PERCEPTIONS OF RAND WATER EMPLOYEES OF ACCESS TO WORKSITE HEALTH PROMOTION PROGRAMMES

by

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ABSTRACT: PERCEPTIONS OF RAND WATER EMPLOYEES OF ACCESS TO WORKSITE HEALTH PROMOTION PROGRAMMES

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Health care access is a significant and growing global health concern. Research indicates millions of individuals lacking access to healthcare services. Health care access is a basic human right, entrenched in the Bill of Rights in the Constitution of the Republic of South Africa, Act no 108 of 1996. Worksites are excellent platforms enhancing employee health and wellness services. It is essential that employees have access to worksite health initiatives, ensuring improved health, reducing absenteeism and increase productivity. It remains a concern whether worksites have adequate health care facilities, offering quality care and if they are accessible to all employees, as legislated in the Bill of Rights. The research undertakes to provide an answer to the question "*what are the perceptions of Rand Water employees regarding access to worksite health care promotion programme services?*"

The goal of the study is to explore the employees' perceptions of accessing worksite health care promotion programmes within Rand Water. The Health Belief Model (HBM) serves as a theoretical framework for the study.

The study follows a qualitative research approach, describing Rand Water employees' perceptions of access to worksite health care promotion programmes. The applied research method was selected, striving to assist decision-making at direct line levels, managerial levels and decision-maker levels to solve problems.

A collective case study design is followed, collecting data directly from participants in their natural environment for studying interactions, attitudes and characteristics. The design assists in understanding and interpreting the meaning relating to their worksite. A non-probability sampling method was chosen, selecting 15 participants

based at the Rietvlei site, who participated in a health care promotion programme. The study includes both genders and all levels of employees.

The study is qualitative of nature. Data was collected through semi-structured interviews with an interview schedule. The one-on-one interview method applies, exploring perceptions of Rand Water employees regarding access to health care promotion programmes.

The study findings indicate various barriers to health care promotion programmes, influencing and denying employees full access to the programme. Barriers range from privacy and confidentiality concerns, accessibility, support, insufficient resources, planning, policies and procedures, cultural barriers and communication. The research confirms influences of access to health care promotion programmes.

The research findings suggest despite sufficient legislation, corroborating the reasons for restricted health care access in the worksite and with an intervention wellness model prepared, employees still experience access barriers to such services. The findings support the academic literature; access and utilisation of health services remain an important and critical global health care concern. The study results indicate access barriers influence utilisation of health services within Rand Water. The literature revealed organisations could benefit significantly through return on investment, providing integrated health and wellness services with full management support, policies and procedures aligned to their workforce.

It is established that worksites cannot remain productive without maintaining health, job satisfaction and morale of their workforce. It is important for organisations to enable access to health care promotion programmes, striving to enhance performance and improved productivity, in identifying and alleviating personal and work-related challenges that may hinder unnecessary absenteeism.

Key terms: access; barriers; worksite; health care promotion programme; employees.

LIST OF ACRONYMS

ART - Antiretroviral Therapy

EAP - Employee Assistance Programme

EAPA-SA - Employee Assistance Professionals Association of South Africa.

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immunodeficiency Syndrome

VCT -Voluntary Testing and Counselling

SHERQ - Safety, Health, Environment, Risk, and Quality

TB - Tuberculosis

UNAIDS - The Joint United Nations Programme on HIV and AIDS

WHO - World Health Organisation

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CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

The Bill of Rights in the Constitution of the Republic of South Africa, Act no 108 of 1996, stipulate access to health as a basic human right. The Constitution's Section 27 notably, provides for the right of access to health, including reproductive health. The access to and utilisation of health services remain a sincere concern to global health care systems (Kronfol, 2012:1240). The 66th World Health Assembly's global survey on workers' health, completed in 2008/2009 amongst 120 countries, indicate that two thirds of countries had limited access to occupational health services (World Health Organisation, 2013:2). Personnel access to health protection and preventative services is limited. This is reason for concern as many adults spend most of their day time at work (WHO, 2013:2).

According to Ball (2009:17), a strategy to enhance employee health and the success of businesses, is implementing health care promotion programmes at worksites. Ball (2009:17) further states, the workforce spends substantial time at their worksites. Businesses depend on employees' health for their success (Neira, 2010:1). According to Person, Colby, Bulova and Eubanks (2010:149), it is important for worksites to be conducive to employee health as worksites are excellent settings to promote employee health and wellness. Employees may have difficulty in accessing such services. In the context of this study, it is unclear how Rand Water employees experience access to worksite health care promotion programmes. The following key concepts apply to the study:

- **Access**

Access in the context of health care is concerned with the processes surrounding the entry of individuals and population groups into the health care delivery system (Neutens, 2015:1). Hanson (in Semm & Palang, 2010:6), defines access as the ease whereby individuals can reach the desired activity sites. Medical care was mentioned as an example. In the context of this study, access means the ease by which Rand Water employees can access worksite health care promotion programmes.

- **Health care promotion programmes**

Health care promotion programmes refer to an integrated and comprehensive set of coordinated health activities implemented at worksites (Ball, 2009:17). Leininger, Adams and DeBeliso (2015:247) define health care promotion programmes as "a set of strategic short term and easy to change actions that sought to optimise labourer health and business performance". A health care promotion programme is a variety of health care promotion activities offered at the worksite, relating to an effort to improve employee health, and enhance productivity and quality of life.

- **Employee**

The South African Labour Relations Act, 1995 (Act No. 66 of 1995) defines employee as "any person who is employed at the worksite". Employee Assistance Professional Association of South Africa Standards (2010:2) refers to the Labour Relations Act, 1995 (Act No. 66 of 1995), defining an employee as a person whose employment is governed by a contract of service, or other relevant employment laws. This research defines an employee as a person contracted by an employer to perform certain duties and responsibilities relating to the business. The definitions above also indicate the dependency of the employee on the employer, receiving remuneration for their duties.

- **Worksite**

The South African Occupational Health and Safety Act 18 of 1993 as amended, defines worksite, often referred to as workplace, as any premise or place where a person performs duties during employment. The *Concise Oxford Dictionary* (2015:962) defines worksite or workplace as an area where an industry is located or where work takes place. The worksite is therefore understood as an area or a site, such as a factory or an office (that can be described as a building), provided by the employer for employees to conduct their duties.

- **Barrier**

A barrier is described as a fence or other obstacle hindering movement or access (*Concise Oxford Dictionary*, 2015:111). In the context of this study, a barrier is a stumbling block or a barricade preventing employees from accessing health services.

1.2   LITERATURE REVIEW

To contextualise this study, it is important to remain aware of governing frameworks for access to health care services in the worksite and barriers preventing employees from full access to these services.

The researcher found, sufficient legislation is prepared to endorse the reasons for health care access in the worksite. The concern remains if worksites have health care facilities offering quality care and if they are accessible to all employees as legislated. As indicated earlier, in South Africa the right to access health care is entrenched in the Bill of Rights of 1996. The Bill of Rights expressively provides that everyone has the right to have access to health care services, including reproductive health. The research study focuses on the perceptions of Rand Water employees regarding access to health care promotion programmes.

The Occupational Health and Safety Act (No. 29 of 1993), amended, imposes a general duty on employers to provide a reasonably conducive environment, providing knowledge, training and supervision necessary, ensuring health and safety. The employer must provide feedback to a health inspector, on all incidents where loss of life, injury or harmful situations occurred. Rand Water is obliged and mandated by legislation to provide their employees access to health care services. The research statement is further supported by the National Occupational Health and Safety Policy (Department of Labour, 2003:40). It outlines the duty of the employer, ensuring a healthy protective environment and safe worksite. The employer is responsible to report accidents and incidents in the worksite.

The South African Compensation for Occupational Diseases and Injuries Act 130 of 1993, confirm the above statement, declaring employees and their dependents sustaining injury, illness or loss of life while working, qualify for compensation. This implies that South African employers care for their workers. The final draft of the Employee Health and Wellness Strategic Framework (Department of Public Service and Administration, 2008:11), provides a set of guidelines to coordinate and manage interventions for employee health and wellness in the worksite. It was corroborated

that along these approaches, perceptions of employees regarding access to health care, need to be explored enabling the utilisation of worksite programmes in compliance with the legislation on health care access.

The policy objective of the National Health Insurance of the Department of Health (2013:1) is, ensuring that everyone has access to appropriate, efficient and quality health services. Based on legislation as identified, it was clear that access to health care services was a priority for public health and worksites. South Africa permits reasonable legislation, ensuring access to health care. It was necessary to explore and understand the perceptions of Rand Water employees on health access so that Rand Water as an organisation could ensure compliance with the governing framework to access health care.

1.3   THEORETICAL FRAMEWORK

For the purposes of this study, the Health Belief model was opted, focusing on health education and health care promotion.

1.3.1 The origin and the theoretical concept of the model

The researcher opted for the Health Belief model as Glanz, Rimer and Viswanath (2008:46) identify it as the most used theory in health education and health care promotion. Champion and Skinner (2008:31) confirmed that the Health Belief model is of the most widely utilised conceptual frameworks in health behaviour research. The Health Belief model is a conceptual framework used to comprehend health behaviour and possible reasons for non-compliance with recommended health actions. The Health Belief model was developed in the 1950's to explain the reasons medical screening and testing programmes offered by the United States public health services were not making an impact. According to this research, the Health Belief model is the most appropriate and relevant for the study, as the model assists contextualising areas impacting negatively of accessing health care services within Rand Water. The model serves as a foundation base to understand the perceptions of Rand Water employees on barriers for accessing health care services. The

findings of the study will inform the organisation on scientific reasons for inaccessibility, providing possible recommended action plans.

1.3.2 Theoretical constructs

The Health Belief model has theoretical constructs, used to envisage reasons why individuals would take responsibility to prevent, attend health screening, and control illness and conditions (Champion & Skinner 2008:47).

1.3.2.1 Perceived susceptibility

Susceptibility refers to beliefs of the likelihood of contracting a disease or condition (Champion & Skinner, 2008:47). The greater the perceived risks, the greater the likelihood of engaging in behaviours reducing the risks (Hayden, 2014:32). Rand Water employees should first believe worksite health care promotion programmes are important and assistive before they could be concerned about accessibility of these health services.

According to Champion and Skinner (2008:47), a person should have a strong believe that there is a likelihood of getting a disease before that person would be interested in submitting to a medical test. This implies that Rand Water employees should first realise the risk of not accessing health care services, and the likelihood of getting infected with diseases. According to Hayden (2008:33), if perceptions are identified and individuals are compelled to understand the risks, they are likely to act. The research intends to explore Rand Water employees' perceptions regarding accessing worksite health care promotion programmes services. The model assisted the research and served as a guide to understand the perceptions.

1.3.2.2 Perceived severity

Champion and Skinner (2008:40) assert that approaches on the seriousness of contracting a disease, include assessments and evaluation of medical and clinical negative results. Hayden (2008:35) explains this approach as a person's judgement of the severity of the illness. Champion and Skinner (2008:47) label the combination

of susceptibility and severity as a perceived threat. The researcher considers that the concept implies that if Rand Water employees do not comprehend accessing worksite health care promotion programme services and the impact of non-access on their lives (such as absenteeism, and the impact on their family life), they would not realise the value of attending the health care promotions at work. The importance to understand their perceptions was asserted, indicating the importance of them realising the consequences of no access to worksite health care promotion programme services.

1.3.2.3   Perceived benefits

Champion and Skinner (2008:47) believe the construct of perceived benefits is an individual's belief of the value or usefulness of a new behaviour in decreasing the risk of developing an illness. According to Champion and Skinner, (2008:47), human beings   tend to adopt healthier behaviours when they believe the new behaviour will reduce their chances of developing a disease. Even though there are perceived benefits for treatment, barriers always stand in way (Champion & Skinner, 2008:47).

1.3.2.4   Perceived barrier

According to Hayden (2008:33), the individual is prompted to evaluate a new behaviour change. Some individuals need to believe that the benefits of the new behaviour, outweigh the results of continuing the old behaviour. The new behaviour should be adopted. Champion and Skinner (2008:47) indicate that Hispanic woman seeking Pap smear tests, perceive cervical cancer as being serious and believe in the positive benefits of the test. Barriers exist, denied seeking Pap smear tests, despite perceiving cervical cancer as being serious. It is further alluded that the barriers were not outweighed by the benefits of the test and did not minimise the seriousness of the condition. The barriers are indicated as fear that the test was painful and a lack of knowledge of places for testing.

Rand Water employees' perceptions are, being prohibited, even though perceiving various illnesses serious. As indicated by the study, their perceptions prohibited them from accessing health care promotion programme services. Champion and Skinner

(2008:47), provide examples: "It could help me, but it may be expensive, have negative side effects, and be unpleasant, inconvenient, or time-consuming". Specific attention was provided to perceptions serving as barriers, accessing worksite health care promotion programme services within Rand Water (Rietvlei). The researcher was allowed insight in gaining and understanding policy development within Rand Water.

1.4   RATIONALE AND PROBLEM STATEMENT

The right to health, including the right to access health care, is guaranteed by the Bill of Rights of 1996. The researcher asserted Rand Water (compared to other worksites) run comprehensive occupational health and worksite employee assistance programmes, providing ingoing and integrated programmes of health care promotion and disease management. A centred approach exists regarding risk reduction for employees. Even with a programme commuted, Person et al. (2010:150) emphasise that the true effectiveness of a worksite wellness programme, depends on the characteristics of the target population and the proportion of the population participating. Should employees show no interest, be unmotivated, or information is not relevant, the well-planned programme can fail. This research explores the question: What are the perceptions of Rand Water employees regarding access to worksite health promotion programmes?

The study aims to indicate the identified perceptions of access to worksite health care promotion programme services that could be used by the organisation to evaluate their current programmes and to implement new and improved measures, based on findings to overcome the identified barriers.

1.5   GOALS AND OBJECTIVES

The goal of the study is to explore the perceptions of the employees of access to worksite health promotion programmes within Rand Water. The objectives formulated to achieve the goal are:
- To contextualise health promotion programmes and the access of employees to these services in the worksite.

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- To gain insight and in-depth understanding of the perceptions of Rand Water employees regarding access to the health promotion programmes.
- To identify access barriers to health promotion programmes within Rand Water.
- To provide recommendations on measures to improve access to worksite health promotion programmes.

1.6 RESEARCH APPROACH

The researcher opted for qualitative research as the approach is more flexible and subjectivity to generate in depth understanding of individuals' experiences, is allowed using qualitative research (Babbie, 2010:34). Qualitative research methods are more likely to generate theoretically richer observations, not easily reduced to numbers and to tap the deeper meanings of human experiences (Babbie, 2010:43). Qualitative methods could be more relevant when flexibility is needed to explore a new phenomenon on which little is known; when there is a need to seek to gain insight, and understanding into the subjective meanings of complex phenomena; to advance or conceptualise and build a theory to be tested for future studies (Babbie, 2010:35). The study is qualitative, aiming to explore personal perceptions of Rand Water employees of access to worksite health care promotion programmes.

1.7 TYPE OF RESEARCH

According to Kumar (2011:9) most of the research in the social sciences is applied. Kumar (2011:9) implies, the research techniques, including the procedures and methods establishing the entire research methodology, are applied to the collection of information on several aspects of a situation, problem or issue. This might involve a collecting information, applied in several ways. The researcher indicates this study with the knowledge gained, could be applied directly to improve accessibility to health care promotion programmes for Rand Water employees.

1.8 RESEARCH METHODOLOGY

A collective case study design was chosen as it is an instrumental case study and it allowed exploring the perceptions of Rand Water employees on health care

promotion programmes. This study involved 15 Rand Water (Rietvlei) employees participating in the same health care promotion programme. Their participation allowed insight and understanding that could inform policy development within Rand Water. Fouché and Schurink (2011:321) suggest that researchers use an instrumental case study to produce theory and new knowledge that may inform policy development.

The study population refers to all Rand Water employees. Sampling is the process of selecting a few participants known as the sample, from a bigger group which is the sampling population (Kumar, 2011:164). A non-probability sampling procedure was used, and the type is purposive sampling. Based upon Strydom (2011a:232), this type of sample is based entirely on the judgement and decision of the researcher. A sample comprises elements containing the most characteristics; it is representative or contain typical attributes of the population.

Strydom (2011a:232) indicates that the judgement of a researcher is a factor in this technique, called judgemental sampling. This study decided on the sample size of 15 employees or until saturation was reached. The sample was drawn from the list of Rand Water employees, based in Rietvlei, participating in a health care promotion programme. Criteria for selection were:

- Only Rand Water employees.
- Based on the Rietvlei site.
- Participating in the health care promotion programme.
- Both genders included.
- All levels of employees considered (from the lowest to the highest rank).

Within probability sampling, random sampling was used from the list compiled, after purposive sampling. Strydom (2011a:230) confirms that in simple random sampling, all cases should be selected according to an interval, for example the fifth or tenth case. The interval was determined as soon as the list was compiled after the purposive sampling procedure. Selected participants participated voluntarily. According to Delport and Fouché (2011:433), in real life human sciences, researchers often need to combine the elements of both approaches, hence the study used both probability and non- probability sample types.

This is a qualitative study, with semi-structured interviewing as data collection method. The interview schedule (Annexure A) served as a guide for the interviews. The one-on-one interview was used to explore perceptions of Rand Water employees regarding access to health care promotion programmes. The one-on-one interview obtained qualitative data on perceptions of the Rand Water employees regarding barriers to access worksite health care promotion programmes in the worksite.

The sample was adequate to conduct individual interviews. Only 15 participants were interviewed, and saturation was reached, therefore using an interview was crucial, as perceptions are sensitive in research. The researcher observed even the non-verbal expressions from the participants. The researcher used an interview schedule of open-ended questions. According to Greeff (2011:352) this allows the participants the freedom to express themselves.

Rand Water is a multicultural community, and the one-on-one interviews gave provision and an allowance to the participants to observe their culture by affording freedom of expression in the language of their choice. The participants in the study expressed themselves in Zulu, English, Afrikaans, Tswana, Sotho and Sepedi. The interviews were audio recorded with the permission of the participants.

Greeff (2011:300) shares that the main purpose of piloting the interview schedule is ensuring that the researcher comprehends certain practical areas of establishing access, making contact and conducting the interview, and for the researchers to become aware of their own level of interviewing skills.

