into policy amendments at the organisational level to limit and/or decrease physical or psychosocial environment risks (Pronk, 2013).

Silcox (2016) elaborates on the impact of poor employee wellbeing on absenteeism and costs and reduced job performance as follows:

- Employees with five or more health risk factors, namely, obesity, tobacco use, and high blood pressure, are twice as likely to be absent due to illness than employees with two risk factors;
- Employees (in the UK) takes over 13 million sick days per year as a result of work-related stress, depression, and anxiety;
- Stressed employees are more likely to report psychosomatic complaints, i.e. exhaustion and fatigue, than employees who are not stressed;
- Stress costs the British economy almost £4 billion per year, which is eight times the cost of accidents and injuries;
- Employees who smoke cost their employer 64 minutes per day in lost productivity;
- In many workplaces, employees report for duty when they are unwell because there is a culture of “presenteeism”, where employees believe that they have to attend work to prove their commitment to the organisation. Employees’ performance and productivity suffer if they attend work when they are unwell.
- Another, less direct, cost of poor employee wellbeing is increased staff turnover. Employees often leave the employ of an organisation for reasons directly linked to ill health. Examples are where they are dismissed on the grounds of

incapacity, or seek alternate employment at an organisation that will make it easier for them to manage a health problem. The costs associated with high staff turnover are advertising, the cost of obtaining temporary cover and induction, and training costs.

South Africa's labour legislation is sensitive to the health and emotional challenges associated with obesity. One strategy, the ethic of care approach, comprises employers identifying employees' needs and providing assistance to meet such needs (Prieto, Mathur-Helm and Dawson, 2018).

When applying Maslow's theory of motivation, it is evident why apparel industry workers would decide to be absent when not feeling well. Health and money are both classified as basic physiological needs; however, health is more basic. An employee with ill-health is not motivated to make money; he is motivated to have his health restored. Once fully recovered, he will be motivated to earn a living and eat healthier (Tareque and Efron, 2018).

### **3.4 Effect of working conditions on employee health behaviour**

Where employees have minimal decision-making authority, minimal recognition compared to output, and other psychosocial stressors have been associated with sedentariness outside of working hours, obesity, smoking, and alcohol use. These risk factors exacerbate health challenges such as tobacco smoking with labour intensive work increase the risk of spinal conditions, as well as higher BMI and labour intensive work on the risk of chronic shoulder disorders. This indicates that WHP programs should focus on both the state of the organisation and individual conduct (Punnett *et al.*, 2009).

Employees deem their mental and emotional well-being as more important at work than physical health with the following factors impacting WHP in this regard: leadership support; workplace flexibility (family-friendly policies); communication (welcoming managers); personal relationships (respect, trust, caring, being approachable); incentives/recognition; and workspaces (ergonomics and comfort) (Dickson-Swift *et al.*, 2014).

WHP programs have shown favourable lifestyle modification, increased work output, and a decline in absenteeism due to illness. Despite low participation, the majority of employees are in favour of WHP. It is thus essential to identify how to influence participation (Rongen *et al.*, 2014).

Workplace health promotion is also known to improve the “perceived health status” of employees, enhancing productivity and improving health program participation (Pohjonen and Ranta, 2001; Kaleta *et al.*, 2009; Hwang, Hong and Kim, 2012; Rongen *et al.*, 2014).

### **3.5 Impact of socioeconomics on WHP**

The South African government post-1994 has adopted neoliberal policies, which has worsened the gap between the rich and the poor and resulted in major deficits in social and health services (Ataguba and Alaba, 2012). Furthermore, it has fast-tracked growth in the private health sector, which services less than 20% of the population, and a decline in government expenditure on health services (Ataguba and Alaba, 2012).

In South Africa, those considered poor socio-economically, experience a burden of disease to a larger extent. This includes malnutrition, communicable diseases (such as TB), injuries and mental health conditions. However, hypertension is quite prevalent in women across socio-economic groups (Ataguba and McIntyre, 2013).

Klasen as cited by Ataguba and Alaba (2012) postulated that the poor “suffer from lack of access to education, quality health care, basic infrastructure, transport, are heavily indebted, have little access to productive resources, and are heavily dependent on remittances and social transfers, particularly social pensions and disability grants” and that these problems are to a greater extent remnants of the country’s history.

In a study conducted at Anglo-Australia, BCW described that the socioeconomic vulnerability they experienced created a sense of disempowerment and resignation to the likelihood of reduced life expectancy (Lingard and Turner, 2015).

An unfavourable work environment has a varied impact dependent on an employee’s gender, socio-economic status, and ethnic background. For that reason, these factors should be incorporated when developing and implementing interventions to mitigate health risks for persons in a low socio-economic position. They are prone to poor eating habits, lack of activity, cigarette smoking, and other environmental hazards, as well as limited access to healthcare and health risk screening (Punnett *et al.*, 2009; Jørgensen *et al.*, 2016). Also, such WHP strategies should be sustained through workplace modifications promoting positive health behaviour. In a small group survey conducted amongst BCW (n=39) approximately 50% of BCW participants responded that bringing

food from home was a form of healthy eating, as well as having material related to nutrition in the canteen area (28%) (Leslie *et al.*, 2013).

The ability to self-manage and have a sense of control over one's life is related to improved health outcomes, coupled with social support in the workplace. The probability of achieving mental and physical health is optimised. On the contrary, a lack of confidence in employment prospects exposes employees to the risk of ill health and leads to racial and socio-economic health inequalities. Where trade unions are organising in workplaces, its members are empowered to manage their scheduling and job security (Hagedorn *et al.* 2016).

Despite incentives to employers to fund preventative health benefits (i.e. smoking cessation), socioeconomic characteristics which guides a person's choice to quit smoking include age; gender; ethnicity; nicotine dependence; psychological factors (i.e. anxiety and stress); comorbid chronic conditions; excessive drinking; readiness to quit; and previous attempts to quit and previous use of nicotine reduction therapy (NRT) (Ozminkowski *et al.* 2011). Furthermore, BCWs has a higher likelihood of smoking and smoking heavily, with less success in quitting smoking, compared to WCWs (Barbeau *et al.*, 2006).

Socioeconomic factors influence the workplace and social setting and have an impact on WHP (Montano, Hoven, and Siegrist, 2014; Auvinen, 2017).

### **3.6 WHP Stakeholders**

In a Finnish study, a taxonomy is created for WHP stakeholders who are: internal stakeholders, interface stakeholders and external stakeholders (Auvinen, Kohtamäki and Ilvesmäki, 2012). Auvinen *et al.* (2012) describe that in healthcare organisations the patient is the key stakeholder and in the workplace it is the employee, as well as peer groups. Furthermore, Human Resources is a key internal stakeholder, as HRM is required to facilitate the WHP and OH&S roll-out. Interface stakeholders are the OH&S service providers and external stakeholders being: government, funding enterprises, retirement funds, employers' unions, trade unions, local authorities, WHP technology providers, and WHP service providers (Auvinen *et al.*, 2012). However, in a South African study, it was reported that WHP initiatives were influenced mainly by leadership and Occupational Health Nurse Practitioners. Trade unions and other employees did not actively participate in developing workplace health policies and procedures (Mchunu and Uys, 2008).

The taxonomy for the different stakeholders is presented in Figure 3.1.

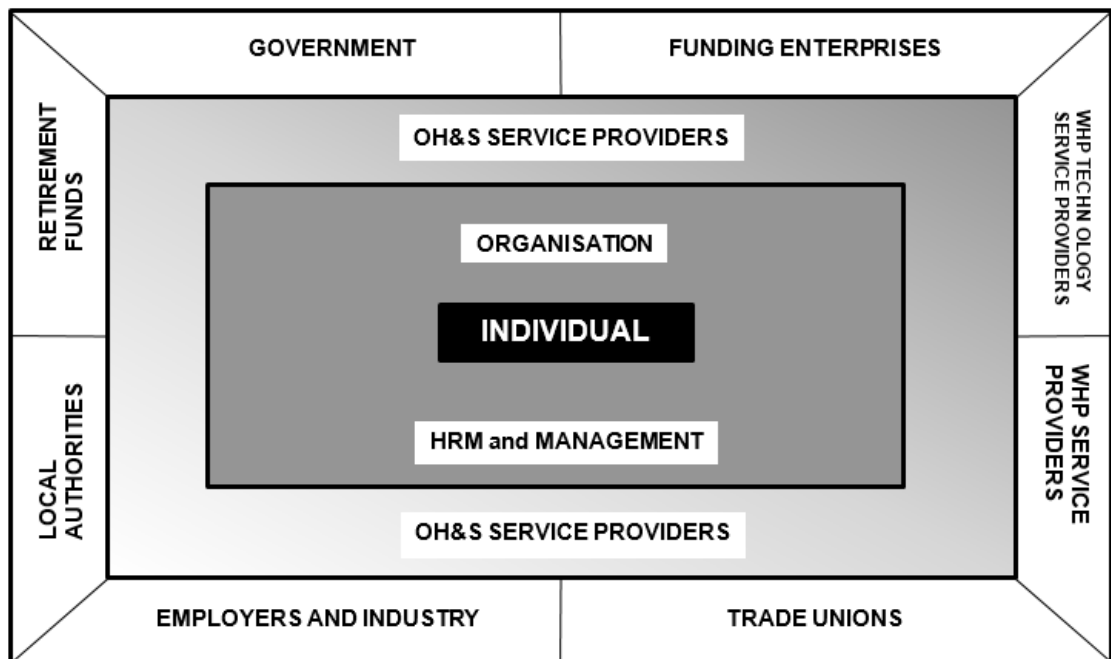


Figure 3.1 Taxonomy of WHP Stakeholders  
Source: (Auvinen, Kohtařnaki and Ilvesřnaki, 2012)

### Internal Stakeholders—Individuals

WHP initiatives are directed at the employees (individuals) with efforts concentrating on illness prevention and lifestyle behaviour change to minimize health risks (Auvinen, Kohtařnaki and Ilvesřnaki, 2012).

### Internal Stakeholders—HRM and Management of Organisations

HRM in many larger organisations has changed with the workforce in many instances being outsourced, with work teams not being in the same venue. Also, many organisations opt for part-time and/or temporary work contracts, and consequently, these employees are not reached by OH&S preventative initiatives (Auvinen, Kohtařnaki and Ilvesřnaki, 2012). It is reported that even in countries with well-structured public healthcare, many organisations are cognisant of the benefits and incentives to continue offering OH&S services.

### Interface Stakeholders—OH&S Providers

The OH&S providers interface between the employees and management, in order to synergise the requirements from both sides, while building a business case based on

the organisation's health status and reporting it in monetary terms – which management finds more understandable (Auvinen, Kohtamäki and Ilvesmäki, 2012).

### **External Stakeholders—Government**

In South Africa, OH&S and workplace conditions are legislated as per the Occupational Health and Safety Act, 1993 and the Basic Conditions of Employment Act, 1997

### **External Stakeholders—Bargaining Councils**

Bargaining Councils agree that for WHP initiatives, effectiveness co-operation is imperative amongst individual workplaces (employers) and trade unions (Auvinen, Kohtamäki and Ilvesmäki, 2012). Such activities are currently in progress. Employers are concerned about the increase of mental health illness and its effect on productivity, and whilst employers understand the benefits of WHP they emphasise that employees should focus on work during working hours (Auvinen, Kohtamäki and Ilvesmäki, 2012).

Trade Unions' concerns about WHP and OH&S focuses on wage negotiations and conditions of employment, with health matters being a secondary matter, as trade unions are concerned that WHP will distract attention from workplace hazards (Auvinen, Kohtamäki and Ilvesmäki, 2012).

### **External Stakeholders—WHP Technology and Service Providers Developers**

WHP technologies include wearable tech, such as wearable fitness trackers (heart rate and blood pressure bracelets and/or wellness watches). However, it is not specifically designed for WHP (Auvinen, Kohtamäki and Ilvesmäki, 2012). Technology services are not integrated to WHP initiatives which creates challenges (Auvinen *et al.*, 2012), yet evidence exist to confirm that wearable tech drives health behaviours of consumers. However, the impact in WHP is unknown (Giddens, Gonzalez and Leidner, 2016).

One way of utilising the data on wearable tech to change health behaviour, would be through self-monitoring. The data can be used to motivate the individual. On the other hand, it may be destructive. The individual could perceive data as a reminder of an unhealthy lifestyle and a reminder of their repeated failed attempts at achieving their health goals (Abraham, 2016).

### External Stakeholders—Pension Funds

Pension funds have a vested interest in the well-being of employees, as large amounts are to be expended at the time of disability and early retirement (Auvinen *et al.*, 2012).

In Finland, legislation governs preventative rehabilitation initiatives, and pension funds have discretionary authority over vocational rehabilitation decisions. Furthermore, co-operation between the OH&S teams and pension funds pro-actively identifies health problems and determines the appropriate course of rehabilitation (Auvinen, Kohtamäki and Ilvesmäki, 2012).

### External Stakeholders—Local Authorities

Local authorities are responsible for primary healthcare services within municipalities, which can also be offered in partnership with Non-Governmental Organisations or the private sector. However, where workplaces offer comprehensive OH&S services, it alleviates the burden of the local authority (Auvinen, Kohtamäki, and Ilvesmäki, 2012).

#### 3.6.1 Employee involvement in WHP

An “employer of choice” is where employees participate in resolving standard operating procedures, education/training, remuneration, and facilitate interpersonal relations. Where WHP incorporates workplace reforms, employees are more likely to agree to it. This would be achieved by merging Occupational Health & Safety (OHS) and WHP, i.e., occupational ergonomics creates a basis to mitigate the risk of musculoskeletal, cardiovascular, and mental health. Employee participation in OHS and WHP may sustain behavioural change (Punnett *et al.*, 2009).

Employee participation is central during the initiation and execution phases of a WHP intervention, as it ensures employee commitment to and ownership of the change process (Tafvelin *et al.*, 2019).

In an Australian study, employees responded as follows to questions relating to benefits barriers to engage with WHP programmes:

Table 3.3 Employee responses to benefits and barriers to engage with WHP

| <b>Employees like programmes that:</b> | <b>Employees dislike programmes that:</b> |
|--|---|
| are free                               | lack choice                               |
| are confidential                       | lack staff engagement                     |

|   |  |
|---|--|
| are easy to participate in              | lack management support                  |
| Are enjoyable                           | are poorly timed                         |
| make them feel valued                   | focus on just information provision      |
| offer opportunities for socialising     | are not targeted to specific issues      |
| increase health and wellbeing knowledge | are not targeted to specific audiences   |
| increase motivation                     | are repetitive                           |
| develop personal skills                 | are based on a “one size fits all” model |
| are available in work time              |  |

(Dickson-Swift *et al.*, 2014)

Non-participation in WHP has not broadly been reported on, however it is valuable to obtain demographic information, especially educational level and income, as unhealthy lifestyles are prevalent among lower socio-economic groups (Robroek *et al.*, 2009). Harbin (2017) asserts that between 20 and 60 percent of employees who are at greater risk for adverse health outcomes, due to smoking, high blood pressure and cholesterol, or sedentary lifestyles are highly unlikely to participate in WHP. Employees have cited that limited free time, afterhours undertakings and being averse to participating in activities with co-workers are major barriers to involvement in WHP (Nöhammer, Stummer and Schusterschitz, 2014). Leslie *et al.* (2013) postulates that BCW utilise their break times for social interactions and rest from physical work. A study amongst Danish workers highlights that where WHP activities are limited to break time, participation in these activities is low (Jørgensen *et al.*, 2016). Social and cultural factors which impact on non-participation of BCW, are that they believe they will be ridiculed for engaging in WHP and that in certain sub-cultures unhealthy lifestyle behaviours are unintentional consequences due to workers participating in WHP being regarded as “weak” (Lingard and Turner, 2015). In order to roll out WHP effectively, it is crucial to create peer-groups to lobby support from employees (Setswe, 2009; Auvinen, 2017).

The European Agency for Safety and Health at Work (2012) identifies the following barriers which impact employee involvement in WHP:

- A lack of occupational safety and health infrastructure.
- A negative perception of occupational health requirements and benefits.
- A lack of relevant skills and qualifications.
- Inadequate cooperation between key stakeholders in the process.
- Bureaucratic requirements.
- The perceived need for major financial investment in a programme.
- The misperception by employers and organisations that WHP has limited or no benefits for the company is too time-consuming and is not their responsibility.



### 3.6.2 Employer involvement in WHP

Milner et al. (2015) postulate that it is questionable whether employees will participate or support WHP where they sense that employers are only seemingly invested in the programme and are not sincere in their efforts to improve employee health.

Milner et al. (2015) further elucidate that theoretically, organisational concern about employee wellbeing can be classed within the framework of social exchange theory (SET), one of the major conceptual paradigms supporting the understanding of employee attitudes and behaviours. There is a general consensus that social exchange may be defined as a 'series of interactions that generate obligations'. SET has been successfully applied in many settings and is based on three main principles:

1) **First principle:** The rules and norms of exchange

These refer to the parties' implied and obvious assumptions and expectations regarding the exchange. The onus is on the employee to respond in kind to the treatment he/she receives. The treatment employees receive determines the employees' perception regarding the extent to which the organisation appreciates their input and 'cares about their wellbeing'. These perceptions in turn, influence employees' organisational attitudes and behaviours.

2) **Second principle:** The resources of exchange—love, status, information, money, goods and services

For organisations, these are reduced to two resources: economic and socio-emotional. Facilitation of WHP and a leadership environment promoting employee wellness encompasses both types of resources by instituting economic resources (providing a service to employees) and socio-emotional resources (creating an atmosphere that employees are appreciated and cared for by the organisation).

3) **Third principle:** Employer-employee exchange relationship

These social exchange interactions develop when employers nurture employees, thus ensuring positive results for both groups. Positive results refer to effective work behaviour and positive employee attitudes. It is argued that the concept of positive results is extended to include facets of employee wellbeing. As employers are progressively more concerned about increasing mental health costs as well as decreased productivity as

a consequence of poor employee wellbeing, it is for that reason likely that this exchange would be of value for employers.

WHP requires a favourable workplace setting and a supportive leadership culture, through education, behaviour change interventions, customised facilities, services, and strategies. In addition, employers should demonstrate a commitment to health and wellness that is fully integrated with the organisation's strategy (Faghri *et al.*, 2010).

It is proposed by Milner *et al.* (2015) that perceptions of organisational commitment to the promotion of employee health facilitate the relationship between providing WHP programmes and policies, and leadership support for WHP and employee wellbeing. The justification for such support is based on practical considerations of resource allocation and the requirement for top-management support for altering unhealthy work design and practices. Figure 3.2 illustrates the theoretical framework, based on SET, to postulate relationships between leadership support, provision of WHP programs and policies, perceptions of organisational commitment to health promotion and employee wellbeing.

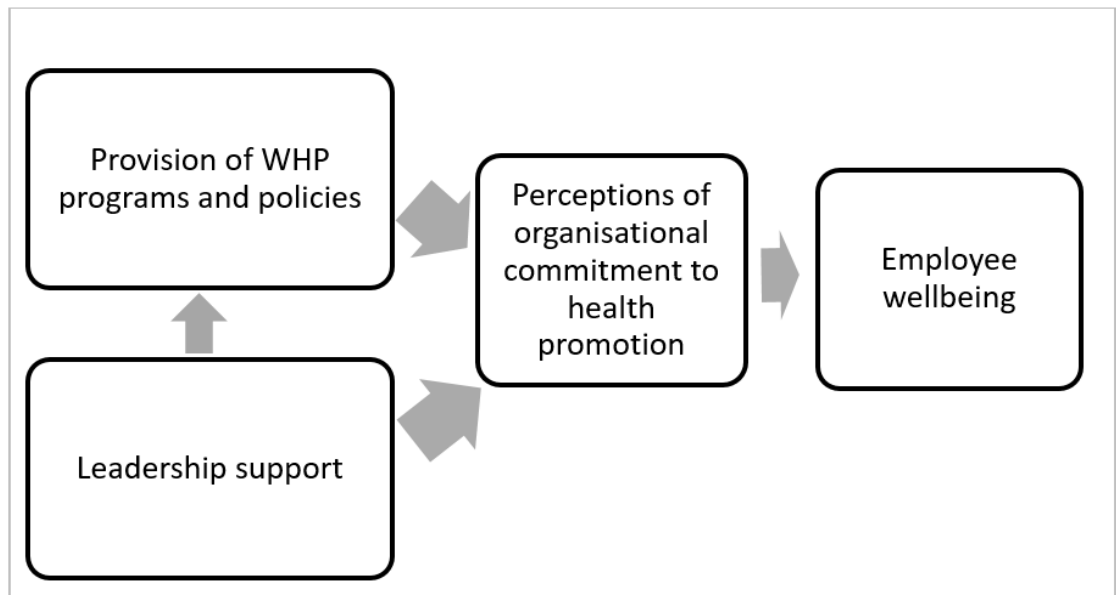


Figure 3.2 Theoretical model linking leadership support, provision of WHP facilities and employee wellbeing

Source: (Milner *et al.*, 2015)

The driving factors for employers to implement WHP are noted in Table 3.4.

Table 3.4 Motivation for employers to carry out WHP

| Internal motivating factors   | External Motivating Factors   |
|---|---|
| <ul style="list-style-type: none"> <li>• WHP impacts on increasing productivity rates and production.</li> <li>• WHP decrease absenteeism and associated illness disability costs.</li> <li>• WHP demonstrates a positive impact on presenteeism.</li> <li>• WHP may result in improved job satisfaction and organisational commitment among employees.</li> <li>• WHP builds staff morale which results in reduction of staff turnover and an improvement in the recruitment of new employees.</li> <li>• WHP may reduce the costs incurred by organisations due to occupational accidents and injuries.</li> <li>• WHP strategies implemented in the workplace can lead to significant cost savings for organisations.</li> </ul> | <ul style="list-style-type: none"> <li>• WHP may have an indirect benefit of improving customer service and result in customer loyalty.</li> <li>• WHP is considered as an attractive employment benefit which entice potential future employees.</li> <li>• Local and governmental support for WHP is important for small and medium-sized organisations, due to limited resources and in-house expertise to design and implement such programmes.</li> <li>• Support programmes by medical aid schemes and/ or other external incentives are useful in encouraging employers to implement and, moreover, to invest in the promotion of workplace health.</li> </ul> |

(European Agency for Safety and Health at Work, 2012)

As indicated previously, even though some employers invest generously in WHP, their priority remains productivity and their financial bottom-line. However, workplace modifications to improve health do not need to be costly. At the same time, the organisation's productivity and bottom-line benefits through less absenteeism and increased staff morale and work ethic (Dickson-Swift *et al.*, 2014).

Employee health and wellness will show positive progress when employers apply or improve: leadership; incorporate health and wellness into daily activities (i.e. communication); include WHP in the organisation's values; develop a strategic plan for WHP, which is reviewed annually and allocate an appropriate budget; all employees to have the opportunity to participate – even those in outlying areas; leverage off existing

public events –health calendar events (encourages participation and strengthens links with the community) (Dickson-Swift *et al.*, 2014).

### **3.7 Effect of WHP on the facilitation of preventive interventions**

The efficacy of WHP is subject to the aspects which define an employee group and the level of participation in the programme (Robroek *et al.* 2009). The cause of lack of participation in WHP differs in employees; for some, it is time and cost and for others, it is the opinion of not being prone to sickness (Olson and Chaney, 2009). In addition to the variables mentioned, participation in WHP is furthermore hindered by a lack of enthusiasm, adverse work programme, and an inconvenient location. However, some employees are driven by their need for lifestyle modification (Rongen *et al.*, 2014). The probability of women and married employees participating in WHP programs are higher than that of men and unmarried colleagues, respectively (Person *et al.* 2010). Furthermore, participation is also more likely in white-collar, full-time employees, senior in age, and small workplace employees, as opposed to shift workers, lower-income, and with lower levels of education (Robroek *et al.*, 2009; Person *et al.*, 2010).

*Healthy People* define comprehensive WHP initiatives as encompassing the following:

- Health awareness and information according to the employees' requirements, with an emphasis on skills development and behaviour change.
- Support structures to promote a healthy lifestyle and decrease the risk of disease, as anticipated by the organisation.
- Incorporating WHP into the organisational structure.
- Linkage to care, i.e., employee assistance programmes (EAP) and other initiatives.
- Workplace testing with linking to health facilities to ensure continuity of care and an appropriate level of care.

According to a study conducted by Robroek *et al.* (2012), seven areas were highlighted as the reasons for non-participation in WHP. The study population consisted of 718 employees (n = 817), of which 205 (28.5%) did not participate in WHP. The non-participants, however, shared their reasons for non-participation. Ranked highest at 41% was, "I am healthy", followed by scheduling challenges, or being unaware of the programme, and lowest ranking at 2% is the view that the employer should not offer WHP, as shown in Figure 3.3.

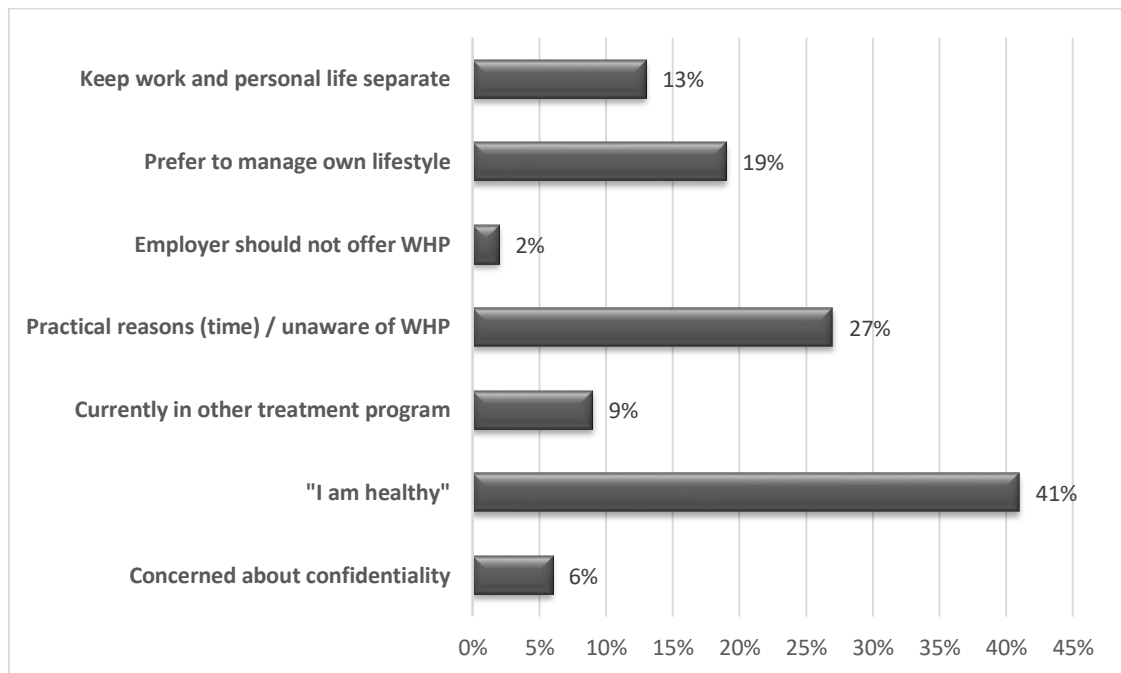


Figure 3.3: Reasons for employee non-participation in WHP

Source: (Robroek *et al.*, 2012)

Commonly applied interventions in WHP programs include health risk assessments (HRA) and health risk reduction programmes (Ott *et al.*, 2010; Rocha *et al.*, 2010). Participation levels vary and are generally low (Robroek *et al.*, 2009).

“The Centers for Disease Control and Prevention (CDC) assert that comprehensive WHP are supported through a philosophy of well-being that supports individuals’ endeavours at altering permanent health practices by implementing policies, plans, assistance, administration, and environmental practices that purposefully encourage and sustain health improvement” (Goetzel *et al.*, 2014).

In the short term, outcomes for WHP programs are favourable in many studies; however, the long-term outcomes should be further investigated. Where employee involvement is encouraged in WHP programs, these programs are found to stimulate healthy behaviours and simultaneously improve psycho-social facets relating to the workplace. The advantages of employee participation in decision-making are improved communication, support, and feedback (Punnett *et al.*, 2009).

Where participation in WHP programs is low and / or varied, the results of such studies are found to be insignificant. The workplace is well suited for WHP, due to access to large groups, and leveraging existing relationships and group dynamics. However, Glasgow *et al.* (1993), as cited by Robroek *et al.* (2009) found that men, blue-collar workers, and smokers seemed less likely to participate in WHP. Robroek *et al.* (2009)

further elucidate that participation in WHP programs can be encouraged by offering incentives and broadening the service offering, as more interventions would appeal to a larger group of employees. Persons from lower socioeconomic environments are not likely to participate in smoking cessation without financial incentives and targeted communications (Ozminkowski *et al.*, 2011). Grossmeier (2018) believes that for smoking cessation, the impact of monetary incentives varies; however, it is likely to increase participation amongst those who have already decided to quit smoking.

### **3.8 Effect of WHP on general cognitive and affective outcomes**

WHP programmes have an indirect impact (value on investment) for employers through improved staff morale, increased work output, reduced employee turnover, and containment of healthcare expenditure (Punnett *et al.*, 2009; Person *et al.*, 2010; Grossmeier, 2016). An analysis of more than 70 articles on WHP indicates that the typical benefit-to-cost ratio for employers, due to WHP, is \$3.50-\$1.00 (reduced absenteeism and healthcare expenditure compared to WHP costs). Also, through WHP, sick leave and absenteeism are reduced by 28%, healthcare expenditure is reduced by 26%, and worker's compensation claims are reduced by 30% (Person *et al.*, 2010; WHO, 2017). Participants in WHP activities have less sick leave and improved psychological wellbeing (Aust and Ducki, 2004; European Agency for Safety and Health at Work, 2012; Healy *et al.*, 2012). Grossmeier (2016) concurs that WHP outcomes positively impacts absenteeism rates, incapacity rates, employee performance and productivity, staff turnover, employee satisfaction, and workplace safety.

Cancelliere *et al.* (2011) asserts that employers should shift its focus from reactive interventions such as healthcare cost-containment and absenteeism management to proactive strategies such as improving on-the-job productivity and investing in preventive and early intervention services.

### **3.9 Effect of WHP on employee's mental level**

Stress is a serious occupational risk in South Africa (Sieberhagen, Rothmann, and Pienaar, 2009). Medical scheme claims are commonly for stress-related diseases, i.e., hypertension, high cholesterol, asthma, depression, menopause, diabetes type 1 & 2, epilepsy, IHD and gastro-oesophageal reflux. Also, 75% of primary healthcare visits are stress-related. Occupational stress poses a negative impact on the health and wellness of employees, as well as negatively impacting employers and the country (South Africa). In organisations the effect of stress translates into increased

absenteeism, increased staff turnover, and lower productivity. This, in turn, affects the bottom-line and adversely impacts the economic growth of the country through lower productivity and increased numbers of employees who are incapacitated or reluctant to work (Sieberhagen, Rothmann, and Pienaar, 2009).