In pilot testing the interview schedule, two participants were selected, portraying similar characteristics of the targeted unit of analysis, as Rand Water employees, not based in Rietvlei. The two participants selected for pilot testing were not part of the main empirical study. The purpose of the pilot test was to assist in producing a usable data collection instrument. This would ensure provision of the information needed (Fink, 2013:7). The pilot study was a practical exercise assisting the researcher to clarify and reconstruct unclear questions.

Data analysis is the process of presenting meaning to the mass of collected data, order and structure (Schurink, Fouché & De Vos, 2011:404). According to Schurink et al. (2011:397), this implies condensing the volume of raw information; single out noteworthy information, identifying significant patterns and deciding on a way to communicate the importance as revealed by the data. The steps as guided by Schurink et al. (2011:403), were followed to analyse the research data. This process is discussed in Chapter 3.

1.9 CHAPTER OUTLINE

This research report comprises the following chapters.

Table 1: Chapter outline

CHAPTER	DESCRIPTION
Chapter one: Introduction to the study	The researcher provides a clear, comprehensive description of the research methodology used in her study. The problem statement, goal and objectives of the study and the research question is discussed. The chapter further includes a discussion of the extent of the problem and rationale of the research and a brief overview of the methodology followed in the study.
Chapter two: Health care promotion programmes in the worksite	The chapter provides a literature review focusing on health care promotion programmes in the worksite.
Chapter three: Research methodology and empirical research	The chapter discusses the research methodology used in the study, including sampling, sampling methods and data collection methods used. The analysis of data is discussed. In this chapter, the researcher provides a detailed report on key findings and analysis thus following the qualitative method of reporting. Furthermore, the researcher compared the literature review with the findings of the study.
Chapter four: Conclusions and recommendations	The chapter presents the key finding and conclusions from the study and discusses recommendations to the work organisation.

1.10   LIMITATIONS OF THE STUDY

Although this research was carefully prepared, awareness was present of its limitations and shortcomings.

1.10.1 The sample

The sample was drawn from the list of Rand Water employees, based in Rietvlei participating in a health care promotion programme. The employees who participated in the health care promotion programme were limited to 15 employees. The study excluded employees of other sites within Rand Water. As a result, the findings are limited to only one site of the organisation.

1.10.2 Hesitancy of the participants

Certain participants were hesitant to answer certain questions, especially concerning the senior management. This was addressed by explaining that they have no obligation to identify their names on the answer sheets. The participants also signed an informed consent form where confidentiality was guaranteed.

CHAPTER TWO
A THEORETICAL OVERVIEW OF ACCESS TO WORKSITE HEALTH CARE PROMOTION PROGRAMMES

2.1 INTRODUCTION

Workers represent half the world's population and are said to be the major contributors to economic development (WHO, 2007:3). According to Ball (2009:17) workplaces are identified as a promising setting for health promotion as most adults spend more time during the day at work than anywhere else. Person at al. (2010:149) believe it is important for worksites to be more conducive to employee health. Large gaps still exist between and within countries about access to occupational health services, despite the availability of effective interventions to promote health at the workplace (WHO, 2007:3).

This chapter reviews the literature dealing with access to worksite health care promotion programmes, by briefly defining worksite health care promotion programmes, the governing framework for access to health care services in the worksite and the components of worksite health care promotion programme services. This chapter further provides the principles of a successful worksite health care promotion programme and barriers for accessing health care services with the intention to provide a theoretical framework for the study.

2.2 DEFINING WORKSITE HEALTH CARE PROMOTION PROGRAMMES

The worksite health care promotion programmes (WHP) or wellness, refers to an integrated and comprehensive set of health care promotion and protection strategies, implemented at the worksite (Ball, 2009:17). This includes programmes such as, HIV and Aids and sexually transmitted diseases, policies, benefits, environmental supports, and links to the surrounding community, structured to improve the health and safety of all employees. Extensive research on worksite health care promotion programmes led to Berry, Mirabito and Baun (2010:4) concluding that a worksite health care promotion programme is designed for the employees and their families to improve their life and to benefit the organisation holistically.

Goetzel and Ozminkowski (2008:304) further define worksite health care promotion programme as the employer's initiatives directed at improving the health and well-being of employees and their families. Rand Water defines an employee wellness programme as a worksite based programme, designated for Rand Water employees and their dependants, enhancing worksite effectiveness through identification, prevention and resolution of personal and productivity issues (Rand Water Employee Wellness Policy, 2012: 2). Considering the above definitions, the researcher deduces worksite health care promotion programme as the employers' strategic tool, enhancing productivity by ensuring the health and wellness of their employees.

2.3 GOVERNING FRAMEWORK FOR ACCESS TO HEALTH CARE SERVICES IN THE WORKSTATION

Sufficient legislation is established, confirming the reasons to health care access at the worksite. The controversy remains whether worksites retain health care facilities offering quality care, accessible to all employees as legislated. In South Africa, the right of access to health care is entrenched in the Bill of Rights of 1996. The Bill of Rights expressively stipulates that everyone has the right to access to health care services, including reproductive health. The research focusses on the Rand Water employees' perceptions of access to health care promotion programmes as articulated.

The Occupational Health and Safety Act 29 of 1996 as amended, imposes a general duty on employers to:

- Provide a reasonably safe and healthy working environment.
- Provide information, training and supervision necessary, ensuring health and safety.
- Report any incident to an inspector, where an employee dies or is injured or when dangerous situations arise.

The researcher therefore indicates, Rand Water is obliged by legislation to provide access to health care services to its employees. The statement is further supported

by the National Occupational Health and Safety Policy (Department of Labour, 2003:40). It outlines the duty of the employer to provide a healthy, safe environment and safe worksite. The employer also has the duty to report accidents and incidents at the worksites.

The Compensation for Occupational Diseases and Injuries Act 130 of 1993 concurs with the above statement by affirming, employees and their dependents who suffered injury, illness or death resulting the performance of work, need to be compensated. This indicates that South Africa cares for its workers.

Conversely, the final draft Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:11) provides a set of guidelines to organise and manage interventions for employee health and wellness at the worksite. The researcher corroborates that accordingly, employees' perceptions of access to health care need to be explored; subsequently worksite programmes can be utilised maximally in compliance with legislation on health care access.

The policy objective of the National Health Insurance of the Department of Health (2013:1) is ensuring entire access to appropriate, efficient and quality health care services. Based on legislation as identified, access to health care services is a priority for public health and worksites. South Africa retain reasonable legislation, ensuring health care access. The research indicates though, that legislation alone is not sufficient. The perceptions of Rand Water employees on health access need to be explored and understood, enabling Rand Water as an organisation, ensuring compliance with the governing framework to access health care.

2.4 WORKSITE HEALTH CARE PROMOTION PROGRAMME IN SOUTH AFRICA

The Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:1) circumscribes the strategy for employee health and wellness within the public service in South Africa. The strategy outlines the functional key pillars for achieving, creating and implementing a healthy and safe working environment in the public service. The strategy only serves as a set of guidelines to organise, implement and manage interventions for worksite health care promotion

programmes. Nyati (2013:47) argues that the worksite health care promotion programme strategy should not be a 'cut and paste' product from another company. Companies do not occupy identical health and wellness challenges and needs. The researcher emphasises that periodically, differences amongst the divisions, business units and sites within the same company, may require further division specific customisation of health care promotion programmes (Nyati, 2013:47).

Exploring the literature on worksite health, established health care promotion programme components vary from organisation to organisation. According to Sparling (2010:3), worksite initiatives often differ in their approaches to improve employee health and contain health care costs. It was observed that several time-tested and accepted principles emerge consistently. In South Africa, this component of the conceptual framework is essentially the core of the Employee Health and Wellness Strategic Framework for the public service. It embodies pillars of strategic functions and building blocks that represent the content or "the what" of areas of intervention in implementation components which form the essence of the most important focus areas in the Employee Health and Wellness Strategic Framework for the Public Service (Department of Public Service & Administration, 2008:34). The worksites health care promotion components are discussed:

2.4.1 HIV/AIDS and TB Management

HIV/AIDS is the most significant and growing public health concern globally (Posse, Meheus, Van Asten, Van der Ven & Baltussen, 2008:904). According to the Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:9), the rationale and intended outcome relating HIV/AIDS management and health care promotion at the worksite, are merely for the mitigation of the impact of the HIV/AIDS epidemic and improvement of public service delivery to alleviate the number of infections and the impact on employees, families, communities and society at large. The HIV/AIDS component comprises the following:

- Prevention.
- Treatment, care and support.
- Human and legal rights and access to justice.
- Monitoring, research and surveillance.

Voluntary Testing and Counselling (VCT) became a key element of worksite health management programmes instituted in large corporations and parastatals operating in South Africa (George & Quinlam, 2009:20). Certain larger corporations, according to George and Quinlam (2009:20), invested considerably in worksite treatment facilities, providing anti-retroviral therapy (ART) for HIV infected employees and clinical care for diseases such as tuberculosis (TB) and sexually transmitted illnesses (STIs).

According to Yawa (2016:6) upon the state of health in South Africa, approximately 17 million individuals living with HIV, receive antiretroviral therapy, whilst 20 million do not receive therapy. Yawa (2016:60) indicates this as a clear indication that 20 million individuals are at risk of developing tuberculosis and cancers. This suggest that 20 million individuals need access to treatment. Venter (2016:13) contends that South Africa maintain the worst gender imbalance concerning access to ART, compared globally. According to Venter (2016:13) it is important for the worksite to become creative with HIV/AIDS management programmes. Male representation at the worksite, exceeds women's and it is a way of commencing HIV management.

The researcher argues that through literature reviewed there are strategies that are available to manage HIV/AIDS, but the statistics of individuals with no access to ART are alarming.

2.4.2 Health and productivity management

According to the Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:10), health and productivity management activities are convergent efforts to improve and promote the basic health of the workforce through:
- Prevention.
- Intervention.
- Awareness.
- Education.
- Risk assessment support.

These efforts mitigate the huge impact and effect of communicable and non-communicable diseases and injuries on the performance and quality of the lifes of individuals. As alluded, this pillar comprises four sub-objectives:

- Disease management and chronic illnesses.
- Mental health and psychosomatic illnesses.
- Injury on duty and incapacity due to ill-health.
- Occupational health education and promotion.

Person et al. (2010:2) concur with the framework as outlined, arguing that integrated worksite wellness should provide ongoing and comprehensive programmes in health care promotion and disease management, with individualised risk reduction for employees as a crucial element. Spenceley (2005:465) argues that access to services for individuals living with chronic diseases, received little emphasis in the research literature, or in health policy reform documents in Canada. It is observed that several worksite health care promotion programmes do not offer integrated wellness services to employees. Chronic management institutes a single entity.

2.4.3 SHERQ management

The National Occupational Health and Safety Policy (Department of Labour, 2003:40) refers to the duty of the employer to provide a healthy, safe environment and safe worksite. The policy adds that the employer also retains the duty and responsibility reporting accidents and incidents at the worksites. According to the Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:10) the Safety, Health, Envirement, Risk and Quality management pillar comprises these sub components:

- Occupational health and safety management.
- Environmental management.
- Risk and quality assurance.

A supportive labour environment was confirmed by Jørgensen, Villadsen, Burr, Punnett and Holtermann (2016:8) as being an important foundation for employee

participation in worksite promotion programmes. The research concurs and believes a safe environment at the worksite enables more productive employees.

2.4.4 Wellness management

According to the Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:10), wellness management strives to meet the health and wellness needs of the labourers through preventative and curative measures by customising interventions from traditional programmes. Such programmes induce, the Employee Assistance, Work Life Balance and Wellness Management programmes. These are found most focussed, appropriate to the uniqueness of the labourers and their mandate. As already alluded, this pillar comprises the following four sub-objectives:

- Individual wellness physical
- Individual wellness psychosocial.
- Organisational wellness.
- Work life balance.

Tlapu, Klopper and Lekalakala-Mokgele (2015:353) agree with the above pillar and cite the concept wellness to include, taking care of individuals (employees) holistically, and indicating taking care of them emotionally, physically, socially, spiritually and psychologically.

The researcher agrees that in practice the pillars are just a guide, and every organisation is unique, and it should structure its components as per the needs.

2.5 Principles of a successful worksite health care promotion programme

Successful worksites initiatives often differ in approaches to improve employee health (Spalding, 2010:3). Applying these principles varies amongst worksites. Spalding (2010:3) further indicates that all the principles are useful to corporate leaders and worksite health care professionals, in reviewing an organisation's health care promotion programme.

2.5.1 Accessibility and convenience

According to Goetzel and Ozminkowski (2008:313) in worksite health care promotion programmes, easy access is confirmed to be crucial in recruiting and maintaining participation. Goetzel and Ozminkowski (2008:313) further identify logistical barriers, such as time and location, as the main reasons employees withdraw from health-promotion programmes. Berry et al. (2010:5) concur with Goetzel and Ozminkowski, arguing on-site integration as essential convenience matters. Hill-Mey, Kumpfer, Merril, Ree and Richardson (2015:4) contend, the accessibility and convenience of worksite health care promotion programmes is crucial and matters most concerning proximity, as classes and noontime lectures often occurs in conference rooms.

2.5.2 The programme should have scope, relevance, and quality

Berry et al. (2010:4) specify that wellness programmes should be comprehensive, engaging and outstanding, ensuring employees' participation. The comprehensive worksite health programmes should comprise elements of health education, supportive social and physical environments, integration of the worksite programme (linked to related programmes) and health screening (Eastern Cape Provincial Administration, 2007:25). Hill-Mey et al. (2015:4) cite, to expand offerings beyond traditional choices, proven, evidence-based programmes should be adopted. The level of quality assurance should be ensured, by confirming accredited health and wellness vendors. The researcher supports the perspectives because employees respond more positively to a more engaging worksite health care promotion programme concerning them (the employees).

2.5.3 Multilevel leadership

Hill-Mey et al. (2015:3) signify that in the classic worksite health care promotion programme, management support at all levels is optimal, including participation and support from the top levels of management through middle management to the employee level. According to Milner, Greyling, Goetzel, Da Silva, Kolbe-Alexander, Patel, Nossel and Beckowsk (2013:520) the role of leadership in a worksite health care promotion programme, is regarded a crucial contributor to the health care

promotion programme initiatives' success. Milner et al. (2013:514) further state that leadership support was identified as the most vital component of successful worksite health care promotion programmes. George and Quinlan (2009:27) concur with Milner et al. (2013:514), arguing that lack of cooperation from management is a serious challenge. An instance is, line managers and supervisors view interventions, such as peer education and 'know your status' campaigns, as factors disrupting daily production at the worksite.

McCleary, Goetzel, Roemer, Berko, Kent and De La Torre (2017:261) emphasise that the success of work site health care promotion programmes depends on organisational commitment and engagement. McCleary et al. (2017:261) further state that senior managers apply a strong level of influence on all aspects of organisational functioning. Gaining their support for worksite health care promotion programmes sends a strong message that management understands the importance of employee health. They are prepared to devote considerable time and resources to identify and address priority health issues. Milner et al. (2013:520) argue that employees are unlikely to become engaged in, or support, employee health initiatives if they feel managers are only superficially interested and not true in their attempts to enhance employee health. McCleary et al. (2017:261) add a culture of health requires buy-in from all levels of an organisation, starting with leadership at a senior level. This study strongly agrees commitment to the health of employees that is demonstrated by management participating in health care promotion programmes, ensuring access and clear policies supporting and guiding the programme.

2.5.4 The health care promotion should be open to all employees

The Policy Guidelines for Integrated Employee Wellness indicate that the wellness programme should be open and accessible to employees at all levels (The Eastern Cape Provincial Administration, 2007:25). Sparling (2008:3) supports this view in stating that programmes providing only for top management, are not acceptable. Sparling (2008:3) further states that programmes should be open to all labourers from all job categories, irrespective of job position and seniority level. According to Sparling (2008:3), worksite health care promotion programmes should be designed

and structured, reaching and addressing the needs all employees, for health care costs and worksite culture to be meaningfully implemented.

2.5.5 Systematic health assessments, feedback, and assistance, monitoring individual health goals

This principle is central to worksite health care promotion. Meaningful feedback, monitoring and regular follow-up are important in assisting employees, sustaining healthy behaviours (Sparling, 2010:3). According to the researcher, evaluation and monitoring assists improving and aligning worksite health care promotion goals. It also ensures partnership that the needs of the employees as identified by them are properly addressed.

2.5.6 Tailor-made health care promotion activities to the needs of the employees

The Rand Water Employee Wellness Programme Policy (2012:5) alluded that interventions should be aligned to the needs of business; they should be needs-driven and targeted to enhance a high performing culture. Berry et al. (2010:4) indicate a wellness programme should be a complement and extension to business priorities. If a programme does not make business sense, it is automatically vulnerable. Worksite health care promotion programmes are incomplete without a thorough assessment of the needs and interests of the community to be served (Hill-Mey et al., 2015:3). The researcher supports the above viewpoints, as each company is unique concerning business methods, and faces unique challenges affecting the workforce. Each company's health care promotion programme is designed and developed to suit the specific need and culture of the organisation.

2.5.7 Attainment of high participation by using creative and appealing incentive-based programmes

Hill-Mey et al. (2015:4) contend that it is estimated, above 70% of worksite health care promotion programmes use an incentive system to increase employee enrolment and participation, which is a recommended component of successful

programmes. Hill-Mey et al. (2015:4) further indicate that incentives can implicate several arrangements; this could be monetary incentives, paid time off work, and material rewards such as offering of a promotional item. Most researchers believe that financial incentives are the most effective. According to Sparling (20010:4), incentives are offered for participation, compliance with behaviour change recommendations, or achievement of certain health goals. The aim of the incentive is, ensuring all participants view health care promotion services as an attractive company benefit (Sparling, 2010:4). Whilst incentives are important to encourage employees to participate, it should be sparingly used.

The study regards the above argument true as it is observed in practice that employees only attend health screening activities if there are incentives, such as t-shirts hand-outs during voluntary testing and counselling activities within Rand Water. It was also observed within Rand Water; promotional items are mostly used as incentives for participation; monetary incentives or time off are not used.

2.5.8 Implement and sustain environmental and policy changes that support healthy behaviours

According to Milner et al. (2013:515), companies with more worksite health care promotion policies and programmes are perceived by employees as more committed to the health and wellbeing of their employees. Companies with elevated levels of leadership involvement incline more policies and programmes. A healthy worksite culture comprises worksite policies and a supportive work environment encouraging participation in the worksite health care promotion programme (Hill-Mey et al., 2015:4). The researcher agrees with the above perspective, as policies and procedures provide distinct guidelines, and ensure commitment by the leadership to the worksite health care promotion programmes.

2.5.9 Link health care promotion services to occupational safety and job performance at all employee levels

According to the World Health Organisation (WHO), primary prevention and alleviation of occupational health hazards should be given priority (WHO, 2007:7). It

is therefore important for supervisors and managers to reinforce safety practice by indicating the relevance of good health as a critical point. Employees that follow safety practices are less prone to error and injuries and are perceived as more productive (Sparling, 2010:3).

2.5.10 Extending health care promotion services to spouses and family members

Health behaviours are shaped and influenced by families and social networks (Sparling, 2010:3). Therefore, companies are wise to extend services to employees and their dependants. Spalding (2010:3) further add that an additional recommended step is for corporate companies to support health projects in local communities to demonstrate their corporate commitment to a healthy lifestyle, beyond the worksite. The researcher concurs, since families are part of a system in communities, societies globally. Families are affected and impacted by social factors in their surroundings.

2.5.11 Systematically evaluate employees' health needs and the effectiveness of health care promotion services and activities in meeting these needs

The Employee Health and Wellness Strategic Framework for the Public Service emphasises that the worksite health care promotion programme should be monitored and evaluated to demonstrate effectiveness and evidence of impact (Department of Public Service and Administration, 2008:34). Sparling (2010:3) concurs by indicating that successful companies constantly evaluate the success of their worksite health care promotion programme. Their findings are used to adapt, customise and improve their services. The researcher believes lack of systematic and regular evaluation could also contribute to the failure of the worksite health care promotion programme.

McCleary et al. (2017:256) mention research found programmes implementing the elements of best practices, improved, compared to ordinary standard programmes. It is reported, discernible reductions in common health risk factors such as physical inactivity, poor diet, and stress levels with programmes based on best practices, achieve greater risk reduction than standard programmes.

When worksite health care promotion programmes are grounded in behaviour theory, implemented effectively using evidence-based principles and measured accurately, they are more likely to improve productivity and performance of the worksite (Goetzel & Ozminkowski, 2008:310).

The research agrees that relevance or application of these principles varies amongst worksites, and all principles are useful and essential. Person et al. (2010: 2) argue that, even if all these elements as identified are present, the true effectiveness of a worksite wellness programme still depends on the characteristics of the target community and the proportion of the community participating in the intervention. Person et al. (2010:2) further argue that if employees are less interested, with a low-level motivation, and information is not addressing personal needs, even a well-planned programme can still fail.

2.6   BARRIERS FOR ACCESSING HEALTH CARE SERVICES

The elements of worksite health care promotion programme are identified. Controversy remains whether employees have access to these health care promotions programmes within Rand Water. The South African Minister of Health Mr Aaron Motswaledi (2013:4), during the 66th session of the World Health Assembly, confirmed the effective interventions and occupational health services, as being both basic and specialised. Access to health care, according to Shook (2005:1), remains a persistent public health concern. Even though access to health care services of the worksite is a legal expectation, not all employees enjoy access. The following barriers were identified in literature in accessing health care services.

2.6.1 Geographical barriers

Employees may not devour access to health care promotion programmes due to geographical constraints. Geographic accessibility is defined as travel impedance, referring to mobile friendly resources between patients and health care providers (Neutens, 2015:14). Kronfol (2012:1240-1241) concurs with Neutens and argues that three aspects of geographical barriers to access health care services exist.

2.6.1.1 Transport

Shook (2005:3) asserts that transportation was identified as a general barrier to health care services. According to Jacobs, Ir, Bigdeli, Annear and Van Damme (2011:290), the availability of transport is crucial to accessing a location of any sort. Kronfol (2012:1240-1241) concurs that transportation is a critical issue, more especially when individuals depend on public transport to access health care, particularly in rural and remote areas. Kronfol (2012:1240-1241) further maintains that individuals with functional impairments, and older individuals, also experience challenges to reach health care services. Shook (2005:2) contends that although the safety, costs and ease of boarding public transport provides opportunities for access, the lack thereof is identified as a barrier. Person et al. (2010:5) support this view by stating that some employees would opt to only attend health care promotion services if they are at their location, and would not consider such services if implemented in other areas. The researcher finds the above view to be true; transport is indeed an enabler and a means for employees to reach their desired location.

2.6.1.2 Rural-urban inequalities

Marrone (2007:191) argues that health care facilities in rural areas tend to be understaffed and experience recruiting health care providers to live and work in remote rural communities, challenging. Marrone (2007:191) further argues that rural location and isolation from urban centres widens the health care disparity gap between the majority and indigenous populations. Kronfol (2012:1241) supports this view by observing that health beliefs of rural individuals can also delay early consultation and referrals with health care facilities resulting in late medical consultations. The researcher believes this indicates the importance to explore Rand Water's geographical location, transport, demarcation of water sites, and how this influences access to health care promotion programmes.

2.6.1.3 Regional variations

Health indicators vary significantly between areas (Kronfol, 2012:1241). Rural areas retain worse health statuses, compared to other urban populations.

2.6.2 Cultural barriers

According to George and Quinlan (2009:200), interventions that 'do not speak' to the individual, taking into consideration factors such as age, gender, social circumstances and culture are often huge stumbling blocks concerning access. Kronfol (2012:1241) further argues that perceptions of cultural sensitivity of services was reported as an important influence on both entering and accepting the health care system and maintaining contact with health care providers. It is agreed that it is important to offer programmes reflecting the diverse cultural, language and racial character of the worksite.

2.6.2.1 Gender

UNAIDS released data indicating South Africa occupies the worst gender imbalance concerning access to ART in the world (Yawa, 2016:6). Posse et al. (2008:911) identify gender factors associated with access barriers, including, inability to be provided with information because of female gender, often requiring a husband's permission to commence treatment, fear of rejection and divorce; other factors like attitudes, belief and fear of side effects were also identified. Person et al. (2010:2) maintain that research indicates that women are generally more likely to participate in worksite wellness programmes than men. Married employees have much higher commitment and participation rates than their single co-workers. It is concurred that health providers should ensure gender sensitive programmes by incorporating a gender balance amongst coordinators and counsellors.

2.6.2.2   Ethnicity and race

Ethnicity and race can also pose as barriers in access to programmes. Brown, Ojeda and Levan (2000:1) believe racial and ethnic groups in the United States are experiencing major disparities in health status. These disparities in health status are compounded by unreasonably reduced access to health care services. Marrone (2007:192) proclaims that language differences indicate to be a serious barrier amongst various cultural and ethnic groups. Marrone (2007:192) further asserts that

even if the health care provider and the patient both speak the same language, the cultural values and experiences of the patient's influence how they engage and communicate their symptoms and how they perceive feedback on their health status. Kronfol (2012:1242) also contends that racial discrimination in public places and public transport may pose an important barrier for some ethnic groups. The argument is found to be of paramount importance and it is asserted that organisations should provide for diversity in language, race, religion and ethnicity, ensuring complete accessibility of services for employees.

2.6.2.3 Nationality

A study from Kuwait reveals differences in access to primary health centres amongst various nationals. Sheikh-Mohammed, Macintyre, Wood, Leask and Isaac (2012:594), in a study on using medical services, found that such services are less used by individuals with lower socioeconomic statuses.

According to the 66th World Health Assembly (2013:2), labourers in underprivileged communities are more likely to be exposed to occupational hazards and to suffer work-related diseases and injuries. Kronfol (2012:1240) mentions that several subsets of the population in most countries continue to face difficulties utilising the range of health services available. It is thus necessary to explore how gender, ethnicity, race and nationality influence the access of health care services within Rand Water.

2.6.2.4   Religion

Religion has an important influence on certain health practices (Kronfol, 2012:1241). The boundaries between religion and other sociocultural factors are not easily discernible but health, as a mirror of society, is influenced by religion. South Africa is a diverse country, and it is important to understand how religion impact on access to treatment. It is also important for clinicians to understand the various beliefs that may arise regarding the cause of the condition and the role the traditional healers and extended family members play in treatment. According to Bham and Ross (2008:548), when providing therapy to patients from the South African Indian Muslim

community, the pig is considered offensive when a therapist is using an animal theme in therapy in relation to religious beliefs. Bham and Ross (2008:548) further mention that religious beliefs and the community's faith in various cures are often strong, influencing all aspects of individuals' lives, including the most affluent and highly educated members of the population. The researcher observed that cultural practices often lead to home remedies and elderly consultations are prioritised. Access to health care services is often the last option and a delay in seeking treatment is frequently experienced.

2.6.3 Organisational barriers to access

The literature review identified certain organisational aspects impeding the access to health services.

According to Jacobs et al. (2011:291), it is a challenge for working individuals enjoying limited free time that do not allow for dealing with emergencies or working times. Person et al. (2010:6) support the above perspective by arguing that employees who were off duty or who worked the night shifts, are periodically expected to make an extra effort to come in during their time off to attend the worksite health care promotion programmes, due to limited available times.

Unqualified health care providers and unfriendly opening hours and waiting time were cited as further access barriers (Jacobs et al., 2011:291). Person et al. (2010:6) state that access barriers to worksite health care promotion programmes is further hindered when sites were short-staffed due to callouts, production schedules being behind scheduled target, or by continuous service operations. It is alluded that administration barriers as outlined above could jeopardise the access of employees to the programme.

2.6.4 Health care providers

Jacobs et al. (2011:290) mention negative staff attitude of health care providers, high staff absenteeism and poor interpersonal relationships as certain identified barriers of access. George and Quinlan (2009:22) further identify violations of confidentiality as

the reason for the limited use of health care promotion programmes and worksite VCT facilities (George & Quinlan 2009:23). Other factors of concern, identified by Kronfol (2012:1243) refer to the subjective quality of care, clinical skills of staff, functioning and referral system.

Interpersonal communication, information sharing and facilitation of patient involvement in decision-making can have a positive feedback when a family member is sick (Kronfol, 2012:1243). Effective communication between a patient and the provider is paramount in a health care setting (Marrone, 2007:191). The researcher is of the perspective that health care providers should be aware of their attitudes and their impact on health care promotion services.

2.6.5 Information technologies

Information and communication technologies became progressively more important in assisting countries to improve the standards of health care provision (Kronfol, 2012:1243). An example given, relates to using tele-radiology and telemedicine providing technical support to health care providers especially in rural areas, lacking specialist care; where physicians are encouraged seeking a second opinion from colleagues and peers (Kronfol, 2012:1242). Marrone (2007:192) mentions that new developments in telemedicine hold promise for increasing the range of health care services to remote indigenous communities. These kinds of initiatives will endure several years to develop across all rural communities.

2.6.6 Social barriers

George and Quinlan (2009:23) mention stigma and other social factors as barriers for accessing voluntary counselling and testing (VCT). Employees fear the stigma and social marginalisation if presumed to be HIV positive during the health screening. According to George and Quinlan (2009:23) stigma and discrimination are attributed as reasons for low uptake of VCT and ART. Lack of assertiveness and low self-esteem by health care users from low socio-economic groups, increase the difficulty of accessing services. This was cited as barriers of access to health care promotion services (Jacobs et al., 2011:290). Health care labourers need to be aware of the

impact of stigma on access to health care services. Privacy and confidentiality during testing and consultations should be maintained at an important level, ensuring employees are not exposed to labelling that will hamper access to health services.

2.6.7 Financial barriers

Socio-economic status was also confirmed to affects an individual's ability to access and obtain essential medical services (Marrone, 2007:193). Financial-based barriers, such as the lack of health insurance coverage, are the most well studied elements of access in the medical literature (Shook, 2005:2). Financial barriers include direct and indirect financial costs, informal charges and the opportunity costs of seeking health care. Kronfol (2012:1243) asserts that families may have to co-pay to cover part of the cost of services, hygiene materials and medicines. This study argues that finances impact negatively on access. If employees have inadequate financial means to access health care promotion programmes, they would not access adequate proper medical care.

2.6.8 Other potential barrier factors

Other potential factors regarding barriers to access, include lack of energy, no interest to the programme being offered, inadequate time during the workday to attend the programme, inefficient time before or after work, involvement in other similar programmes or activities, lacking interest to participate with co-workers, lack of self-discipline, current injury or ill-health, or lack of support of by the supervisor (Ball, 2009:9). The researcher concurs that periodically the barriers to access are with the recipients of service and not the employer.

2.6.9 Emotional and cognitive barriers

According to George and Quinlan (2009:22) emotional and cognitive barriers, such as little knowledge of VCT, denial of personal risk of HIV infection, perceptions of little benefit from VCT and fears of testing positive, the implications for future employment if tested positive. Such barriers are some of the main reasons employees fear health screening, for fear of discrimination.

2.7 THE EFFECTS OF ACCESS TO WORKSITE HEALTH CARE PROMOTION PROGRAMMES

While worksite health care promotion programmes continue as a popular employer provided benefit, it should be noted that not all are comprehensive and integrated; some still lack the essential ingredients for effectiveness (McCleary et al., 2017:256). According to Leininger et al. (2015:247), participation in worksite health care promotion programmes can improve lifestyle-related health indicators, including cardiovascular disease risk factors, stress levels and sedentary behaviour. McCleary et al. (2017:256) concur that full participation in health care promotion programmes have the following effects:

- Enhances employee morale.
- Improves employee engagement.
- Reduces health risk.
- Saves costs.
- Improves productivity of the worksite.

Berry et al. (2010:8) contend that a variety of studies confirm the health conditions that contribute most to lost productivity, are the following:

- Depression.
- Anxiety.
- Migraines.
- Respiratory illnesses.
- Arthritis
- Diabetes
- Back and neck pain.

Work site health programmes are associated with changes in the health habits of workers. Goetzel and Ozminkowski (2008:303) further argue that worksite health care promotion programmes maintain increasing importance, contributing to improved health for several Americans. Studies suggest that programmes grounded in behaviour change theory and utilised tailored communications and focused

counselling for individuals at risk, are prone to produce a positive return on investments in those programmes.

Berry et al. (2010:8) contend growing evidence exists that work site health care promotion programmes can yield acceptable financial returns to employers that invest in them. Berry et al. (2010:8) further state that analyses on annual health care claims are normally higher amongst nonparticipants in worksite wellness programmes than amongst participants with a high-risk health status (Berry et al., 2010:80). Research consistently indicates that the costs to employers from health-related lost productivity minimise those of health insurance.

According to Ball (2007:30), on the literature evaluated concerning the benefits of current comprehensive worksite health care promotion programmes, it demonstrated positive outcomes of improved health behaviours, employee productivity (presentism and absenteeism), and an improved financial outcome of employers. Ball (2007:19) further asserts that successful worksite health care promotion programmes have been shown not only to appreciably improve the health of employees, but also the financial outcome of their employers. Personal health is not a luxury in a company; it is such an intimate issue, when invested and executed appropriately, it can create deep bonds and improve employee morale (Berry et al., 2010:8).

The researcher agrees with the above perspective. Worksite health care promotion programmes are not a 'nice to have' for work organisations, but a strategic tool to assist in alleviating personal and work-related challenges that impact negatively on productivity.

2.8 SUMMARY

This chapter contextualises the theme of worksite health care promotion programmes and provides a theoretical framework from which the study departs. The literature assists in providing extensive information suggested by various authors on access barriers to health care promotion programmes. The chapter reviewed the definition of the health care promotion programme with the purpose of providing context and clear

understanding, providing a definite understanding and knowledge of the subject under review.

The governing framework for access was discussed, indicating departure, providing sufficient legislation, confirming the reasons for health care access of the worksite. The literature reviewed the components of the worksite health care promotion programme in South Africa and further elaborated on the principles of a successful worksite health care promotion programme. The literature confirmed that the worksite promotions are not 'carved in stone', but each worksite should have a programme according to its operational needs.

Barriers for accessing health care promotion programmes were also reviewed and elaborated extensively. The literature review attempted to identify the best and promising practices defining effective health care promotion programmes and the effects they have on worksites. The next chapter discusses the empirical study.

CHAPTER 3
EMPIRICAL RESEARCH

3.1 INTRODUCTION

Chapter 3 aims at discussing the empirical part of this study, including the research methodology, ethical aspects of the study and the detailed presentation of the empirical data collected. The research findings are discussed based on the themes and sub-themes emerging from data collected.

3.2 RESEARCH APPROACH

The research opted for qualitative research as the approach was said to be more flexible, allowing research procedures to evolve as more observations are collected. Subjectivity to generate in depth understandings of the meaning of humans' experiences is allowed using qualitative research (Babbie, 2010:34); qualitative research methods are more likely to generate theoretically richer observations, not easily reduced to numbers and to tap the deeper meanings of human experiences (Babbie, 2010:43). Qualitative methods could be more relevant when flexibility is needed to explore a new phenomenon on which little is known, or when a need exists to seek insight and understanding into the subjective meanings of complex phenomena or to advance or conceptualise and build a theory that can be tested for future studies (Babbie, 2010:35). The study is qualitative, as the researcher aimed to explore personal perceptions of Rand Water employees of access to worksite health care promotion programme services.

3.3 TYPE OF RESEARCH

According to Kumar (2011:9), most of the research in the social sciences is applied. Kumar (2011:9) implies that the research techniques including the procedures and methods that form the entire body of research methodology are applied to the collection of information on several aspects of a situation, challenge, issue. It may represent a situation where information collected and assembled can be applied in other ways. The type of the research was thus applied, as the knowledge gained

could be applied directly to improve accessibility to health care promotion programme services for the Rand Water employees.

3.4   RESEARCH DESIGN AND METHODOLOGY

3.4.1   Research design

The collective case study design is an instrumental case extended to several incidents, intending to explore and describing a subject for gaining new knowledge (Fouché & Schurink, 2011:322). For this research, a collective case study design was undertaken, since it was an instrumental case study and it allowed exploring the perceptions of Rand Water employees towards health care promotion programmes. In this study under review, 15 employees who participated in the same health care promotion programme, within Rand Water in Rietvlei were explored. This allowed insight and understanding that would inform policy development within Rand Water.

Fouché and Schurink (2011:321) suggest that researchers use an instrumental case study to produce theory and innovative knowledge that may inform policy development.

3.4.2   Research population, sample and sampling method

A population or universe is the set of elements from which a researcher draws a sample (Blair, Czaja & Blair, 2014:88). A population boundary, or population boundaries are the conditions separating those who are of interest in the research from those who are not (Blair et al., 2014:108). Strydom (2011a:223) describes a population as the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned. The population was all employees of Rand Water.