Continuous work-related stress combined with a lack of leadership support translates into a series of health disorders such as depression, anxiety, and cardiovascular disease and influences an employee's ability to make positive lifestyle changes (i.e., smoking or alcohol overuse) (Dickson-Swift *et al.*, 2014).

Comprehensive WHP programs should include strategies with access to mental health services, stigma eradication, and mental health awareness (Jarman *et al.*, 2016).

Employers who create a culture of providing care for the psychosocial requirements of employees show evidence of improved mental and emotional health of employees (Noblet and LaMontagne, 2006; Dickson-Swift *et al.*, 2014). Such a culture is entrenched in the organisation's framework and is not in isolation to the WHP strategy and need to make employees feel appreciated. To achieve this culture, managers and staff should commend their colleagues for doing a great job. Additionally, employees appreciate receiving a birthday card or incentives in appreciation of extra effort, as employees appreciate when management is involved in the employee's well-being. Employees' physical health is impacted by how they perceive themselves to be valued and supported by the organisation. Counselling services at the workplace enables employees to manage personal challenges distressing them at work (Dickson-Swift *et al.*, 2014). Workplace counselling provides employees with assistance to deal with, among others, psychological, emotional, and behaviour challenges, which may impact their productivity (Kirk and Brown, 2003; Mcleod, 2010; Dickson-Swift *et al.*, 2014).

### **3.10 Cost of Occupational accidents and diseases in South Africa**

In South Africa, occupational accidents and diseases cost approximately R30 billion per annum (3.5% of the GDP). Approximately 120 000 employees encounter accidents or illness as a result of their occupation, of which just below 1% results in fatalities. Occupational health and safety is a matter of importance in South Africa, and advocacy and awareness campaigns, as well as inspection blitzes, are being carried out regularly. Sectors, where employees are at risk of injury, are mining, construction, steel, and agriculture (Sieberhagen, Rothmann and Pienaar, 2009).

An impediment for BCW to participate in physical activity as a means of WHP are personal illness or injury (33%) (Leslie *et al.*, 2013). Workers of advanced age are inclined to suffer chronic health conditions with increased health risks, which requires more care, limits mobility, and are more challenging and expensive to treat than the chronic conditions that are more common in younger age groups (Hymel *et al.*, 2011).

### **3.11 Conclusion**

Imperatives to the success of WHP include strategic alignment, management support, employee participation, leadership, specific goals, exhaustive planning, focus on employee needs, resourceful, and smooth integration into the workplace environment (Person *et al.*, 2010). WHP programmes focused on healthy eating, exercise and tobacco use with little or no consideration of workplace dynamics (both the physical environment and the organisational culture) can make to such behaviours are of limited benefit (Dickson-Swift *et al.*, 2014).

A key driving factor for WHP is managing healthcare expenditure. Studies suggest that through behaviour change and appropriate marketing approaches, combined with individual counselling sessions, such expenditure can be controlled (Harbin, 2017).



## CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY

### 4.1 Introduction

This section expands on the research design and methodology employed in this study to conceptualise and design the quantitative and qualitative research to measure employee perceptions on WHP.

### 4.2 Research design

Research design is a procedural plan or strategy of investigation in order to acquire answers to research questions or problems (Mouton, 2001; Kumar, 2011). Also, Kumar (2011) postulates that the plan is implemented in a manner that answers questions validly, objectively, accurately and economically. It also represents the actions for data collection and directs the researcher in the collection, analysis, and interpretation of the observed facts (Leedy and Ormrod, 2010).

According to Leedy and Ormrod (2015) qualitative research studies typically serve one or more of the following purposes:

- **Exploration.** They can help one gain initial insights into what has previously been a little-studied topic or phenomenon.
- **Multifaceted description.** They can reveal the complex, possibly multi-layered nature of certain situations, settings, processes, relationships, systems, or people.
- **Verification.** They allow one to test the validity of certain assumptions, claims, theories, or generalizations within real-world contexts.
- **Theory development.** They can enable one to develop new concepts or theoretical perspectives related to a phenomenon.
- **Problem identification.** They can help one uncover key problems, obstacles, or enigmas that exist within the phenomenon.
- **Evaluation.** They provide a means through which one can judge the effectiveness of particular policies, practices, or innovations.

Quantitative research analyse numeric representations of the world, using surveys and questionnaire data amongst others in the form of counts, levels, or Likert-format responses (Yoshikawa *et al.*, 2008).

Quantitative research designs are specific, well structured, have been tested for their validity and reliability, and can be explicitly defined and recognised, while qualitative research designs either lack these elements or have them to a lesser extent (Kumar, 2011). However, qualitative research designs are, therefore, often based on deductive rather than inductive logic, are flexible and emergent in nature, and are often non-linear and non-sequential in their operationalisation. Therefore, most qualitative designs are not as structured and sequential as quantitative ones.

The researcher considered the most suitable research design to be a cross-sectional study design in the form of a case study in order to discover an in-depth exploration of the aspects to be understood (Kumar, 2011). Ridder (2017) asserts that case study research incorporates different scientific goals and the collection and analysis of data. This technique also illustrates the use of a design in which qualitative methods are used to provide a depth of understanding to complement the breadth of understanding afforded by quantitative methods (Palinkas et al., 2011). Cross-sectional studies allow the researcher to select the scope of the research, the sample, and contacts the respondents to obtain the relevant information.

Creswell, as cited by Ragab and Arisha (2017), asserts that mixed methods research design provides a valuable account of the different ways in which qualitative and quantitative methods can be combined in the research design to accomplish research aims. Integrating these methods makes a study more credible to larger audiences since it encapsulates the environment more holistically (Yoshikawa *et al.*, 2008).

#### **4.3 Research methods**

In this study, the researcher selected explanatory sequential mixed methods, as the researcher firstly collected the data quantitatively and analysed the results. After that, he augmented with data collected qualitatively to provide context within the case study (Creswell, 2014).

A survey questionnaire method was used to collect quantitative data. This approach allowed the researcher to measure the results in order to confirm or corroborate relationships and to contribute to the body of knowledge (Leedy and Ormrod, 2010). The nature of the investigation necessitated a questionnaire (Kumar, 2011). The Health Care Fund Clinics are seen as an employer initiative, and participants may have been reluctant to answer honestly in the absence of anonymity. Questionnaires were also selected due to the unknown literacy level of participants and the geographic locations of the clinics (Kumar, 2011). To further simplify the questionnaire, yet quantify the

participant's perceptions, a Likert scale was used as an evaluation mechanism (Leedy and Ormrod, 2010). The questionnaire concentrated on the potential effects of WHP with responses ranging from 1 (Strongly agree) to 5 (Strongly disagree), with 3 providing the option for "unsure".

An interview method was used to collect qualitative data. Transcribed interview responses are coded for the frequency of mention of themes, the numbers of words or keywords, or the complexity of vocabulary and statistically analysed (Yoshikawa *et al.*, 2008). This method allowed the study to be more holistic (Leedy and Ormrod, 2010).

#### **4.4 Sampling and data collection**

The data collection was initiated by obtaining quantitative data after that qualitative data of a much lesser size was collected. The population size of clothing workers in Cape Town as of June 2018 was 17447 (Jeftha, 2018). In total 121 employees completed the questionnaire, thus ensuring a 100% response rate. Only clothing workers were included and no experts to ensure that the data gathered focused on the employee's perception and or perspective. Participation in the study was voluntary, and the sampling procedure was, therefore, open and non-probabilistic. Participants were informed of the objective and background of the problem, as well as the organisation's agreement for the study to be conducted. The researcher utilised shop stewards to create awareness amongst staff of the study. The concept of WHP was explained to the participants as the health interventions offered by the organisation.

The population consisted of managers, clinical staff, and workplace health promoters which totalled 25.

##### **4.4.1 Quantitative sampling and data collection**

Clothing Workers who attended the Health Care Fund clinics were approached by a research fieldworker, who would do an introduction of him/herself thereafter introducing the research being conducted with an emphasis that permission for the study has been granted. The fieldworker explained the requirement of informed consent and those willing to participate were handed the research questionnaires (see Appendix D), and they completed the questionnaires while in the waiting area. There was no disturbance in the flow of the clinic. Despite the fact that convenience sampling involves selecting participants immediately available (Walliman, 2011), the sampling method was appropriate as clothing workers who accessed services at the Health Care Fund clinics were sampled. The rationale for the data collection method was based on the theory that participants would be more attentive to the task of completing the questionnaire

and would provide more accurate responses when they were contextualised in the environment that they are evaluating.

#### **4.4.2 Qualitative sampling and data collection**

To augment the data collected quantitatively, as well as to provide context to the case study (Creswell, 2014), a qualitative facet of measurement was necessary. The researcher's judgment was used in the selection of the sample, in accordance with case study research (Sharma, 2017). A sample size of 20 was selected, consisting of managers, clinical staff and workplace health promoters.

The researcher formulated a list of 26 questions with open-ended answers in an interview schedule (see Appendix E). Interviews would have been conducted face-to-face or telephonically with the participants; however, due to the work commitments of the participants, this was not possible. The researcher distributed copies of the questionnaires, either as hard copies or via email. The total number of respondents was five (5).

#### **4.5 Data analysis**

Qualitative data were analysed through content analysis, where quantitative data were analysed through Statistical Package for the Social Sciences (SPSS). Content analysis, a method which can be used qualitatively or quantitatively for systematically analysing written, verbal, or visual documentation, goes back to the 1950s and the study of mass communication (White and Marsh, 2006). In this study, interview responses were transcribed, coded and processed through content analysis. SPSS is commonly used by academics for quantitative data analysis. This study applied SPSS to generate descriptive statistical results, reliability testing and so on.

#### **4.6 Trustworthiness**

In qualitative research, validity and reliability are replaced by the construct trustworthiness. Trustworthiness takes into account authenticity, credibility, transferability, dependability and confirmability. The voluntary participation of respondents in this study ensured authenticity. Participants provide unbiased opinions on the topic of investigation.

Credibility was ensured by the specific systematic procedures for data gathering and analysis. In this study the researcher consulted experienced research professionals on all aspects of the research process, the research design and methodology in order to

ensure that all flaws and biases in the research study were identified ahead of the main study. Transferability was ensured through the detailed background information. This allows for the context of the study to be made clear and for the researcher to compare the current study with other similar contexts.

In order to ensure confirmability of this study, the limitations and researcher assumptions of the current study were noted and due consideration was given to their potential effects. Thick description of the methodology allowed the integrity of the research results to be addressed. Dependability is enhanced in this way and others who read the research can audit, critique or repeat the research (Statistics Solutions, 2019).

#### **4.7 Ethical considerations**

Different institutions have formulated codes of ethics to inform ethical standards and professionalism in research. Codes of ethics cover issues related to: physical and mental harm to respondents, covert or hidden research, and invasion of privacy, violations of anonymity and confidentiality, deception, coercion, plagiarism and fabrication or concealment of findings. Standards also place emphasis on the researcher-respondent relationship to ensure respondents are protected. Most ethical guidelines require that all aspects regarding the study be communicated to respondents in a written form. The options to take part in the study or refuse as well as withdrawal at any stage of the study must also be communicated and informed consent forms are commonly used for this purpose.

Prior to undertaking the research, the researcher applied for the required ethical clearance from the Cape Peninsula University of Technology. An informed consent form that includes information on the researcher, all relevant contact details, institution where research is based, the nature and purpose of the research, anonymity, confidentiality, and withdrawal clauses were designed. At the beginning of each interview and questionnaire administration, written consent from respondents were requested upon communication of the consent form contents.

#### **4.8 Conclusion**

This chapter section focused on research design and methodology. Furthermore, it elaborated on the process of sampling and data collection, both quantitatively and qualitatively, as well as the data analysis. Ethical considerations and procedures were also provided. The next chapter presents the findings of the study.

## CHAPTER FIVE: RESULTS

### 5.1 Introduction

The research methodology chapter presented the methodology that was appropriate for the study aimed at the determination of the effectiveness of the WHP programme in the Clothing and Textile industry in the Western Cape. In particular, the methodology chapter presented in detail relevant data analysis process that helped to examine and summarise data gathered through questionnaires and interviews in order to answer the following main research questions:

- What are the main benefits of WHP for Clothing and Textiles employees (CTEs)?
- How does WHP affect CTE's physical, mental, and social wellbeing in Cape Town?
- What are the CTEs' perceptions of general cognitive and affective outcomes?
- Which approach can be used to improve CTEs' participation in WHP effectively?

The research results presented in this chapter form a basis of the next chapter that deals with the conclusions, recommendations and scope for further research.

### 5.2 Quantitative data analysis

#### 5.2.1 Descriptive statistics

According to Leedy and Ormrod (2015), descriptive statistics describe a body of data and the major functions of descriptive statistics are:

- Some statistics describe what the data look like;
- where their centre or midpoint is;
- how broadly they are spread; and
- how closely two or more variables within the data are inter-correlated.

In total, 121 questionnaires were distributed to the targeted group (research sample size). All questionnaires were provided face-to-face with an explanation of the study, accompanied by a letter requesting informed consent and instructions for completing the questionnaire. Out of 121 questionnaires distributed to the targeted group, the researcher received back 121 questionnaires.

To accommodate literacy challenges and translation, the field workers were close by to assist respondents where needed.

Table 5.1 below illustrates the descriptive statistics applied in this research. The data confirmed the total number of sample, range, minimum, maximum and standard deviation with a total number of 121 respondents from the statements.

Table 5. 1 Descriptive Statistics (n = 121)

|  | Min | Max | Mean | Std. Deviation |
|--|-----|-----|------|----------------|
| Age  | 1   | 5   | 3.37 | 1.205          |
| Gender   | 1   | 2   | 1.33 | .472           |
| Edu level  | 1   | 6   | 2.17 | 1.459          |
| Employment   | 1   | 5   | 3.36 | 1.455          |
| HIV status   | 1   | 2   | 1.12 | .331           |
| TB test  | 1   | 2   | 1.31 | .463           |
| 1a (I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering.) | 1   | 5   | 1.83 | .986           |
| 1b (WHP has assisted me to prevent the beginning of health problems)   | 1   | 5   | 1.95 | 1.079          |
| 1c (My physical problems has reduced due to my participation in the WHP programme)                           | 1   | 5   | 2.15 | 1.070          |
| 1d (I have noticed no effect of WHP on my physical health)   | 1   | 5   | 2.72 | 1.273          |
| 1e (I feel healthier due to participating in the WHP programme service offering)                             | 1   | 5   | 2.02 | .987           |
| 1f (I feel more productive because I am participating in the WHP programme service offering)                 | 1   | 5   | 2.09 | 1.103          |
| 2a (I feel more motivated because the company offers WHP programmes)   | 1   | 5   | 1.98 | 1.162          |
| 2b (I enjoy participating in WHP programme offers)   | 1   | 5   | 1.98 | .996           |
| 2c (I experience better coping with stress and pressure due to participating in WHP programme offers)        | 1   | 5   | 2.10 | 1.158          |
| 2d (Without WHP I felt more stressed)  | 1   | 5   | 2.35 | 1.131          |
| 2e (I am feeling more satisfied in my workplace because the organisation offers WHP)                         | 1   | 5   | 2.02 | 1.025          |
| 3a (My contact with colleagues deepens due to participation in WHP programme service offering)               | 1   | 5   | 2.13 | 1.016          |
| 3b (I feel appreciated by the organisation due to WHP service offering)                                      | 1   | 5   | 1.97 | .912           |
| 3c (I enjoy more personal contacts within my workplace due to participating in WHP programme offers)         | 1   | 5   | 2.18 | 1.057          |
| 3d (There are no better intra-team relationships due to WHP)   | 1   | 5   | 2.12 | 1.005          |
| 3e (Participating in WHP programme service offering motivates me to be a role model for colleagues)          | 1   | 5   | 2.08 | 1.053          |

|   | Min | Max | Mean | Std. Deviation |
|---|-----|-----|------|----------------|
| 3f (I experience a better basis of conversation with my supervisor, relating to my health)                    | 1   | 5   | 2.28 | 1.199          |
| 4a (Participating in WHP programme service offering makes the prevention of illnesses financially affordable) | 1   | 5   | 2.03 | 1.008          |
| 4b (I do not have to organise health related visits in my private time due to WHP)                            | 1   | 5   | 2.17 | 1.046          |
| 5a (I now know more about a healthy lifestyle due to the WHP programme offering)                              | 1   | 5   | 1.85 | 1.046          |
| 5b (Medical assistance in the workplace is of special importance to me)                                       | 1   | 5   | 1.79 | 1.016          |
| 5b2 (I have undergone health testing offered through WHP)   | 1   | 5   | 1.92 | 1.092          |
| 5c (My attitude has improved towards my health due to WHP)  | 1   | 5   | 1.86 | .994           |
| 5d (I am paying more attention to my health since participating in WHP service offering)                      | 1   | 5   | 1.86 | 1.051          |
| 5e (I am feeling motivated because the workplace offers WHP)  | 1   | 5   | 1.79 | 1.042          |
| 5f (I feel more relaxed after work due to participating in WHP programme service offering)                    | 1   | 5   | 1.94 | 1.098          |
| Valid N   |     |     |      |                |

### 5.2.1.1 Interpretation of descriptive statistics

#### N (Sample)

“N” indicates the number of cases for every variable and the data demonstrated that all questions had been responded to.

#### Mean & Standard Deviation

The data indicated that, on average, the data is equally distributed at 2.06 where standard deviation lies between one standard deviation underneath and one standard deviation above the mean.

### 5.2.1.2 Correlation Matrix

The data demonstrates that the strongest correlations exists for responses for the category “General cognitive and affective outcomes”. The data analysis indicate very weak to weak correlations for the question “I have noticed no effect of WHP on my physical health”.



The strongest relationship between two variables for the dataset was between “I am feeling motivated because the workplace offers WHP” (M = 1.79, SD = 1.042) and “I feel more relaxed after work due to participating in WHP programme service offering” (M = 1.94, SD = 1.098),  $r = .841$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between two variables “I now know more about a healthy lifestyle due to the WHP programme offering” (M = 1.85, SD = 1.046) and “I am paying more attention to my health since participating in WHP service offering” (M = 1.86, SD = 1.051),  $r = .822$ ,  $p < .01$ ,  $n = 121$ .

Another strong positive correlation was observed between two variables “My attitude has improved towards my health due to WHP” (M = 1.86, SD = .994) and “I am feeling motivated because the workplace offers WHP” (M = 1.79, SD = 1.042),  $r = .807$ ,  $p < .01$ ,  $n = 121$ .

A strong positive correlation exists between “I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering” (M = 1.83, SD = .986) and “WHP has assisted me to prevent the beginning of health problems” (M = 1.95, SD = 1.079),  $r = .705$ ,  $p < .01$ ,  $n = 121$ .

The data demonstrates a strong positive correlation between “I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering” (M = 1.83, SD = .986) and “I feel healthier due to participating in the WHP programme service offering” (M = 2.02, SD = .987),  $r = .706$ ,  $p < .01$ ,  $n = 121$ .

Another strong positive correlation was observed between “I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering” (M = 1.83, SD = .986) and “I enjoy participating in WHP programme offers” (M = 1.98, SD = .996),  $r = .726$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between “I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering” (M = 1.83, SD = .986) and “I feel appreciated by the organisation due to WHP service offering” (M = 1.97, SD = .912),  $r = .763$ ,  $p < .01$ ,  $n = 121$ .

The data demonstrates a strong positive correlation between “WHP has assisted me to prevent the beginning of health problems” (M = 1.95, SD = 1.079) and “I feel more

motivated because the company offers WHP programmes" (M = 2.09, SD = 1.162),  $r = .744$ ,  $p < .01$ ,  $n = 121$ .

A strong positive correlation was observed between "I experience better coping with stress and pressure due to participating in WHP programme offers" (M = 2.10, SD = 1.158) and "I am feeling more satisfied in my workplace because the organisation offers WHP" (M = 2.02, SD = 1.025),  $r = .722$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between "I experience better coping with stress and pressure due to participating in WHP programme offers" (M = 2.10, SD = 1.158) and "I do not have to organise health related visits in my private time due to WHP" (M = 2.17, SD = 1.046),  $r = .715$ ,  $p < .01$ ,  $n = 121$ .

Another strong positive correlation was observed between "I am feeling more satisfied in my workplace because the organisation offers WHP" (M = 2.02, SD = 1.025) and "Participating in WHP programme service offering motivates me to be a role model for colleagues" (M = 2.08, SD = 1.053),  $r = .740$ ,  $p < .01$ ,  $n = 121$ .

The data demonstrates a strong positive correlation between "I am feeling more satisfied in my workplace because the organisation offers WHP" (M = 2.02, SD = 1.025) and "I do not have to organise health related visits in my private time due to WHP" (M = 2.17, SD = 1.046),  $r = .759$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between "My contact with colleagues deepens due to participation in WHP programme service offering" (M = 2.13, SD = 1.016) and "Participating in WHP programme service offering motivates me to be a role model for colleagues" (M = 2.08, SD = 1.053),  $r = .714$ ,  $p < .01$ ,  $n = 121$ .

A strong positive correlation was observed between "I feel appreciated by the organisation due to WHP service offering" (M = 1.97, SD = .912) and "I do not have to organise health related visits in my private time due to WHP" (M = 2.17, SD = 1.046),  $r = .705$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between "Participating in WHP programme service offering motivates me to be a role model for colleagues" (M = 2.08, SD = 1.053) and "I experience a better basis of conversation with my supervisor, relating to my health" (M = 2.28, SD = 1.199),  $r = .747$ ,  $p < .01$ ,  $n = 121$ .

Another strong positive correlation was observed between “Participating in WHP programme service offering motivates me to be a role model for colleagues” (M = 2.08, SD = 1.053) and “I am paying more attention to my health since participating in WHP service offering” (M = 1.86, SD = .994),  $r = .718$ ,  $p < .01$ ,  $n = 121$ .

The data demonstrates a strong positive correlation between “Participating in WHP programme service offering makes the prevention of illnesses financially affordable” (M = 2.03, SD = 1.008) and “I do not have to organise health related visits in my private time due to WHP” (M = 2.17, SD = 1.046),  $r = .722$ ,  $p < .01$ ,  $n = 121$ .

A strong positive correlation was observed between “Medical assistance in the workplace is of special importance to me” (M = 1.79, SD = 1.016) and “I have undergone health testing offered through WHP” (M = 1.92, SD = 1.092),  $r = .766$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between “I have undergone health testing offered through WHP” (M = 1.92, SD = 1.092) and “I am feeling motivated because the workplace offers WHP” (M = 1.79, SD = 1.042),  $r = .767$ ,  $p < .01$ ,  $n = 121$ .

Another strong positive correlation was observed between “I have undergone health testing offered through WHP” (M = 1.92, SD = 1.092) and “I feel more relaxed after work due to participating in WHP programme service offering” (M = 1.94, SD = 1.098),  $r = .767$ ,  $p < .01$ ,  $n = 121$ .

There was a strong positive correlation between “I am paying more attention to my health since participating in WHP service offering” (M = 1.86, SD = 1.051) and “I feel more relaxed after work due to participating in WHP programme service offering” (M = 1.94, SD = 1.098),  $r = .780$ ,  $p < .01$ ,  $n = 121$ .

### **5.2.1.3 Reliability testing**

Reliability is the stability with which a measuring instrument produces a specific result when the entity being measured has not changed and further suggests that accurate measurement requires consistency (Leedy and Ormrod, 2010). Cronbach’s alpha provides a measure of the internal consistency of a test or scale; it is expressed as a number between 0 and 1 (Tavakol and Dennick, 2011) with an acceptable reliability score is one that is 0.7 and higher (Heale and Twycross, 2015).

Table 5.2 illustrates the case processing summary, and Table 5.3 demonstrates the results of data reliability using Cronbach's Alpha.

Table 5.2 Case Processing Summary

|       |          | N   | %     |
|-------|----------|-----|-------|
| Cases | Valid    | 121 | 100.0 |
|       | Excluded | 0   | .0    |
|       | Total    | 121 | 100.0 |

Table 5.3 Reliability Statistics

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|------------------|--|------------|
| .971             | .972   | 26         |

The Cronbach's Alpha coefficient for the 26 items applicable to the research survey is high at the value of 0.971. This high value implies a high level of consistency amongst the variables and that all the variables are statistically consistent with one another.

### 5.2.2 Demographic data analysis and interpretation

The demographic variables were divided into categories, analysed, and interpreted on a nominal scale and visually represented in pie and bar charts (Kumar, 2011; Walliman, 2011; Leedy and Ormrod, 2015).

Figure 5.1 indicates the percentage of male respondents versus female respondents. The gender distribution for the sample is 67% females and 33% male. This finding is indicative of the industry norm.

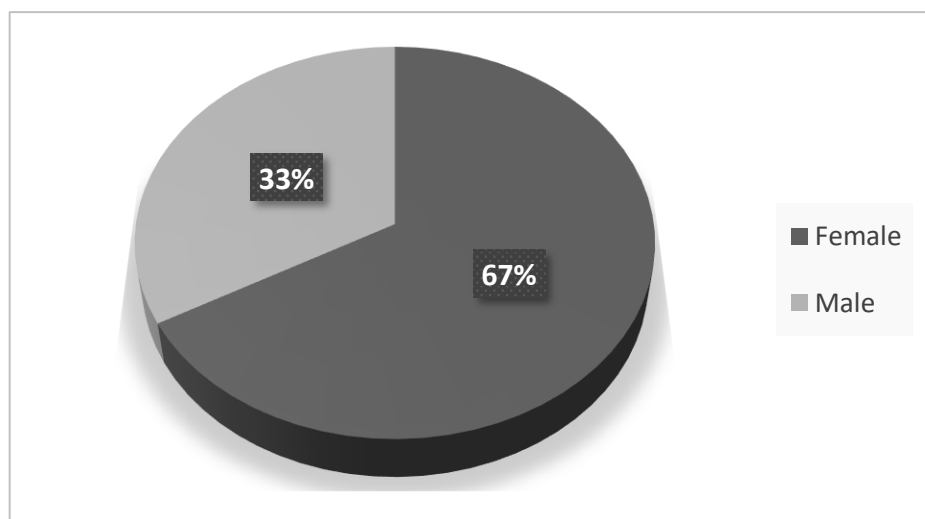


Figure 5.1: Gender distribution of respondents

Figure 5.2 illustrates the age distribution of the respondents, with the majority (27%) of the respondents ranging between the ages of 41 -50 years old. This is followed by 24% of respondents ranging between the ages of 31 – 40 years old. 6% of the responded are younger than 20 years of age.

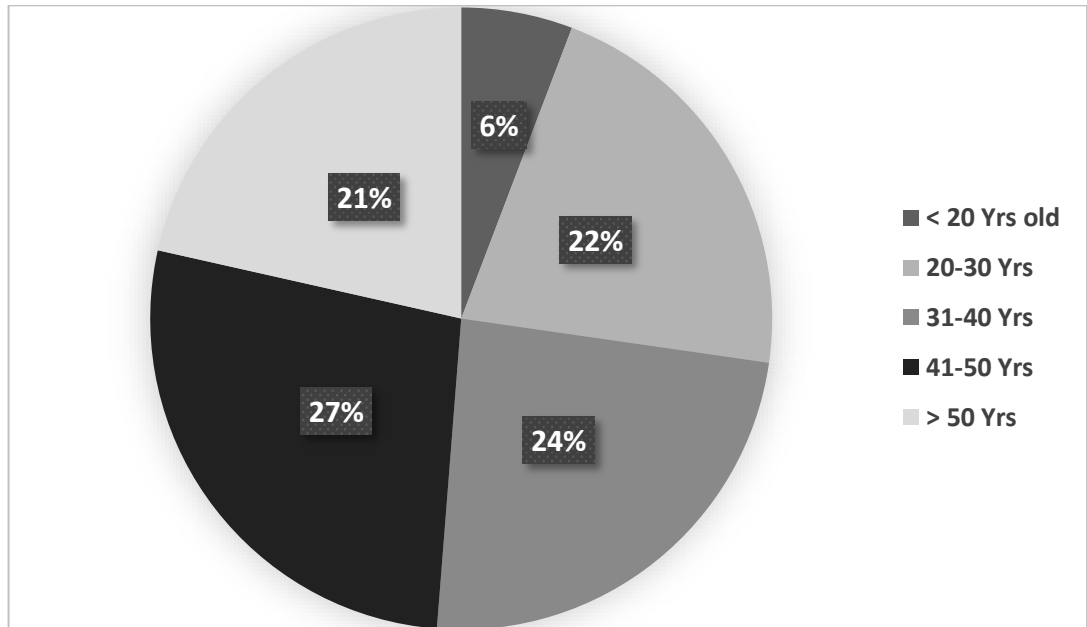


Figure 5.2: Age distribution of respondents

As shown in Figure 5.3, 50% of respondents have completed Grade 12, with 34% of respondents having an education level below Grade 8.

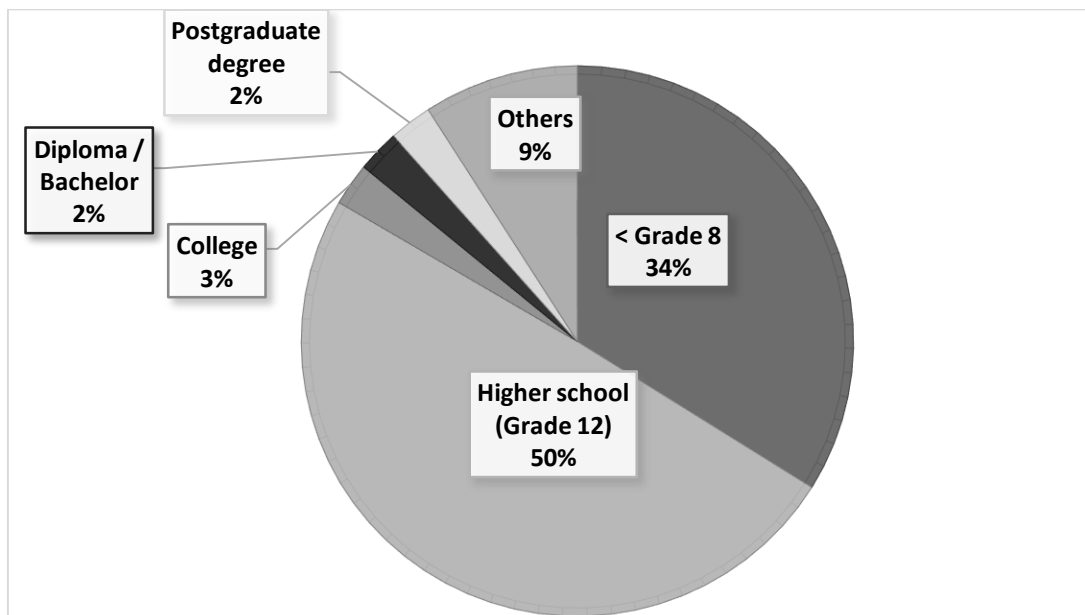


Figure 5.3: Education level of respondents

According to Figure 5.4, the majority of respondents (33,9%) have been employed for longer than 10 years. 23,1% of the respondents have been employed between 3 and 5 years, with 29,8% of the respondents' length of service being equally divided between less than one year (14,9%) and 1-2 years (14,9%).

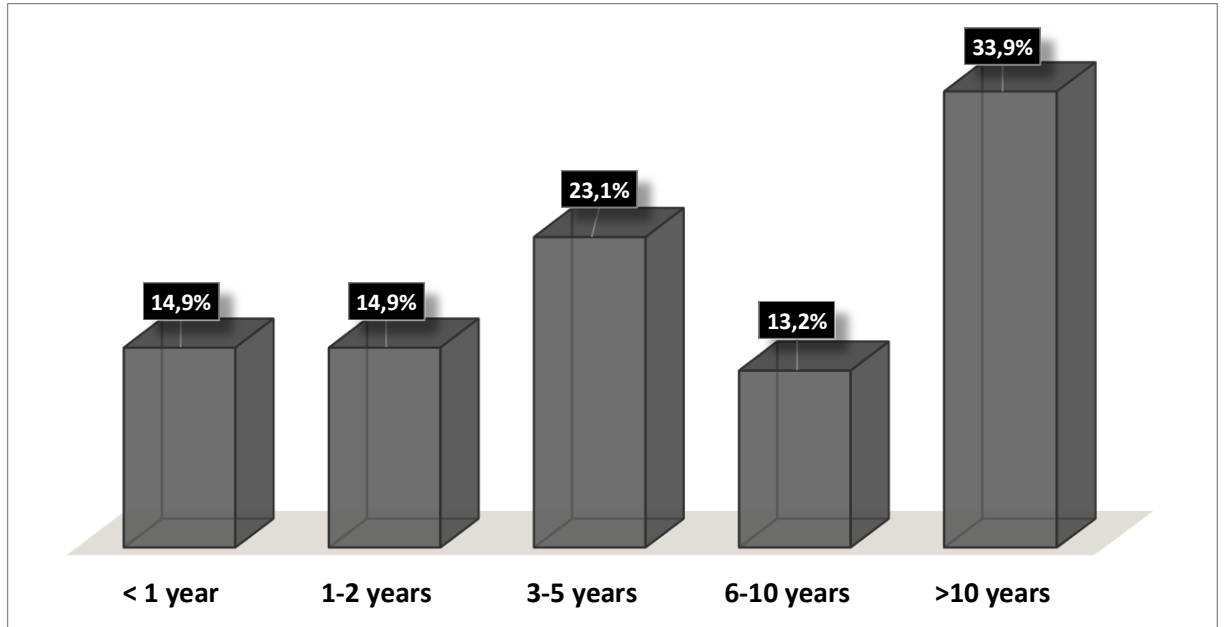


Figure 5.4: Length of employment with organisation

As shown in Figure 5.5, Most of the employees (88%) are aware of their HIV status, while 12% of the respondents are unaware of their HIV status. This indicates that the Clothing & Textiles organisation is focused on delivering HIV services for maximum efficacy and efficiency to end the AIDS epidemic by 2030 (UNAIDS, 2015).

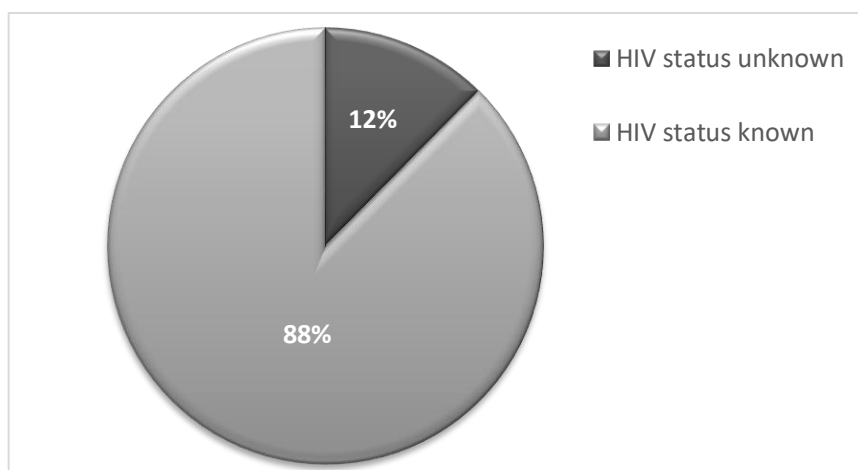


Figure 5.5: Knowledge of HIV status

Figure 5.6 indicates the known HIV status of the respondents. The age group 41 to 50 has the highest number of respondents were unaware of their HIV status.

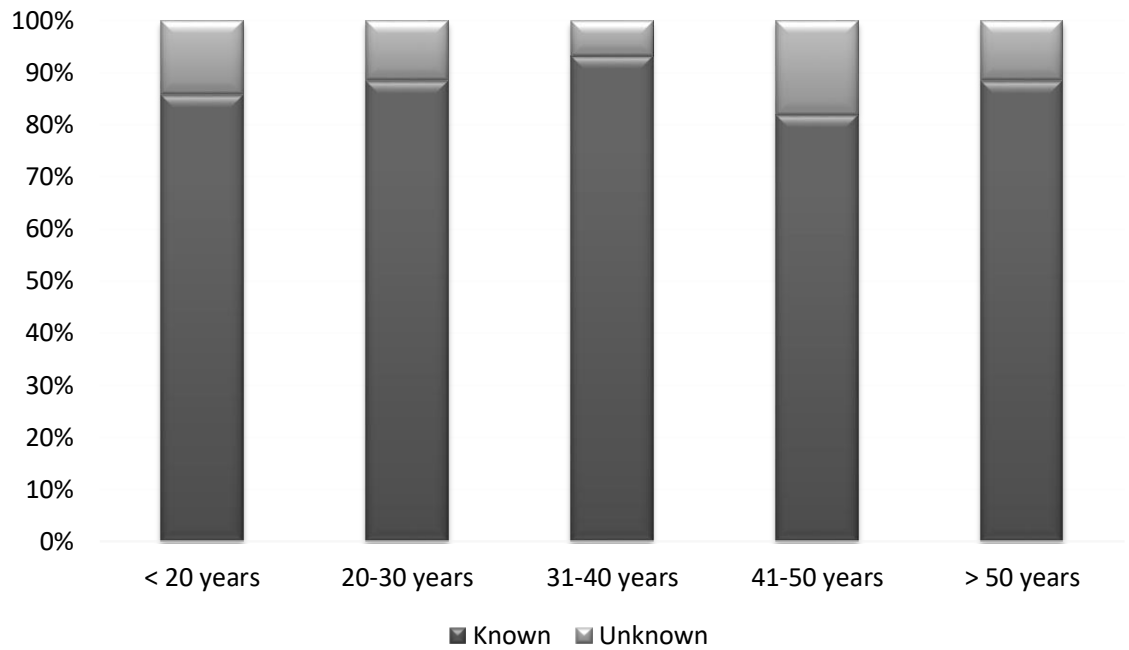


Figure 5.6: HIV Status known by age

According to Figure 5.7, the majority (69%) of respondents have undergone TB testing.

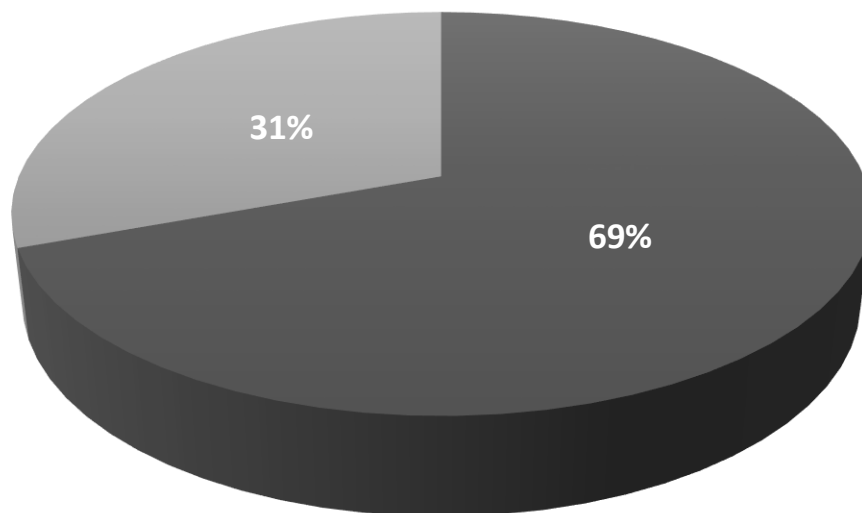


Figure 5.7: TB testing amongst respondents

### 5.2.3 Decision-making session data analysis

The quantitative data in the second part of the questionnaire was collated and transcribed into a Microsoft Excel worksheet, and each record was given a coding number and each response was coded per category. No responses were discarded. Out of a total of 3 146 response codes, all were unanswered.

The quantitative data was categorised in a group of statements as follows:

- Physical effects;
- Mental effects;
- Social effects;
- Facilitation of Preventative activities; and
- General cognitive and affective outcomes

SPSS was used to analyse the quantitative data with a 95% confidence rating (See Appendix F).

The results of the decisions by the CTEs on the effect of WHP are noted as follows:

#### **5.2.3.1 Physical effects**

25.6% of respondents are “unsure” whether they have noticed no effect of WHP on their physical health, while 50.4% responded “agree” and “strongly agree” to the question **(1d)**.

Furthermore, 84.3% of respondents “agree” and “strongly agree” that they feel physically better due to participating in the WHP service offering **(1a)**. This clearly indicates the significance of WHP in improving the employees’ health at work.

In total, 76.9% of respondents “agree” and “strongly agree” that they feel more productive because they are participating in the WHP programme service offering **(1f)**.

#### **5.2.3.2 Mental effects**

At least 17.4% of respondents are “unsure” whether they felt more stressed without WHP, with the same percentage (17.4%) of respondents confirming that they “disagree” and “strongly disagree” that they felt more stressed without WHP **(2d)**.

A total of 83.5% of respondents “agree” and “strongly agree” that they enjoy participating in WHP programme offers **(2b)**.

81.8% of respondents “agree” and “strongly agree” that they are feeling more satisfied in their workplace because the organisation offers WHP **(2e)**.

#### **5.2.3.3 Social effects**



In general, the respondents are relatively unsure whether there has been an improvement in social effects due to WHP.

The respondents who are “unsure” whether there are no better intra-team relationships due to WHP amounts to a total of 22.3% while a total of 70.2% “agree” to “strongly agree” **(3d)**.

However, 77.7% of respondents “agree” to “strongly agree” that their contact with colleagues deepened due to participation in WHP **(3a)**.

In addition, 86.0% of respondents “agree” to “strongly agree” that they feel appreciated by the organisation due to WHP service offering **(3b)**.

It is worthwhile to note that 11.6% of respondents are “unsure” whether they enjoy more personal contacts within their workplace due to participating in WHP **(3c)**.

#### **5.2.3.4 Facilitation of Preventative activities**

81.8% of the respondents “agree” to “strongly agree” that participating in WHP makes the prevention of illnesses financially affordable, yet 7.4% of respondents stated they are “unsure,” and 10.7% of respondents “disagree” to “strongly disagree” **(4a)**.

A total of 11.6% of respondents “disagree” to “strongly disagree” that they do not have to organise health-related visits in their private time due to WHP, while 12.4% is “unsure” **(4b)**.

#### **5.2.3.5 General cognitive and affective outcomes**

At least 86.0% of respondents “agree” to “strongly agree” that their attitude has improved towards their health due to WHP **(5c)**.

86.8% of respondents “agree” to “strongly agree” that they now know more about a healthy lifestyle due to the WHP programme offering **(5a)**.

The respondents who “agree” to “strongly agree” that they feel more relaxed after work due to participating in WHP programme service offering amounts to 83.5%, while 11.6% “disagree” to “strongly disagree” **(5f)**.

It is worthwhile to note that 86.8% of respondents “agree” to “strongly agree” that medical assistance in the workplace is of particular importance to them **(5b)**.

### **5.3 Qualitative data analysis**

Leedy and Ormrod (2015) postulate that the following steps are typical in content analysis:

- 1) The researcher identifies the specific body of material to be studied. If this body is relatively small, it is studied in its entirety. If it is quite large (e.g., if it consists of all newspaper articles written during a particular period), a sample (perhaps a random sample) is selected.
- 2) The researcher defines the characteristics or qualities to be examined in precise, concrete terms. The researcher may identify specific examples of each characteristic as a way of defining it more clearly.
- 3) If the material to be analysed involves complex or lengthy items (e.g., works of literature, transcriptions of conversations), the researcher breaks down each item into small, manageable segments that are analysed separately.
- 4) The researcher scrutinises the material for instances of each characteristic or quality defined in Step 2. When judgments are objective—for instance, when the study involves looking for the appearance of certain words in a text-only one judge or rater, is necessary. When judgments are more subjective—for instance, when the study involves categorizing discrete sections of textbooks as conveying various messages about the nature of science—two or three raters are typically involved, and a composite of their judgments is used.

The five interview responses were transcribed and their responses were entered into a Microsoft Excel worksheet and the most relevant points were highlighted. A coding framework was selected and coding categories were created, as per the highlighted sections, and corresponding sentences were categorised accordingly (Schreier, 2012). Sentences were either summarised or copied verbatim into the coding categories.

#### **5.3.1 Qualitative content analysis**

A content analysis was employed in this study. The qualitative data in the interview questionnaires were collated and transcribed into a Microsoft Excel worksheet (see Appendix G). Each record was given a coding number, and each response was condensed to align the responses to the secondary research questions, as well as create congruence between the responses.

The qualitative data were categorised in a group of statements as follows:

- What are the main benefits of WHP for the Clothing and Textiles employees (CTEs)?
- How does WHP affect CTE's physical, mental, and social wellbeing in Cape Town?
- What are the CTEs' perceptions of general cognitive and affective outcomes?
- Which approach can be used to improve CTEs' participation in WHP effectively?

#### **5.3.1.1 The main benefits of WHP for the CTEs**

Access to appropriate healthcare through WHP is experienced through the availability of CIHCF clinics and on-site workplace health services **(1N)**.

Health testing has increased through the implementation of WHP, by means of CIHCF clinic services and on-site workplace testing services **(1O)**.

The respondents confirmed that the services offered through WHP are: Awareness, Education and Training (employees and shop stewards), Psycho-Social Services, HR Counselling, Health & Safety, Condom distribution and health testing **(1U)**.

In addition, family members of employees are eligible to participate in WHP through access to support groups for family counselling, and having access to the Primary Health Care services offered at the CIHCF clinics **(1W)**.

In explaining the main benefits of WHP within the clothing and textile industry, most interviewees mentioned CIHCF costs as a motivating factor. However, employee wellbeing was also high on the agenda for employers. Interviewees agreed that WHP led to an increase in worker productivity and increased overall satisfaction with the work environment among co-workers.

According to the respondents, organisations benefit from WHP because their employees are healthier and better motivated when working in an improved working environment. The results of healthier and motivated employees are a reduction in sickness-related absence and other health-related costs, improved quality of products and services, increased innovation and an increase in productivity. One respondent added that WHP also contributes to the image of the organisation and makes it more attractive as an employer: "This is why companies with great WHP policies can attract

the best staff in Cape Town.” The respondents agreed that when WHP is aligned with the company’s goals and fits the overall strategy, philosophy and culture, positive effects and benefits are achieved. One respondent noted that WHP leads to “fewer costs that would normally arise due to absenteeism, accidents and diseases reduced.” Another stated that “the public relations task of a company becomes significantly less arduous as the company becomes more attractive both to customers and to employees.” Another added that WHP “leads to less job turnover as the human resources department finds its job easier when employees feel safe and protected in an organization.” One individual noted that because of their workplace health promotion programme, they were introduced to health awareness and resulted in them being engaged in duties.

#### **5.3.1.2 The impact of WHP on CTEs Cape Town**

The respondents agree that the implementation of WHP has improved employees’ physical well-being with a positive impact realised on absenteeism and psychosocial issues **(1H)**.

Employees’ mental well-being has improved through the implementation of WHP, as counselling is available to employees **(1I)**.

At a peer level, employee interaction has improved due to the implementation of WHP; however, one respondent (20%) stated that there had been no significant improvement **(1J)**.

Employee interaction with management has improved through the implementation of WHP; however one respondent (20%) stated that there had been no significant improvement **(1K)**.

Open conversations relating to employees’ health has been facilitated through education sessions, support groups, counselling sessions, and open discussions with peers about health issues **(1L)**.

Employees’ productivity has improved due to the implementation of WHP as employees are healthier, aware of their health status, and absenteeism has decreased **(1P)**.

60% of respondents confirm that there is excellent top management support for WHP, whilst 20% confirms top management support is only at the initial stages and a further

20% confirms that top management will only engage where there are benefits to productivity **(1Q)**.

According to the interview respondents, wellbeing at work means “good and healthy working environment”, “an environment that is safe, ergonomic and motivated workplace”, “leadership”, “less workload or proper distribution of workload”, “well-managed workplace”, “recognition of workers’ rights and safety”, “adequate compensation” and “appreciation”. Many respondents mentioned good and healthy working atmosphere. The Respondents described workplace health promotion as “it makes the person more effective”, “scope of physical exercise”, “keep deep impact in health and work performance”, “health body have a healthy mind”. The majority of the respondents answered that a “good working atmosphere promotes good health”.

#### **5.3.1.3 The CTEs’ perceptions of WHP**

Decreases in employees’ absenteeism have been noted and this is due to interventions by shop stewards, as well as access to CIHCF clinics, which reduces time-off from production **(1M)**.

#### **5.3.1.4 Approaches to improve CTEs’ participation in WHP**

A total of 40% of respondents stated that management participates in OH&S, while 60% of respondents confirmed that management facilitates WHP activities **(1A)**.

In addition, 80% of respondents confirm that employees are encouraged to participate in WHP through information sessions. However, 20% believe that it is due to the CIHCF clinics **(1B)**.

The channels of communication used in WHP are Management, Shop Stewards, Information, Education & Communication (IEC) sessions, Clinics, Notice Boards and Lay counsellors **(1E)**.

40% of respondents state that there are no challenges for employees to access WHP activities, while 60% of respondents maintain that time-off is a challenge, as sessions are over tea and lunch breaks **(1F)**.

In identifying barriers to successfully implementing WHP, 40% of respondents confirmed there are none; a further 40% confirmed funding and 20% reported availability of time as a barrier **(1G)**.

60% of respondents state that there are no incentives provided for participation in WHP activities. However, a subset of these respondents do confirm that employees are

compensated for attending the CIHCF clinics. 80% of respondents confirmed that compensation for CIHCF clinic attendance is an incentive **(1S)**.

Wellness champions are utilised to head up wellness projects, speak at events, and serve as peer educators **(1V)**.

The organisation ensures confidentiality through policies and procedures, capturing patient data on secure databases, and providing anonymous data to management and all records are stored in an access-controlled environment **(1Y)**.

Employees can be encouraged to participate in WHP through the company and shop stewards providing education sessions **(1Z)**.

All respondents had a positive impression of well-being at work within the clothing and textile industry. The respondents appreciate the well-being action and activities that the organisation offers. Generally, the respondents are happy with the wellbeing activities in the industry. However, the respondents had some suggestions to improve and support wellbeing at work. A “good working atmosphere” was the most prominent suggestion that the respondents suggested. Also, the nature of work, physical, and mental health promotion were other suggestions that the majority of the respondents brought up.

#### **5.4 Conclusion**

The data validity and reliability were tested and data were presented in a form of frequency tables and graphs. Interview data were analysed by using categories and codes to identify themes. The next chapter discussed the findings and draws conclusions and recommendations.

## **CHAPTER SIX: DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS**

### **6.1 Introduction**

Chapter 5 outlined the key results of the questionnaires administered to the respondents. This chapter aimed to interpret these results and explain the implications of the findings. The main function of this chapter was to answer “what is the effect of workplace health promotion on clothing & textiles employees’ perception of downstream outcomes within the organisation” by explaining how the results supported the answer and how it fitted in with the existing knowledge on the topic.

### **6.2 Discussion**

As previously mentioned, this research study aimed at exploring the clothing & textiles employees’ perceptions of downstream outcomes of workplace health promotion. The research questions to be answered are as follows:

- 1) Do Clothing and Textile employees (CTEs) perceive WHP as beneficial to their personal health status?
- 2) What are the main benefits of WHP for the Clothing and Textiles employees (CTEs)?
- 3) How does WHP affect CTE’s physical, mental and social wellbeing in Cape Town?
- 4) What are the CTEs’ perceptions of general cognitive and affective outcomes?
- 5) Which approach can be used to improve CTEs’ participation in WHP effectively?

#### **6.2.1 Demographic Data**

The majority of the respondents in this study were female (67%). This is representative of the gender profile of both local and global clothing manufacturing employees (Edries, Jelsma, and Maart, 2013). The age breakdown is indicative of the labour force in the City of Cape Town. Fifty percent of the respondents have completed Grade 12. However, we find that this is followed by 34% of the respondents having an education level less than Grade 8. Forty-seven, one percent (47.1%) of respondents have been employed within the industry for over six years. Some key health-related information about respondents is summarised below.

With 88% of respondents confirming that they are aware of their HIV status, this indicates that the industry is showing excellent progress in reaching the UNAIDS 95-

95-95 goal. This achievement is made possible by the SACTWU Worker Health Programme. The programme has lay-counsellors at the CIHCF clinics and offers testing at the workplace. In a corporate setting it is cited that HIV/AIDS education encourages the uptake of HIV testing in the workplace and that males and senior employees are less likely to undergo HIV testing than females and more junior staff members (Arimoto *et al.*, 2013). The feedback in the interviews emphasised the services such as education sessions, training of employees and shop stewards, testing services and linkage to ARVs where required. The age group with the highest percentage of respondents not knowing their HIV status are between the ages of 41 - 50 years. There are however respondents in all the age groups not being aware of their HIV status.

Sixty-nine percent of respondents indicated that they were tested for TB. This figure is realistic, as TB screening questions form part of the protocol for HIV testing with TB being prevalent in the clothing and textiles industry.

#### **6.2.2 CTEs perception of WHP on their personal health status**

As mentioned previously the CIHCF offers employees: primary health care services, which is extended to include physiotherapy, occupational therapy, and psychological services. In addition, HIV/AIDS services are offered as a stand-alone service. The interview respondents (managers, clinical staff and workplace health promoters) highlighted that employees are compensated when attending the CIHCF clinics during working hours. This forms part of a bargaining agreement, which benefits both the employer and the employee. The clinics are strategically placed within reasonable proximity to the factories. This ensures that employees can access the clinics during working hours and return within approximately 2 hours (with no deduction in wage hours). Furthermore, employees have access to health services at the CIHCF clinics, as well as workplace health services. These services have resulted in an increase in health testing. In the study conducted by Arimoto *et al.* (2013) it is asserted that employees prefer to be tested for HIV outside of the workplace. However, this study has found that employees are receptive to testing at the workplace and at off-site clinics. This study concludes that CTEs holds a positive perception of WHP on their personal health status, with more than 70% of respondents agreeing that WHP has caused them to feel physically better and improved their productivity. WHP in this study is furthermore perceived to assist in stress management, participation in WHP and job satisfaction. Respondents also perceived to have deepening relationships with colleagues and supervisors due to participation in WHP, whilst being motivated to be role models to colleagues.



### 6.2.3 The impact of WHP on CTE's wellbeing in Cape Town

Twenty-five, six percent of respondents were unsure whether they have noticed any effect of WHP on their physical health, and 50.4% are confident that they noticed no effect. A study amongst BCW's in Australia identified that changing health behaviour is a great challenge; however they highlighted this as an important factor in maintaining a healthy lifestyle (Lingard and Turner, 2015). The responses to this statement are however contradicted by 84.3% of respondents in this study feeling physically better due to participation in the WHP service offering. Upon reviewing the responses to the statement, "I feel more productive because I am participating in the WHP programme service offering", 76.9% selecting "agree" and "strongly agree" is aligned to statement **1a**. In a study amongst WCWs in Austria, when responding to the statement, "Feeling physically better due to participating in WHP programme offers", 67.5% of respondents answered either disagreed or was indecisive (Nöhammer, Schusterschitz and Stummer, 2013). In addition, only 13.5% of respondents felt more productive due to participation in WHP. The managers, clinical staff and workplace health promoters are in agreement that the implementation of WHP has improved employees' physical wellbeing with a positive impact realised on absenteeism and psychosocial issues.

Participation in WHP programme offerings is enjoyed by 83.5% of the respondents. Sixty-five of respondents were more stressed before WHP. The managers, clinical staff and workplace health promoters indicated that psychosocial counselling is provided to employees. These responses provide insight into the efficacy of this intervention. Feeling more satisfied in their workplace because the organisation offers WHP is the sentiment of 81.8% of respondents. In the study by Nöhammer, Schusterschitz and Stummer (2013) 15.2% of respondents felt more satisfied with work because the company offers WHP.

In total, 52.13% of respondents, in the study by amongst WCWs, were indecisive on whether employee-perceived effects of WHP had a relation to social issues (Nöhammer, Schusterschitz and Stummer, 2013). In this study, the researcher found that the respondents are relatively unsure whether there has been an improvement in social effects due to WHP. A perception that there are no better intra-team relationships due to WHP is experienced by 70.2% of respondents. However, 86.0% of employees felt appreciated by the organisation due to the WHP service offering, compared to 57.4% in the study by Nöhammer, Schusterschitz and Stummer (2013). 80% of the managers, clinical staff and workplace health promoters noted that at a peer level, employee interaction has improved due to the implementation of WHP. However, one

respondent (20%) stated that there had been no significant improvement. It is noteworthy that 11.6% of respondents are unsure whether they enjoy more personal contacts within their workplace due to participating in WHP. This percentage is significantly lower than the 39.2% reported in the study amongst WCWs (Nöhammer, Schusterschitz and Stummer, 2013).

#### **6.2.4 CTEs' perceptions of general cognitive and affective outcomes**

It was reassuring that 81.8% of employees perceived participating in WHP made the prevention of illnesses financially affordable. The managers, clinical staff, and workplace health promoters noted that WHP is offered through a partnership with government and universities. This model ensures that the government's burden is alleviated by this service to CTEs (as State patients) directly. There are cost savings to the CIHCF in that it has access to expensive resources at no or low cost (researchers and/or students).

One of the findings from data analysis was that the majority of employees (86.0%) confirmed that their attitude has improved towards their health due to WHP. Furthermore, a marginally higher percentage (86.8%) perceived that they now know more about a healthy lifestyle due to the WHP programme offering. In addition, 83.5% of employees felt more relaxed after work due to participating in the WHP programme service offering. 86.8% of employees consider medical assistance in the workplace of particular importance to them. It is thus evident that the CTEs' perception of their general cognitive and affective outcomes have been positively impacted through the WHP offering.

#### **6.2.5 Approach to improve CTEs' participation in WHP**

Success factors highlighted are robust HIV/AIDS policies that guide the WHP related to HIV/AIDS. Also, as a trade union and bargaining council initiative, all relevant stakeholders are actively involved in ensuring the implementation of WHP. Regular feedback reports are provided on the achievements through WHP, as it is a strategic objective. It would be beneficial to integrate the OHAS and WHP initiatives or to have one committee to align the strategies in both areas. It has been noted that the respondents are motivated to be role models to their peers and thus creates opportunities for Wellness Champions at factory level to promote health and wellbeing.

### 6.3 Recommendations

This section elaborates on recommendations in respect to future research studies as well as organisation specific interventions.

#### **The following limitations of this research have been noted as:**

The study was conducted in a South African organisation within the Clothing and Textiles industry in Cape Town and excluded all other areas and sectors. It is advisable that a larger study be conducted across South Africa in order to measure the perceptions of a more diverse group of respondents.

The study was focused on the perceptions of CTEs and did not consider health metrics such as Cholesterol, Blood pressure, Blood Glucose, HIV Viral Load, TB cure rate, amongst others. Utilising this data will assist in correlating the employee perceptions to their health status over a period of time. Such a study will provide significant insight into the improvement of WHP initiatives.

The study did not include absenteeism data, and this was an important theme in the responses of the managers, clinical staff and workplace health promoters. A study is, therefore, recommended where absenteeism data forms part of the research. Further research is desired to understand the key health care costs within the industry and how further costs can be mitigated. In addition, CTEs' families are eligible to access the CIHCF clinic services and it would be prudent to include these dependents in future studies.

#### **Recommendations to the organisation:**

It is the opinion of the researcher that the organisation should consider behavioural change strategies, as the respondents were relatively unsure whether there has been an improvement in social effects due to WHP. Even though this study did not investigate behavioural risks as obesity, physical inactivity, poor diet and substance abuse (Edries, Jelsma and Maart, 2013), it would be beneficial to include it in a behavioural change strategy. In addition, CTEs are prone to musculoskeletal challenges (Wang *et al.*, 2007; Edries, Jelsma and Maart, 2013) and the assistance of roving biokineticists to evaluate workplaces and provide treatment. The development of an App is recommended which is utilised by CTEs to log when they experience pain. The App should gather data of the time, where the pain is experienced, the severity and what activity the CTE was engaged in. Such a programme will well augment the

current service offering. In addition, and as an initiative within the behavioural change strategy, the organisation should consider partnerships with loyalty programmes designed specifically towards BCWs. Such programmes have both health and financial benefits for the employees. The loyalty programme should be included in the behaviour change strategy. A recipe section linked the App will assist with poor diet and obesity, whilst providing recipes which are affordable and avoids foods which exacerbates NCDs.

This research has been conducted to investigate the perceptions of CTEs on the downstream outcomes of WHP and whilst the general perception is that CTEs have a positive perception on WHP, there is an absence of a quality measurement tool. It is therefore recommended that the organisation develop a free to use USSD questionnaire which is sent to patients after every visit to the CIHF. The questionnaire should address questions pertaining to the visit, and gather information regarding the overall perception of WHP. This data should be used to evaluate the quality of the programme and to advise changes where needed. An electronic health record should be created for each employee to assist in patient health tracking and improving general quality of services.

Lastly, as a consequence of the positive perceptions of CTEs on WHP, the researcher recommends that the organisation partner in research initiatives to showcase the CIHCF's operating model, which can serve as a model for the implementation of the National Health Insurance (NHI) through workplaces in South Africa.

#### **6.4 Conclusion**

The focus of this research study was specifically aimed at determining the effect of workplace health promotion on clothing & textiles employees' perception of downstream outcomes within the organisation. It resulted from the notion that employee perceptions of blue-collar workers on WHP should be investigated. While some respondents were unsure of whether WHP has been beneficial to their personal health status, in general, the respondents answered the questions favourably, whether agreeing or strongly agreeing to the statements. It is the opinion of the researcher that the defined study objectives were fully addressed.