Sampling is the process of selecting a few (a sample) from a bigger group, being the sampling population (Kumar, 2011:164). A non-probability sampling procedure was used and the type was purposive sampling. According to Strydom (2011a:232), this type of sample is based entirely on the judgement of the researcher, in that a sample

is composed of elements containing the most characteristic, representative or typical attributes of the population. Strydom (2011a:232) confirms this technique is also called judgemental sampling as the judgement of the researcher is a factor. For this study, a sample size was chosen, where it opted for 15 employees or until saturation would be reached. The sample was drawn from the list of Rand Water, based in Rietvlei and who participated in a health care promotion programme. Criteria for selection were:

- Only Rand Water employees.
- Based in Rietvlei as a site.
- Participated in the health care promotion programme.
- Both genders to be included.
- All levels of employees to be included (from the lowest to the highest rank).

Within probability sampling random sampling was used from the list compiled after the purposive sampling. Strydom (2011a:230) confirms that in simple random sampling, all cases should be selected according to an interval, for example every fifth or tenth case. The interval was determined as soon as the list was compiled after the purposive sampling procedure. Selected participants still participated voluntarily.

3.4.3 Data collection method

Because this was a qualitative study, the study opted for semi-structured interviewing as a data collection method. The interview schedule (see Appendix 5) served as a guide for the interviews. The one-on-one interview was used to explore perceptions of Rand Water employees regarding access to health care promotion programmes. According to Greeff (2011:351), researchers use semi-structured interviews to gain a detailed understanding of a participant's belief on, or perceptions or account of a specific topic.

The one-on-one interview was used to obtain qualitative data on perceptions of the Rand Water employees regarding barriers to access worksite health care promotion programme services. The sample was also minimal, conducting individual interviews. Because only fifteen respondents were interviewed; using an interview was crucial, as perceptions are a sensitive research topic. The researcher could observe even the

non-verbal expressions from the participants. The researcher used an interview schedule of open-ended questions and this according to Greeff (2011:352) allowed the participants to express themselves freely. It was identified that Rand Water is a multicultural community, and the one-on-one interviews gave provision to the participants to observe their culture by allowing the freedom of expression in the language of their choice. The participants in the study spoke in Zulu, English, Tswana, Afrikaans and Sepedi. The interviews were audio recorded with the permission of the participants.

Greeff (2011:300) agrees that the purpose of piloting the interview schedule is to enable the researcher to understand certain practical aspects of establishing access, making contact and conducting the interview, and becoming aware of the level of interviewing skills. The researcher, in pilot testing the interview schedule, selected two participants who portrayed similar characteristics of the targeted unit of analysis, who were part of Rand Water employees and were not based in Rietvlei. The two participants selected for pilot testing were not part of the main empirical study. A pilot test's purpose is to assist the researcher to produce a data collection instrument, usable, providing the information needed (Fink, 2013:7). The pilot study assisted in clarifying and reconstructing unclear questions.

3.4.4 Data analysis

The goal of analysing qualitative data is to summarise what was seen or heard concerning frequently-used words, phrases, themes, or patterns aiding understanding and interpreting the emerged (Nieuwenhuis, 2007:100). According to Schurink et al. (2011:397), this implies condensing the volume of raw information; single out noteworthy information, identifying significant patterns and deciding a way to communicate the importance as revealed by the data.

Step 1: Planning recording of data
For collecting the data, an audio recorder was organised and appointments arranged with all selected participants for the interviews. Consent was obtained from the participants, prior commencement of the interviews and each participant signed the

consent form. A safe, noise free environment was created for the interviews. Audio recordings and field notes were used to create transcripts for data analysis.

Step 2: Data collection and preliminary analysis

With the permission of participants, all interviews were audio recorded and field notes were made during the interviews. Schurink et al. (2011:403) believe field notes provide the raw data of participant observation, and it is also advisable that researchers should write the most complete and comprehensive field notes possible. Each interview conducted, was compared with the field notes collected. The literature was browsed to establish preliminary commonalities in the participant responses. Extensive literature was consulted, establishing how others worked with their data, thus also taking special note not to rush into premature conclusions.

Step 3: Managing the data

For the analysis process, researchers organise their data into file folders, index cards or computer files (Schurink et al., 2011:408). Researchers further convert their files to appropriate text units, for example a word, a sentence, an entire story, for analysis either manually or by computer. For this research, the audio recorder was used to listen to the recorded interviews and the content was fully transcribed. The audio recordings were saved on a laptop in a specified folder. Proper labelling was ensured concerning dates, places, and interviewees, ensuring information was properly identified. The nonverbal cues and information written was typed and organised, assisting with the full analysis. The file was stored using a password protected zip file to protect against hackers.

Step 4: Reading and writing memos

It is ideal for the researcher to read the transcripts in their entirety, often several times to be immersed in the details, attempting a sense of the interview as whole prior to analysing it (Schurink et al., 2011:409). The authors conversely state that writing memos in the margins of field notes or transcripts assists in this initial process of exploring a database. Memos and short notes were made in the margins of the scripts noting essential information collected and non-verbal communications were noted.

Step 5: Generating categories and coding the data

Schurink et al. (2011:410) identify that the process of category generation involves noting regularities in the setting or individuals chosen for the study. They further add that as categories of meaning emerge, the researcher search for those that have internal convergence and external divergence, thus categories should be internally consistent but distinct from one another (Schurink et al., 2011:410). In this research, transcripts were used to describe and classify data. Data was classified in themes, meanings, recurring ideas and common experiences. Colour markers were used to assist in identifying and organising data into different themes.

Step 6: Testing emergent understandings and searching for explanations

According to Schurink et al. (2011:416) as categories and patterns are discovered in the data, researchers should engage in critically challenging the patterns, seeming apparent. The authors further emphasised the process includes evaluating and assessing the data for their usefulness and centrality. For this study, the data was scrutinised and evaluated extensively for its usefulness and assessed whether it explored perceptions as in the goal of the study.

Step 7: Interpreting and developing typologies

The process of interpretation involves making sense of the data, and the lessons learned from it (Schurink et al., 2011:416). The process entails the researcher forming a broader opinion on understanding the data through diverting to themes and sub-themes emerging from the study (Schurink et al., 2011:416). As typologies developed, conceptual linkages between the various phenomena were made (Schurink et al., 2011:416). For this study, the aim included exploring perceptions of Rand Water employees of access to worksite health care promotion programme services (Schurink et al., 2011:417). According to the authors, first-order interpretation is based on the categories of meaning of the individuals being studied and in the second-order interpretation, the researcher elicits an underlying sense of meaning in the data.

Step 8: Visualising, representing and displaying

It is in the final phase of the spiral where the data is presenting a packaging of information established in text, tabular or figure form (Schurink et al., 2011:418). For

this research, the report written was presented, in accordance to the guidelines of the Department of Social and Criminology at the University of Pretoria. The results provided a detailed description of the perceptions of Rand Water employees on access to work site health care promotion programmes. The research report presents how the research was conducted, its findings and its recommendations. Verbatim responses from participants substantiated the research results.

3.4.5 Trustworthiness

Trustworthiness is established when findings as closely as possible reflect the meanings as described by the participants (Lietz, Langer & Furman, 2006:444). The authors further established that trustworthiness is not something that naturally occurs, but is the result of rigorous scholarship that includes using defined procedures. Qualitative research should as closely as possible reflect the thoughts, feelings and experiences of the individuals participating in research studies (Lietz et al., 2006:444).

Ensuring trustworthiness of the data, the researcher attended sessions with the research supervisor, Prof C.E. Prinsloo, who validated the findings presented as verbatim examples, as true reflection of the research participants' experience. In the study under review, the researcher explored perceptions of Rand Water employees of access to health care promotion programme services. The perceptions of the participants were prioritised over that of the researcher. Threats to trustworthiness, including challenges such as, reactivity and biases on the part of the researcher and the participants, were possible. The following strategies ensured trustworthiness:

- **Reflexivity**

Reflexivity involves considering the multiple identities and perspectives of researchers in consideration of ways in which these factors could both support the process of data analysis, while also acknowledging the potential for reactivity and bias (Lietz et al., 2006:448). Reflexivity is the active acknowledgement by the researcher that own actions and decisions will inevitably influence the meaning and context of the experience under investigation. Self-introspection ensured reflexivity, to be distinguished from the participants. The differences and commonalities existing

between the participants and the researcher were also explored. The researcher acknowledged the fact that her own actions and decisions inevitably impacted upon the meaning and context of the experiences under investigation.

- **Audit trail**

An audit trail allows a researcher the freedom to make unique research decisions not previously prescribed, while still requiring each decision and justification be recorded (Lietz et al., 2006:451). It is acknowledged that an audit trail is an important part of establishing rigor in qualitative work as it describes the research procedures. An audit trail allowed the researcher to follow her own research procedures (Lietz et al., 2006:451).

- **Member checking**

Member checking involved sending participants the findings from the analysis for them to discuss which aspects of the data analysis best fit their perspectives (Lietz et al., 2006:453). According to Lietz et al. (2006:453) member checking is a respondent validation and it allows participants to also review findings and challenge the accuracy of the work. The researcher checked with participants that she understood their responses correctly and that the analysis reflected their perceptions.

3.5 Ethical considerations

Human beings are the object of the study in social sciences research. This often endures unique ethical problems (Strydom, 2011b:113). The researcher engaged the participants, bearing the following ethical considerations in mind.

3.5.1 Voluntary participation

The norm of voluntary participation in a research study is more easily said than to be applied in practice (Rubin & Babbie, 2010:257). No participant should be forced to participate in a research study (Babbie, 2010:62). A major tenet of research ethics is that participation should be voluntary. Participants in the research were made aware that they are participating in a research voluntarily and permission was obtained from Rand Water management to conduct a research. A letter of consent was handed to

the participants to request their voluntary participation. Rubin and Babbie (2010:257) emphasise that participants should be informed of all the consequences of the study, and consent to participate in it should be obtained. Participants were aware that they could withdraw from the study at any time, with no negative consequences. The researcher informed the participants that an audio recorder would be used for capturing the interview process. The participants were elucidated on the value of the study and its importance.

3.5.2 Violation of privacy/anonymity/confidentiality

Confidentiality is the cornerstone of the worksite health and promotion programme within Rand Water and is clearly articulated in their policy document. The researcher ensured that she obliges with the Rand Water Health and Promotion Policy on the handling of confidential information. The identities of participants were not revealed during data collection and in the final report. Everyone has the right to privacy and it is their right to decide when, where, to whom and to what their attitudes, beliefs and behaviour will be revealed (Strydom, 2011b:119). Effort was made, ensuring the identities of participants are never revealed or linked to the information they provided, without their knowledge or prior permission (Padgett, 2008:62).

3.5.3 Debriefing of participants

The researcher must rectify any misperceptions that may have arisen in the minds of participants, after completion of the research project (Strydom, 2011b:122). The researcher did the debriefing with participants after the interviews. If the researcher would identify harm to any of the respondents, the researcher would immediately have referred the participants to the employee assistance professional, who is a professional counsellor rendering EAP services for Rand Water. It was however not necessary for any referral.

3.5.4 Distress and emotional harm

Many qualitative interviews elicit intense discussion of painful life events such as divorce, death of a family member, and domestic abuse (Padgett, 2008:69). The

topic of the research required personal perceptions which might have elicited emotions. The researcher was aware of this, and participants were supported emotionally throughout their engagement in the research. The researcher personally assessed each participant after each interview and established if they were not impacted negatively. Researchers should decide in advance for referrals to professional counselling if emotional responses are likely to occur (Padgett, 2008:69). The researcher encouraged using Rand Water's free counselling toll-free services to participants as a means of support post-participation.

3.5.5 Deception of participants

Deception refers to misleading participants, deliberately misrepresenting facts or withholding information from participants (Struwig & Stead, in Strydom, 2011b:118). The researcher identified herself to the participants, thoroughly discussed the purpose of the study and how participants were selected was clearly articulated (Rubin & Babbie, 2010:259).

3.5.6 Informed consent

Informed consent becomes a necessary condition rather than a luxury or an impediment (Hakim in Strydom, 2011b:117). Obtaining informed consent implies that all possible information on the goal of the investigation; the expected duration of the participants' involvement; the procedures which will be followed during the investigation; the possible advantages and disadvantages and dangers to which participants may be exposed; and the credibility of the researcher, be rendered to potential subjects or their legal representative (Royse, Williams, Tutty & Grinell in Strydom, 2011b:117). Participants were informed that the researcher would use an audio recorder and permission was granted.

3.5.7 Actions and competence of the researcher

The interviews and study were conducted in a competent manner. It was endeavoured conducting the study accurately and ethically (Strydom, 2011b:123). Plagiarism was another important aspect that the researcher was conscious of during

the recording and reporting of the study (Strydom, 2011b:123). The research was conducted under the close supervision of an experienced supervisor, Prof C.E. Prinsloo from the University of Pretoria. The researcher completed a module in research methodology module (MWT 864) at the University of Pretoria.

3.5.8 Publications of findings

The researcher introduces the findings of the study to the readers in a written form (Strydom, 2011b:126). The findings of the study were simplified and formatted in a language understood by all. Feedback was given to the organisation and subject of study in writing. The participants and Rand Water were informed that the research report would be published and data would be stored at the Department of Social Work and Criminology, University of Pretoria, for a period of 15 years. The researcher explained to the participants and Rand Water that the final report and results will remain the intellectual property of the University of Pretoria.

3.6 PRESENTATION OF EMPIRICAL DATA

This section serves the purpose of analysing and interpreting the data collected from the participants. Data was analysed with the aim of extracting recurring ideas, experiences, meaning and common themes, as the study followed the qualitative research methodology. The sequence of the presentation of data commenced with the biographical information on the participants, presented in tables and figures followed by the research findings of the semi-structured interviews presented according to specific themes and sub-themes. The researcher drew conclusions, reflecting the research problem initiated by the study. Participants spoke in various African languages including Afrikaans and English; therefore, data presented in verbatim format will be in various African languages and interpreted into English.

The qualitative data from participants was collected by the researcher and analysed for presentation in this section.

3.7 BIOGRAPHICAL INFORMATION

The aim of presenting this section is to draw a profile of the employees that participated in this study, and furthermore, to collect data on the personal detail of the participants.

- **Gender of participants**

Figure 1: Gender of participants

Gender of Participants

26.66%
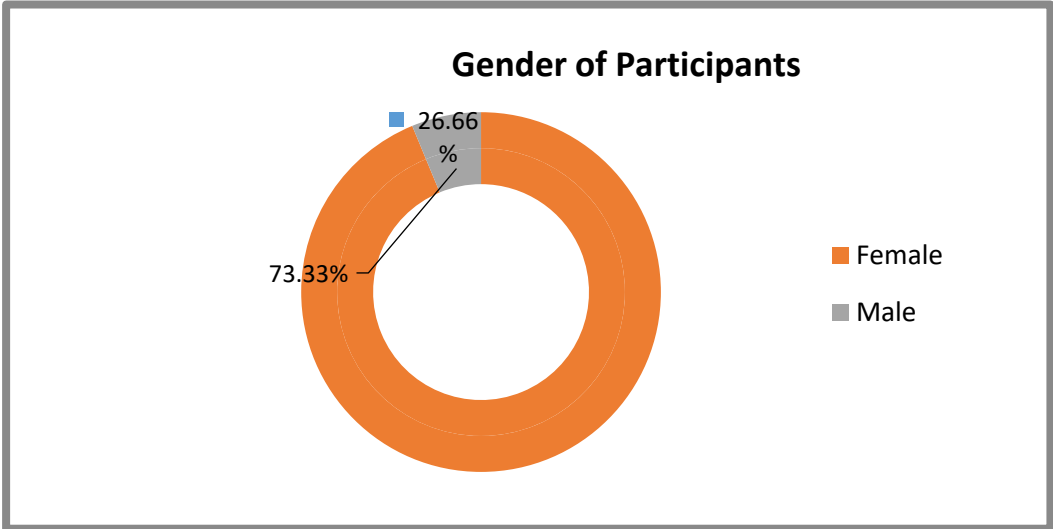
73.33%

Female
Male

The number of females who participated in this study is relatively high and accounted for 73.33% of the participants in the study. According to Person et al. (2010:150), research indicates that women are more likely to participate in worksite health care promotion programmes than men. Kronfol (2012:1241) concurs that women are major health care users. The most general belief is that men do not care as much about their health. Reference was made on 'blue collars' in that they are less likely to participate when they perceive the health care promotion strategy as something of no relevance ([Scanes]:3).

The research as revealed in Figure 1, indicates more females than males use the health care promotion programmes and participated in the study within Rand Water.

- **Age distribution of participants**

Figure 2: Age distribution of participants
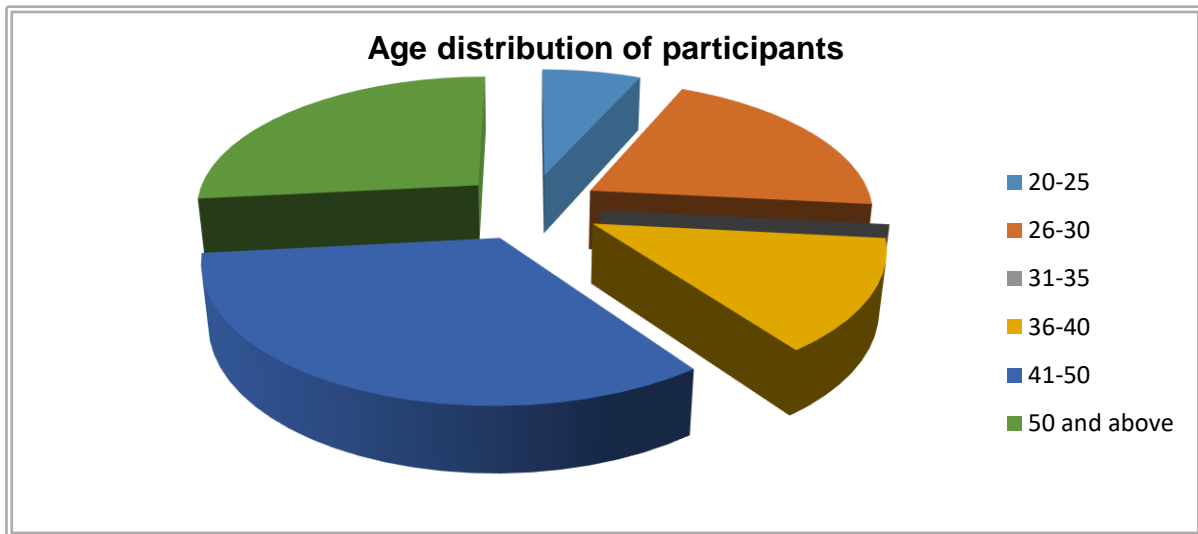
Figure 2 indicates the ages of the participants ranged from 20 to 50 and higher, with most of the participants falling within the 41 to 50 and higher age group at 33.33%. In this study, the lower participation rate was aged 31 to 35 years at 0%. Figure 2 indicates that the age group between 41 and 50 and above was the most strongly represented. The finding of the study concurs with other research that also found that men who choose to participate in health care promotion were older and overweight ([Scanes]:3). This study could however not determine if the older men in this study were overweight. Rosbroek, Van Lenthe, Van Empelen and Burdorf (2009:6) differ and argue that age has no effect on participation in health care promotion programmes.