In this final chapter, the research outcomes were discussed, where findings are explained based on both the quantitative and qualitative studies. The research problem, questions, and objectives were revisited and conclusions drawn from the

study. Recommendations and limitations of the research study were successfully provided.

It is suggested that the recommendations in this document be considered and applied in an attempt to mitigate downstream health expenditure, which could have been avoided.

## BIBLIOGRAPHY

Abraham, M. (2016) *Wearable technology A health-and-care actuary's perspective*. Available at: <https://www.getqardio.com/qardiocore-wearable-ecg-ekg-monitor-iph0>.

Acharya, A. S. *et al.* (2013) 'Sampling: why and how of it?', *Indian Journal of Medical Specialities*, 4(2), pp. 3–7. doi: 10.7713/ijms.2013.0032.

Arimoto, Y. *et al.* (2013) *Stigma, social relationship and HIV testing in the workplace: Evidence from South Africa*, Center for Economic Institutions.

Arnett, D. K. (2016) 'Setting Out the Case for Evidence-Based Workplace Health Programs', *American Journal of Health Promotion*, 30(7), pp. 566–567. doi: 10.1377/hlthaff.2016.1183.

Ataguba, J. E. O. and Alaba, O. (2012) 'Explaining health inequalities in South Africa: A political economy perspective', *Development Southern Africa*, 29(5), pp. 756–764. doi: 10.1080/0376835X.2012.730962.

Ataguba, J. E. O. and McIntyre, D. (2013) 'Who benefits from health services in South Africa?', *Health Economics, Policy and Law*, 8(1), pp. 21–46. doi: 10.1017/S1744133112000060.

Aust, B. and Ducki, A. (2004) 'Comprehensive health promotion interventions at the workplace: Experiences with health circles in Germany', *Journal of Occupational Health Psychology*, 9(3), pp. 258–270. doi: 10.1037/1076-8998.9.3.258.

Auvinen, A.-M. (2017) 'Understanding the Stakeholders as a Success Factor for Effective Occupational Health Care', *Occupational Health*, pp. 25–43. doi: <http://dx.doi.org/10.5772/57353>.

Auvinen, A. M., Kohtamäki, K. and Ilvesmäki, A. (2012) 'Workplace health promotion and stakeholder positions: A Finnish case study', *Archives of Environmental and Occupational Health*, 67(3), pp. 177–184. doi: 10.1080/19338244.2011.598892.

Baicker, K., Cutler, D. and Song, Z. (2010) 'Workplace wellness programs can generate savings', *Health Affairs*, 29(2), pp. 1–8. doi: 10.1377/hlthaff.2009.0626.

Barbeau, E. M. *et al.* (2006) 'Results of a union-based smoking cessation intervention for apprentice iron workers ( United States )', *Cancer Causes and Control*, 17, pp. 53–61. doi: 10.1007/s10552-005-0271-0.

Bengtsson, M. (2016) 'How to plan and perform a qualitative study using content analysis', *NursingPlus Open*. Elsevier, 2, pp. 8–14. doi: 10.1016/j.npls.2016.01.001.

Business/Partners (2014) *The South African textile and clothing industry – an overview*. Available at: <http://www.businesspartners.co.za/knowledge-hub/manufacturing-fund/posts/south-african-textile-clothing-industry-overview-3252/>.

Cancelliere, C. *et al.* (2011) 'Are workplace health promotion programs effective at improving presenteeism in workers? A systematic review and best evidence synthesis of the literature', *BMC Public Health*. BioMed Central Ltd, 11(1), p. 395. doi: 10.1186/1471-2458-11-395.

CDC (2016) 'Workplace Health Model'.

Centres for Disease Control (2016) *Workplace Health Promotion: Using the workplace to improve nation's health*. Available at: <https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/aag-workplace-health.pdf>.

Creswell, J. W. (2014) *Research design: qualitative, quantitative, and mixed methods approaches*. 4th editio. Singapore: Sage Publications.

Currás, H. T. (2017) 'Are there healthy companies? Three ways to answer this question', *Magazine of economics, business and society*, pp. 57–67.

Dai, J. B., Lee, N. K. S. and Cheung, W. S. (2009) 'Performance analysis of flexible material handling systems for the apparel industry', *The International Journal of Advanced Manufacturing Technology*, 44(11–12), pp. 1219–1229. doi: 10.1007/s00170-008-1916-4.

Dickson-Swift, V. *et al.* (2014) 'What really improves employee health and wellbeing: Findings from regional Australian workplaces', *International Journal of Workplace Health Management*, 7(3), pp. 138–155. doi: 10.1108/IJWHM-10-2012-0026.

Diego Montano, Hanno Hoven and Johannes Siegrist (2014) 'Effects of organisational-level interventions at work on employees' health: a systematic review', *BMC Public Health*, 14:135. doi: 10.1186/1471-2458-14-135.

Dollard, M. *et al.* (2007) 'National surveillance of psychosocial risk factors in the workplace : An international overview', *Work & Stress*, 21(1), pp. 1–29.

Dombrowski, J. J., Snelling, A. M. and Kalicki, M. (2014) 'Health Promotion Overview', *Workplace Health & Safety*, 62(8), pp. 342–349. doi: 10.1177/216507991406200805.

Edries, N. (2005) *EMPLOYEE WELLNESS PROGRAMME IN CLOTHING/TEXTILE MANUFACTURING COMPANIES: WHAT ARE THE EFFECTS?*, University of Cape Town.

Edries, N., Jelsma, J. and Maart, S. (2013) 'The impact of an employee wellness programme in clothing/textile manufacturing companies: A randomised controlled trial', *BMC Public Health*, 13(1), p. (Unknown). doi: 10.1186/1471-2458-13-25.

Ellis, T. J. and Levy, Y. (2008) 'Framework of Problem-Based Research : A Guide for Novice Researchers on the Development of a Research-Worthy Problem', 11.

Eton Systems (2012) *Eton Systems : Installation at Eton Fashion, Video on Youtube*. Available at: <https://www.youtube.com/watch?v=UKCCXKRw8eo> (Accessed: 8 September 2019).

Eton Systems (2019) *Eton Systems: Above and Beyond*. Available at:

<https://www.etonsystems.com/en/> (Accessed: 8 September 2019).

European Agency for Safety and Health at Work (2012) *Motivation for employers to carry out workplace health promotion*. doi: 10.2802/50267.

European Network for Workplace Health Promotion (2012) 'ENWHP - European Network for Workplace Health Promotion', p. 32. Available at:  
[http://www.enwhp.org/fileadmin/user\\_upload/pdf/ENWHP-image\\_brochure-final.pdf](http://www.enwhp.org/fileadmin/user_upload/pdf/ENWHP-image_brochure-final.pdf).

Faghri, P. D. *et al.* (2010) 'Assessment of a worksite health promotion readiness checklist', *Journal of Occupational and Environmental Medicine*, 52(9), pp. 893–899. doi: 10.1097/JOM.0b013e3181efb84d.

Fox, M. A. *et al.* (2018) 'Implications of applying cumulative risk assessment to the workplace', *Environment international*, 115, pp. 230–238.

Gahlot, N., Mehta, M. and Singh, K. (2017) 'Occupational health problems among female sewing machine operators', *Indian Journal of Health & Wellbeing*, 8(2), pp. 122–126.

Giddens, L., Gonzalez, E. and Leidner, D. (2016) 'I track, therefore I Am: Exploring the impact of wearable fitness devices on employee identity and well-being', *22nd Americas Conference on Information Systems*, pp. 1–5.

Goetzel, R. Z. *et al.* (2014) 'Do workplace health promotion (wellness) programs work?', *Journal of Occupational and Environmental Medicine*, 56(9), pp. 927–934. doi: 10.1097/JOM.0000000000000276.

Grossmeier, J. (2016) 'From Return on Investment to Value on Investment of Workplace Health Programs', *American Journal of Health Promotion*, 30(7), pp. 574–576.

Grossmeier, J. (2018) 'The Art of Health Promotion: Ideas for improving health outcomes', *American Journal of Health Promotion*, 32(4), pp. 1145–1156. doi: 10.1177/0890117118765037.

Hagedorn, J. *et al.* (2016) 'The role of labor unions in creating working conditions that promote public health', *American Journal of Public Health*, 106(6), pp. 989–995. doi: 10.2105/AJPH.2016.303138.

Hampson, S. *et al.* (2016) 'Workplace health protection and promotion communication : current perspectives', *Occupational Health Southern Africa*, 22(5), pp. 17–20.

Harbin, T. (2017) 'Examining Employee Perceptions to Improve Workplace Health Promotion Programs', *Employment relations Today*, pp. 41–47. doi: 10.1002/ert.

Heale, R. and Twycross, A. (2015) 'Validity and reliability in quantitative studies', *Evidence-Based Nursing*, 18(3), pp. 66–67. doi: 10.1136/eb-2015-102129.

Healy, G. *et al.* (2012) *Reducing prolonged sitting in the workplace - An evidence review: Full report*. Available at: [file:///C:/Users/STF2408/Downloads/CHW\\_Sitting\\_Full\\_Web\\_Final.pdf](file:///C:/Users/STF2408/Downloads/CHW_Sitting_Full_Web_Final.pdf).



HSRC (2013) *Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2013-17*.

Hwang, W. J., Hong, O. and Kim, M. J. (2012) 'Factors Associated with Blue-collar Workers' Risk Perception of Cardiovascular Disease', *Journal of Korean Academy of Nursing*, 42(7), p. 1095. doi: 10.4040/jkan.2012.42.7.1095.

Hymel, P. A. *et al.* (2011) 'Workplace Health Protection and Promotion: A New Pathway for a Healthier—and Safer—Workforce', *Journal of Occupational and Environmental Medicine*, 53(6), pp. 695–702. doi: 10.1097/JOM.0b013e31822005d0.

Isaacs, A. A. *et al.* (2014) 'Original Research: A snapshot of noncommunicable disease profiles and their prescription costs', *South African Family Practice*, 56(1), pp. 43–49. Available at: <http://safpj.co.za/index.php/safpj/article/viewFile/3711/4833>.

James T Croasmun and Lee Ostrom (2011) 'Using Likert-Type Scales in the Social Sciences', *Journal of Adult Education*, 40(1), pp. 19–22.

Jarman, L. *et al.* (2016) 'Workplace health promotion and mental health: Three-year findings from partnering Healthy@Work', *PLoS ONE*, 11(8), pp. 1–14. doi: 10.1371/journal.pone.0156791.

Jeftha, C. (2018) 'Strategic Planning Conference'.

Jørgensen, M. B. *et al.* (2016) 'Does employee participation in workplace health promotion depend on the working environment? A cross-sectional study of Danish workers', *BMJ Open*, 6, pp. 1–9. doi: 10.1136/bmjopen-2015-010516.

Kaleta, D. *et al.* (2009) 'Factors influencing self-perception of health status', *Central European Journal of Public Health*, 17(3), pp. 122–127. doi: 10.21101/cejph.b0367.

Kirk, A. K. and Brown, D. F. (2003) 'Employee assistance programs: A review of the management of stress and wellbeing through workplace counselling and consulting', *Australian Psychologist*, 38(2), pp. 138–143. doi: 10.1080/00050060310001707137.

Kumar, R. (2011) *Research Methodology: A step-by-step guide for beginners*. Third edit, Sage Publications. Third edit. Sage Publications.

Leedy, P. D. and Ormrod, J. E. (2010) *Practical research: planning and design*. 9th Editio, Teaching Sociology. 9th Editio. New Jersey: Merrill. doi: 10.2307/1318509.

Leedy, P. D. and Ormrod, J. E. (2015) *Practical Research: Planning and Design*. 11th Editi. Essex: Pearson Education Limited. doi: 10.15713/ins.mmj.3.

Leslie, J. H. *et al.* (2013) 'Factors affecting healthy eating and physical activity behaviors among multiethnic blue- and white-collar workers: a case study of one healthcare institution.', *Hawai'i journal of medicine & public health : a journal of Asia Pacific Medicine & Public Health*, 72(9), pp. 300–6. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24069570><http://www.pubmedcentral.nih.gov/article-render.fcgi?artid=PMC3780461>.

Lingard, H. and Turner, M. (2015) 'Improving the health of male , blue collar construction workers : a social ecological'.

Ljungblad, C. *et al.* (2014) 'Workplace health promotion and working conditions as determinants of employee health', *International Journal of Workplace Health Management*, 7(2), pp. 89–104. doi: 10.1108/IJWHM-02-2013-0003.

Matsoma, N. J. and Ambe, I. M. (2017) 'Demand planning approaches employed by clothing industry stakeholders in Gauteng, South Africa', *Journal of Transport and Supply Chain Management*, 11(0), pp. 1–9. Available at: <https://jtscm.co.za/index.php/jtscm/article/view/228/447>.

Mchunu, G. (2012) 'Proposed guidelines for a workplace health promotion policy and implementation framework.', *Occupational Health Southern Africa*, 18(2), pp. 5–12.

Mchunu, G. and Uys, L. (2008) 'The state of workplace health promotion in South Africa: An exploratory study.', *Occupational Health South Africa*, 14(6), pp. 26–32. Available at: [https://scholar.google.co.za/scholar?hl=en&q=The+state+of+workplace+health+promotion+in+South+Africa&btnG=&as\\_sdt=1%2C5&as\\_sdtp=](https://scholar.google.co.za/scholar?hl=en&q=The+state+of+workplace+health+promotion+in+South+Africa&btnG=&as_sdt=1%2C5&as_sdtp=).

McLellan, R. K. (2017) 'Work, Health, And Worker Well- Being: Roles And Opportunities For Employers', *Health Affairs*, 36(2), pp. 206–213.

Mcleod, J. (2010) 'The effectiveness of workplace counselling : A systematic review', *Counselling and Psychotherapy Research*, 10(4), pp. 238–248.

Milner, K. *et al.* (2015) 'The relationship between leadership support, workplace health promotion and employee wellbeing in South Africa', *Health Promotion International*, 30(3), pp. 514–522. doi: 10.1093/heapro/dat064.

Mouton, J. (2001) *How to succeed in your master's and doctoral studies: a South African guide and resource book*, *International Journal of Social Research Methodology*. doi: 10.1080/13645570210163989.

Müller-Debus, A. K., Thauer, C. R. and Boerzel, T. A. (2009) 'Firms, Associations and the Governance of HIV/AIDS in South Africa.', *Journal for Human Rights/Zeitschrift für Menschenrechte*, 3(2).

Nattrass, N. and Seekings, J. (2012) *Differentiation within the South African Clothing Industry : Implications for Wage Setting and Employment*.

Noblet, A. and LaMontagne, A. D. (2006) 'The role of workplace health promotion in addressing job stress', *Health Promotion International*, 21(4), pp. 346–353. doi: 10.1093/heapro/dal029.

Nöhammer, E., Schusterschitz, C. and Stummer, H. (2013) 'Employee perceived effects of workplace health promotion', *International Journal of Workplace Health Management*, 6(1), pp. 38–53.

Nöhammer, E., Stummer, H. and Schusterschitz, C. (2014) 'Employee perceived barriers to

participation in worksite health promotion', *Journal of Public Health (Germany)*, 22(1), pp. 23–31. doi: 10.1007/s10389-013-0586-3.

Olson, A. and Chaney, J. D. (2009) 'OVERCOMING BARRIERS TO EMPLOYEE PARTICIPATION IN WHP PROGRAMS', *American Journal of Health Studies*, 24(3), pp. 353–357.

Otoo, K. N. (2017) 'Trade union services and benefits in Africa', in *African Labour Research Network*, pp. 399–404.

Ott, M. G. *et al.* (2010) 'Impact of an occupational health promotion program on subsequent illness and mortality experience', *International Archives of Occupational and Environmental Health*, 83, pp. 887–894. doi: 10.1007/s00420-010-0521-7.

Ozminkowski, R. J. *et al.* (2011) 'Best practices for smoking cessation: Implications for employer-based programs', *American Journal of Health Promotion*, (September). doi: 10.4278/0890-1171-22.1.tahp-1.

Palinkas, L. A. *et al.* (2011) 'Mixed method designs in implementation research', *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), pp. 44–53. doi: 10.1007/s10488-010-0314-z.

Pauncu, E. (2012) 'Workplace health promotion', in *Emutom*, pp. 1–17.

Person, A. L. *et al.* (2010) 'Barriers to participation in a worksite wellness program', *Nutrition Research and Practice*, 4(2), pp. 149–154. doi: 10.4162/nrp.2010.4.2.149.

Pohjonen, T. and Ranta, R. (2001) 'Effects of worksite physical exercise intervention on physical fitness, perceived health status, and work ability among home care workers: Five-year follow-up', *Preventive Medicine*, 32(6), pp. 465–475. doi: 10.1006/pmed.2001.0837.

Prieto, L. C., Mathur-Helm, B. and Dawson, K. N. (2018) 'The ethic of care: an HR strategy to address obesity in the workplace', *Human Resource Management International Digest*, 26(2), pp. 12–15. doi: 10.1108/HRMID-07-2017-0131.

Pronk, N. P. (2013) 'Integrated worker health protection and promotion programs: overview and perspectives on health and economic outcomes.', *Journal of Occupational and Environmental Medicine*, 55(12), pp. 952–967. doi: 10.1097/JOM.000000000000031.Integrated.

Pronk, N. P. (2015) 'Fitness of the US Workforce', *Annual Review of Public Health*, 36(1), pp. 131–149. doi: 10.1146/annurev-publhealth-031914-122714.

Punnett, L. *et al.* (2009) 'A Conceptual Framework for Integrating Workplace Health Promotion and Occupational', *Public Health Reports*, 124(1), pp. 16–25. doi: Doi 10.1177/00333549091244s103.

Ragab, M. A. and Arisha, A. (2017) 'Research Methodology in Business: A Starter's Guide', *Management and Organizational Studies*, 5(1), p. 1. doi: 10.5430/mos.v5n1p1.

- Ridder, H.-G. (2017) 'The theory contribution of case study research designs', *Business Research*. Springer International Publishing, 10(2), pp. 281–305. doi: 10.1007/s40685-017-0045-z.
- Robroek, S. J. W. *et al.* (2009) 'Determinants of participation in worksite health promotion programmes: A systematic review', *International Journal of Behavioral Nutrition and Physical Activity*, 6, pp. 1–12. doi: 10.1186/1479-5868-6-26.
- Robroek, S. J. W. *et al.* (2012) 'Moral issues in workplace health promotion', *International Archives of Occupational and Environmental Health*, 85(3), pp. 327–331. doi: 10.1007/s00420-011-0675-y.
- Rocha, G. M. N. *et al.* (2010) 'Integrated preventive care coverage effectiveness in high-risk worksites in Mexico', *International Archives of Occupational and Environmental Health*, 83, pp. 813–821. doi: 10.1007/s00420-010-0550-2.
- Rongen, A. *et al.* (2013) 'Workplace health promotion: A meta-analysis of effectiveness', *American Journal of Preventive Medicine*. Elsevier Inc., 44(4), pp. 406–415. doi: 10.1016/j.amepre.2012.12.007.
- Rongen, A. *et al.* (2014) 'Barriers and facilitators for participation in health promotion programs among employees: A six-month follow-up study', *BMC Public Health*, 14(1), pp. 1–10. doi: 10.1186/1471-2458-14-573.
- Rossinen, S. (2018) *Evaluating the manufacturing of a work outfit: Case SWW Smart and Safe Work Wear*.
- SACTWU (2019) SACTWU. Available at: <http://www.sactwu.org.za/> (Accessed: 9 February 2019).
- Sadchikova, A. S. and Rodin, M. M. (2017) 'The use of applied software for the professional training of students studying humanities', *AIP Conference Proceedings*, 1797(January). doi: 10.1063/1.4972455.
- Schreier, M. (2012) *Qualitative Content Analysis in Practice*, Sage Publications. London: Sage Publications.
- Setswe, G. K. G. (2009) 'Best practice workplace HIV/AIDS programmes in South Africa: A review of case studies and lessons learned', *African Journal of Primary Health Care and Family Medicine*, 1(1), pp. 82–87. doi: 10.4102/phcfm.v1i1.30.
- Sharma (2017) 'Pros and cons of different sampling techniques', *International Journal of Applied Research*, 3(7), pp. 749–752. Available at: [www.allresearchjournal.com](http://www.allresearchjournal.com).
- Sieberhagen, C., Pienaar, J. and Els, C. (2011) 'Management of employee wellness in South Africa: Employer, service provider and union perspectives', *SA Journal of Human Resource Management*, 9(1), pp. 1–14. doi: 10.4102/sajhrm.v9i1.305.
- Sieberhagen, C., Rothmann, S. and Pienaar, J. (2009) 'Employee health and wellness in South Africa: The role of legislation and management standards', *SA Journal of Human*

*Resource Management*, 7(1), pp. 18–26. doi: 10.4102/sajhrm.v7i1.144.

Silcox, S. (2016) 'Making a case for employee health promotion', *Occupational Health & Wellbeing*, 68(3), pp. 10–11. Available at: [http://search.proquest.com.ezp.waldenulibrary.org/docview/1774897575?accountid=14872%5Cnhttp://sfxhosted.exlibrisgroup.com/waldenu?url\\_ver=Z39.88-2004&rft\\_val\\_fmt=info:ofi/fmt:kev:mtx:journal&genre=unknown&sid=ProQ:ProQ%3Aabiglobal&atitle=Making+a+case+fo](http://search.proquest.com.ezp.waldenulibrary.org/docview/1774897575?accountid=14872%5Cnhttp://sfxhosted.exlibrisgroup.com/waldenu?url_ver=Z39.88-2004&rft_val_fmt=info:ofi/fmt:kev:mtx:journal&genre=unknown&sid=ProQ:ProQ%3Aabiglobal&atitle=Making+a+case+fo).

South African Market Insights (2019) *South Africa's Manufacturing industry, Manufacturing and economics*. Available at: <https://www.southafricanmi.com/south-africas-manufacturing-industry.html> (Accessed: 26 October 2019).

Struwig, F. W. and Stead, G. B. (2001) *Planning, designing and reporting research*. Cape Town: Pearson Education.

Tafvelin, S. *et al.* (2019) 'Employees' and line managers' active involvement in participatory organizational interventions: Examining direct, reversed, and reciprocal effects on well-being', *Stress and Health*, 35, pp. 69–80. doi: 10.1002/smi.2841.

Tareque, M. A. and Effron, J. E. (2018) 'Worker's Health and Productivity', *American Journal of Management*, 18(2), pp. 70–79.

Tavakol, M. and Dennick, R. (2011) 'Making sense of Cronbach's alpha', *International journal of medical education*, 2, pp. 53–55. doi: 10.5116/ijme.4dfb.8dfd.

Terry, P. E. *et al.* (2008) 'Association between nine quality components and superior worksite health management program results', *Journal of Occupational and Environmental Medicine*, 50(6), pp. 633–641. doi: 10.1097/JOM.0b013e31817e7c1c.

Tilly, C. (UCLA) *et al.* (2013) *Informal Worker Organizing as a Strategy to Improving Subcontracted Work in the Textile and Apparel Industries of Brazil, South Africa, India and China*.

Tshoose, C. (2014) 'Placing the right to occupational health and safety within a human rights framework : trends and challenges for South Africa', *Comparative and International Law Journal of Southern Africa*, 47(2), pp. 276–296.

UNAIDS (2015) *Understanding Fast-Track: Accelerating action to end the AIDS epidemic by 2030, Un aids*.

Walliman, N. (2011) *Research Methods The Basics*. First. New York: Roulledge. doi: doi:10.4324/9780203836071.

Wang, P. C. *et al.* (2007) 'Work-organisational and personal factors associated with upper body musculoskeletal disorders among sewing machine operators', *Occupational and Environmental Medicine*, 64(12), pp. 806–813. doi: 10.1136/oem.2006.029140.

Welman, C., Kruger, F. and Mitchell, B. (2005) *Research Methodology*.

White, M. D. and Marsh, E. E. (2006) 'Content Analysis : A Flexible Methodology', *Library Trends*, 55(1), pp. 22–45.

WHO (2017) *Protecting workers' health*. Available at: <http://www.who.int/news-room/fact-sheets/detail/protecting-workers'-health> (Accessed: 4 September 2019).

Williams, C. (2007) 'Research Methods', *Journal of Business & Economic Research*, 5(3), pp. 65–72.

Yoshikawa, H. *et al.* (2008) 'Mixing Qualitative and Quantitative Research in Developmental Science: Uses and Methodological Choices', *Developmental Psychology*, 44(2), pp. 344–354. doi: 10.1037/0012-1649.44.2.344.

Zungu, L. and Setswe, K. (2007) 'An integrated approach to the prevention and promotion of health in the workplace: a review from international experience', *SA Family Practice*, 49(6), pp. 6–9. doi: 10.1080/20786204.2006.10873433.

## APPENDICES

### APPENDIX A: ETON Systems - ETON select

# INCREASE EFFICIENCY!



ENG

**ETON SYSTEMS**  
*Above and beyond*

## INCREASING PRODUCTIVITY 30–100%

For more than 45 years Eton systems has improved production efficiency in textile industries, all around the world. More than 4000 systems have been installed at the plants of big and small prestige customers in Europe, USA, South America and Asia. The improvements in efficiency varies between 30% to 100% which makes Eton systems one of the most a valuable investments for global textile enterprises.

## IMPROVING QUALITY 40–150%

To be a world-class supplier it's vital to optimize and secure all steps of the production flow. The Eton system allows you to track measure and fine-tune each of these steps, making it easy to follow-up, adjust and improve quality.



HB Garment, Philippines.

## IMPROVING YOUR ORGANISATION

We provide the tools and the training to give you total control of your organisation. The information available from our software will have a far reaching impact on all areas of your business.

Eton Systems training team provides on-going support and education to enable you to improve your knowledge throughout the whole company.

## IMPROVING YOUR STAFF

Keep staff and attract new staff through ergonomic and efficient work places.

Possibility to produce and earn more money without industrial injury and fatigue.



Xing Lang, China

## IMPROVING FLEXIBILITY

Have a flexible production to support your customers with short delivery times and cost efficiently run different products and sizes.

## ROI WITHIN 1–3 YEARS

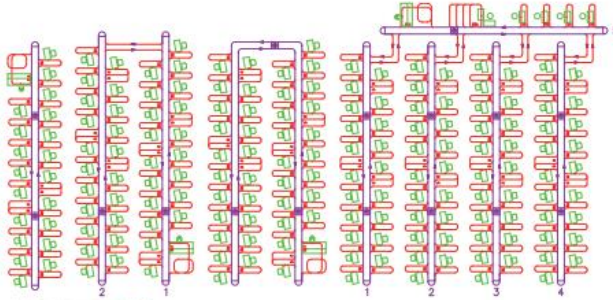
Improving production efficiency will substantially improve your profitability as well as your cost efficiency, due to a better utilization of staff, machinery, WIP (Work in Process) and space. Our customers normally see a positive return on their investment within 1 – 3 years, depending on the nature and complexity of their production.

Is this interesting for your company? Please contact us.





# FLEXIBLE SOLUTIONS



## ABOVE AND BEYOND

"We know the importance of history – ours has taken us beyond the present and into the future.

We know that meeting expectations is never enough, and that getting the job done is only half the story. And we know that good relations lead to even better results and even greater heights, where every move pushes the limits and every step is above and beyond."

# INCREASE EFFICIENCY IN ALL BUSINESS



**ETON SYSTEMS**  
*Above and beyond*

ETON SYSTEMS AB | BOX 15001, SE-507 15 GÅNGHESTER, SWEDEN  
TEL +46 (0)33 23 12 00 | MAIL@ETON.SE | WWW.ETONSYSYSTEMS.COM

## APPENDIX B: Clothing Industry Health Care Fund Brochure



### Membership Contribution

- Membership of the Fund is compulsory for all employees earning below an agreed ceiling wage rate.
- The ceiling wage rate is determined on an annual basis through negotiations between the Trade Union and the Employers.



### HEALTH CENTRES

#### **ATHLONE (Medical & Dental)**

TEL: (021) 696 4460/1/2

FAX: (021) 696-4497

#### **ATLANTIS (Medical)**

TEL: (021) 577 1004/1715

FAX: (021) 577-3107

#### **DELFT (Medical & Dental)**

TEL: (021) 954 4090/1/2

FAX: (021) 954 4201

#### **ELSIES RIVER (Medical)**

TEL: (021) 932 3030/6471

FAX: (021) 932-6381

#### **GRASSY PARK (Medical)**

TEL: (021) 706 5835/6

FAX: (021) 706-2143

#### **MITCHELLS PLAIN (Medical & Dental)**

TEL: (021) 391 4924

FAX: (021) 391-4273

#### **SALT RIVER (Medical & Optical)**

TEL: (021) 460 4150/2

FAX: (021) 477-1832

#### **SALT RIVER (Dental)**

TEL: (021) 460-4117

FAX: (021) 477-5564



## **CLOTHING INDUSTRY HEALTH CARE FUND**

### **INDUSTRIA HOUSE**

350 Victoria Road

Salt River

7925

**Tel:** (021) 460 4111

**Fax:** (021) 460 4190

## THE HEALTH CARE FUND

- The Funds is a non-profit organization privately funded by contributions from clothing employees and employers.
- It provides a package of primary health care services.
- Metro areas receive services at the 7 health centers in Athlone, Atlantis, Delft, Elsies River, Grassy Park, Mitchells Plain and Salt River.
- Additional services are physiotherapy, occupational therapy and psychology services provided by students from UCT, UWC and US.
- There is no limit on the number of times workers and their dependants may attend the health centers.
- Services are also provided by General Practitioners (GPs) Only principal members are allowed to go for not more than 7 (seven) visits in 12 months.

### Definitions

#### **Principal member:**

An employee engaged in a factory. Each member of the Health Care Fund receives a Health Care Fund Card. This card serves as identification to the health service providers of this member and in addition, lists the names of their dependants as members of the Health Care Fund.

#### **Dependant:**

- A declared spouse of the contributor living at the same address
- The unmarried children under the age of 18 of the contributor, including natural offspring, stepchildren or adopted children; and
- The unmarried children of the contributor, including natural offspring, stepchildren or adopted children, over the age of 18 but under 25, who are at school or who are full-time students at a tertiary institution or who are physically or mentally disabled.

## PACKAGE OF CARE

### Acute and Chronic Service

- Family planning, PAP smears, hormone and other gynecological problems and counselling.
- Treating minor ailments e.g. coughs, colds, bumps, boils, and accident and emergency care e.g. bruises and minor injuries and burns.
- Treating adult and children with chronic health problems: diabetes, hypertension (high blood pressure), asthma, epilepsy (fits), etc.
- Handling disability cases

### Social Work and Psychological Services

- Marriage counseling, family therapy, helping members deal with personal problems such as anxiety, work and home pressure, family deaths, domestic violence and counseling and substance abuse.

### Oral Health Care

- Cleaning and polish, dentures, fillings, dental extractions and limited orthodontic (braces)

### Optical/Eye Care

- Free eye examinations and lenses at the point of service;
- Cost of any additional lens work i.e. tints or other extras, as well as the frame, are paid directly by the members, the equivalent of a co-payment



### Physiotherapy and Occupational Therapy

- Physiotherapy is concerned with assessing, treating and preventing human movement disorders, restoring normal function and manages pain in adults and children.

- Occupational therapy includes work assessments, functional capacity evaluation, return-to-work programmes and supported employment.



### Health and Wellness Promotion

- Talks on a range of topics are presented at the health centres and factories. Topics covered include mental health, cancer awareness, substance abuse, stress management and teenage pregnancy. Other topics can be added according to the needs of either the patients or employees.
- The health and wellness promotion programme also offer substance abuse support and development programmes. A staff member visits a factory and will plan the programme around the needs of employees.

### HIV/AIDS and Voluntary Counseling and Testing (VCT)

- Doing testing at the centers
- Dealing with specific problems such as Sexually Transmitted Infections including HIV

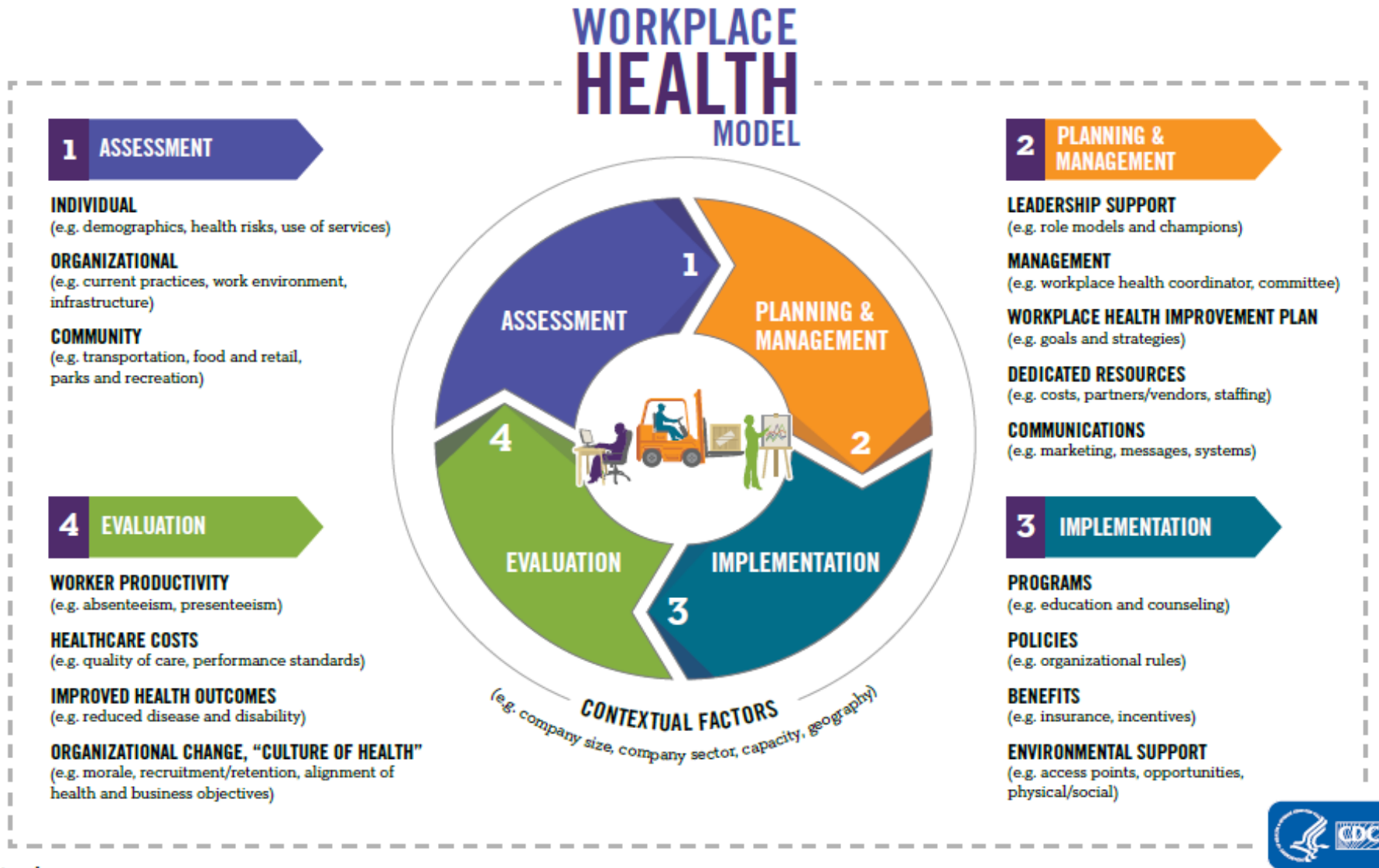
### Maternity Leave

The members must continuously contribute for one year and be a continuous member for a year in order to qualify for maternity benefits

### Exclusions

- The CIHCF doesn't have a trauma unit
- No provision of any routine diagnostic procedures or tests including basic clinical pathology, radiology i.e. chest x-rays, blood glucose, urine microscopy
- No routine care for pregnant mothers
- No additional payment for hospitalization

## APPENDIX C: Workplace Health Model



## APPENDIX D: Consent letter – Clothing Industry Health Care Fund



**Faculty of Business and Management Sciences**  
(Cape Town Campus)  
Mr Rudi De Koker  
Telephone: +27 +21 447 0543  
E-mail: [inkcubeko.business@gmail.com](mailto:inkcubeko.business@gmail.com)  
Department: Business Administration

---

Mrs Leslin Augustine  
National Bargaining Council for the Clothing Manufacturing Industry  
Industria House  
350 Victoria Road  
Salt River  
7925

9 February 2018

### **MBA: RESEARCH STUDY CONSENT LETTER**

Principal Investigator: Mr. Rudi De Koker

Co-Investigator: Dr. Bingwen Yan (Research supervisor, CPUT)

Physical Address: Faculty of Engineering  
Cape Peninsula University of Technology  
Bellville Campus  
Symphony Way  
7535

We hereby seek permission to conduct research for the dissertation entitled: Employee perceptions of downstream outcomes of health promotion: a case study of the clothing and textiles industry in South Africa. The research is being conducted by Mr. Rudi de Koker and Dr. Bingwen Yan (research supervisor). The dissertation will be submitted in fulfilment of the requirements for the Master of Technology Degree in Business Administration by Mr. Rudi De Koker.

#### **Purpose of the Research**

The purpose of this research is to investigate:

- a) what effect Workplace Health Promotion (WHP) has on an employee's physical, mental, and social level;
- b) what is the effect of WHP on the facilitation of preventive activities;
- c) what is the effect of WHP on general cognitive and affective outcomes; and
- d) based on the current effect of WHP, what can be improved to bring more benefits to employees?

#### **Participants to the Proposed Research**

The proposal is to conduct this research at National Bargaining Council for the Clothing Manufacturing Industry, Western Cape. We request that you allow us (the investigators) to

contact the relevant persons with the objective of exploring their experiences and perceptions on WHP at the organisation and its relevant stakeholders.

### Benefits of participating

It is envisaged that the outcome of the proposed research will be advantageous to all industries by providing insight into the perception of employees in relation to WHP. Such insight will benefit future strategic planning and result in improved participation in WHP, which equates to healthier employees.

### Ethics

The strictest confidentiality will be maintained while collecting data from all participants and information used to fulfil the requirements of this research at National Bargaining Council for the Clothing Manufacturing Industry. Findings reporting integrity will be upheld by the Investigators.

### Declaration by Participant

I, Dr. N. Behardien, am aware of the research project that will be conducted in CPUT's consent letter. I hereby approve the research to be conducted in our organisation.

I further (tick appropriate box):

- approve that the data collected may be used and kept for future studies
- request that the data collected be used and discarded


  

Signed at (place) Salt River on (date) 25/2/18  
2018.

Signature: [Handwritten Signature]

Print name: Dr. Nabel Behardien

CLOTHING INDUSTRY HEALTH  
CARE FUND  
P.O. BOX 1142  
WOODSTOCK  
7915



**Dr Nabel Behardien**  
Clinical Director  
Clothing Industry Health Care Fund

**Tel:** 021 460 4110  
**Fax:** 021 460 4190  
**Cell:** 082 777 3399  
**Email:** nbehardien@cibc.co.za

4th Floor, Industria House  
350 Victoria Rd, Salt River 7925  
P.O. Box 1142, Woodstock 7915

## APPENDIX E: Quantitative Research Questionnaire



*Faculty of Business and Management Sciences*

*Mr Rudi De Koker*

*Telephone: +27 +21 447 0543*

*E-mail: [inkcubeko.business@gmail.com](mailto:inkcubeko.business@gmail.com)*

*Department: Business Administration*

---

### RESEARCH QUESTIONNAIRE

Date: 28 September 2018

Dear Sir / Madam

**Re: Employee perceptions of downstream outcomes of health promotion: a case study of the clothing and textiles industry in South Africa**

I am currently studying my MTech: Business Administration at Cape Peninsula University of Technology (CPUT), in the department of Commerce. I am conducting a research project on whether employees perceive Workplace Health Promotion as beneficial to their personal health status. Workplace Health Promotion relates to education sessions or training provided on health issues, HIV Testing Services and visits to the clinic with the doctor or pharmacy. This research is very important, as it will assist in the development of the Workplace Health Promotion programme.

The objective of this research questionnaire is to collect data from clients at the clinic in the form of providing answers to the questionnaire. Participation in this study is voluntary as well as confidential and your participation will not impact the current services received from the clinic. The questionnaire is in the form of a Likert Scale, which from strongly agree to strongly disagree.

Please note that, for accuracy and truthfulness of this research, respondents are asked not to focus on whether the answer is 'right' or 'wrong' but, rather focus on personal perceptions OR experiences on the given questions and / or statements. I would like to take this opportunity and thank you for your contribution in this research project. Your involvement is highly valued.

Yours sincerely

Rudi de Koker

I, \_\_\_\_\_, I have been invited to participate in research about Employee perceptions of downstream outcomes of health promotion.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have, has been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant \_\_\_\_\_  
Signature of Participant \_\_\_\_\_  
Date \_\_\_\_\_



## 1.1 Demographical data

### 1. Age

|                        |  |
|------------------------|--|
| Less than 20 years old |  |
| 20-30                  |  |
| 31-40                  |  |
| 41-50                  |  |
| More than 50           |  |

### 2. Gender

|        |  |
|--------|--|
| Female |  |
| Male   |  |

### 3. Educational level

|                          |  |
|--------------------------|--|
| Less than Grade 8        |  |
| Higher school (Grade 12) |  |
| College                  |  |
| Diploma / Bachelor       |  |
| Postgraduate degree      |  |
| Others (please indicate) |  |

### 4. Length of employment in organization

|                    |  |
|--------------------|--|
| Less than 1 year   |  |
| 1-2 years          |  |
| 3-5 years          |  |
| 6-10 years         |  |
| More than 10 years |  |

### 5. Do you know your HIV status

|     |  |
|-----|--|
| Yes |  |
| No  |  |

### 6. Have you ever been tested for TB

|     |  |
|-----|--|
| Yes |  |
| No  |  |

## 1.2 Decision-making session

Decision making on the statements below should reflect your feeling of the topic. Select the number by using a “tick” for each statement which corresponds with your level of agreement.

| Decision Codes | Strongly agree | Agree | Unsure | Disagree | Strongly Disagree |
|----------------|----------------|-------|--------|----------|-------------------|
|                | 1              | 2     | 3      | 4        | 5                 |

| Code     | STATEMENTS  | Decision-making |   |   |   |   |
|----------|---|-----------------|---|---|---|---|
| <b>1</b> | <b>Physical effects</b>   |                 |   |   |   |   |
| 1a       | I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering.   | 1               | 2 | 3 | 4 | 5 |
| 1b       | WHP has assisted me to prevent the beginning of health problems.  | 1               | 2 | 3 | 4 | 5 |
| 1c       | My physical problems has reduced due to my participation in the WHP programme.                            | 1               | 2 | 3 | 4 | 5 |
| 1d       | I have noticed no effect of WHP on my physical health.  | 1               | 2 | 3 | 4 | 5 |
| 1e       | I feel healthier due to participating in the WHP programme service offering.                              | 1               | 2 | 3 | 4 | 5 |
| 1f       | I feel more productive because I am participating in the WHP programme service offering.                  | 1               | 2 | 3 | 4 | 5 |
| <b>2</b> | <b>Mental effects</b>   |                 |   |   |   |   |
| 2a       | I feel more motivated because the company offers WHP programmes.  | 1               | 2 | 3 | 4 | 5 |
| 2b       | I enjoy participating in WHP programme offers.  | 1               | 2 | 3 | 4 | 5 |
| 2c       | I experience better coping with stress and pressure due to participating in WHP programme offers.         | 1               | 2 | 3 | 4 | 5 |
| 2d       | Without WHP I felt more stressed.   | 1               | 2 | 3 | 4 | 5 |
| 2e       | I am feeling more satisfied in my workplace because the organisation offers WHP.                          | 1               | 2 | 3 | 4 | 5 |
| <b>3</b> | <b>Social effects</b>   |                 |   |   |   |   |
| 3a       | My contact with colleagues deepens due to participation in WHP programme service offering.                | 1               | 2 | 3 | 4 | 5 |
| 3b       | I feel appreciated by the organisation due to WHP service offering.                                       | 1               | 2 | 3 | 4 | 5 |
| 3c       | I enjoy more personal contacts within my workplace due to participating in WHP programme offers.          | 1               | 2 | 3 | 4 | 5 |
| 3d       | There are no better intra-team relationships due to WHP.  | 1               | 2 | 3 | 4 | 5 |
| 3e       | Participating in WHP programme service offering motivates me to be a role model for colleagues.           | 1               | 2 | 3 | 4 | 5 |
| 3f       | I experience a better basis of conversation with my supervisor, relating to my health.                    | 1               | 2 | 3 | 4 | 5 |
| <b>4</b> | <b>Facilitation of preventative activities</b>  |                 |   |   |   |   |
| 4a       | Participating in WHP programme service offering makes the prevention of illnesses financially affordable. | 1               | 2 | 3 | 4 | 5 |
| 4b       | I do not have to organise health related visits in my private time due to WHP.                            | 1               | 2 | 3 | 4 | 5 |

|          |  |   |   |   |   |   |
|----------|--|---|---|---|---|---|
| <b>5</b> | <b>General cognitive and affective outcomes</b>  |   |   |   |   |   |
| 5a       | I now know more about a healthy lifestyle due to the WHP programme offering.           | 1 | 2 | 3 | 4 | 5 |
| 5b       | Medical assistance in the workplace is of special importance to me.                    | 1 | 2 | 3 | 4 | 5 |
| 5b       | I have undergone health testing offered through WHP.                                   | 1 | 2 | 3 | 4 | 5 |
| 5c       | My attitude has improved towards my health due to WHP.                                 | 1 | 2 | 3 | 4 | 5 |
| 5d       | I am paying more attention to my health since participating in WHP service offering.   | 1 | 2 | 3 | 4 | 5 |
| 5e       | I am feeling motivated because the workplace offers WHP.                               | 1 | 2 | 3 | 4 | 5 |
| 5f       | I feel more relaxed after work due to participating in WHP programme service offering. | 1 | 2 | 3 | 4 | 5 |

## APPENDIX F: Qualitative Interview Schedule

### 1.1 Interviews with Managers

|    |   |
|----|---|
| 1A | How do you as a manager participate in WHP at your organisation?                  |
| 1B | How do you encourage staff to participate in WHP at your organisation?            |
| 1C | What has been key successes in WHP at your organisation?                          |
| 1D | What directed the strategic intent and/or objectives of WHP in your organisation? |
| 1E | What channels of communication is used in WHP at your organisation?               |
| 1F | What challenges do employees face to access WHP?                                  |
| 1G | What are the barriers to successfully implementing WHP at your organisation?      |
| 1H | How has the implementation of WHP improved employees' physical well-being?        |

|    |   |
|----|---|
| 1I | How has the implementation of WHP improved employees' mental well-being?                        |
| 1J | How has the implementation of WHP improved employee interaction at peer level?                  |
| 1K | How has the implementation of WHP improved employee interaction with management?                |
| 1L | How has the implementation of WHP facilitated open conversations relating to employees' health? |
| 1M | How has the implementation of WHP decreased employees' absenteeism?                             |
| 1N | How has the implementation of WHP increased access to appropriate healthcare?                   |
| 1O | How has the implementation of WHP increased health testing of employees?                        |
| 1P | How has the implementation of WHP improved employees' productivity?                             |
| 1Q | How is top management supporting the WHP?   |

**APPENDIX G: SPSS Data Statistics**

|                |         | Age   | Gender | Edu level | Emplmt | HIV status | TB test | 1a   | 1b    | 1c    | 1d    | 1e   | 1f    | 2a    |
|----------------|---------|-------|--------|-----------|--------|------------|---------|------|-------|-------|-------|------|-------|-------|
| N              | Valid   | 121   | 121    | 121       | 121    | 121        | 121     | 121  | 121   | 121   | 121   | 121  | 121   | 121   |
|                | Missing | 0     | 0      | 0         | 0      | 0          | 0       | 0    | 0     | 0     | 0     | 0    | 0     | 0     |
| Mean           |         | 3.37  | 1.33   | 2.17      | 3.36   | 1.12       | 1.31    | 1.83 | 1.95  | 2.15  | 2.72  | 2.02 | 2.09  | 1.98  |
| Median         |         | 3.00  | 1.00   | 2.00      | 3.00   | 1.00       | 1.00    | 2.00 | 2.00  | 2.00  | 2.00  | 2.00 | 2.00  | 2.00  |
| Std. Deviation |         | 1.205 | .472   | 1.459     | 1.455  | .331       | .463    | .986 | 1.079 | 1.070 | 1.273 | .987 | 1.103 | 1.162 |
| Variance       |         | 1.452 | .223   | 2.128     | 2.117  | .110       | .214    | .972 | 1.164 | 1.144 | 1.620 | .974 | 1.217 | 1.350 |
| Range          |         | 4     | 1      | 5         | 4      | 1          | 1       | 4    | 4     | 4     | 4     | 4    | 4     | 4     |
| Minimum        |         | 1     | 1      | 1         | 1      | 1          | 1       | 1    | 1     | 1     | 1     | 1    | 1     | 1     |
| Maximum        |         | 5     | 2      | 6         | 5      | 2          | 2       | 5    | 5     | 5     | 5     | 5    | 5     | 5     |

| 2b   | 2c    | 2d    | 2e    | 3a    | 3b   | 3c    | 3d    | 3e    | 3f    | 4a    | 4b    | 5a    | 5b    | 5b2   |
|------|-------|-------|-------|-------|------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 121  | 121   | 121   | 121   | 121   | 121  | 121   | 121   | 121   | 121   | 121   | 121   | 121   | 121   | 121   |
| 0    | 0     | 0     | 0     | 0     | 0    | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     |
| 1.98 | 2.10  | 2.35  | 2.02  | 2.13  | 1.97 | 2.18  | 2.12  | 2.08  | 2.28  | 2.03  | 2.17  | 1.85  | 1.79  | 1.92  |
| 2.00 | 2.00  | 2.00  | 2.00  | 2.00  | 2.00 | 2.00  | 2.00  | 2.00  | 2.00  | 2.00  | 2.00  | 2.00  | 2.00  | 2.00  |
| .996 | 1.158 | 1.131 | 1.025 | 1.016 | .912 | 1.057 | 1.005 | 1.053 | 1.199 | 1.008 | 1.046 | 1.046 | 1.016 | 1.092 |
| .991 | 1.340 | 1.279 | 1.050 | 1.032 | .832 | 1.117 | 1.010 | 1.110 | 1.437 | 1.016 | 1.095 | 1.094 | 1.032 | 1.193 |
| 4    | 4     | 4     | 4     | 4     | 4    | 4     | 4     | 4     | 4     | 4     | 4     | 4     | 4     | 4     |
| 1    | 1     | 1     | 1     | 1     | 1    | 1     | 1     | 1     | 1     | 1     | 1     | 1     | 1     | 1     |
| 5    | 5     | 5     | 5     | 5     | 5    | 5     | 5     | 5     | 5     | 5     | 5     | 5     | 5     | 5     |

| 5c   | 5d    | 5e    | 5f    |
|------|-------|-------|-------|
| 121  | 121   | 121   | 121   |
| 0    | 0     | 0     | 0     |
| 1.86 | 1.86  | 1.79  | 1.94  |
| 2.00 | 2.00  | 2.00  | 2.00  |
| .994 | 1.051 | 1.042 | 1.098 |
| .988 | 1.105 | 1.087 | 1.205 |
| 4    | 4     | 4     | 4     |
| 1    | 1     | 1     | 1     |
| 5    | 5     | 5     | 5     |

|       |                 | <b>Age</b>    |         |                  |                       |
|-------|-----------------|---------------|---------|------------------|-----------------------|
|       |                 | Freque<br>ncy | Percent | Valid<br>Percent | Cumulative<br>Percent |
| Valid | < 20 Yrs<br>old | 7             | 5.8     | 5.8              | 5.8                   |
|       | 20-30 Yrs       | 26            | 21.5    | 21.5             | 27.3                  |
|       | 31-40 Yrs       | 29            | 24.0    | 24.0             | 51.2                  |
|       | 41-50 Yrs       | 33            | 27.3    | 27.3             | 78.5                  |
|       | > 50 Yrs        | 26            | 21.5    | 21.5             | 100.0                 |
|       | Total           | 121           | 100.0   | 100.0            |                       |

|       |        | <b>Gender</b> |         |                  |                       |
|-------|--------|---------------|---------|------------------|-----------------------|
|       |        | Freque<br>ncy | Percent | Valid<br>Percent | Cumulative<br>Percent |
| Valid | Female | 81            | 66.9    | 66.9             | 66.9                  |
|       | Male   | 40            | 33.1    | 33.1             | 100.0                 |
|       | Total  | 121           | 100.0   | 100.0            |                       |

|       |                             | <b>Edu level</b> |         |                  |                       |
|-------|-----------------------------|------------------|---------|------------------|-----------------------|
|       |                             | Freque<br>ncy    | Percent | Valid<br>Percent | Cumulative<br>Percent |
| Valid | < Grade 8                   | 41               | 33.9    | 33.9             | 33.9                  |
|       | Higher school (Grade<br>12) | 60               | 49.6    | 49.6             | 83.5                  |
|       | College                     | 3                | 2.5     | 2.5              | 86.0                  |
|       | Diploma / Bachelor          | 3                | 2.5     | 2.5              | 88.4                  |
|       | Postgraduate degree         | 3                | 2.5     | 2.5              | 90.9                  |
|       | Others                      | 11               | 9.1     | 9.1              | 100.0                 |
|       | Total                       | 121              | 100.0   | 100.0            |                       |

|       |            | <b>Emplmt</b> |         |                  |                       |
|-------|------------|---------------|---------|------------------|-----------------------|
|       |            | Freque<br>ncy | Percent | Valid<br>Percent | Cumulative<br>Percent |
| Valid | < 1 year   | 18            | 14.9    | 14.9             | 14.9                  |
|       | 1-2 years  | 18            | 14.9    | 14.9             | 29.8                  |
|       | 3-5 years  | 28            | 23.1    | 23.1             | 52.9                  |
|       | 6-10 years | 16            | 13.2    | 13.2             | 66.1                  |
|       | >10 years  | 41            | 33.9    | 33.9             | 100.0                 |
|       | Total      | 121           | 100.0   | 100.0            |                       |



|       |       | <b>HIV status</b> |         |               |                    |
|-------|-------|-------------------|---------|---------------|--------------------|
|       |       | Frequency         | Percent | Valid Percent | Cumulative Percent |
| Valid | Yes   | 106               | 87.6    | 87.6          | 87.6               |
|       | No    | 15                | 12.4    | 12.4          | 100.0              |
|       | Total | 121               | 100.0   | 100.0         |                    |

|       |       | <b>TB test</b> |         |               |                    |
|-------|-------|----------------|---------|---------------|--------------------|
|       |       | Frequency      | Percent | Valid Percent | Cumulative Percent |
| Valid | Yes   | 84             | 69.4    | 69.4          | 69.4               |
|       | No    | 37             | 30.6    | 30.6          | 100.0              |
|       | Total | 121            | 100.0   | 100.0         |                    |

**1a - I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 52        | 43.0    | 43.0          | 43.0               |
|       | Agree             | 50        | 41.3    | 41.3          | 84.3               |
|       | Unsure            | 11        | 9.1     | 9.1           | 93.4               |
|       | Disagree          | 3         | 2.5     | 2.5           | 95.9               |
|       | Strongly Disagree | 5         | 4.1     | 4.1           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**1b - WHP has assisted me to prevent the beginning of health problems**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 47        | 38.8    | 38.8          | 38.8               |
|       | Agree             | 52        | 43.0    | 43.0          | 81.8               |
|       | Unsure            | 10        | 8.3     | 8.3           | 90.1               |
|       | Disagree          | 5         | 4.1     | 4.1           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**1c - My physical problems has reduced due to my participation in the WHP programme**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 34        | 28.1    | 28.1          | 28.1               |
|       | Agree             | 56        | 46.3    | 46.3          | 74.4               |
|       | Unsure            | 16        | 13.2    | 13.2          | 87.6               |
|       | Disagree          | 9         | 7.4     | 7.4           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**1d - I have noticed no effect of WHP on my physical health**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 20        | 16.5    | 16.5          | 16.5               |
|       | Agree             | 41        | 33.9    | 33.9          | 50.4               |
|       | Unsure            | 31        | 25.6    | 25.6          | 76.0               |
|       | Disagree          | 11        | 9.1     | 9.1           | 85.1               |
|       | Strongly Disagree | 18        | 14.9    | 14.9          | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**1e - I feel healthier due to participating in the WHP programme service offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 37        | 30.6    | 30.6          | 30.6               |
|       | Agree             | 60        | 49.6    | 49.6          | 80.2               |
|       | Unsure            | 12        | 9.9     | 9.9           | 90.1               |
|       | Disagree          | 8         | 6.6     | 6.6           | 96.7               |
|       | Strongly Disagree | 4         | 3.3     | 3.3           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**1f - I feel more productive because I am participating in the WHP programme service offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 39        | 32.2    | 32.2          | 32.2               |
|       | Agree             | 54        | 44.6    | 44.6          | 76.9               |
|       | Unsure            | 13        | 10.7    | 10.7          | 87.6               |
|       | Disagree          | 8         | 6.6     | 6.6           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**2a - I feel more motivated because the company offers WHP programmes**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 49        | 40.5    | 40.5          | 40.5               |
|       | Agree             | 49        | 40.5    | 40.5          | 81.0               |
|       | Unsure            | 8         | 6.6     | 6.6           | 87.6               |
|       | Disagree          | 6         | 5.0     | 5.0           | 92.6               |
|       | Strongly Disagree | 9         | 7.4     | 7.4           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**2b - I enjoy participating in WHP programme offers**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 39        | 32.2    | 32.2          | 32.2               |
|       | Agree             | 62        | 51.2    | 51.2          | 83.5               |
|       | Unsure            | 10        | 8.3     | 8.3           | 91.7               |
|       | Disagree          | 4         | 3.3     | 3.3           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**2c - I experience better coping with stress and pressure due to participating in WHP programme offers**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 43        | 35.5    | 35.5          | 35.5               |
|       | Agree             | 48        | 39.7    | 39.7          | 75.2               |
|       | Unsure            | 12        | 9.9     | 9.9           | 85.1               |
|       | Disagree          | 11        | 9.1     | 9.1           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**2d - Without WHP I felt more stressed**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 28        | 23.1    | 23.1          | 23.1               |
|       | Agree             | 51        | 42.1    | 42.1          | 65.3               |
|       | Unsure            | 21        | 17.4    | 17.4          | 82.6               |
|       | Disagree          | 14        | 11.6    | 11.6          | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**2e - I am feeling more satisfied in my workplace because the organisation offers WHP**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 38        | 31.4    | 31.4          | 31.4               |
|       | Agree             | 61        | 50.4    | 50.4          | 81.8               |
|       | Unsure            | 10        | 8.3     | 8.3           | 90.1               |
|       | Disagree          | 6         | 5.0     | 5.0           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**3a - My contact with colleagues deepens due to participation in WHP programme service offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 30        | 24.8    | 24.8          | 24.8               |
|       | Agree             | 64        | 52.9    | 52.9          | 77.7               |
|       | Unsure            | 14        | 11.6    | 11.6          | 89.3               |
|       | Disagree          | 7         | 5.8     | 5.8           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**3b - I feel appreciated by the organisation due to WHP service offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 34        | 28.1    | 28.1          | 28.1               |
|       | Agree             | 70        | 57.9    | 57.9          | 86.0               |
|       | Unsure            | 9         | 7.4     | 7.4           | 93.4               |
|       | Disagree          | 3         | 2.5     | 2.5           | 95.9               |
|       | Strongly Disagree | 5         | 4.1     | 4.1           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**3c - I enjoy more personal contacts within my workplace due to participating in WHP programme offers**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 29        | 24.0    | 24.0          | 24.0               |
|       | Agree             | 63        | 52.1    | 52.1          | 76.0               |
|       | Unsure            | 14        | 11.6    | 11.6          | 87.6               |
|       | Disagree          | 8         | 6.6     | 6.6           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**3d - There are no better intra-team relationships due to WHP**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 35        | 28.9    | 28.9          | 28.9               |
|       | Agree             | 50        | 41.3    | 41.3          | 70.2               |
|       | Unsure            | 27        | 22.3    | 22.3          | 92.6               |
|       | Disagree          | 4         | 3.3     | 3.3           | 95.9               |
|       | Strongly Disagree | 5         | 4.1     | 4.1           | 100.0              |
| Total |                   | 121       | 100.0   | 100.0         |                    |

**3e - Participating in WHP programme service offering motivates me to be a role model for colleagues.**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 36        | 29.8    | 29.8          | 29.8               |
|       | Agree             | 59        | 48.8    | 48.8          | 78.5               |
|       | Unsure            | 12        | 9.9     | 9.9           | 88.4               |
|       | Disagree          | 8         | 6.6     | 6.6           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
| Total |                   | 121       | 100.0   | 100.0         |                    |

**3f - I experience a better basis of conversation with my supervisor, relating to my health**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 30        | 24.8    | 24.8          | 24.8               |
|       | Agree             | 60        | 49.6    | 49.6          | 74.4               |
|       | Unsure            | 9         | 7.4     | 7.4           | 81.8               |
|       | Disagree          | 11        | 9.1     | 9.1           | 90.9               |
|       | Strongly Disagree | 11        | 9.1     | 9.1           | 100.0              |
| Total |                   | 121       | 100.0   | 100.0         |                    |