- **Home language of participants**

Figure 3: Home language of participants
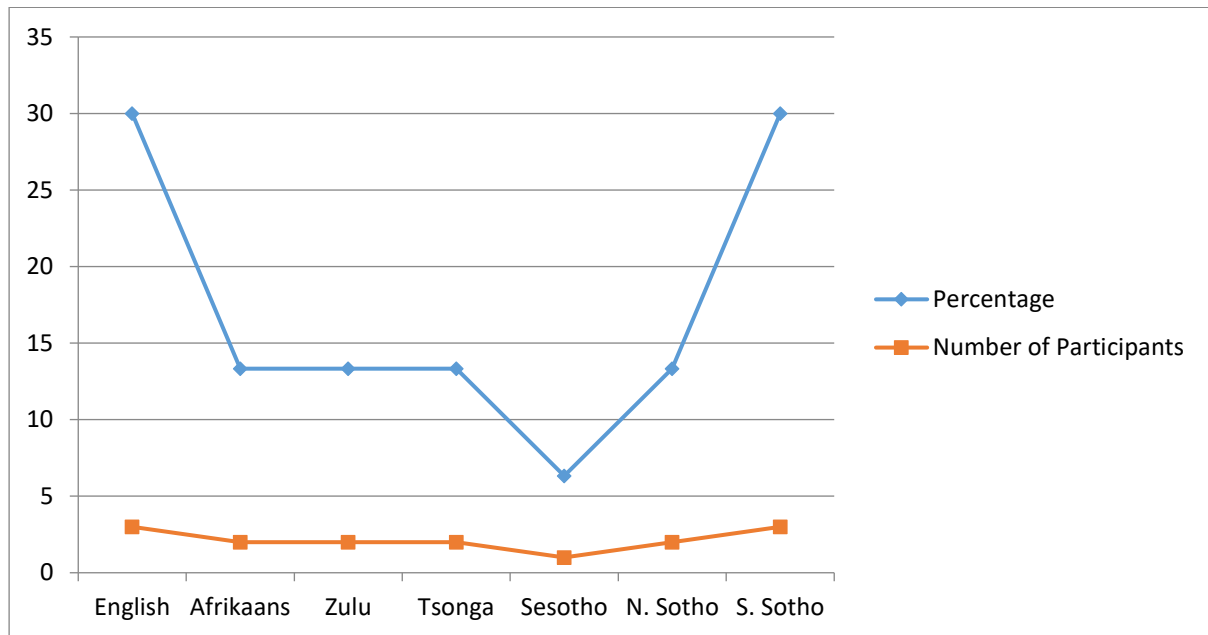
The language distribution illustrates that the home language of most of the participants is English and South Sotho at 30%. The second highest group of home languages is Afrikaans, Zulu, Tsonga, and North Sotho at 13.33% whilst the least home languages indicated is Sesotho at 6.33%. It is interesting to note the various languages of participants in the study. According to Schyve (2007:360) barriers to effective communication include amongst others, differences in language, cultural, and low health education. The study findings reflect the various cultural groups. This confirms Rand Water comprises employees communicating in various languages. This will receive further interrogation when analysing the findings considering the language as a barrier to access.

- **Number of years employed at Rand Water**

Figure 4: Number of years employed at Rand Water
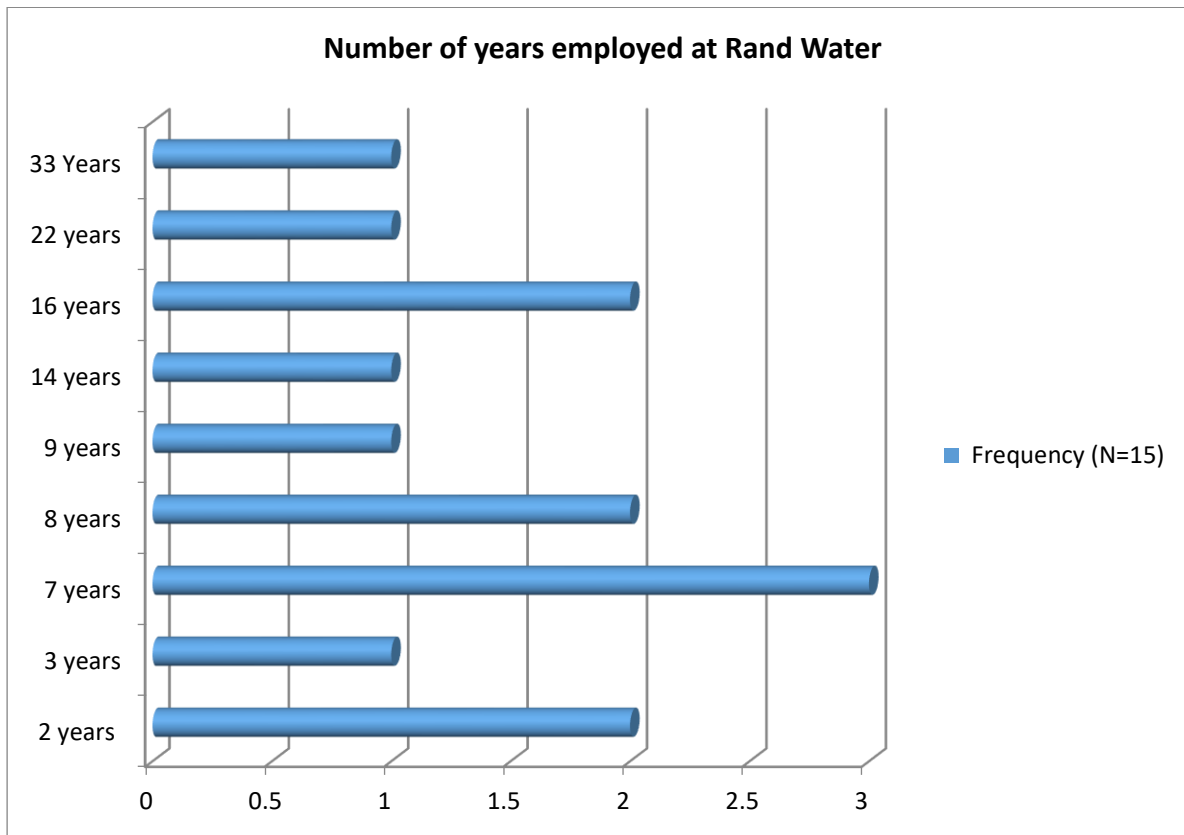
The length of service reported by the participants ranged between two years and thirty-three years of service. From the vast range of experiences, it could be postulated to be the adequate time for most participants to become exposed to the health care promotion programme within Rand Water. The researcher believes if the health care promotion programme was properly marketed, it would allow adequate time for knowledge on the policy and procedures of the programme. This will also receive further interrogation when analysing the findings, considering the knowledge and understanding of worksite health care promotion services within Rand Water.

- **Work components**

Table 2: Work components

Work components of participants	Frequency =15	Percentage
Canteen services	2	13.33%
Environmental Management Services	2	13.33%
Finance	1	6.66%
Human Resource Management	4	26.66%
Sanitation	1	6.66%
Strategic Asset Management	1	6.66%
Switchboard	1	6.66%
Operations	1	6.66%
Legal services	1	6.66%
Protective services	1	6.66%
Total	**15**	**100%**

The above table indicates the distribution of participants regarding their work components. Human Resources Management has a higher participation rate in the health care promotion programme, followed by the Canteen Services. It is also interesting to note that study findings confirmed time and scheduling of the health care promotion programme presents access challenges to certain participants. Some participants from Canteen Services, indicated inadequate time to attend the employees' wellness programme. They are often busy preparing meals during the time of the programmes. Leininger et al. (2015:80) also confirmed that the time limitations are mostly the barriers amongst those occupying food services positions.

- **Educational level of participants**

Table 3: Educational level of participants

Educational level of participants	Frequency (15)	Percentage
Post graduate	3	20%
Degree	3	20%
Diploma	4	26.67%
Grade 12	3	20%
Below grade 12	2	13.33
Total	**15**	**100%**

The level of education of all the participants ranged between Grade 12 and postgraduate degrees, with most participants having Grade 12 and a completed degree. A percentage of 13.33% of participants maintain below matric level. This is an interesting finding considering Table 3, as at least 86.67% of the participants are considered literate and multilingual by holding Grade 12 and higher qualifications.

Rosbroek et al. (2009:6) found that education levels do not affect participation in health care promotion programmes. Mchunu and Uys (2008:27) believe, based on the previous study findings, employees' characteristics were expected having a remarkable influence on their engagement in health care promotion programmes. According to Mchunu and Uys (2008:27), participants in such programmes were expected to be of younger age, well educated, female, non-smokers and white-collar workers and this is in contrast with the findings of (Rosbroek et al, 2009:6). The current study found the educational level of the participants was from below matric to the post-graduate level.

- **Job categories**

Table 4: Job categories

Job category	Frequency (N=15)	Percentage
Legal Advisor	1	6.66%
Canteen Supervisor	1	6.66%
General Worker	1	6.66%
Finance Supervisor	1	6.66%
Office Admin	1	6.66%
Employment Equity Coordinator	1	6.66%
Senior Gardener	1	6.66%
Project Coordinator	1	6.66%
Performance Management Practitioner	1	6.66%
Protective Services Officer	1	6.66%
Welder	1	6.66%
Switch Board Operator	1	6.66%
Administration Clerk	1	6.66%
Waitress	1	6.66%
Training and Development Officer	1	6.66%
TOTAL	**15**	**100%**

Table 4 illustrates the highest job level of participants, as supervisor, a coordinator and practitioner at the level of supervisor and middle manager. Most participants in the study hold lower level positions. From this sample in this research study the level of involvement by managers in the health care promotion programme, was found to be minimal.

3.8   DISCUSSION OF THEMES AND SUB-THEMES

Table 5 summarises identified themes and sub-themes, following the data analysis.

Table 5: Identified themes and sub-themes

MAIN THEMES	SUB-THEMES
Main theme one: Knowledge and understanding of worksite health care promotion services rendered within Rand Water	**Sub-theme 1:** Participants have knowledge and understanding of worksite health care promotion programme services rendered within Rand Water.
Main theme two: Geographical barriers to access	**Sub-theme 1:** The impact of distance and travelling to health care promotion programmes. **Sub-theme 2:** Participants' experience of location of EAP offices as a barrier to access
Main theme three: Cultural impediments to access	**Sub-theme 1**: Ethnicity and race as barriers to access **Sub-theme 2:** Communication as a barrier to access
Main theme four: Organisational barriers to access	**Sub-theme 1:** Time and scheduling of the health care promotion programme as a barrier to access **Sub-theme 2:** The impact of Insufficient allocation of resources as barriers to access.
Main theme five: Level of support by management to health care promotion programme	**Sub-theme 1:** Participants' experience of management support to health care promotion programmes **Sub-theme 2:** Top management's support to health care promotion programmes **Sub-theme 3:** The direct line manager's support to health care promotion programmes
Main theme six: The level of involvement in the planning of health care promotion programme	**Sub-theme 1:** The participants' experiences of planning of health care promotion programmes
Main theme seven: Health needs as addressed by the health care promotion programme	**Sub-theme1:** Certain health needs are not addressed by the health care promotion programme
Main theme eight: Employees' knowledge and access to health-related policies and procedures	**Sub-theme 1:** The knowledge of participants regarding health care promotion policies and procedures. **Sub-theme 2:** The accessibility of health care promotion policies and procedures.

Information collected from the main study was categorised into themes and sub-themes. In presenting the data analysis, the direct excerpt views of the participants supported by literature and this research, are summarised. The following themes and sub-themes are identified:

3.7.8 Main theme 1 - Knowledge and understanding of worksite health care promotion services rendered within Rand Water

Knowledge and understanding of health care promotion programmes, is important for employees. From the participants' responses, it was clear that they had knowledge on specific health care promotion programme services rendered at their worksite. The following excerpts testify to this.

Participant 1*: I know that we have an Employee Wellness Department within Rand Water. Each site has a Wellness Practitioner; and they provide interventions. Usually it's bi-monthly. Periodically the services are aligned with whatever is been commemorated that month. In Wellness calendar October is Wellness Week. Men's health, Women's Health is in August and the like. They focus on promotion and they enable the employees to focus on their health and usually the nurses come in.*

Participant 4: *From the knowledge that I know, the health-related problem is offered by Rand Water for us and our families. We get programmes such HIV/AIDS screening, cholesterol, Breast Cancer. We have educational programmes and counselling services for our work and at home.*

Participant 8: *Wellness week that runs once a year. Various health initiatives done under Employee Health and Wellness.*

Participant 7: *It is about road show that we have. Wellness tells us about health issues. We always get emails telling us about our health and how we can work around these illnesses like diabetic and all those type of issues. We have Finance Department where they can help you and assist you with financial problems. Mentally if you have a problem you can access those individuals. There is quite a lot.*

Participant 9: *I do know that Rand Water has a wellness programme, accessible to all employees. It can be accessible when employees have problems.*

Participant 15: *Health service that I am aware of is the wellness department available to all employees. If for example you are experiencing any health problems, for example, psychological problems you can come and they can assist you.*

The participants indicated a reasonable understanding and knowledge of the worksite health care promotion programme. The research disclosed that Rand Water retain a work site health care promotion programme, known and understood by the participants as the Employee Health and Wellness Programme that includes HIV/AIDS testing. The findings concur with Ball (2009:17), referring to worksite health care promotion programmes or wellness programmes as coordinated and comprehensive sets of health care promotion implemented at the worksite and include HIV/AIDS and Sexually Transmitted Diseases. The current study however confirms the findings by George and Quinlam (2009:20) who attests that Voluntary Testing and Counselling is one of the core components of the worksite health management programmes in South Africa. The participants in the study noted that the worksite health care promotion programme within Rand Water is for employees and their dependants and the programme offers a variety of health programmes which runs according to the health and wellness observant calendar. This was confirmed by Leininger et al. (2015:246) who asserted that worksite health care promotion programmes include a variety of health care promotion activities, and it also vary by worksite. The health care promotion programme was referred to by participants as offering educational programmes that focus on promoting the health of the employees.

The Eastern Cape Provincial Administration (2007:25) concurs that comprehensive worksite health programmes should include elements of health education. The participants in the study mentioned that programmes are accessible when the employees experience health-related problems.

The participants in the study presented a reasonable understanding and knowledge of the health promotion programme within Rand Water. From the vast range of

experiences, it could be postulated that this is enough time for most participants for exposure to the Rand Water health care programme.

3.7.9 Main theme 2 - Geographical barriers to access

Many geographical barriers exist in accessing services in the country. Accessing health care promotion programmes at a worksite is no exception. In this study, the participant's cited the barriers as including distance and travelling as well as office locations to be some of the factors that have an impact on their ability to access promotional programmes. These factors are thus discussed as sub-theme 01 and sub-theme 02 respectively.

- **Sub-theme 1 - The impact of distance and travelling to health care promotion programmes**

Participants mentioned numerous factors impacting the access to services. The location of work sites may be in a setting hindering access to health care programmes. Employees often have no control over this factor.

Participant 7: *The previous one me and my colleagues could not attend because of an important work we must do. There you go offsite and by the time you come back you are too late for the sessions. Usually if it is too late in the morning you already have started with your job. Periodically you are working 100 kilometres or 200 kilometres away from your job, in that way you cannot leave the job. Periodically if they can plan in the morning and make sure there is nothing major planned, but when is late in the afternoon it happens that you are not close to that site to attend or participate in that type of thing.*

Participant 7: *I think is basically sites where we are situated. You have access coming from there to offices, luckily nowadays we have different health practitioner closer to you to office, previously we have to arranging with a supervisor to arrange transport with the driver to come and see them, it was a struggle organising sessions through your supervisor. Because they have to organise sessions for you but it easier now.*

Participant 11: *Periodically we have a problem with transport and location of where we work, and this can be overcome by a bit of help and input by senior managers.*

Participant 13: *Barriers access that we experience, I can hinder out the distance as a barrier from Vereeniging to Rietvlei. Travelling is a problem, like today we came here from Vereeniging for a session.*

Participant 15: *No, I do not experience any problem, even though the challenge might be the distance of the location where I should attend the Wellness Programme.*

The participants in the study cited travelling and distance as a hindrance to access services intended for them. In some instances, participants were required to travel long distances to access the programme. According to the participants, vast distances were the reason why they forego accessing valuable information. The researcher agrees distance is a problem often delaying implementing the worksite health care promotion programmes. Findings concur with the literature reviewed, as confirmed by Person et al. (2010:5), stating that some employees would only attend health care promotion services provided they are at their location, and would not attend if such services are in other further areas. Kronfol (2012:1241) agrees that distance indicates limited access to health care. Shook (2005:10) agrees with the research findings and asserts, longer distances travelled, and unavailability of a driver for individuals to health care services, relates to decreased utilisation of health services. Posse et al. (2008:908) identified the length of the travel time and the long distance from and to the health facility as the most mentioned barriers of access.

- **Sub-theme 2 - Participants' experience of location of EAP offices as a barrier to access**

This sub-theme refers to the public location of offices and not to distances that must be travelled. Going to an office for a health care issue may be a private matter. It is often a challenge when offices are in a setting where individuals are visible while they would have preferred privacy. An office without privacy was mentioned as a barrier to access of services.

Participant 2: *Ke nagana gore ge ba ka re direla plek mo batho ba ka berekelang moteng, baseke ba hlakahlakana le batho ba babang, ka gore bamo di ofising tsa HR, ge bana le plek ya bona like Clinic nyana or eng, akitse mara ke nagana gore go tla ba better.* **Translation:** I think if they can be allocated a place to work from. They need not be amongst other offices; they are currently situated in HR. They need to have their own offices like a small clinic. I don't know, but I think it will be a better solution.