**4a - Participating in WHP programme service offering makes the prevention of illnesses financially affordable**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 36        | 29.8    | 29.8          | 29.8               |
|       | Agree             | 63        | 52.1    | 52.1          | 81.8               |
|       | Unsure            | 9         | 7.4     | 7.4           | 89.3               |
|       | Disagree          | 8         | 6.6     | 6.6           | 95.9               |
|       | Strongly Disagree | 5         | 4.1     | 4.1           | 100.0              |
| Total |                   | 121       | 100.0   | 100.0         |                    |

**4b - I do not have to organise health related visits in my private time due to WHP**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 29        | 24.0    | 24.0          | 24.0               |
|       | Agree             | 63        | 52.1    | 52.1          | 76.0               |
|       | Unsure            | 15        | 12.4    | 12.4          | 88.4               |
|       | Disagree          | 7         | 5.8     | 5.8           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5a - I now know more about a healthy lifestyle due to the WHP programme offering**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 52        | 43.0    | 43.0          | 43.0               |
|       | Agree             | 53        | 43.8    | 43.8          | 86.8               |
|       | Unsure            | 4         | 3.3     | 3.3           | 90.1               |
|       | Disagree          | 6         | 5.0     | 5.0           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5b - Medical assistance in the workplace is of special importance to me**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 56        | 46.3    | 46.3          | 46.3               |
|       | Agree             | 49        | 40.5    | 40.5          | 86.8               |
|       | Unsure            | 7         | 5.8     | 5.8           | 92.6               |
|       | Disagree          | 3         | 2.5     | 2.5           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5b2 - I have undergone health testing offered through WHP**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 50        | 41.3    | 41.3          | 41.3               |
|       | Agree             | 52        | 43.0    | 43.0          | 84.3               |
|       | Unsure            | 4         | 3.3     | 3.3           | 87.6               |
|       | Disagree          | 9         | 7.4     | 7.4           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5c - My attitude has improved towards my health due to WHP**

|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 49        | 40.5    | 40.5          | 40.5               |
|       | Agree             | 55        | 45.5    | 45.5          | 86.0               |
|       | Unsure            | 7         | 5.8     | 5.8           | 91.7               |
|       | Disagree          | 5         | 4.1     | 4.1           | 95.9               |
|       | Strongly Disagree | 5         | 4.1     | 4.1           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5d - I am paying more attention to my health since participating in WHP service offering**

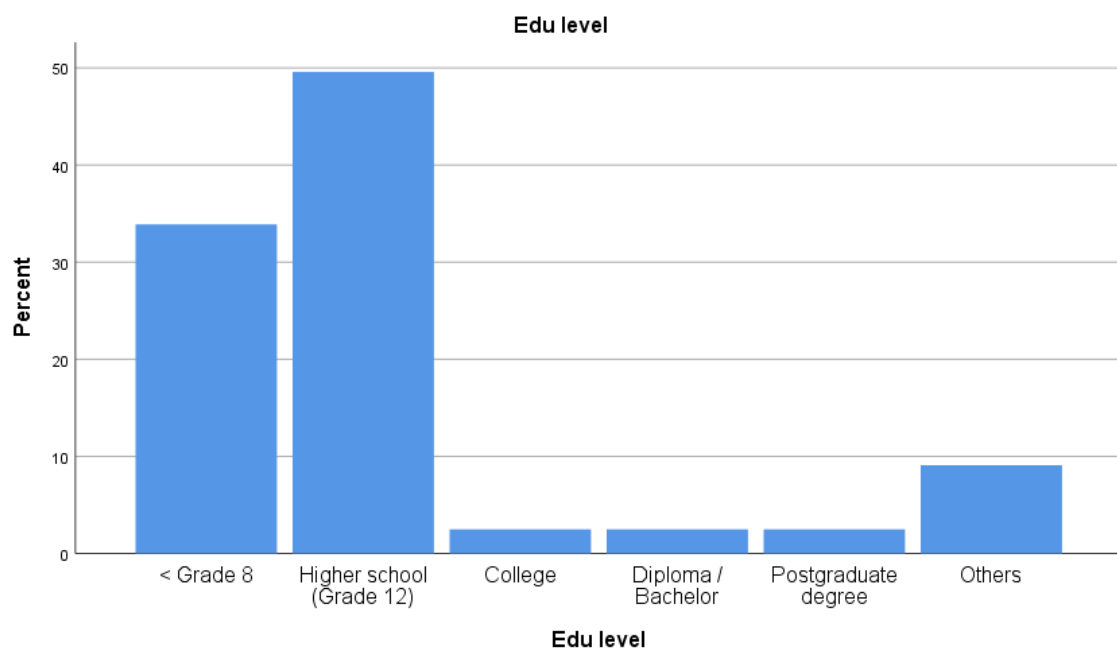
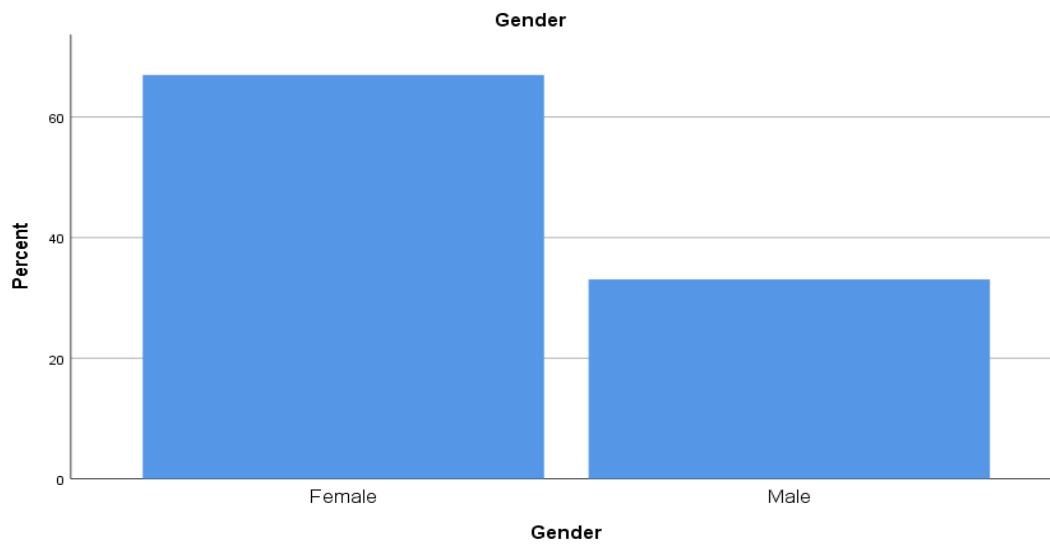
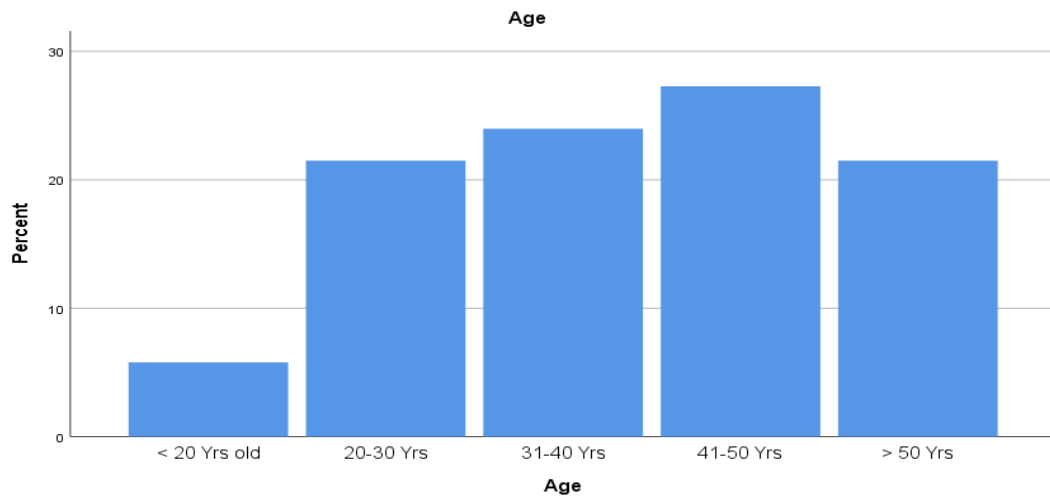
|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 51        | 42.1    | 42.1          | 42.1               |
|       | Agree             | 55        | 45.5    | 45.5          | 87.6               |
|       | Unsure            | 2         | 1.7     | 1.7           | 89.3               |
|       | Disagree          | 7         | 5.8     | 5.8           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5e - I am feeling motivated because the workplace offers WHP**

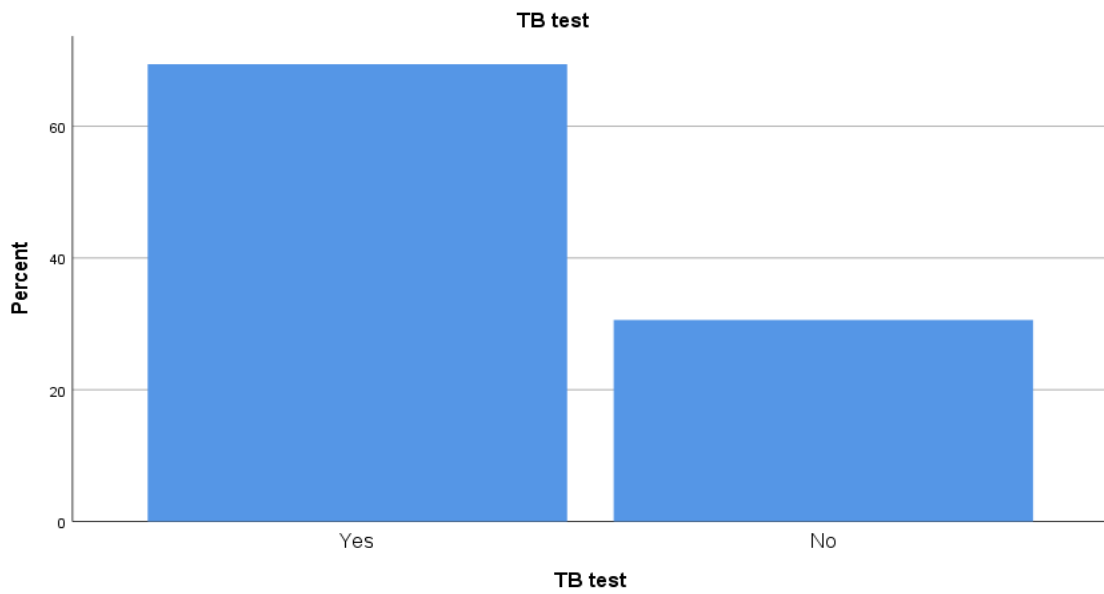
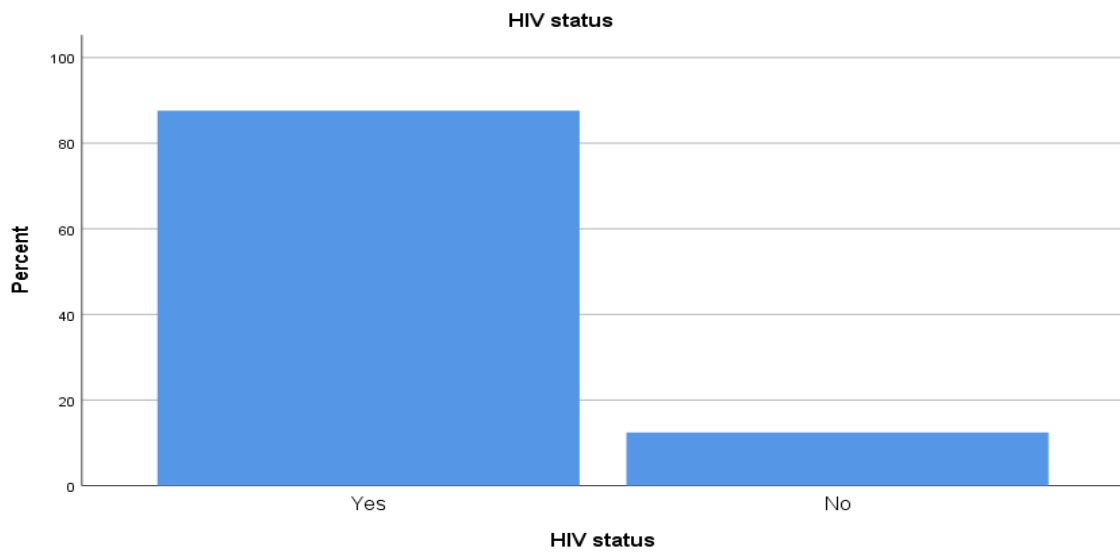
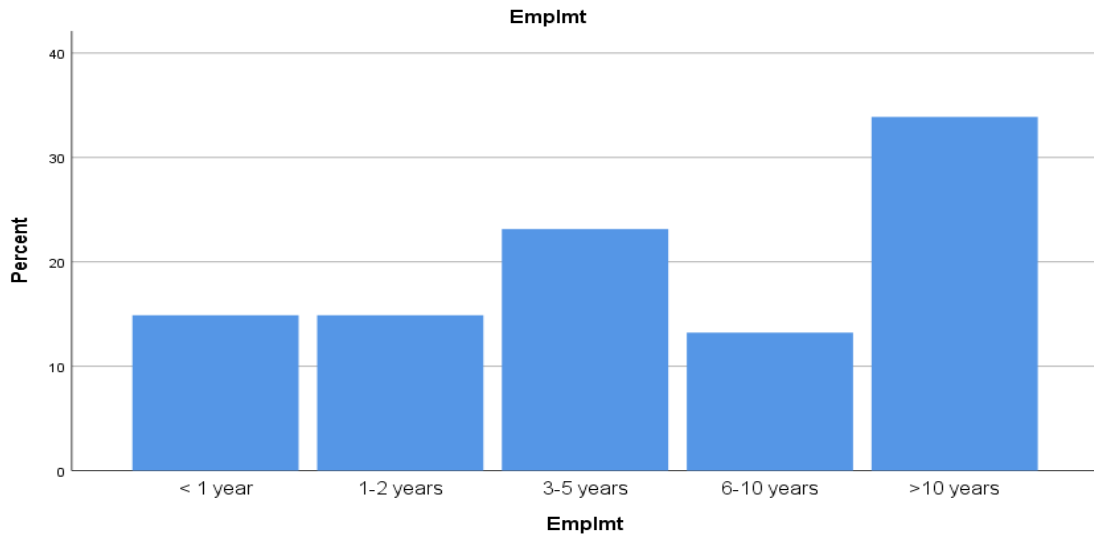
|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 58        | 47.9    | 47.9          | 47.9               |
|       | Agree             | 48        | 39.7    | 39.7          | 87.6               |
|       | Unsure            | 4         | 3.3     | 3.3           | 90.9               |
|       | Disagree          | 5         | 4.1     | 4.1           | 95.0               |
|       | Strongly Disagree | 6         | 5.0     | 5.0           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |

**5f - I feel more relaxed after work due to participating in WHP programme service offering**

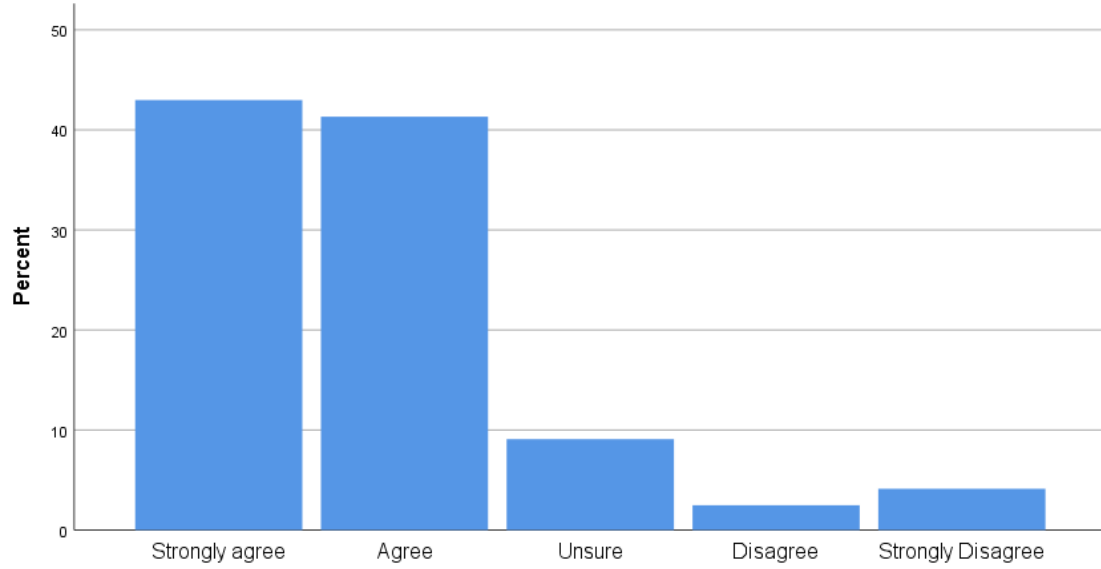
|       |                   | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------|-------------------|-----------|---------|---------------|--------------------|
| Valid | Strongly agree    | 48        | 39.7    | 39.7          | 39.7               |
|       | Agree             | 53        | 43.8    | 43.8          | 83.5               |
|       | Unsure            | 6         | 5.0     | 5.0           | 88.4               |
|       | Disagree          | 7         | 5.8     | 5.8           | 94.2               |
|       | Strongly Disagree | 7         | 5.8     | 5.8           | 100.0              |
|       | Total             | 121       | 100.0   | 100.0         |                    |



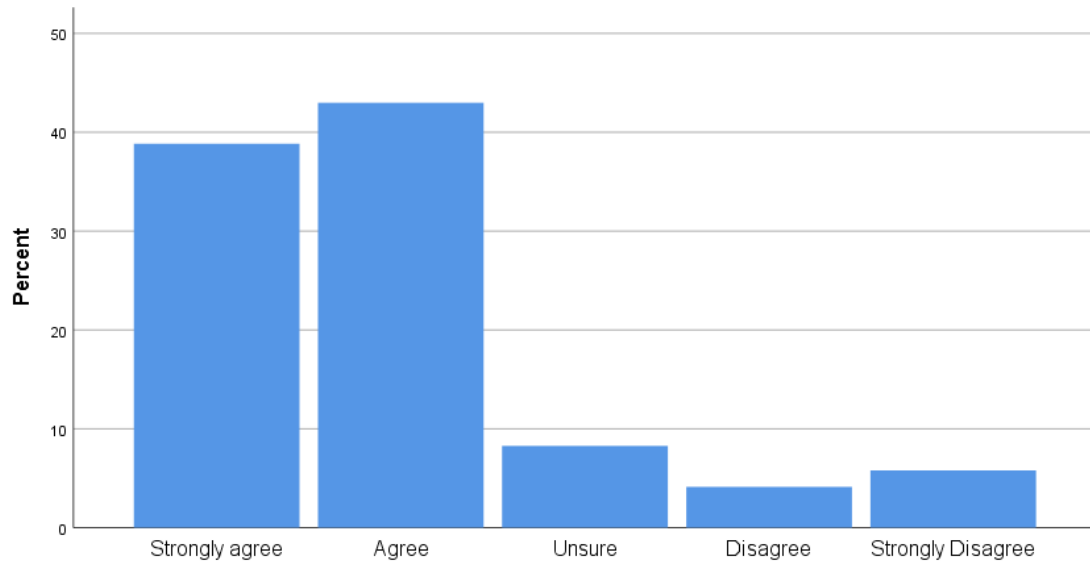




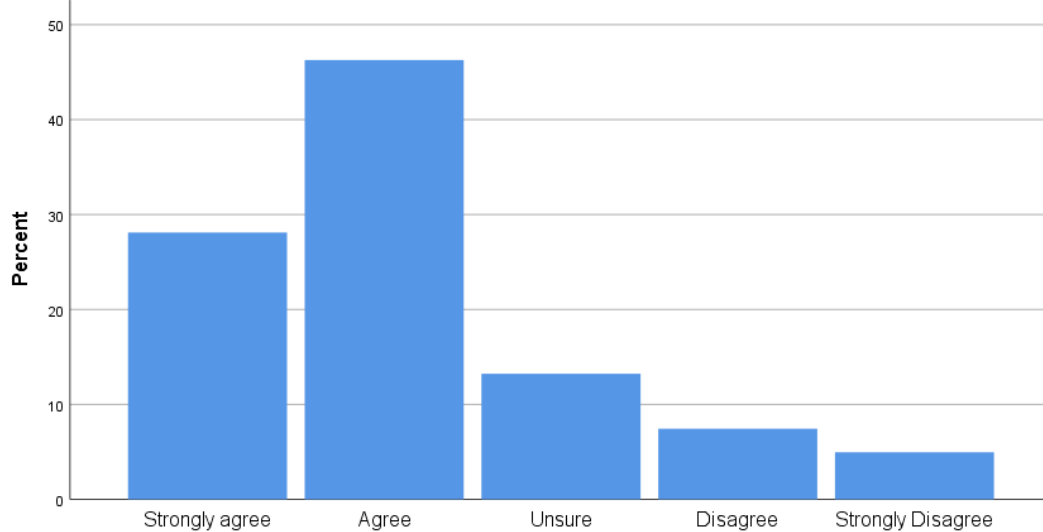
**1a - I feel physically better due to participating in the Workplace Health Promotion (WHP) service offering**



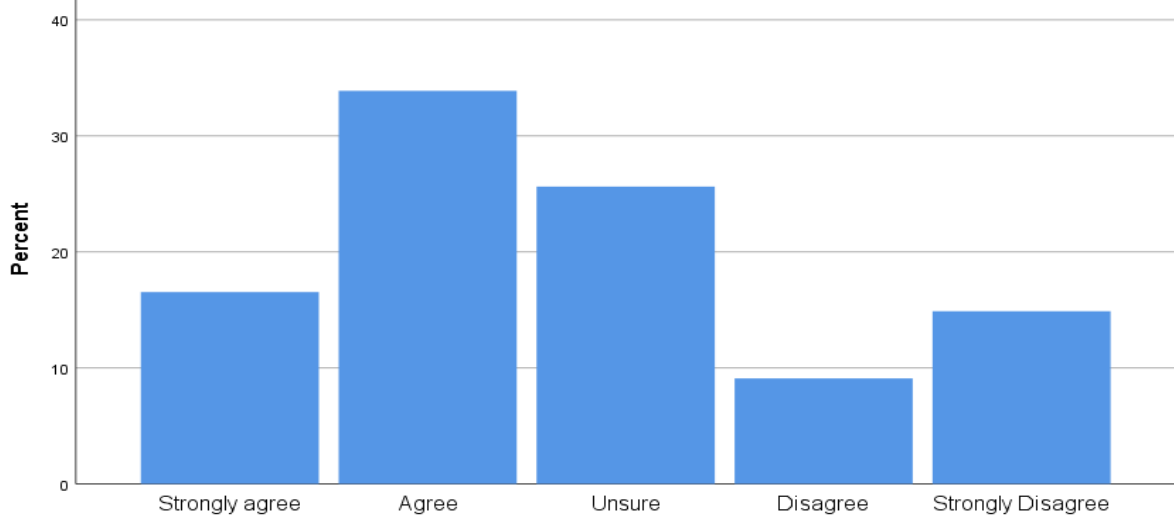
**1b - WHP has assisted me to prevent the beginning of health problems**



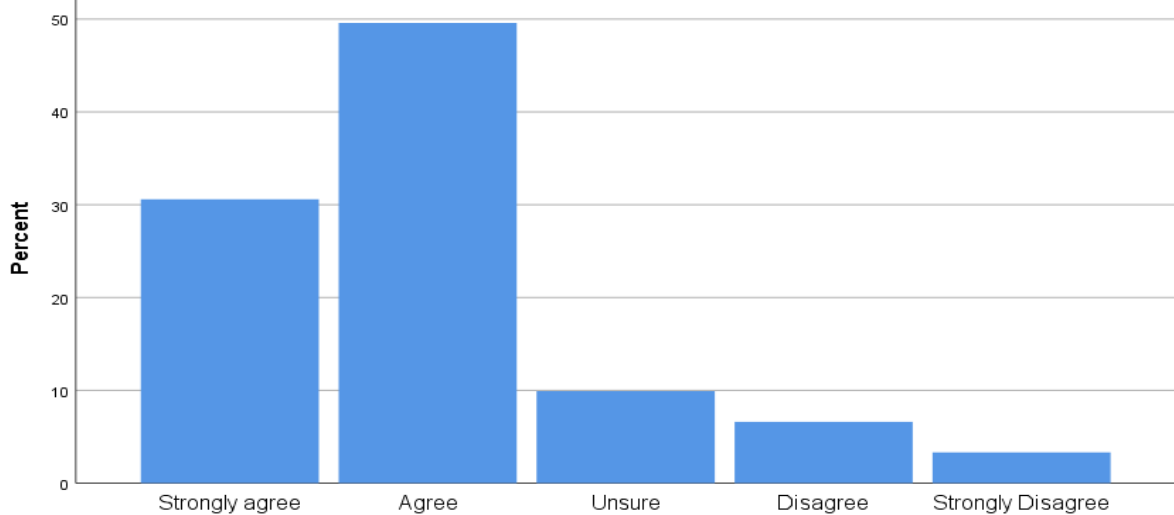
**1c - My physical problems has reduced due to my participation in the WHP programme**



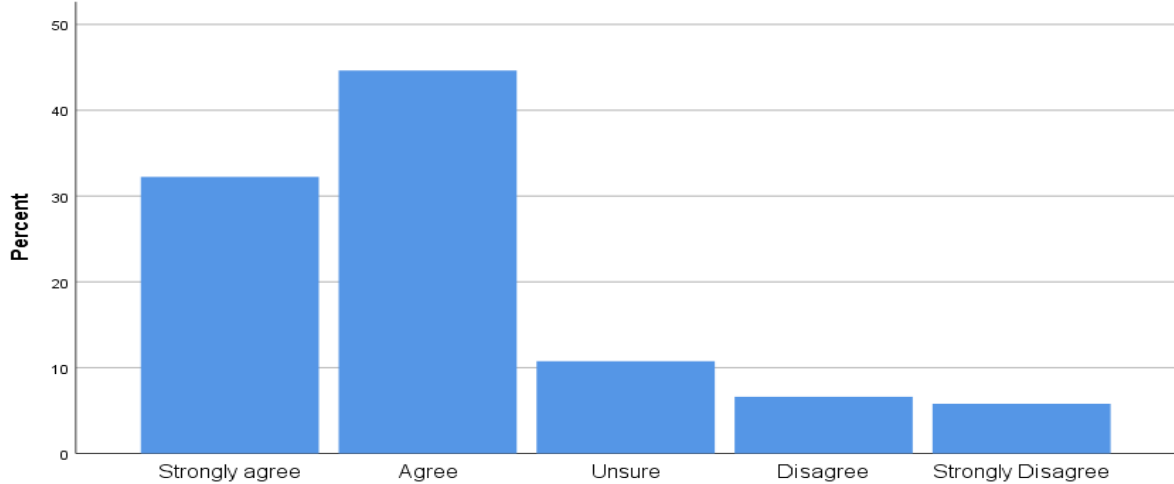
**1d - I have noticed no effect of WHP on my physical health**



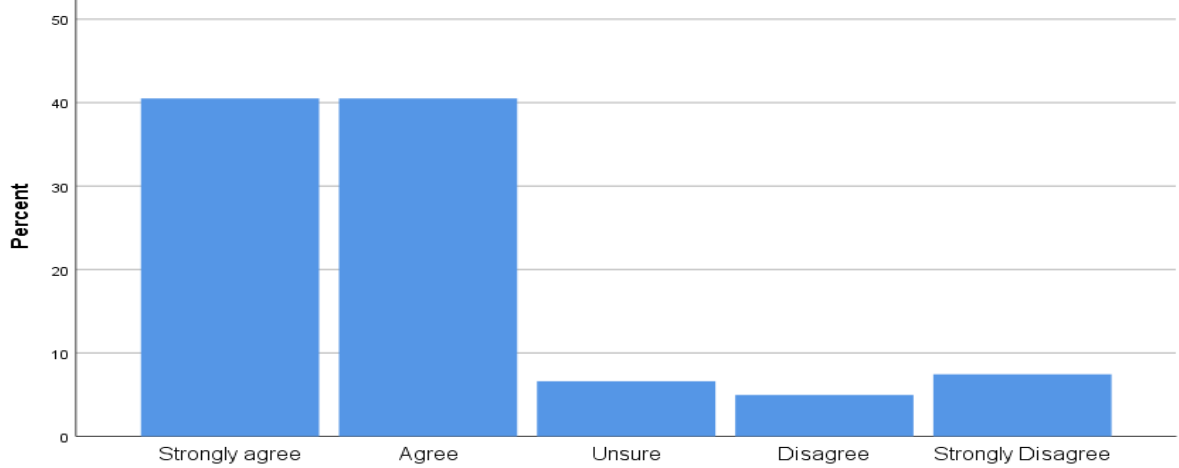
**1e - I feel healthier due to participating in the WHP programme service offering.**



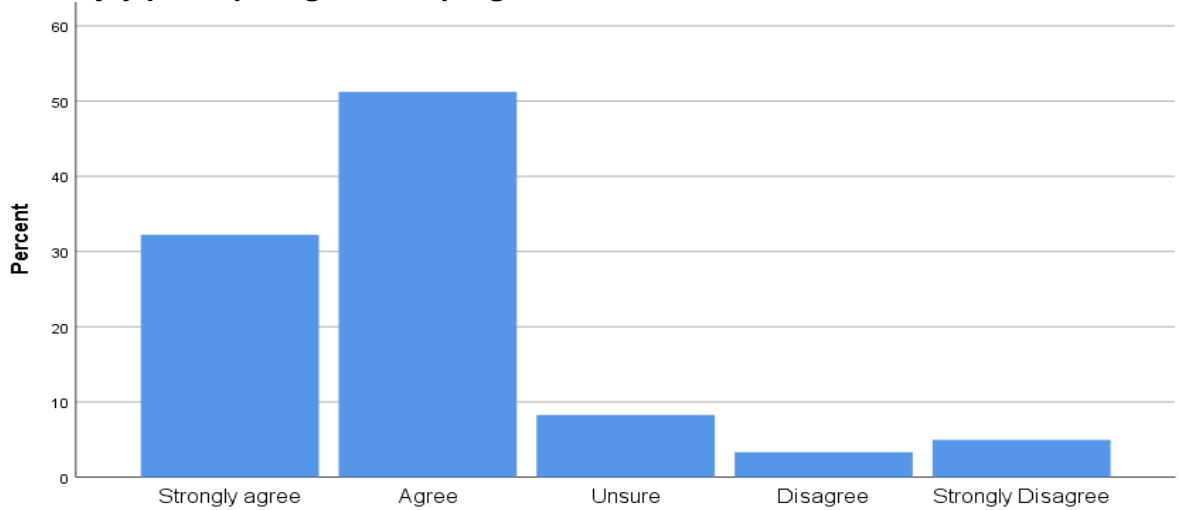
**1f - I feel more productive because I am participating in the WHP programme service offering**