Participant 4: *It does play a big role. We are afraid of being judged and being labelled. Offices should be far away. As it stands now it is in an open area, it is a disadvantage. Private counselling one on one is a barrier. Location is a barrier at this stage.*

Participant 4: *Counselling offices are not properly located. What I mean is that there is lack of privacy. When u walk in you are often noticeable. Only one person is allocated per site, and she is often occupied. When she is busy with other clients, it is not easy to be attended at the moment time. Lack of privacy, you are afraid you will be seen when counsellors been busy. We ourself are too busy to attend the programme.*

Participant 5: *Ngiyacabanga kulena ukuthi bona bayawenza umsebenzi wabo kahle, kodwa mina into engiyibona iyinkinga ukuthi ihoviso laba liphakathi kwamanye ama hovisi. Ngalokho akulula ukuthi ungakhuluma kahle yonkinto ngoba awazi nokuthi lento oyikhulumayo iyezwakala kuleli elinye ihovisi. Ihovisi labo mengase kuthiwa liyauswa nje la. Ngoba futhi siyasaba ukuthi abantu bazolokhu besibona siza kuma hovisi abo bese bethi shuthi sinezinkinga. Inkinga nje engikhala ngayo kakhulu ihovisi. Mayelana nawo wonke amanye ama-services kuncono ngoba bawenzela ekudeni, basuke beqashe amatende abekwe ngaphandle, uma ufuna ukuya khona ayikho inkinga ngoba bakude, abekho ehovisi.* **Translation:** I think they do their job well. My only concern is their office because it is between other offices; you can be heard when attending. There is no privacy because other individuals will see you going to wellness office and see that you have problems. So, my main problem is

where their offices are situated. Other programmes, I am okay with the venue, it is better because they set up tents externally, you go if you wish.

Participant 7: *I think is sites where we are situated. You have access coming from there to offices, luckily nowadays we have different health practitioner closer to you to office, previously we must arrange with a supervisor to arrange transport with the driver to come and see them, it was a struggle organising sessions through your supervisor. Because they must organise sessions for you but it easier now.*

Participant 8: *In term of the EAP site of it, they should put more resources, provide private location separate location re look at where the programme is situated. It is important to locate Wellness office in a private area; I am aware that* individuals *are looking, if I knock on the door,* individuals *know I come for therapy.*

The participants in the study argued that the location of the health care promotion programme offices impact negatively on privacy and confidentiality during consultations, hindering access. Participants indicated that offices for health care promotion programmes need to be in a secluded area not near other offices. Participants emphasised they are based within the Human Resource department. Goetzel and Ozminkowski (2008:313) confirm these assertions and identify location as a reason employee discontinue health-promotion programmes. Hill-Mey et al. (2015:4) contend the accessibility and convenience of worksite health care promotion programme concern employees. According to participants, other employees might recognise an individual accessing health care promotion programme offices and label them experiencing personal problems. It is the researcher's view that this might result in stigma and labelling.

3.8.3 Main theme 3 - Cultural impediments to access

This section will focus on how cultural impediments impact on access to health promotion programme. The focus will be on ethnicity and race as well as communication which is a means by which health care providers access cultural beliefs.

- **Sub-theme 1 - Ethnicity and race as barriers to access**

Ethnicity and race are often cited as barriers for accessing health promotion programme.

Participant 7: *For me it was difficult at first, the first 2 years; just to understand everybody mostly because of racial issues and different colours just to understand everybody. Me as white male going to an African woman to discuss my personal issues or my health, you feel embarrassed and you don't want to talk about it, you don't say anything. It was a barrier at first, but as time goes on and you get time to spend with the individuals you start to understand them they start understanding you. As time goes by it heal you from the problem you have.*

Participant 8: *Eeh, availability again, takes note of all cultures within Rand Water and availability of EAP Practitioners.*

The study revealed that in some instances it is important that a person of another race might find it challenging to consult and disclose their personal challenges to a health care labourer of a different race and culture. This was found, by participants, to be an embarrassment, impacting disclosing personal medical problems. Brown et al. (2000:8) agree, indicating that barriers to using health services are often compounded by health care labourers, not understanding the cultures of their patients.

According to Jacobs et al. (2011:294) provision of culturally sensitive health care services is recommended and health care labourers of the same ethnic groups need to be employed to match those whose concerns are to be addressed. The researcher notes in agreement to the above findings, it is important to offer health care promotion programmes reflecting the diverse cultural and racial structure of the community.

- **Sub-theme 2 – Communication as a barrier to access**

Differences in languages pose challenges in accessing services.

Participant 7: *A big role. You always think you will say things wrong and you will be stupid. You can work out the barriers of language, for myself I am Afrikaans and I am doing this in English. You always think of you say something wrong or you can't express yourself in a way that make you better or make you more understandable. It helps a lot if we can have a neutral language to work in.*

Participant 9: *The programme and communication is in English. Periodically they do industrial theatre where they do a lot of local ethnic language, and periodically it's bothering. They periodically put English words but it is important that anybody should understand. In case where an interpreter is required it should be taken into account.*

Participant 11: *There is a problem periodically with a language. If the interpreter is not interpreting properly. However, if one can't interpret properly we go to one that can help with interpretation.*

Participant 15: *Ok. Language plays a big role Rand Water. Rand Water is a big company it has individuals from different backgrounds. That has been here for long so if you were having a certain Health Programme, I would say language is important to have few languages available to explain to individuals within Rand Water, because certain employees are not intellect in English. English can be one of the languages they use, but it is important to have other languages to include the employees who cannot speak English.*

Participant 12: *Language play a big role, you need to have somebody that when you speak to, you are on the same page. They are able to bring out a good understanding and not a fancy talking. Plain simple talking, understand simple words it makes it easier.*

Most of the participants in the study view language as a barrier to access health care promotion programmes. Rand Water was cited by participants as a huge diverse company, comprising employees from various multicultural communities. The study finding is confirmed in Table 3 indicating the home languages of participants.

The study findings support the assertion by Marrone (2007:193) that language barriers present a formidable obstacle to accessing adequate health care and he also emphasised effective communication between a patient and the provider which he said is paramount in any health care setting. Schyve (2007:360) indicates that effective communication with patients, in this case employees, is critical to the quality of care.

Kronfol (2012:1242) argues that language barriers were shown to limit access to health care promotion programmes. Marrone (2007:193) further argues that language differences signify to be a serious barrier. This correlates with the research findings where participants indicated that "you will say things wrong and you will be stupid". In view of the participants' diverse inputs regarding how they experience language as a barrier, the view is that communication strategies for Rand Water should be accommodative and diverse to reach employees according to their language preferences, specifically during health awareness.

3.8.4. Main theme 4 - Organisational barriers to access

Certain organisational issues are indicated barriers in access to health services. This include time and scheduling as well as sufficient allocation of resources and these factors are discussed in detail hereunder

- **Sub-theme 1 - Time and scheduling of health care programmes as a barrier to access**

Participant 2: *Eng, dinako tsa rona di ka mokgwa omomg, gee le lunch,ke nako ya batho ya goja, ka gore re direla batho dijo,gomme gar a swanela go tloga ko Canteen batho ba hloka dijo. So go boima go tlogela mmereko.* **Translation:** Yes, our times is the problem if its lunch time we are unable to leave our worksites, we prepare food for staff. It's the problem for us to leave the job to go and attend the services.

Participant 11: *Yes … reason being there are times where work schedules do not allow like when there is maintenance breakdown and so forth. Time planning during*

shut downs and break downs, if we can get these two not to overlap each other, that will be a lot better.

Participant 12*: I think us as being in the switchboard we work from 8hoo-16hoo. It is difficult because if colleagues are off I can't go we are short staff maybe they should come to our office and just check your blood pressure. I don't have anybody to relieve me. I miss out of what is been offered.*

Participant 14: *Nna ge le ka re provider, nje re le batho ba canteen, ga re na nako, ge le ka fetsa ka batho, then bese rona batho ba Canteen the special one, en ne direla batho ba bangwe, because rona ne re bereka ne re sa kgone go attender re sebetsa, ne ke kgopela gore nje, le refe nako, letleng as Health Service ko Canteen, le tlo buwa seo ne le buwa le batho bale, because ga re kgone go attender. Nako enngwe, jwale ka ge ke tshilo, gore go clasher dinako, o kereye nako enngwe, ge ba dira di programme tse tsa bona, rona re ko Canteen, re thusa ba setseng, and like are kgone ko bona.so like go ka better if like bona ge ba ka kgona maybe ba dire ka lunch time for everybody.* **Translation:** As Canteen employees if you can only provide us our own programme service when you are done with all others, you simply come to our department as Health Service, because we don't have time provide a special one for us, and come to our department and present what you presented with other people because we are unable to attend. Sometimes as I have indicated before, times of the programme clashes, we are sometimes expected to assist those remaining. If possible it will be better if programme can be done during lunch times for all.

Goetzel and Ozminkowski (2008:313) also identified time and scheduling as the reasons employees withdraw from health-promotion programmes. The researcher realised that certain employees occupying specific types of jobs, experience time and scheduling as a barrier to access health services. The participants in the study indicated that periodically the times for the health programmes clash with shut downs and break downs and the two coincides.

Occupations of switchboard operators and canteen services are continuous and the participants cited difficulty striking the balance between attending and working. The

research findings agree with research done by Leininger et al. (2015:80), who cited that the time limitations were the third most mentioned barriers amongst food services employees working. Ball (2009:800) also identified that the most commonly reported barriers to using employee wellness services were no time during a work day.

According to the researcher, the health care promotion programme is implemented during the working hours within Rand Water, and as literature denotes, employees do not have time to attend fully as the times periodically clash with their own work schedules.

- **Sub-theme 2 – The impact of insufficient allocation of resources as barriers to access**

Allocation of resources presents challenges for access if they are not sufficient. The participant in the study held a similar view as discussed in detail hereunder.

Participant 1: *In terms of the EAP site of it, they should put more resources, provide private location separate location. Re look at where the programme is situated.*

Participant 2: *Concerning accessing Wellness individuals, or Wellness Practitioners, what is the challenge is maybe the ratio or number of Practitioner to employees. They have a walk-in policy but you find that because of the high volume of individuals who come, there is a challenge concerning the bookings. Challenges concerning the wellness programme, maybe the challenge is attendance. I don't have a challenge in accessing in accessing the programme.*

Participant 4: *More staff should be made available in order for this programme to be effective and in order for more individuals to be able to use the programme, so that they can go anytime so that it can fit with their busy schedules and work that we have to do. And it increases their chances of being help secondly the issue of privacy should be dealt with offices should be far away, you would not be afraid of being judged and labelled.*

Participant 8: *The only barrier is limited availability of EAP individuals, and the resources are limited. In term of the EAP site of it, they should put more resources, provide private location separate location re look at where the programme is situated.*

Participant 15: *I think my view will be we do know there is a health service within Rand Water the challenge would be we need to have practitioner per site, if they can be communicated to us, who deals with what and what time can we access for example, a practitioner at what time, and where.*

It is evident that insufficient allocation of resources impacts negatively on the worksite health care promotion programme within Rand Water. Participants in the study confirm these assertions by indicating the barriers to access as limited availability of EAP individuals and the resources. The main challenge was the ratio of practitioners to the number of employees. According to the participants, this is insufficient to attend to the needs of Rand Water workforce. According to the EAPA SA Standards of South Africa (2011:8), it is suggested that the worksite should have one health care labourer for every 500 employees, depending on the staff component and staff quantity per sites, for centralised workforce utilising a combination model.

Participants in the study recommended privacy for location of health care promotion offices for confidentiality reasons. The researcher concludes that access to health care promotion programmes is therefore affected by insufficient allocation of resources and health care labourers and their offices, comprising privacy and confidentiality, affecting attendance of services. This is a concern as the protection of the rights to privacy and confidentiality is one of the key principles of the Rand Water Employee Wellness Programme Policy (Rand Water Employee Wellness Policy, 2012:4).

3.8.5 Main theme 5 - Level of support by management to health care promotion programmes

The support of management for health care promotion programmes are relevant. Rand Water has various levels of managers at group executive manager level, senior manager level, middle manager and supervisory level.

- **Sub-theme 1 – The participants' experience of management support to health care promotion programmes**

Participant 2: *Ke nagana gore ke buwe ka di levels tse fapafapaneng tsa di managers, nkare ba bagololo ba rena, gashi ke ba babone, batla di programming tse, like battle re ba bone, re ba bone bat sea madi, maybe di programme tse di diretswe rena fela.* **Translation**: Let's speak different levels, the big big bosses we have not seen them attending the programme, like they need to come and do blood tests. Maybe these programmes are meant for us only.

Participant 2: *Mara bona ba re fa cheletse gore dilo tse di diragale.* **Translation:** Managers only provide financial support for the programme to happen.

Participant 2: *Mara tsa rona di mangers, ba re supporter, bare reye koo, ga rena le mathatha ba kgona go reisa, bare re bone di Social worker.* **Translation:** Our line managers support us, they encourage us to go, when we have problems, they refer us to see Social Workers.

Participant 3: *There is a lot of support our line manager support the programme and he also attend and encourage the staff to attend the health care programme. Other managers should be encouraged to attend.*

Participant 4: *They do sponsor the programme financially. They only refer their subordinates and they don't attend. The big boss lends the money, they don't attend, support is not shown physically but financially.*

Participant 5: *Engingakusho la ukuthi kuma manager ethu, bayincosana abayayo ukuyo supporta amaprogrammes abo. Into nje abayenzayo ukuthi bakhiphe imali ukuthi kwenziwe. Kodwa mayelana nokuthi ba supporte, kuya abancane babo, abayi bonke. Abanye bavele bahlale ema hovisisini abo okuyinto esithena amandla ngoba siyazibuza ukuthi kuyini kulokhe kuya thina kuphela kulama programme, bona bengayi bebe bengaba phathi bethu.* **Translation:** What I can say is that, with regard to our managers, only a few go to support their programmes. What they do is inject

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financial support to the programmes. With regard to them supporting, only the junior managers attend and even them not all of them get to go. Some of them just stay in their offices and this is highly demoralising because we wonder why we must always go to the programmes and they don't especially because they are our seniors

Participant 6: *I would like to see more managers being involved in wellness programme. I guess they would like to do at own things privately but their involvement or their visibility is important. Management need to be involve, managers need to understand when to refer someone to counselling and when not to.*

Participant 8: *My perception is that Managers are supportive in allowing employee time off. But I have realised managers do not participate It does impact on the effectiveness of the programme. Managers should form part of the health care promotion programme.*

Participant 9: *First of all, I want to say thank you to Rand Water as company to make this Wellness programme available to employees, I have used the service, thank you to management however I would like to see all management from different divisions participate. Periodically it is as if managers are exempted from issues (laughing). They are human beings. It is encouraging to see them queuing with us waiting to be tested for HIV/AIDS or blood sugar testing, or waiting for nutritional information. I would like to see that.*

Participant 12: *I think Managers need to participate for it is part of wellness they also need to do their sugars I see lot of individuals don't go. If we don't have this facility where else can we go?*

Participant 14: *I see they support. We are invited by managers I think they support because there are wellness days within Rand Water.*

Participant 15: *The level of support from managers is important. As individuals, we look at how managers are involved. And if they show less interest it will also make us feel that the programme offered are not important. They must give a support so that*

they lead by example and show us how important is the Health Programmes within Rand Water. That will be my view.

In the sample from this study it was evident that few managers attend the health care promotion programme. The participants further attest that direct line managers provide mostly emotional support to employees to attend health care promotion programmes; they provide them with time off and encourage them to attend the health care promotion programme. This was confirmed by the responses of participants 03 and participants 05. Participants in the study strongly believe that top management mostly provides financial support and remain in their offices. However, a few of them attend and according to participant perspectives, this raise questions to "why only us?"

The research findings are supported by McCleary et al. (2017:261) asserting that a culture of health requires collaboration from all levels of an organisation. This starts with leadership at a senior level and commitment to the health of employees, saturating through the organisation and is exemplified by participating in programmes. The research indicates that this commitment would encourage the employees to reciprocate their employer's concern for their health by full participation in the health care promotion programme. Hill-Mey et al. (2015:7) concur with the research findings and argue that employees are unlikely to become involved in, or support, organisational health-related initiatives. They feel managers are only superficially interested in the programme and not true in their attempts to enhance employee health.

According to Milner et al. (2013:515), managerial support and participation was identified in other studies as notable characteristics of well-attended programmes. McCleary et al. (2017:261) further identify that leadership support is apparent when senior and middle management are visible programme advocates, personally engage in activities, and provide the necessary resources earmarked for health care promotion. Milner et al. (2013:515) agree and further argue that senior managers exert a strong influence on all aspects of organisational functioning. Gaining the support of top management for worksite health care promotion programme, sends a clear message that management understands the importance of employee health.

3.8.6 Main theme 6 - The participants' experiences of planning of health care promotion programme.

Participants indicated that they would want to be regarded as stakeholders in the programmes and that they want to be involved in planning. Non-involvement in the planning of health care will also be a factor to be discussed in detail hereunder.

- **Sub-theme 1 - Participants experience non-involvement in the planning of health care promotion programme**

Participant 1: *I am not involved in my official capacity, but because the initiatives that they do are important my role is to inform my staff and let them know and attend.*

Participant 4: *They don't involve us at all they bring services to us, and they invite us to attend.*

Participant 6: *Personally, I don't get involve I wish to be involve, so that* individuals *with disabilities can be involve. Programme are readily there. They should include* individuals *with disabilities.*

Participant 8: *As an employee, I am not directly involved in the planning, however I avail myself to attend.*

Participant 9: *Because of my own work, I am not necessarily involved in the planning I only compile the evaluation form and I see they take my suggestions.*

Participant 11: *At the moment, I am not involved in any of that, as I am withdrawn from that section.*

Participant 12: *I actually would like to get involved one day, but am not involved.*

Participant 15: *My level of involvement is low level. I don't get involved in the programme.*

Most participants in the study argued that they are not involved in the planning of the health care promotion programme but indicated that there was a need for their involvement in the planning of all the programmes. According to Posse et al. (2008:908) the most mentioned barrier to access, is the limited involvement of the managers in the programme planning process. The participants cited they received readymade packaged programmes. They expressed their need to be part of the planning process. It was found that the programme addresses the needs of the health care labourers and not the needs of the workforce. This then can cause a barrier to access, since there is no joint decision-making during planning of the services. The study findings correlate with Ball (2009:75) confirming that by including supervisors in the planning and development of wellness services and policies, may increase their accountability for programme success. Ball (2009:75) further emphasises in agreement that such a strategy may increase supervisors' likelihood to allow an employee to participate in worksite health care promotion programmes. Mchunu (2012:7) is also in agreement by attesting that in the planning process, employee engagement could improve the chance of positive health behaviour changes. Mchunu (2012:7) strongly emphasises that involvement from a stakeholder forms the foundation of the implementation process.