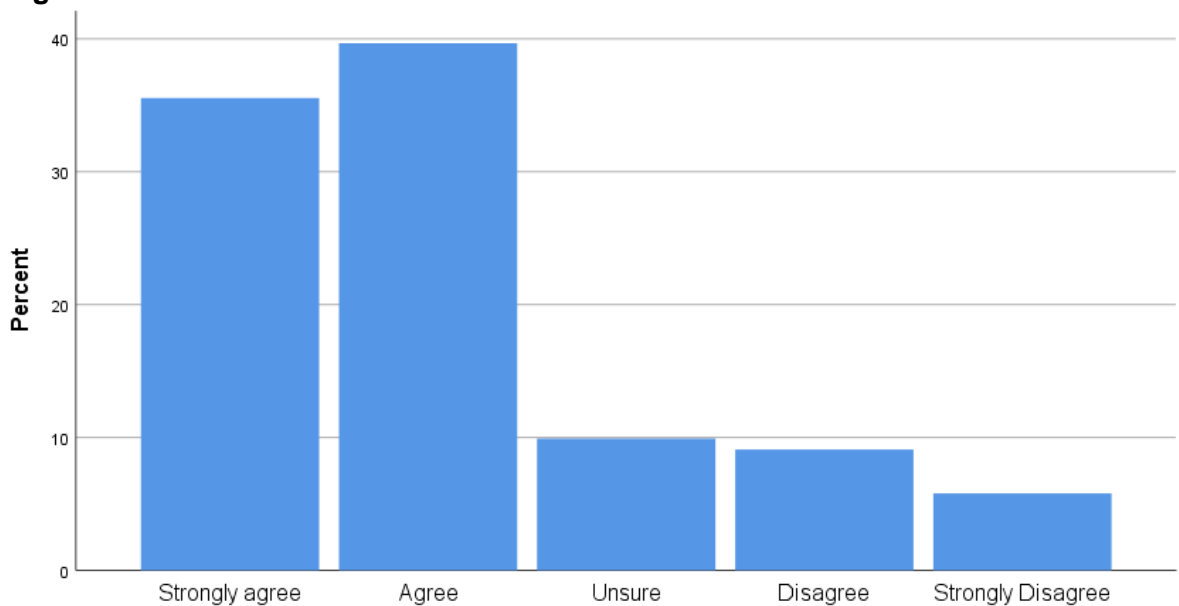
**2a - I feel more motivated because the company offers WHP programmes**



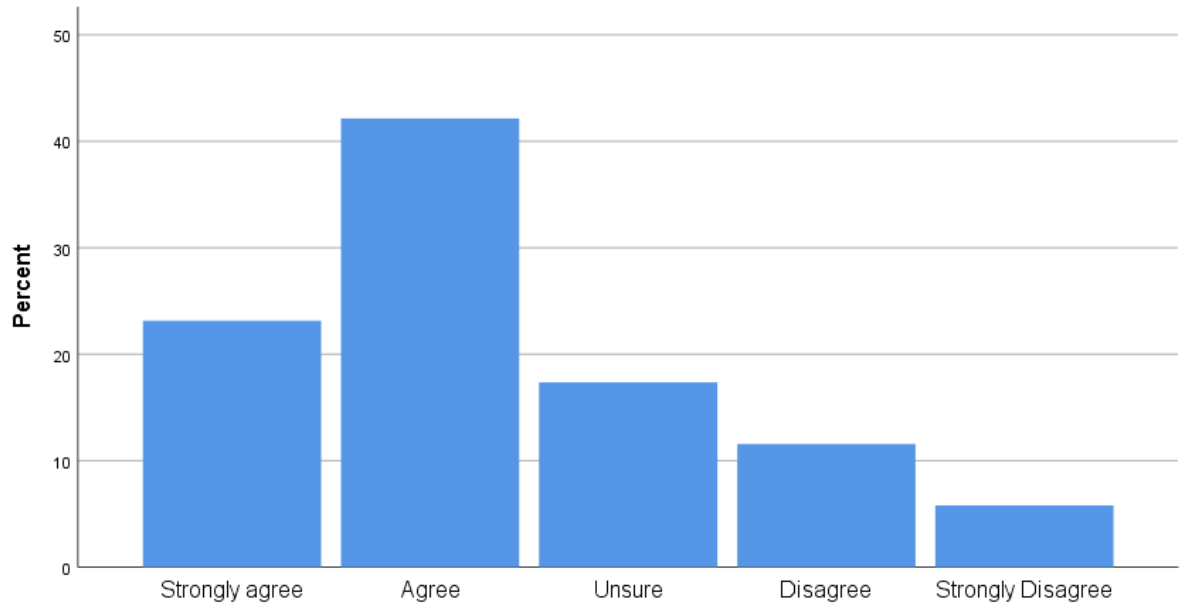
**2b - I enjoy participating in WHP programme offers**



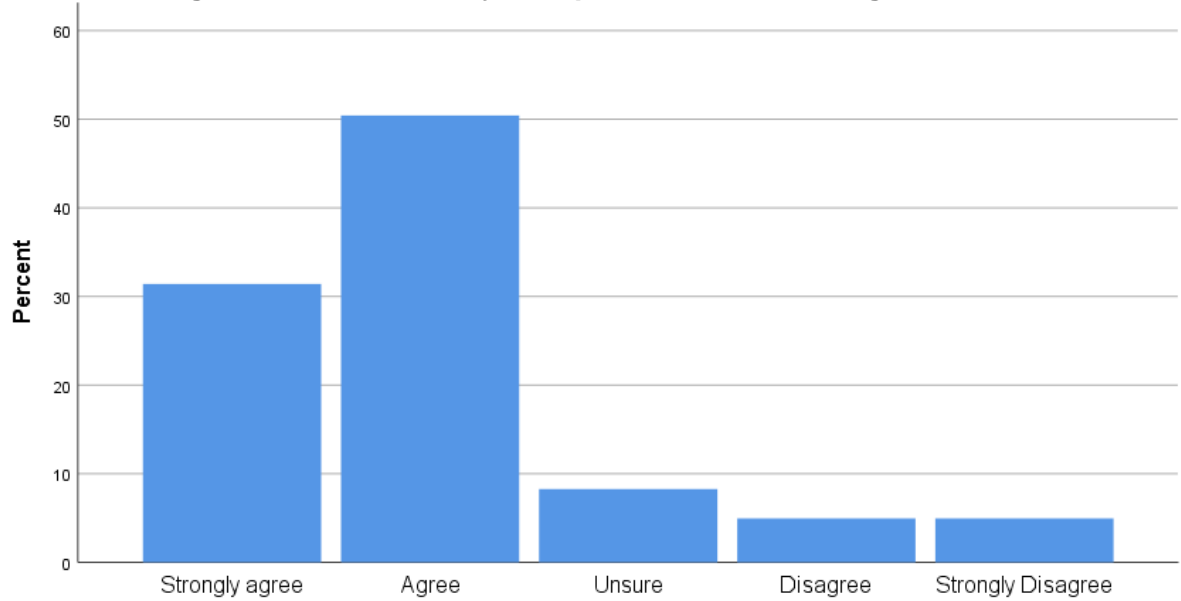
**2c - I experience better coping with stress and pressure due to participating in WHP programme offers.**



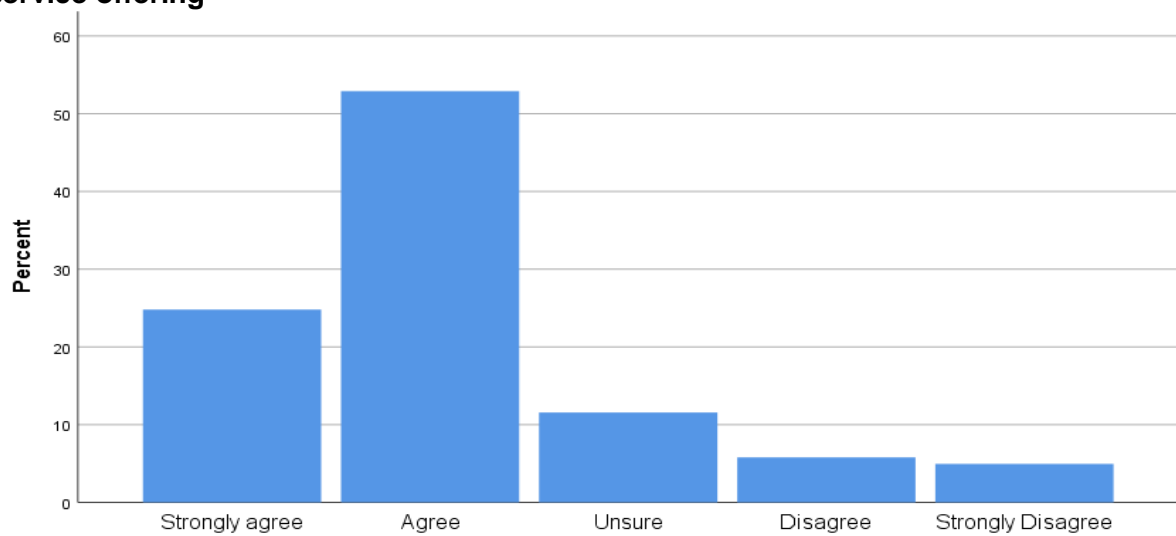
**2d - Without WHP I felt more stressed**



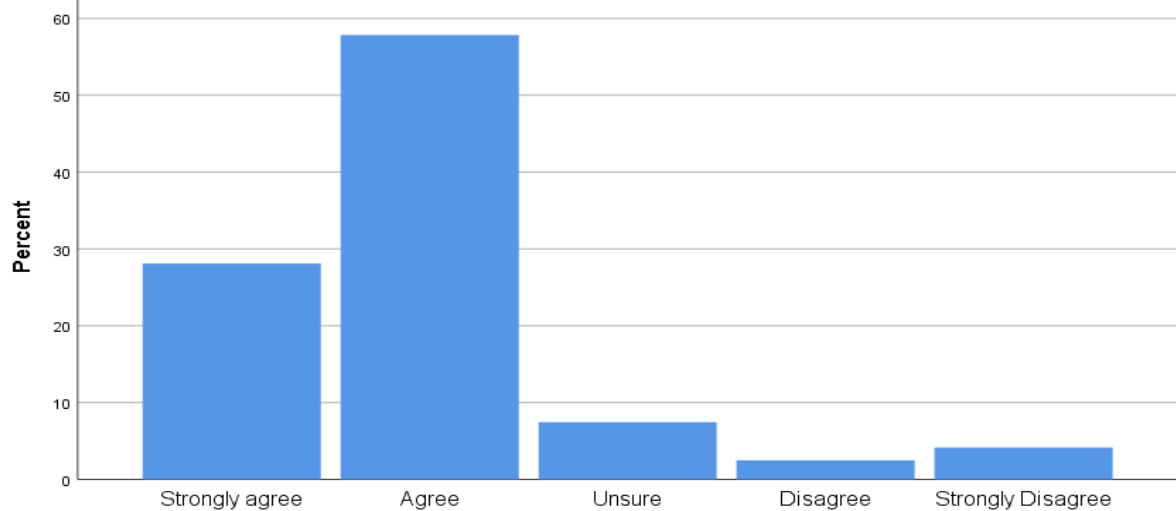
**2e - I am feeling more satisfied in my workplace because the organisation offers WHP**



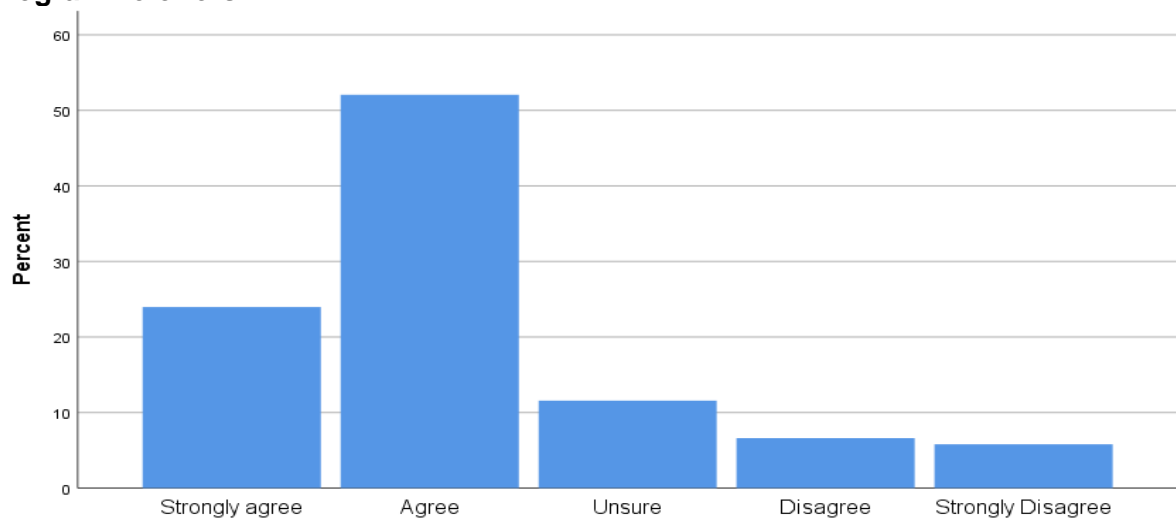
**3a - My contact with colleagues deepens due to participation in WHP programme service offering**



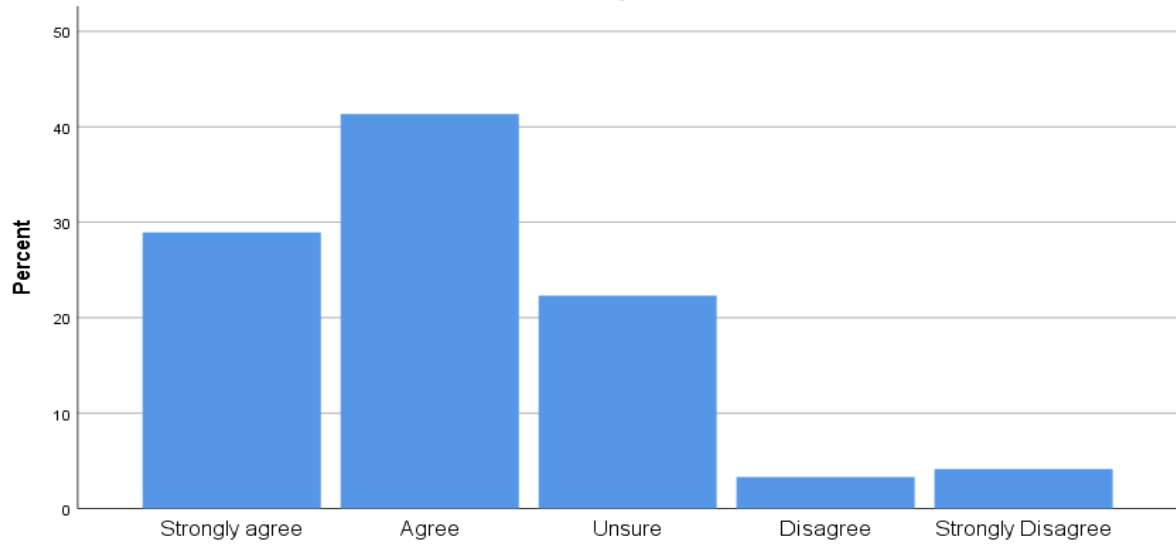
**3b - I feel appreciated by the organisation due to WHP service offering**



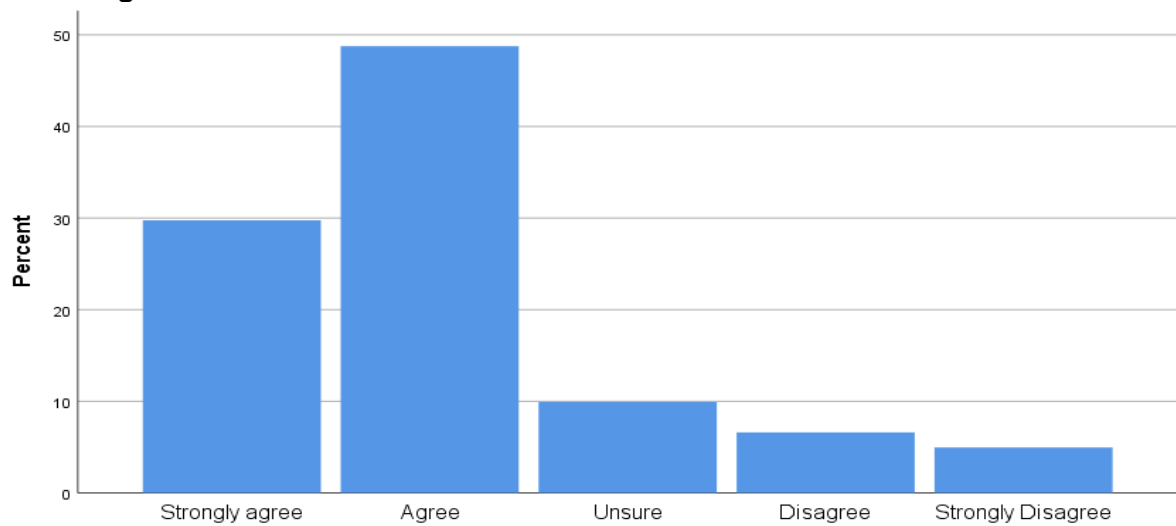
**3c - I enjoy more personal contacts within my workplace due to participating in WHP programme offers**



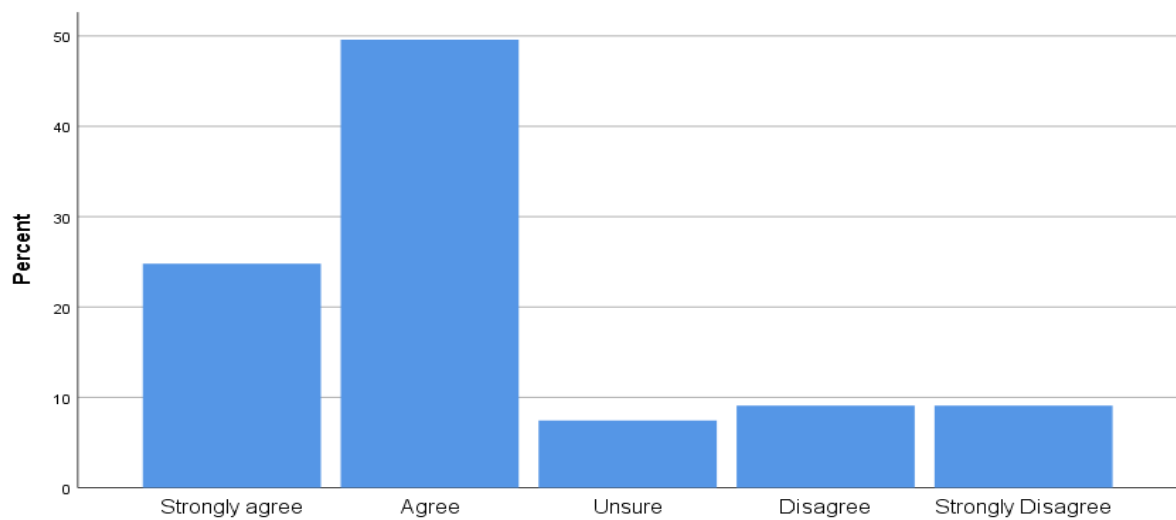
**3d - There are no better intra-team relationships due to WHP**



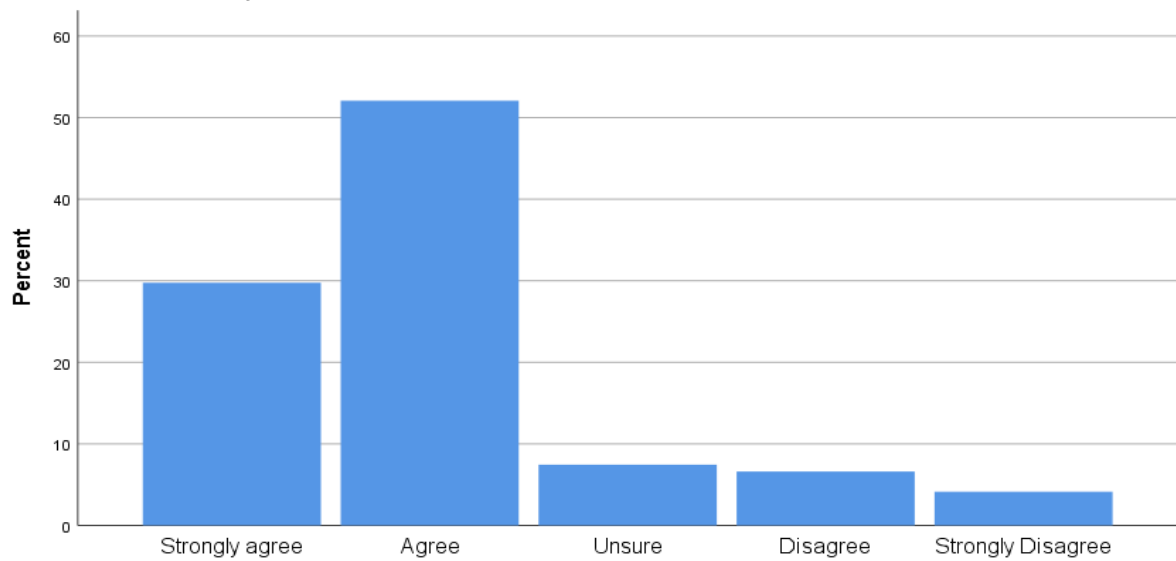
**3e - Participating in WHP programme service offering motivates me to be a role model for colleagues**



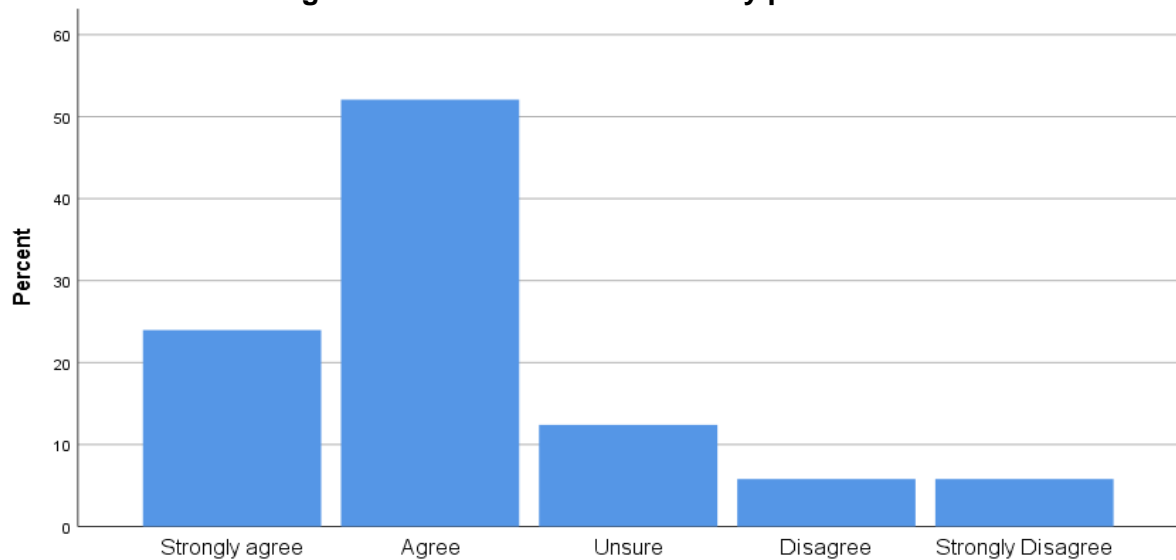
**3f - I experience a better basis of conversation with my supervisor, relating to my health**



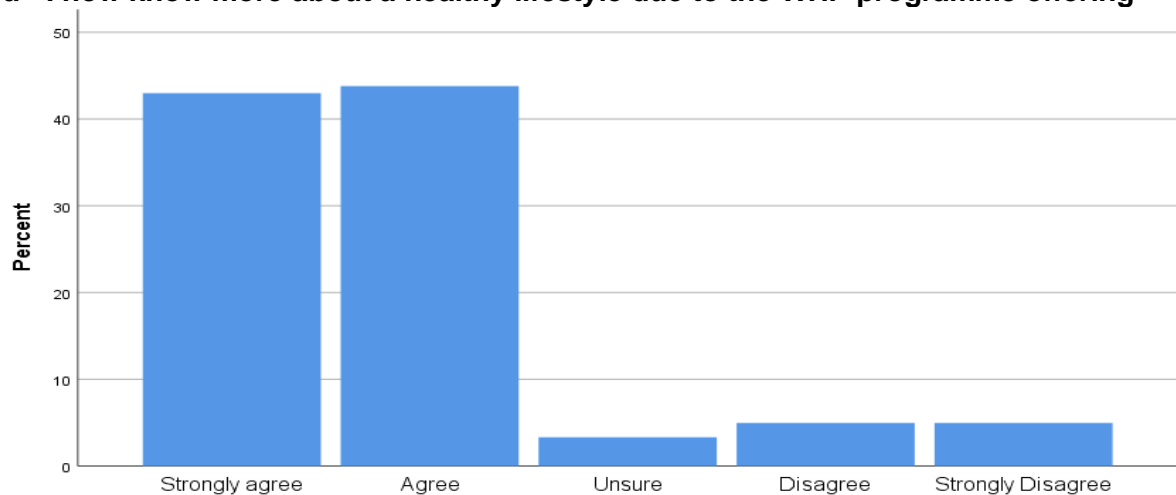
**4a - Participating in WHP programme service offering makes the prevention of illnesses financially affordable**



**4b - I do not have to organise health related visits in my private time due to WHP**

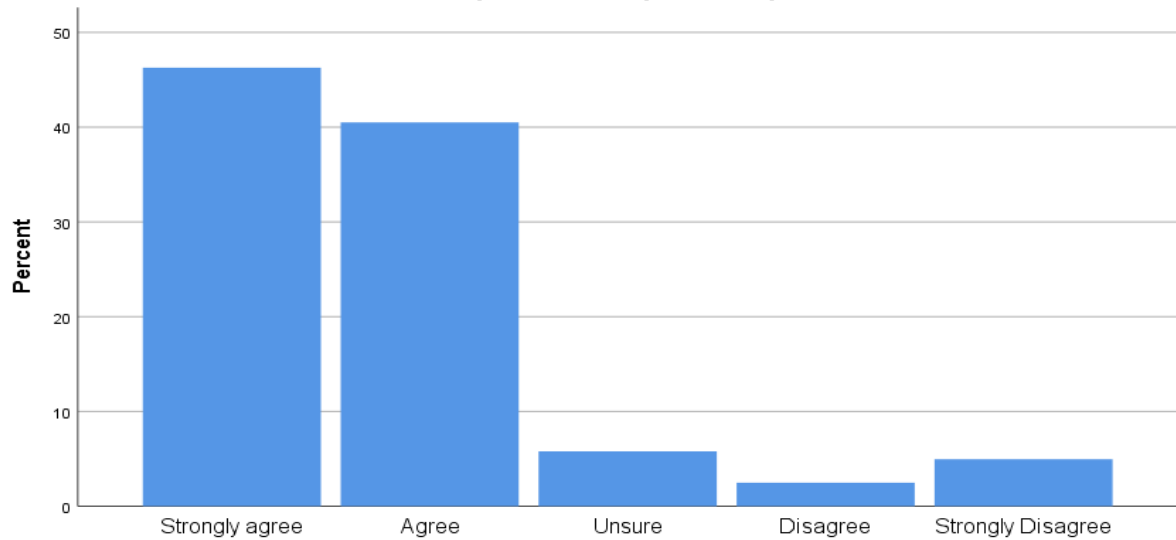


**5a - I now know more about a healthy lifestyle due to the WHP programme offering**

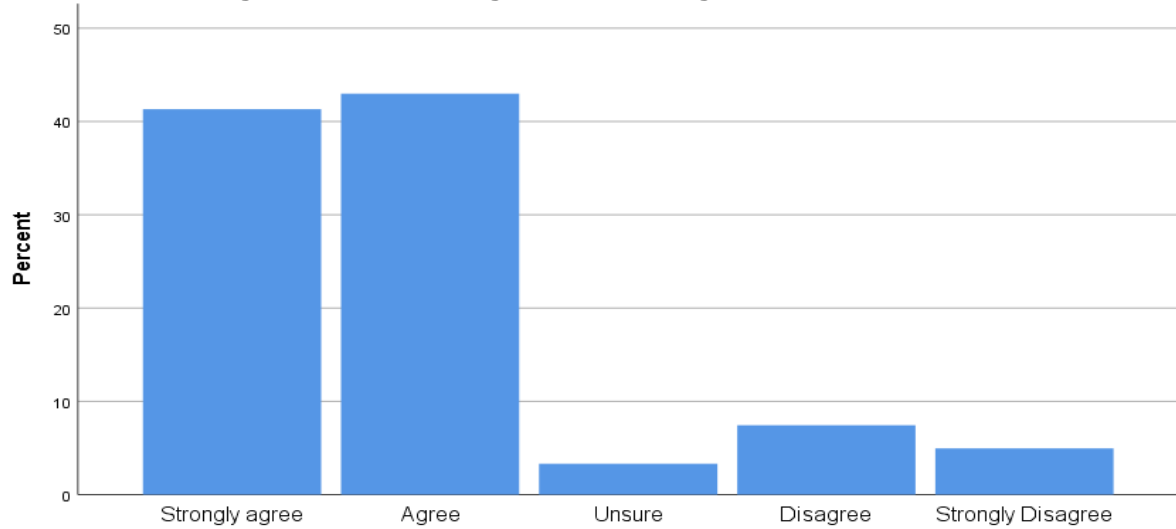




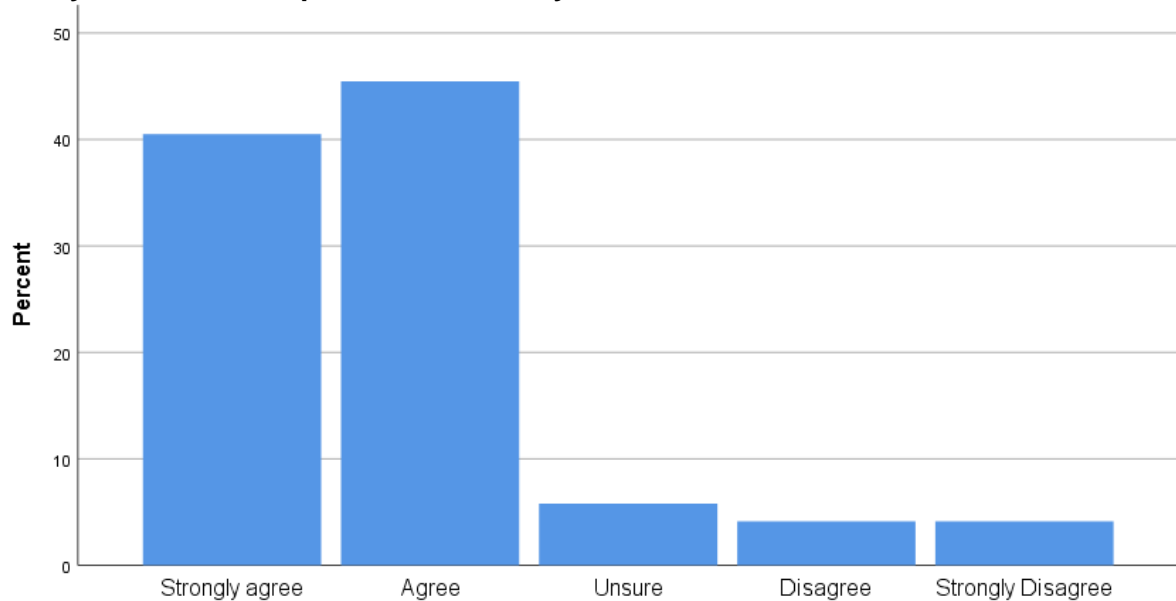
**5b - Medical assistance in the workplace is of special importance to me**