3.8.7 Main theme 7 - Health needs as addressed by the health care promotion programme

Participants verbalised the need for specific services to be included in health care promotion programmes.

Participant 3: *We are women and we need family planning on site, and we are unable to access it as it is not available.*

Participant 6: *Personally, as a blind person, ensure the gyms are accessible to* individuals *on wheel chairs.*

Participant 7: *I think there like periodically we got mental issues that we need to resolve, if we can have sessions like that, also with our normal monthly sugars*

quarterly test that we have. You can sessions like that even with our finance and Policy and Procedures that we have more often, it can also help resolve issues that started as small and generate into something big, stop it before its spread into something big. Yes, if you can add something like that into the programme. I know it is been done and it is not done enough.

Participant 8: *Eeh, make use of online access programme. If I cannot get an EAP Practitioner, I should be able to book online for service.*

Participant 9: *We can have presentations on Wellness Policy and procedures and also encourage managers to attend and be more involved with the Wellness Programme, Wellness can play a critical role, when it comes to presentations on interpersonal skills for employees and for managers. The drive should come from Wellness Programme. Wellness should also focus on being proactive, rather than being reactive.*

Participant 12: *They should make another link that give lot of information like they should focus on the environment are you happy with your environment and they should tell us about our love ones who are sick depression and TB on the link.*

Participant 15: *I suggest if also they can do a survey with individuals within Rand Water about how we see the health programme within Rand Water, how it impact us, what value are they adding to us and how we respond to the programme.*

In view of the participants' diverse inputs on health needs as addressed by the programme, the participants' perspectives indicate that the programme is not providing an integrated health care promotion service and thus it does not meet their full required needs. This study finding indicates an access limit barrier to health care promotion programmes if employees feel their comprehensive needs are not being addressed holistically.

The research findings correlate with Ball (2009:75) indicating that employees are more likely to access and participate in health care promotion programmes when the services are considered attractive and serving their needs. Jacobs et al. (2011:291)

concur with the research finding by alluding that failure to deliver integrated health services with complementary programmes provided to a target group, is also a barrier to access. Person et al. (2010:2) further argue that comprehensive worksite health care promotion programmes should provide integrated on-going programmes. Mchunu and Uys (2008:30) concur with the study findings and indicate that health care promotion interventions mainly focus on individual health, hence the health care promotion activities do not provide a comprehensive holistic approach. Mchunu and Uys (2008:30) emphasise that the programme often targets one health problem such as HIV/AIDS, rather than focusing on disease prevention.

3.8.8 Main theme 8 - Employees' knowledge and access to health-related policies and procedures

Policies and procedures regarding health care promotion also influence employees' experiences of accessing services.

- **Sub-theme1 – The knowledge of participants regarding health care promotion policies and procedures**

Participant 2: Go na le communication, yeo every fiwago batho bamo mmerekong, mara ga shi re hlaolosetsiwe ka tsona, nna gare tsebe ka tsona. **Translation:** There is a communication given to employees at work; they have not explained to us, I don't know about the policies and procedures.

Participant 2: *Aowa di Policy and Procedures, di mo laptop, and nna mmereko waka oko kitchen and ake na laptop ko kitchen ke bereka ka di komiki ... ake kgone go di accessor, unless key a ko manager waka, ke mo kgopela gore a mpulele tsona.* **Translation:** No, the policies and procedures are on the laptops, and my work is in the kitchen to make tea, and I don't have access to laptop, Unless I go to my manager to ask to view them.

Participant 7: *I don't know all the policy on that but I know you are not allowed to break individuals down individuals, must not victimised or make individuals useless or worthless if they have health issues.*

Participant 9: *On policy and procedures, my answer will be no I personally have not read through that information.*

Participant 12: *(There was silence), I think for us, eh…HIV/AIDS Policy eh… is the most important one, HIV/AIDS Policy.*

Participant 15: *Oh well. I think to be honest, as an individual am ignorant. I have never been too involved. I do not look at the Policy and Procedures.*

According to Milner et al. (2013:515), companies with more worksite health care promotion programme policies and programmes are more likely to be perceived as being committed to their employees.

According to the final draft of the Employee Health and Wellness Strategic Framework (Department of Public Service Administration, 2008:11) policies and procedures exist to provide a set of guidelines to organise and implement interventions for employee health and wellness in the worksite. It is evident that the participants in the study experienced limited knowledge of health care promotion policies and procedures within Rand Water.

Participants in the study, indicated ignorance because they did not consult the policies the policies and procedures at their disposal. According to Milner et al. (2013:515), companies with more worksite health care promotion programme policies, comprise employees who are more likely to perceive them as committed. Conversely, companies with elevated levels of leadership involvement indicate companies with more policies and programmes. Certain participants in the study had no access to laptops and as a result, they failed to peruse the information on policy and procedures.

Other participants argued that policies are available but they do not know much about such policies and procedures. The researcher is of the opinion that the health care promotion programmes cannot be utilised maximally in compliance with legislation on health care access if employees are not aware of factors governing the

worksite health care promotion programme. The participants in the study cited that information on policy and procedures is available but not known fully. Mchunu (2012:7) indicates that the underlying assumption is that if the employees are knowledgeable and aware that the policy exists and the organisation is committed to their health and safety, they are more likely to access the programmes offered.

- **Sub-theme 2 – The accessibility of health care promotion policies and procedures**

Despite ignorance of policies and procedures, participants were aware of the availability of these policies and procedures.

Participant 1: *Yes, they are. Planned Surgical Procedure Policy, I know where to get the form from.*

Participant 3: *We are able to access them without a problem. We are able to get copy, when we attend health care promotion programme.*

Participant 5: *Yebo, siyakhona ukufinyelela kuwo ngoba bawafake kwi-intranet. Uyakhona ukungena kwi-intranet uwafunde. Okunye futhi abakwenzayo ukthi uma kunoshintsho kumapolisi abo bayasiza basitshele ukuthi khona okushintshile ngawo. Bayafinyelela kubantu bonke.* **Translation**: They are on the intranet so we are able to access them easily. If they changed or amended, they inform us.

Participant 8: *They are available on the intranet.*

The right to access to health care is entrenched in the Bill of Rights of 1996. It is interesting to note that participants in the study argued to have access to policy and procedures within Rand Water. The policies and procedures were confirmed by participants to be available on the intranet. Certain employees with access to computers, confirmed that they can access health policies and procedures with ease. Participants without access to computers have limited access to policies and procedures.

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The researcher contends that this confirms ignorance as cited by the participants on the knowledge of the policies and procedures. This may suggest that the policies and procedures of the programmes are accessible but are not known to most of the employees, due to ignorance as cited by the participants in the study. According to EAPA SA Standards (2010:4) there should be an appropriate model for service delivery, reflecting detailed procedures, and the model should be accessible to its intended users. The researcher concludes that access to policy and procedures is confirmed by others, who have the relevant tools, and those without computers do not have access and knowledge and understanding of policies and policies is minimal to participants in the study. Mchunu (2012:5) concurs and attests that experts in the field of health care promotion recommend that stakeholders should be engaged in the phases of policy development; this will increase the likelihood of successful policy implementation, ensuring employees are knowledgeable on the policy existence.

3.9   CONCLUSION

In this chapter, the research findings arising from the data collected from participants through one on one interviews with an interview schedule were presented and analysed according to the themes and sub-themes that emerged. The study was carried out within Rand Water, and fifteen employees (from the Rietvlei site) participated in the study. Eight major themes and sub-themes were identified. The empirical data collected proved access barriers to health care promotion programmes within Rand Water. The researcher found that Rand Water employees who participated in the study, have knowledge and understanding of the health care promotion programme offered within Rand Water. This could be attributed and attested to by the number of years that the participants are in the employ of Rand Water as indicated in figure 4. The study revealed, policies and procedures dealing with the health of the employees, are accessible to most of the participants in the study. Conversely, those policies and procedures were found not to be known by certain participants.

The study also revealed that the health care promotion programme was not addressing certain needs of the participants holistically. The study further revealed

that participants in the study were not involved in the planning of health care promotion programme activities intended for them. This impacts on access as most of the activities planned are not addressing the needs of the employees. This came out when participants were asked whether the programme addressed their needs.

The location of health care promotion offices indicated a barrier to access, impacting on confidentiality and privacy during consultations. Distance and travelling to attend health care promotions programmes, confirmed to be the access barrier for those not based onsite. The research results also revealed the limited resources concerning health care labourers and how this impact on access to services. The study revealed cultural impediments like race and language, present challenges to access.

The research findings further revealed the times and scheduling of the programmes as the other barrier for access in some departments, especially in areas operating continuously throughout the day. The main barrier was the management support to the health care promotion programme. The study revealed that managers only offer emotional and financial support to the programme but do not necessarily attend the programme.

The study managed to explore barriers of access to health care promotion programme within Rand Water. The research findings confirmed that health care promotion programmes present access barriers, impacting negatively on access, thus affecting utilisation.

CHAPTER 4
CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Based on the research data presented in the previous chapter, key findings will be discussed, conclusions drawn and recommendations will be made in this chapter. It will be ascertained whether the results relate to the goal and objectives of the study.

4.2 RESEARCH GOAL AND OBJECTIVES

The goal of the study was to explore the perceptions of Rand Water employees of access to worksite health promotion programmes within Rand Water. The goal of the study was achieved through the following objectives.

Objective 1 - To contextualise health promotion programmes of the worksite and the access of employees to these services

The literature review in Chapter 2 allowed the researcher to explore and contextualise the main discussion within the academic and literature field on access to health care promotion and access by employees to these services. The Health Belief model provided a theoretical underpinning to understand health behaviour and to realise possible reasons for non-compliance with recommended health actions. The literature review suggested that even though individuals perceive health problems to be serious and believe there would be positive benefits in seeking help, perceived barriers exist preventing employees seeking help. This theoretical construct correlates with the study findings as various access barriers were identified, as revealed by the study that impacted access negatively.

Even though the employees perceived the value of the health programme as beneficial and important, barriers prohibited them from accessing health care promotion programme services. The following transcripts confirm the correlation. There was a correlation between the study findings and the Health Belief model used to contextualise the health care promotion and access to services in the study.

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It was also discussed in Chapter 1, that the greater the perceived risk, the greater the likelihood of engaging in behaviours to reduce the risk. This theoretical construct indicates that employees should first believe worksite health care promotion programmes are important and assistive before they would consider accessibility. Literature attests that health care promotion programmes should be a complement and extension to business priorities. Should a programme not indicate business sense, it is automatically vulnerable. It could be deduced based on minimal attendance, that the programme might not be addressing the needs of management. The study found employees are not included in the planning of the health care promotion programme projects.

The literature review suggests that individuals should perceive the severity of the health problems prior to acting upon it. This theoretical construct implies that if employees do not understand accessing worksite health care promotion programme services, and the impact of non-access on their lives (such as the impact on absenteeism, and on family life), they would not perceive the value of attending the health care promotions at work.

The literature review indicated sufficient legislation confirming the reasons for health care access of the worksite. The study also found that Rand Water have an Employee Health and Wellness policy with other health related policies and procedures, as confirmed by the participants.

Objective 2 - To gain insight and in-depth understanding of the perceptions of Rand Water employees regarding access to the health promotion programmes

The second objective was to gain insight and an in-depth understanding of the perceptions of Rand Water employees regarding access to the health care promotion programme services. The study gave insight that participants experienced limited knowledge and understanding of worksite health care promotion programme policies and procedures that would enhance access to health care. Policies and procedures on health care promotion influence employees' experiences of accessing services.

The study revealed that participants were uninformed and were often not perceiving the policies and procedures at their disposal. Certain participants in the study cited not having access to computers and they could not peruse the information on policies and procedures. Other participants argued that policies are available but they do not know much about such policies and procedures. This clearly indicates that the health care promotion programme cannot be utilised maximally in compliance with legislation on health care access. Employees are not aware of factors governing the worksite health care promotion programme. The literature review concurs that policies and procedures exist, providing a set of guidelines to organise and implement interventions for employee health and wellness at the worksite.

The literature review further asserted that worksite health care promotion programmes comprise a variety of health care promotion activities, and it varies by worksite. This correlates with the participants' knowledge and understanding of the programme. The participants in the study noted that the worksite health care promotion programme within Rand Water is for employees and their dependants and the programme offers a variety of health programmes, running according to the health and wellness observant calendar. Not all employees have knowledge of the health care promotion programme services rendered at their worksite.

Responses of the participants revealed that the health care promotion programme was referred to be offering educational programmes, focussing on promoting the health of the employees. The participants' perceptions correlate with the literature, concurring that comprehensive worksite health programmes should comprise elements of health education.

The literature review indicated sufficient legislation established to confirm the reasons for health care access of the worksite. The participants confirmed that Rand Water comprise an Employee Health and Wellness policy and other health related policies and procedures.

The literature suggests that the key principles of a successful worksite health care promotion programme of the classic worksite health care promotion programme model, comprise management support at all levels including participation and support

from the top management levels to middle management, to the employee level. The study findings correlated that management presents minimal support, impacting negatively on access to health care promotion programmes. The study revealed that the health care promotion programme is not accessible to all employees, as opposed to the principles that the programme should be accessible to employees at all levels.

The study further revealed various access barriers to health care promotion, providing an insight into perceptions of Rand Water employees regarding access.

Objective 3 - Identifying access barriers to health promotion programmes within Rand Water

The third objective of the study was to identify access barriers to health promotion programmes within Rand Water. Several access barriers were identified during the data collection. Based on the data collected the following access barriers were identified.

The study identified that Rand Water employees experience limited support by management to the health promotion programme which impacts negatively on access by lower level employees to the health care promotion programme. The literature review in chapter 2 suggests that programmes should be open to all labourers from all job categories irrespective of job position and seniority level. The study also revealed in the information on job categories that only certain categories participate in the health care promotion programme.

Chapter 3 of the study identified that participants experienced the location of offices as a barrier to access. The location of offices impact negatively on privacy and confidentiality as other employees fear to be labelled and judged for having personal problems. This correlates with the literature review as it found the location as the main reasons employees discontinued attending health promotion programmes. The literature review further identified that if confidentiality is violated there would be limited use of health services. The participants in the study concurs with the literature review, recommending that health promotion programmes need to be in a secluded area away from HR offices in a clinic-like setup.

The study revealed insufficient allocation of resources impacting negatively on access to health care promotion programmes. The finding correlates with the literature review stating, access barriers to worksite health care promotion programmes is hindered by short-staffed health care professionals. The literature identified unqualified health care professionals as barriers to access. The literature further suggests that the ratio of health care professional as per employee is 1:500. This conclusion correlates with the study findings where participants identified the ratio or number of health care practitioners to employees, as a challenge. The study findings further concurred by identifying that the programme should be made available to more staff to be effective. More individuals should be enabled to use the programme, ensuring employees attendance, considering busy schedules.

Research results suggested time and scheduling of the health care promotion programme as a challenge for attendance. A correlation exists between literature reviews as it emphasised inadequate time during the workday to attend the health care promotion programme. Literature further found that the time limitations were the third most important barrier amongst food services. The finding correlates with the views of the participants in the study, "*Yes, our times is the problem if it's lunch time we are unable to leave our worksites, we prepare food for staff. It's the problem for us to leave the job to go and attend the services.*"

Table 2 indicates a contradiction, indicating the distribution of participants regarding their work components. Human Resources Management maintain a higher participation rate at 26.66% in the health care promotion programme, followed by Canteen Services at 13.33%. This implies that certain employees occupying specific positions, experience time and scheduling barriers, joining health services.

The study revealed that participants indicated they need to be regarded as stakeholders of the programmes, involved in planning. The literature review emphasised the most mentioned barrier to access, is the limited involvement of the managers of the programme planning process. The finding of the study concurs as most participants in the study were from the lower level of management. In the context of this study, management was thus not involved in the planning. The level of

involvement by managers in the health care promotion programmes was minimal. The study findings correlate with the literature review, confirming including supervisors in the planning and development of wellness services and policies, may increase their accountability for the programme success. The study also found employees who participated in the study, were not involved in the planning of the health care promotion programme. The literature review suggests that wellness programmes should be engaging and outstanding, otherwise employees will not participate. This correlates with research findings.

The study found that distance and travelling impact on access to a health care promotion programme. The literature review confirmed that several geographical barriers exist in accessing services in the country. Participants in the study concur by mentioning numerous factors impacting the possibility to access services. The location of work sites, over which employees often do not have control, may be in a setting hindering access to health care promotion programmes. The literature review concurs that distance limits access to health care.

Certain health needs are not addressed by the health promotion programmes, resulting in an access barrier. The finding correlates with the participants' views on the need for specific services to be included in health care promotion programmes. Family planning was mentioned as an example of the services perceived to be included. The research findings correlate with the literature denoting employees being more likely to access and participate in health promotion programmes, if the services are considered attractive, serving their needs.

Ethnicity and race was experienced as access barrier. The study revealed that in some instances a person of another culture might find it challenging to consult and disclose their personal challenges to a health care labourer of a different culture. This was found by participants in the study to be an embarrassment and impacting on disclosure of personal problems. The literature review also alluded that cultural gaps affect the choice of a health provider. Literature concurs that provision of culturally sensitive health care services is recommended and health care labourers of the same ethnic groups need to be employed, matching those with concerns.

It is concluded that the study achieved its intended objectives, managing to identify the access barriers.

Objective 4 - To provide recommendations on measures to improve access to worksite health promotion programmes

The study successfully explored the perceptions of Rand Water employees of access to health promotion programmes. Based on the findings of the study, it provides recommendations to address access barriers employees experienced and identified through the study. The aim is to direct those recommendations to Rand Water employee wellness management and policy makers.

The study outcomes of the explored perceptions of access to health care services can be used by the organisation to implement planned strategies to overcome the explored barriers, and ensuring measures to improve access to health care services. The following research question was explored in the study: *"What are the perceptions of Rand Water employees regarding access to health promotion programmes?"* The research question was answered during the data collection and data analysis phase of the research process, exploring and emphasising employees' perceptions of access barriers in attending health promotion programme within Rand Water.