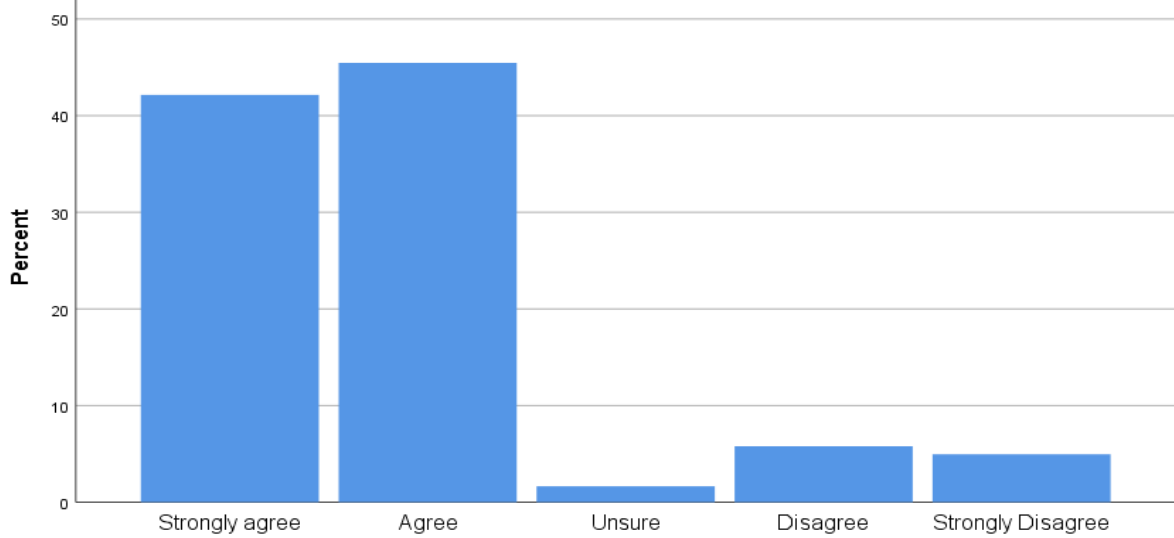
**5b2 - I have undergone health testing offered through WHP**



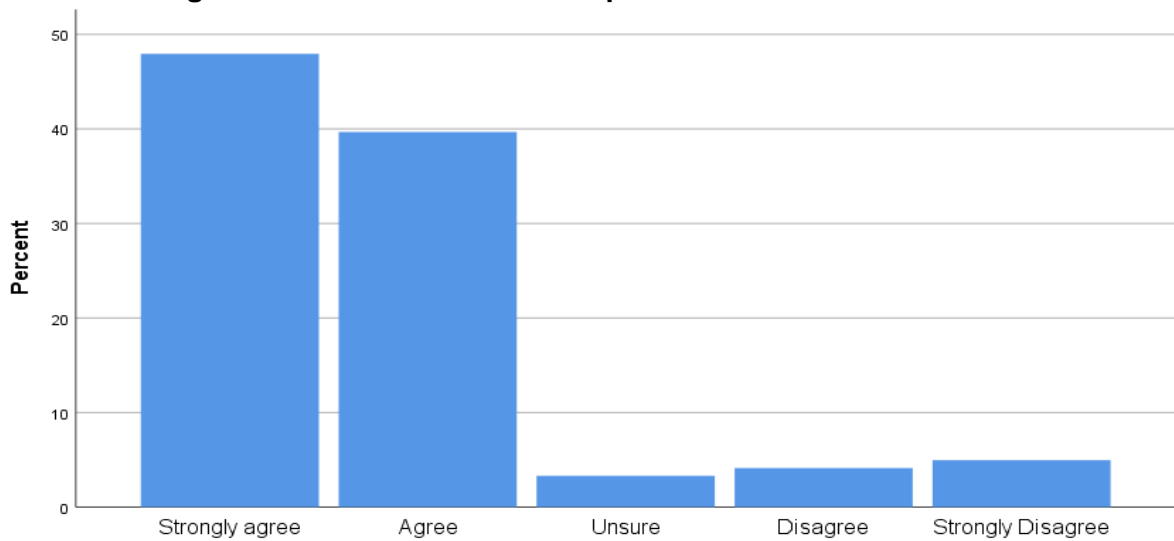
**5c - My attitude has improved towards my health due to WHP**



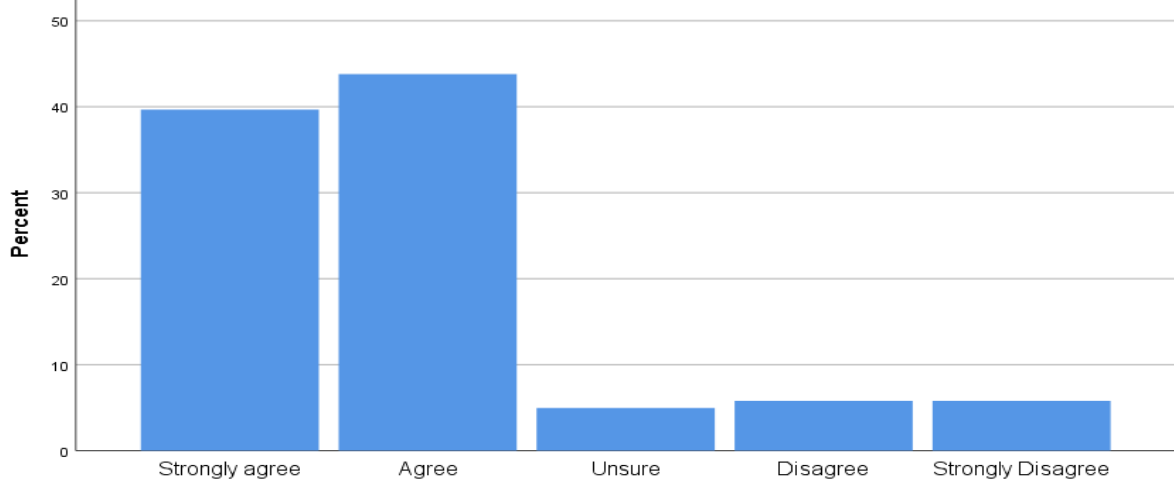
**5d - I am paying more attention to my health since participating in WHP service offering**



**5e - I am feeling motivated because the workplace offers WHP**



**5f - I feel more relaxed after work due to participating in WHP programme service offering**



## APPENDIX H: Correlation

|     |                     | Age    | Gen    | Edu    | Emp    | HIV   | TB     | 1a     | 1b     | 1c     | 1d     | 1e     | 1f | 2a | 2b | 2c | 2d | 2e |
|-----|---------------------|--------|--------|--------|--------|-------|--------|--------|--------|--------|--------|--------|----|----|----|----|----|----|
| Age | Pearson Correlation | 1      |        |        |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     |        |        |        |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
| Gen | Pearson Correlation | -.071  | 1      |        |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .437   |        |        |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
| Edu | Pearson Correlation | -.227* | .001   | 1      |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .012   | .994   |        |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
| Emp | Pearson Correlation | .630** | -.091  | .001   | 1      |       |        |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .000   | .318   | .988   |        |       |        |        |        |        |        |        |    |    |    |    |    |    |
| HIV | Pearson Correlation | .030   | .109   | .041   | -.146  | 1     |        |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .746   | .235   | .652   | .109   |       |        |        |        |        |        |        |    |    |    |    |    |    |
| TB  | Pearson Correlation | -.116  | .106   | .032   | -.142  | .077  | 1      |        |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .205   | .249   | .729   | .121   | .402  |        |        |        |        |        |        |    |    |    |    |    |    |
| 1a  | Pearson Correlation | .003   | -.007  | .252** | -.144  | .038  | .039   | 1      |        |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .973   | .940   | .005   | .116   | .681  | .674   |        |        |        |        |        |    |    |    |    |    |    |
| 1b  | Pearson Correlation | -.043  | -.082  | .133   | -.126  | -.029 | .047   | .705** | 1      |        |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .637   | .371   | .147   | .167   | .750  | .606   | .000   |        |        |        |        |    |    |    |    |    |    |
| 1c  | Pearson Correlation | -.082  | .017   | .176   | -.137  | -.029 | .008   | .592** | .635** | 1      |        |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .371   | .851   | .054   | .135   | .752  | .928   | .000   | .000   |        |        |        |    |    |    |    |    |    |
| 1d  | Pearson Correlation | -.040  | .253** | -.005  | -.169  | .163  | .260** | .421** | .390** | .294** | 1      |        |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .663   | .005   | .957   | .063   | .075  | .004   | .000   | .000   | .001   |        |        |    |    |    |    |    |    |
| 1e  | Pearson Correlation | .006   | .000   | .147   | -.099  | .042  | .129   | .706** | .604** | .651** | .350** | 1      |    |    |    |    |    |    |
|     | Sig. (2-tailed)     | .946   | .999   | .107   | .279   | .651  | .158   | .000   | .000   | .000   | .000   |        |    |    |    |    |    |    |
| 1f  | Pearson Correlation | -.057  | -.026  | .156   | -.182* | .106  | .125   | .581** | .655** | .659** | .309** | .656** | 1  |    |    |    |    |    |

|    |                     |       |       |       |        |       |      |        |        |        |        |        |        |        |        |        |        |        |
|----|---------------------|-------|-------|-------|--------|-------|------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|    | Sig. (2-tailed)     | .535  | .776  | .088  | .046   | .248  | .173 | .000   | .000   | .000   | .001   | .000   |        |        |        |        |        |        |
| 2a | Pearson Correlation | .034  | -.172 | .164  | -.085  | -.016 | .025 | .587** | .744** | .559** | .200*  | .560** | .664** | 1      |        |        |        |        |
|    | Sig. (2-tailed)     | .710  | .059  | .072  | .353   | .859  | .786 | .000   | .000   | .000   | .028   | .000   | .000   |        |        |        |        |        |
| 2b | Pearson Correlation | .008  | -.089 | .187* | -.132  | .111  | .089 | .726** | .573** | .567** | .218*  | .628** | .617** | .670** | 1      |        |        |        |
|    | Sig. (2-tailed)     | .933  | .333  | .040  | .150   | .227  | .332 | .000   | .000   | .000   | .016   | .000   | .000   | .000   |        |        |        |        |
| 2c | Pearson Correlation | -.063 | -.030 | .128  | -.155  | .011  | .005 | .598** | .671** | .634** | .262** | .625** | .698** | .639** | .631** | 1      |        |        |
|    | Sig. (2-tailed)     | .496  | .744  | .162  | .089   | .903  | .955 | .000   | .000   | .000   | .004   | .000   | .000   | .000   | .000   |        |        |        |
| 2d | Pearson Correlation | -.053 | .033  | .100  | -.072  | -.027 | .018 | .455** | .417** | .522** | .236** | .500** | .509** | .404** | .422** | .553** | 1      |        |
|    | Sig. (2-tailed)     | .566  | .719  | .277  | .431   | .770  | .841 | .000   | .000   | .000   | .009   | .000   | .000   | .000   | .000   | .000   |        |        |
| 2e | Pearson Correlation | .015  | -.063 | .098  | -.161  | -.080 | .060 | .646** | .687** | .614** | .253** | .626** | .670** | .616** | .597** | .722** | .556** | 1      |
|    | Sig. (2-tailed)     | .868  | .492  | .283  | .078   | .384  | .516 | .000   | .000   | .000   | .005   | .000   | .000   | .000   | .000   | .000   | .000   |        |
| 3a | Pearson Correlation | -.047 | -.074 | .114  | -.146  | -.099 | .108 | .538** | .477** | .633** | .267** | .504** | .539** | .468** | .489** | .548** | .496** | .654** |
|    | Sig. (2-tailed)     | .606  | .417  | .214  | .111   | .281  | .237 | .000   | .000   | .000   | .003   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 3b | Pearson Correlation | .034  | -.013 | .142  | -.054  | -.097 | .064 | .763** | .574** | .552** | .279** | .658** | .525** | .566** | .687** | .555** | .431** | .660** |
|    | Sig. (2-tailed)     | .711  | .887  | .120  | .559   | .291  | .488 | .000   | .000   | .000   | .002   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 3c | Pearson Correlation | .012  | -.005 | .066  | -.168  | -.041 | .039 | .509** | .695** | .529** | .329** | .499** | .615** | .627** | .480** | .639** | .414** | .644** |
|    | Sig. (2-tailed)     | .897  | .960  | .473  | .065   | .654  | .673 | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 3d | Pearson Correlation | .010  | .071  | .099  | -.082  | -.122 | .151 | .509** | .421** | .564** | .288** | .493** | .479** | .344** | .436** | .469** | .439** | .540** |
|    | Sig. (2-tailed)     | .915  | .439  | .280  | .369   | .183  | .099 | .000   | .000   | .000   | .001   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 3e | Pearson Correlation | -.005 | -.022 | .056  | -.188* | -.030 | .153 | .671** | .641** | .669** | .291** | .591** | .625** | .587** | .614** | .608** | .528** | .740** |
|    | Sig. (2-tailed)     | .959  | .812  | .544  | .039   | .747  | .094 | .000   | .000   | .000   | .001   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 3f | Pearson Correlation | -.021 | -.004 | .148  | -.164  | .080  | .009 | .597** | .494** | .604** | .232*  | .543** | .573** | .572** | .620** | .544** | .450** | .641** |
|    | Sig. (2-tailed)     | .819  | .969  | .105  | .072   | .386  | .921 | .000   | .000   | .000   | .010   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 4a | Pearson Correlation | .031  | -.023 | .019  | -.150  | .038  | .157 | .685** | .607** | .490** | .345** | .653** | .500** | .620** | .657** | .611** | .370** | .645** |
|    | Sig. (2-tailed)     | .736  | .801  | .838  | .100   | .682  | .086 | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 4b | Pearson Correlation | -.012 | -.050 | .084  | -.157  | .082  | .096 | .642** | .694** | .558** | .250** | .609** | .629** | .647** | .620** | .715** | .435** | .759** |

|     |                     |       |       |        |       |       |      |        |        |        |        |        |        |        |        |        |        |        |
|-----|---------------------|-------|-------|--------|-------|-------|------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|     | Sig. (2-tailed)     | .896  | .589  | .361   | .086  | .373  | .295 | .000   | .000   | .000   | .006   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5a  | Pearson Correlation | .077  | .016  | .099   | -.123 | .054  | .078 | .630** | .532** | .422** | .306** | .601** | .510** | .546** | .573** | .618** | .403** | .702** |
|     | Sig. (2-tailed)     | .399  | .861  | .280   | .179  | .558  | .398 | .000   | .000   | .000   | .001   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5b  | Pearson Correlation | -.025 | -.030 | .154   | -.112 | .126  | .047 | .664** | .705** | .443** | .361** | .587** | .537** | .633** | .572** | .599** | .368** | .588** |
|     | Sig. (2-tailed)     | .784  | .743  | .092   | .220  | .167  | .610 | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5b2 | Pearson Correlation | .043  | .021  | .161   | -.149 | .213* | .100 | .660** | .654** | .496** | .373** | .620** | .601** | .636** | .558** | .666** | .401** | .686** |
|     | Sig. (2-tailed)     | .643  | .818  | .078   | .103  | .019  | .276 | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5c  | Pearson Correlation | .023  | -.113 | .120   | -.120 | .028  | .076 | .631** | .561** | .521** | .285** | .623** | .566** | .489** | .586** | .584** | .340** | .681** |
|     | Sig. (2-tailed)     | .801  | .216  | .188   | .190  | .760  | .407 | .000   | .000   | .000   | .002   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5d  | Pearson Correlation | .009  | -.107 | .119   | -.124 | -.021 | .003 | .685** | .648** | .515** | .294** | .541** | .521** | .585** | .602** | .642** | .385** | .714** |
|     | Sig. (2-tailed)     | .925  | .242  | .193   | .174  | .816  | .970 | .000   | .000   | .000   | .001   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |
| 5e  | Pearson Correlation | .011  | -.125 | .238** | -.146 | .078  | .120 | .662** | .613** | .477** | .268** | .588** | .568** | .630** | .605** | .605** | .311** | .721** |
|     | Sig. (2-tailed)     | .904  | .171  | .008   | .110  | .396  | .190 | .000   | .000   | .000   | .003   | .000   | .000   | .000   | .000   | .000   | .001   | .000   |
| 5f  | Pearson Correlation | .067  | -.043 | .246** | -.107 | .066  | .068 | .653** | .624** | .554** | .340** | .578** | .631** | .640** | .571** | .680** | .379** | .720** |
|     | Sig. (2-tailed)     | .467  | .638  | .007   | .244  | .473  | .459 | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |

Cont.

| 3a | 3b | 3c | 3d | 3e | 3f | 4a | 4b | 5a | 5b | 5b2 | 5c | 5d | 5e | 5f |
|----|----|----|----|----|----|----|----|----|----|-----|----|----|----|----|
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |
|    |    |    |    |    |    |    |    |    |    |     |    |    |    |    |



|       |       |       |       |       |       |       |       |       |       |       |       |   |  |  |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|---|--|--|
| 1     |       |       |       |       |       |       |       |       |       |       |       |   |  |  |
| .706" | 1     |       |       |       |       |       |       |       |       |       |       |   |  |  |
| .000  |       |       |       |       |       |       |       |       |       |       |       |   |  |  |
| .505" | .577" | 1     |       |       |       |       |       |       |       |       |       |   |  |  |
| .000  | .000  |       |       |       |       |       |       |       |       |       |       |   |  |  |
| .563" | .614" | .536" | 1     |       |       |       |       |       |       |       |       |   |  |  |
| .000  | .000  | .000  |       |       |       |       |       |       |       |       |       |   |  |  |
| .714" | .671" | .638" | .596" | 1     |       |       |       |       |       |       |       |   |  |  |
| .000  | .000  | .000  | .000  |       |       |       |       |       |       |       |       |   |  |  |
| .606" | .588" | .472" | .497" | .747" | 1     |       |       |       |       |       |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  |       |       |       |       |       |       |       |   |  |  |
| .525" | .690" | .558" | .506" | .625" | .517" | 1     |       |       |       |       |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  |       |       |       |       |       |       |   |  |  |
| .590" | .705" | .589" | .574" | .667" | .632" | .722" | 1     |       |       |       |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  |       |       |       |       |       |   |  |  |
| .528" | .606" | .560" | .493" | .662" | .592" | .637" | .641" | 1     |       |       |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  |       |       |       |       |   |  |  |
| .438" | .559" | .579" | .442" | .538" | .493" | .699" | .630" | .708" | 1     |       |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  |       |       |       |   |  |  |
| .490" | .541" | .533" | .412" | .578" | .533" | .654" | .669" | .740" | .766" | 1     |       |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  |       |       |   |  |  |
| .580" | .601" | .500" | .426" | .600" | .544" | .545" | .584" | .693" | .639" | .641" | 1     |   |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  |       |   |  |  |
| .540" | .586" | .541" | .458" | .718" | .647" | .587" | .689" | .822" | .667" | .752" | .738" | 1 |  |  |
| .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  | .000  |   |  |  |

|        |        |        |        |        |        |        |        |        |        |        |        |        |        |   |
|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---|
| .538** | .623** | .565** | .447** | .593** | .576** | .633** | .630** | .750** | .737** | .767** | .807** | .763** | 1      |   |
| .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |        |   |
| .575** | .539** | .591** | .460** | .610** | .608** | .589** | .647** | .725** | .707** | .767** | .794** | .780** | .841** | 1 |
| .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   | .000   |   |

\*. Correlation is significant at the 0.05 level (2-tailed).

\*\*.. Correlation is significant at the 0.01 level (2-tailed).

N=121



## APPENDIX I: Content Data Analysis

| Theme         | Code | Interview Questions   | CONDENSED RESPONSES                |   |                                    |
|---------------|------|---|------------------------------------|---|------------------------------------|
|               |      |   | MGT1                               | MGT2  | MGT3                               |
| Participation | 1A   | How do you as a manager participate in WHP at your organisation?                  | Management participates in OH&S    | Management facilitates the WHP activities   | Management participates in OH&S    |
| Participation | 1B   | How do you encourage staff to participate in WHP at your organisation?            | Information sessions               | Information sessions  | Information sessions               |
| Strategy      | 1C   | What has been key successes in WHP at your organisation?                          | HIV/AIDS Programme                 | Health sessions during working day - Low downtime   | HIV/AIDS Programme                 |
| Strategy      | 1D   | What directed the strategic intent and/or objectives of WHP in your organisation? | Down-time due to HIV/AIDS          | Down-time due to illness - CIHCF clinics offer alternative to long queues at State facilities | Down-time due to HIV/AIDS          |
| Participation | 1E   | What channels of communication is used in WHP at your organisation?               | Management, Shop Stewards, Clinics | Information, Education & Communication (IEC) sessions, Clinic, Notice Boards                  | Management, Shop Stewards, Clinics |
| Participation | 1F   | What challenges do employees face to access WHP?                                  | None                               | Time - Sessions during tea and lunch breaks   | None                               |
| Participation | 1G   | What are the barriers to successfully implementing WHP at your organisation?      | None                               | Lack of funding   | None                               |

| Theme              | Code | Interview Questions   | CONDENSED RESPONSES   |  |   |
|--------------------|------|---|---|--|---|
|                    |      |   | MGT1  | MGT2   | MGT3  |
| Physical Effects   | 1H   | How has the implementation of WHP improved employees' physical well-being?                      | Good  | Reduced absenteeism, Psychosocial issues being addressed                   | Good  |
| Mental Effects     | 1I   | How has the implementation of WHP improved employees' mental well-being?                        | Good, counselling is available to employees                               | Good, counselling is available to employees                                | Good, counselling is available to employees                               |
| Social Effects     | 1J   | How has the implementation of WHP improved employee interaction at peer level?                  | Good, as employees are well educated on health matters                    | Better team integration  | Good, as employees are well educated on health matters                    |
| Social Effects     | 1K   | How has the implementation of WHP improved employee interaction with management?                | Good, regular interaction between shop stewards and management            | Communication has improved between management and employees                | Good, regular interaction between shop stewards and management            |
| Social Effects     | 1L   | How has the implementation of WHP facilitated open conversations relating to employees' health? | WHP employees provide education sessions                                  | Employees do not have a sense of stigma. Support groups have been created. | WHP employees provide education sessions                                  |
| Affective Outcomes | 1M   | How has the implementation of WHP decreased employees' absenteeism?                             | Absenteeism has reduced. Shop stewards assists with further intervention. | Absenteeism reduced, as less time off required to access health services.  | Absenteeism has reduced. Shop stewards assists with further intervention. |

| Theme                             | Code | Interview Questions   | CONDENSED RESPONSES  |  |  |
|-----------------------------------|------|---|--|--|--|
|                                   |      |   | MGT1   | MGT2   | MGT3   |
| Benefit                           | 1N   | How has the implementation of WHP increased access to appropriate healthcare? | Employees are compensated when attending the CIHCF clinics during working hours.                           | Certain health services (i.e. BP, Chol., Glucose and HIV testing) offered at the workplace.                        | Employees are compensated when attending the CIHCF clinics during working hours. |
| Benefit                           | 1O   | How has the implementation of WHP increased health testing of employees?      | Testing is conducted twice a year at our factory   | Lay counsellors are available at the CIHCF clinics and visits are done to the workplace where testing is conducted | Testing is conducted twice a year at our factory                                 |
| Physical Effects / Mental Effects | 1P   | How has the implementation of WHP improved employees' productivity?           | Very good  | Employees are healthier, aware of their health status and more productive  | Very good  |
| Social Effects                    | 1Q   | How is top management supporting the WHP?                                     | Very good  | Collaboration with the union, Health Care Fund and SWHP  | Very good  |
| Strategy                          | 1R   | How does government support the WHP initiative at your organisation?          | Implementation of services via NGOs  | Government provides certain resources to programmes, to alleviate the burden on the State                          | Very good through partnerships   |
| Participation                     | 1S   | How are employees incentivised to participate in any activities?              | Employees are compensated for visits to the clinic during working hours, on presentation of a certificate. | No incentive, unless other activities are also provided which has incentives                                       | No incentive   |

| Theme         | Code | Interview Questions  | CONDENSED RESPONSES  |  |  |
|---------------|------|--|--|--|--|
|               |      |  | MGT1   | MGT2   | MGT3   |
| Strategy      | 1T   | What does your organisation's teams involved in WHP comprise of?       | TB programme, HIV programme, Circumcision programme, Homebased Care, Cancer programme, Women and Child abuse programmes, and access to counsellors | Trainer, Nurse, Lay Counsellor, Data-Capturer and/or M&E Officer   | TB, HIV/AIDS, Circumcision, Homebased Care, Cancer Support Groups, Women & Child Abuse programs, Lay Counsellors |
| Benefit       | 1U   | What are the services offered by a WHP team?                           | Training and Consultations   | Awareness & Education, Clinical healthcare services, Social Services   | Education and Training, Consultations.   |
| Participation | 1V   | How are wellness champions involved in WHP?                            | Being involved as speakers and guests at various programme   | N/A  | By being speakers at various programs  |
| Benefit       | 1W   | How are the family members of employees participating in WHP?          | Family support groups and consultations are offered.   | In affiliated clinics, workers are encouraged to bring in their dependants and families to access health care services on offer.                       | By being in Family Support Groups and Consultation   |
| Strategy      | 1X   | How do you do Monitoring & Evaluation of WHP and what are the metrics? | Feedback is provided through worker forums, union branch meetings and council meetings.  | Completes registers and/or patient records. Verify and validate, capture and report.   | We get positive feedback from workers, branch and council meetings   |
| Participation | 1Y   | How does your organisation ensure confidentiality of WHP data?         | Confidentiality policy.  | All client and patient data is captured onto a secure database, collated information is reported & distributed which does not reflect individual data. | Confidentiality policy.  |

| Theme         | Code | Interview Questions   | CONDENSED RESPONSES                                      |   |  |
|---------------|------|---|--|---|--|
|               |      |   | MGT1   | MGT2  | MGT3   |
|               |      |   |  | Records are stored within a controlled access setting |  |
| Participation | 1Z   | What measures are taken to encourage employees to participate in WHP? | The company and shopstewards provide education sessions. | education sessions                                    | The company and shopstewards provide education sessions. |

**Cont.**

| Theme         | Code | Interview Questions   |   |
|---------------|------|---|---|
|               |      |   | MGT5                                      |
| Participation | 1A   | How do you as a manager participate in WHP at your organisation?                  | Management facilitates the WHP activities |
| Participation | 1B   | How do you encourage staff to participate in WHP at your organisation?            | Information sessions                      |
| Strategy      | 1C   | What has been key successes in WHP at your organisation?                          | HIV/AIDS Programme                        |
| Strategy      | 1D   | What directed the strategic intent and/or objectives of WHP in your organisation? | Manage productivity and absenteeism       |

|                  |    |   |  |
|------------------|----|---|--|
| Participation    | 1E | What channels of communication is used in WHP at your organisation?                             | Information, Education & Communication (IEC) sessions, Clinic, Notice Boards   |
| Participation    | 1F | What challenges do employees face to access WHP?  | Time - Sessions during tea and lunch breaks. Breaks are employees' personal time. Loss of wages when attending sessions during working time. |
| Participation    | 1G | What are the barriers to successfully implementing WHP at your organisation?                    | Potential clash with productivity time   |
| Physical Effects | 1H | How has the implementation of WHP improved employees' physical well-being?                      | Reduced absenteeism, Increased productivity  |
| Mental Effects   | 1I | How has the implementation of WHP improved employees' mental well-being?                        | Employees are more positive at work  |
| Social Effects   | 1J | How has the implementation of WHP improved employee interaction at peer level?                  | Improvement in peer interaction  |
| Social Effects   | 1K | How has the implementation of WHP improved employee interaction with management?                | Employees are more likely to speak to management about health matters  |
| Social Effects   | 1L | How has the implementation of WHP facilitated open conversations relating to employees' health? | Employees are more open to discuss health issues with peers  |

|                                   |    |   |   |
|-----------------------------------|----|---|---|
| Affective Outcomes                | 1M | How has the implementation of WHP decreased employees' absenteeism?           | Absenteeism has reduced. Employees attending the CIHCF clinics are compensated for loss of wages, as per the rules. |
| Benefit                           | 1N | How has the implementation of WHP increased access to appropriate healthcare? | Employees are very open to attend the CIHCF clinics to seek treatment for medical conditions                        |
| Benefit                           | 1O | How has the implementation of WHP increased health testing of employees?      | Collaboration with union, Bargaining council and health practitioners ensures testing is conducted                  |
| Physical Effects / Mental Effects | 1P | How has the implementation of WHP improved employees' productivity?           | Productivity has increased  |
| Social Effects                    | 1Q | How is top management supporting the WHP?                                     | Top management will engage where there are benefits to productivity   |
| Strategy                          | 1R | How does government support the WHP initiative at your organisation?          | Government provides certain resources to programmes, to alleviate the burden on the State                           |
| Participation                     | 1S | How are employees incentivised to participate in any activities?              | Time off work is provided   |
| Strategy                          | 1T | What does your organisation's teams involved in WHP comprise of?              | Trainers, Nurses and Lay counsellors  |

|               |    |  |  |
|---------------|----|--|--|
| Benefit       | 1U | What are the services offered by a WHP team?                           | Health Awareness, Condom distribution, Testing for HIV and screening for TB and other STI's  |
| Participation | 1V | How are wellness champions involved in WHP?                            | Peer educators   |
| Benefit       | 1W | How are the family members of employees participating in WHP?          | Health Care Fund clinics also cover the children of primary members with primary health care services  |
| Strategy      | 1X | How do you do Monitoring & Evaluation of WHP and what are the metrics? | The awareness and testing teams use workplace registers and consent forms when conducting activities at companies, and these are then given to our M& E department for capturing |
| Participation | 1Y | How does your organisation ensure confidentiality of WHP data?         | Confidentiality policy   |
| Participation | 1Z | What measures are taken to encourage employees to participate in WHP?  | The company and shopstewards provide education sessions.   |