4.3   KEY FINDINGS

The study indicates the following key findings:

- The semi -structured interview schedule was utilised as a data collection method and it was a relevant and valuable tool to assist exploring access barriers to health care promotion programmes for the study.

- The study found more females at 73.33 %, than men at 26.66% use and access the health care promotion programme within Rand Water. The study confirmed the literature reviewed in Chapter 2, emphasising women are generally more likely than men, to participate in worksite health care promotion programmes.

- The research found limited access by management to the health promotion programme within Rand Water. Table 2, in Chapter 3, also confirms the findings by indicating the categories of employees attending the health promotion programmes within Rand Water. The literature attests that the support of management for health promotion programmes are extremely relevant. The study findings agree with the literature that a culture of health requires participation from all levels of an organisation. This should commence with leadership at a senior level, committed to the health of employees that permeates through the organisation, exemplified by participating in programmes.

- The findings of the study revealed the location of offices as a barrier to access. Literature identified, offices in a setting where individuals are visible while preferring privacy, is indicated as a barrier to access of services. Literature confirmed location as a reason why employees discontinue attending health-promotion programmes. The Employee Health and Wellness services is based at HR offices, impacting negatively on access, as participants mentioned fear of being labelled for experiencing problems and stigma associated with personal problems and medical conditions.

- The study indicated insufficient allocation of resources impacts negatively on the worksite health care promotion programme within Rand Water. This was revealed by participants in the study, indicating that the barrier to access is limited availability of EAP professionals. The main challenge was found by the study to be the ratio of practitioners to the number of employees. The study revealed this ratio implicated insufficient attendance to the needs of the Rand Water workforce. Literature in Chapter 2 suggests that the worksite should have one health care labourer for every 500 employees, depending on the staff component and number of staff per sites, for centralised workforce utilising a combination model.

- Time and scheduling of the health promotion programme, present challenges to access. The study found departments that operate certain functions throughout the day, cannot be left unattended. The study identified areas like Canteen services and Switch board as examples. The study further revealed that periodically the times for the health programmes clash with shut-downs and

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break-downs in other departments and an overlap is indicated at times concerning labour and times presenting the programmes.

- Literature further identified that the most commonly reported barrier in attending employee wellness services, were inadequate time during working hours. This concurs with the findings on time and scheduling of the health promotion programme. The health care promotion programmes are implemented during the working hours within Rand Water, and as literature denotes, the employees have inadequate time to attend programmes fully, as the times periodically clash with their own work schedules. Consultations and involvement of management supervisors in the planning of a project, could improve the status quo.

- Findings confirmed non-involvement of employees in the planning of health care promotion programme. The study revealed that participants need to be regarded as stakeholders in the programmes and planning. Literature confirmed that the most mentioned barrier to access in other research studies is the limited involvement of the managers in the programme planning process. Non-involvement in the planning could suggest that the programme addresses the needs of the health care labourers and not the needs of the workforce. This indicates a barrier to access, since there is no joint decision-making in the planning of services.

- The study found that distance and travelling impact on access to health care promotion programmes. Literature confirmed several geographical barriers in accessing services in the country. Accessing health care promotion programmes at a worksite is not an exception. Participants mentioned numerous factors impacting the possibility to access services. The location of work sites, over which employees often do not have control, may be in a setting that hinders access to health care promotion programmes. Literature agrees that distance shows to limit access to health care. The researcher concludes that distance is a challenge that often delays implementing and access to the worksite health care promotion programmes within Rand Water.

- The research study found that the health care promotion programme does not address certain health needs. Participants verbalised the need for specific services to be included in health care promotion programmes. Family planning was indicated. The research findings correlate with the literature, denoting that employees are more likely to access and participate in health care promotion programmes when the service is considered attractive, serving their needs.

- Participants experience ethnicity and race as access barrier. The study revealed that in some instances it is important that a person of another culture might find it challenging to consult and disclose their personal challenges to a health care labourer of a different race and culture. This was found by participants in the study to be an embarrassment and impacting on disclosure to real problems. The literature consulted also alluded that cultural gaps affect the choice of a health provider. The research confirmed that it is important to offer health and wellness programmes, taking into consideration the diversity of the organisation. According to literature consulted, provision of culturally sensitive health care services is recommended. Health care labourers of the same ethnic groups need to be employed to match those whose concerns are to be addressed.

- Differences in languages indicate challenges in accessing and using services. Most of the participants in the study, viewed language as a barrier to accessing health care promotion programmes. Differences in languages indicate challenges in accessing and using services. The study revealed that Rand Water is a huge company, which is diverse and comprises employees from various multicultural communities. The study findings support the assertion by literature that language barriers present a formidable obstacle to accessing adequate health care and emphasised effective communication between a patient and the provider, paramount in any health care setting. The study findings correlate with the participants indicating "you will say things wrong and you will be stupid". In view of the participants' diverse inputs experiencing language as a barrier, the researcher is of the view that communication strategies for Rand Water should be accommodative and diverse to reach employees, according to their language preferences during health awareness.

- Participants experienced limited knowledge of worksite health care promotion programme policies and procedures. Policies and procedures regarding health care promotion also influence employees' experiences of accessing services. Literature confirms that companies with more worksite health care promotion programme policies and programmes see that employees, are more likely to be committed.

- Literature reviewed further identified that policies and procedures are incorporated to provide guidelines to organise and implement interventions for employee health and wellness in the worksite. Participants in the study cited being ignorant and often not perceiving the policy and procedures at their disposal. Certain participants in the study cited not having access to computers and as a result, they fail to peruse the information on policy and procedures. Other participants argued that policies are available but they have inadequate knowledge on such policies and procedures.

- The research indicates, health care promotion programmes cannot be utilised maximally in compliance with legislation on health care access if employees are unaware of what govern the worksite health care promotion programme. Information on policy and procedures is available but not fully known. The method marketing the policy and procedures of the health care promotion programme is inappropriate and assistive in disseminating the information.

- The study also revealed that despite ignorance to policies and procedures, participants were aware of the availability of these policies and procedures. Certain employees with access to computers, confirmed they can access health policies and procedures with ease. Participants without access to computers have limited access to policies and procedures.

4.4 RECOMMENDATIONS

4.4.1 General recommendations

Considering the above findings, it is recommended that:

- Rand Water as a worksite, should ensure access to health promotion programmes to all its employees.

- The following access barriers should be addressed:

  o Location of Employee Health and Wellness offices should ensure privacy and confidentiality as per EAPA SA Standards and Rand Water policy. This can be accomplished by locating wellness counselling offices in secluded areas away from other offices, ensuring privacy.

  o The ratio to health care providers should be aligned as recommended by EAPA SA Standards. This will improve waiting times and other delays as identified in the study.

  o It is important for health care providers to involve employees during planning of employee health and wellness programmes; this could improve access as employees' needs would be addressed. The study found that employees would want to be regarded as stakeholders and partners in the programmes and that they want to be involved in planning. This can be accomplished by circulating forms annually enquiring on services employees need to perceive, included in the health and wellness programme activities. This strategy would ensure joint decision-making and may increase the employees' accountability in programme success.

  o Language presents a barrier for accessing health and wellness programme; health providers should peruse the profile of the employees attending and ensure that communication strategies provide for all. This could also be achieved by matching the clients with the right health care provider as per the racial and cultural setting during counselling services. Interpreters should be utilised where possible, during health promotion programmes.

  o Participants experienced limited knowledge of health care promotion policies and procedures. Policies and procedures regarding health care promotion

also influence employees' experiences of accessing services. It is recommended that supervisory training should be performed annually and emphasis should be on health care promotion policy and procedures. It is further recommended that health care providers should intensify their marketing strategies of the health care promotion programme. They should form part of the monthly induction programme of new employees and booklets of policy and procedures should be made available in all languages. Policy statements should be placed on the walls around the buildings for employees with no access to computers, as identified by the study.

o Certain health needs are not addressed by the health promotion programmes. It is recommended that the programme offers and provides an integrated health care promotion service meeting the full requirements and needs of Rand Water employees. This would also improve utilisation rates and access to services. The services of the health promotion programmes should be reviewed constantly, indicated in the survey

o The support of management for health promotion programmes are of extreme relevance. Access to health care is a basic human right, as stated in the Bill of Rights in the South African Constitution of 1996. The Occupational Health and Safety Act 29 of 1996 as amended, imposes a general duty on employers to provide a reasonably safe and healthy working environment, to provide information, training and supervision necessary, ensuring health and safety. It is recommended that Rand Water should ensure access to health promotion programmes for all its employees.

o Time and scheduling of the health care promotion programme presents challenges to access. It is recommended that scheduling of programmes should be conforming to the Rand Water corporate calendar. Management and supervisors should be engaged and involved in the planning of health care promotion programmes, ensuring there is no overlap.

o Distance and travelling impact access to health promotion programmes. It is recommended that demarcation of sites regarding provision of health care

promotion programmes should be aligned appropriately, ensuring convenience and access of services.

4.4.2 Recommendations for future study

The following areas of study are recommended for future research:

- The research conducted explored the access barriers within a demarcated population, namely Rietvlei which is a site within Rand Water. The researcher recommends that further study needs to be done and extended towards other sites of Rand Water like Central Depot, Zwartkopjies an in depth understanding of the access barriers in health care promotion programmes in the whole organisation and how they impact on absenteeism within Rand Water. There needs to be a greater understanding on the access barriers in health care promotion programmes so that the organisation can also evaluate if the current programme has the return on investment.

4.5 CONCLUSIONS

The access to and utilisation of health services has always been a global and critical concern to the health care systems. It was reflected in previous research studies that about two thirds of countries still had low coverage of labourers with Occupational Health services. The research deemed it imperative to also explore the access barriers to health promotion programmes within Rand Water. Sufficient legislation is established to confirm the reasons for health care access in the worksite. Reservations remain whether worksites retain health care facilities offering quality care and if they are accessible to all employees as legislated. The study confirms that access barriers still exist within Rand Water. Chapter 2 of the study had focused on a theoretical overview of access to worksite health promotion programmes. The literature provides an overview to address access barriers of the health promotion programme.

Chapter 3 of the research outlines the empirical part of the study. The research findings indicated access barriers to health promotion programmes within Rand

Water. The access barriers impact negatively on utilisation of the health and wellness programme services. The access barriers identified from the study findings were not known and not emphasised to management. It is imperative that Rand Water employee wellness programme management develop strategies on addressing the access barriers within the worksite to improve access to services. Chapter 4 provides recommendations on how Rand Water employee wellness programme can address certain issues raised by the participants in the study. Employees spend most of their time at work; the business environment also depend on the health of workers. It may be important for worksites to enable access to health promotion programmes with the aim of improving productivity and alleviating unnecessary absenteeism due to illness.

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APPENDICES

APPENDIX 1: ETHICAL CLEARANCE LETTER

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

2 December 2016

Dear Prof Lombard

Project:	**Perceptions of Rand Water employees of access to worksite Health promotion programmes**
Researcher:	**Mashilo EM**
Supervisor:	**Prof CE Prinsloo**
Department:	**Social Work and Criminology**
Reference number:	**94661342(GW20161108HS)**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 1 December 2016. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate Studies and Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail:tracey.andrew@up.ac.za
Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Dr L Blokland; Dr R Fasselt; Ms KT Govinder; Dr E Johnson; Dr C Panebianco; Dr C Puttergill; Dr D Reyburn; Prof GM Spies; Prof E Taljard; Ms B Tsebe; Dr E van der Klashorst; Mr V Sithole

APPENDIX 2: LETTER OF INTENT

Faculty of Humanities
Department of Social Work and Criminology

31/08/2016
Our Ref: Prof CE Prinsloo
Tel: (012) 420-2601
E-mail: reineth.prinsloo@up.ac.za

Ref. Makubu Mashilo
Tel. 072 869 0959
E-mail: mmashilo2@gmail.com

The Senior Manager Human Resource
Rand Water
522 Impala Road
Glenvista
0208

Dear Sir

REQUEST FOR PERMISSION TO PERFORM EMPIRICAL RESEARCH
MMAKUBU MASHILO - STUDENT NUMBER 94661342

I am a registered student for the following programme at the Department of Social Work, University of Pretoria: Masters Social Work (Health Care). I am required to write a mini-dissertation, resulting from a research project, under the supervision of Prof CE (Reineth) Prinsloo. The research study has been approved by the Departmental Research Panel and will only proceed once the Faculty Research Proposal and Ethics Committee has approved the proposal and data collection instrument. The following information from the research proposal is shared with you, although a copy of the research proposal will be provided to you if needed.

The envisaged title of the study is: Perceptions of Rand Water employees of access to Worksite Health Promotion Programmes.

The goal of the study is to explore the perceptions of Rand Water employees of access to Health Promotion Programme Services in Rand Water.

The objectives of the study are:
- To contextualise health care programmes in the workplace and the access of employees to these services.

Department of Social Work & Criminology
Room 10-9, Level 10, Building
University of Pretoria, Private Bag X20
Hatfield 0028, South Africa
Tel +27 (0)12 420 2601
Fax +27 (0)12 420 2093
Email reineth.prinsloo@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

- To gain insight and in-depth understanding of the perceptions of Rand Water employees regarding access to the Health Promotion Programme services.
- To identify access barriers to Health Promotion Programme services in Rand Water.
- To provide recommendations on measures to improve access to health care services.

The envisaged target group of the study is Rand Water employees who are based in Rietvlei and who participated in a Health Promotion Programme. Both genders will be included as well as from all levels.

I intend to do the empirical part of the study through means of 15 open-ended, semi-structured interviews with identified employees of Rand Water in Rietvlei. This request will not result in any demands from you or your staff. No costs will be incurred by this request.

I undertake responsibility to provide you with a copy of the final report – if required.

It would be appreciated if you will consider this request and grant written permission (on an official letter head of your agency) to proceed with the project, at your earliest convenience.

Kind regards

Ms Mmakubu Mashilo

....
STUDENT (94661432)

Prof CE Prinsloo

ASSOCIATE PROFESSOR AND SUPERVISOR

APPENDIX 3: PERMISSION TO CONDUCT RESEARCH FROM RAND WATER

RAND WATER

HEAD OFFICE
522 Impala Road, Glenvista, 2058
P O Box 1127, Johannesburg, 2000, South Africa
Tel: (011) 682-0911 Fax (011) 682-0449/0555

MEMORANDUM

To	:	Group HR Executive : Wayida Mohamed
From	:	Employee Wellness : Mmakubu Mashilo
Subject	:	Request to conduct a research project within Rand Water
Date	:	2016/09/03

I currently work as a Wellness Practitioner (20599) within the HR OPS Division in Rand Water. I am also studying for a Master's Degree in Health Care at the University of Pretoria (94661342).

1. Motivation

In order to complete the research report for my dissertation/ thesis, I am expected to conduct research : **Perceptions of Rand Water employees of access to Worksite Health Promotion Programmes**. The target population for the research will be Rand Water employees who are based in Rietvlei. The sample will be drawn from employees from all levels who participated in Health Promotion Programme. Therefore, it is on this basis that I request permission to conduct this research within the organisation.

2. Ethical obligations

As part of the data collection of my research, I undertake and commit to the following:

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- To keep the information provided by Rand Water employees with the sternest possible confidentiality.

- To protect the participants and the organisation from potential detriment and/or prejudice.

- To make the report available to the organisation upon completion.

3. Recommendation and approval

It is hereby recommended that approval be granted for my research to be conducted at Rand Water.

Requested by: Supported by:

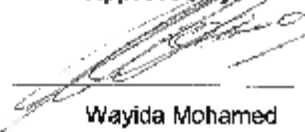2016/09/03

Mmakubu Mashilo   Hudson Malla
Wellness Practitioner   Senior HR Manager

Recommended by: Approved by:

Maureen Miles   Wayida Mohamed
Talent Manager   Group HR Executive

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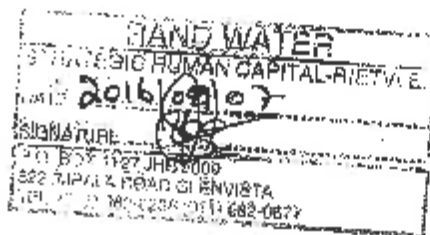
APPENDIX 4: LETTER OF INFORMED CONSENT

Faculty of Humanities
Department of Social Work and Criminology

29/01/2018

INFORMED CONSENT

1. NAME OF RESEARCHER
Mmakubu Mashilo
Student number: 94661342
Tel: 072 869 0969

2. RESEARCH TITLE
Perceptions of Rand Water employees of access to worksite health care promotion programmes.

3. PURPOSE OF THE RESEARCH
The goal of the study is to explore the perceptions of Rand Water employees of access to worksite health care promotion programme services within Rand Water.

4. DESCRIPTION OF PROJECT
Because the aim of the research is to explore the perceptions of Rand Water employees of access to health care promotion Programme Services within Rand Water, the researcher will conduct one-to-one interviews, guided by a semi-structured interview schedule, with the selected participants. The researcher will explore their perceptions of access to the health care promotion programmes at their worksite. The interview will take between 45 minutes to an hour. All interviews will be recorded with a digital recorder for the researcher to be able to transcribe the content and analyse the research data. Participants are guaranteed of confidentiality and their responses will be anonymous in the final research report.

5. NUMBER OF PARTICIPANTS
Fifteen (15) participants will be asked to take part in the research project.

6. RISKS INVOLVED IN THE RESEARCH
The participants will not be subjected to any harm and the research endeavour to conduct this research in a manner that will minimize possible harm. Should any participants perceived to be negatively affected by the research, a debriefing session would be conducted.

7. BENEFITS OF THE RESEARCH
There are no economic benefits for participating in this research project. The long-term benefits are that by talking about their perceptions of accessing health care

promotion programmes and possible barriers it will be contributing towards the recommendations the research findings will propose and as a result, measures may be developed to address them.

8.   VOLUNTARY PARTICIPATION

Although the researcher seeks my permission to be part of the research, it does not obligate me to do so. My participation is voluntary. I will be free to withdraw my participation at any point, and will experience no negative consequences.

9.   RECORDS OF PARTICIPATION IN THIS RESEARCH

The information provided will be protected and my responses will be kept confidential. Recordings and transcripts will be stored in a locked cabinet. The only individuals who will have access to this information will be those directly involved with this research project that have been trained in methods to protect confidentiality. The research information will be safely stored at the Department of Social Work and Criminology, University of Pretoria for a period of fifteen years and for the purposes of research and archiving. The results of this research may appear in publications but participants will not be identified.

10.   CONTACT PERSONS

If I want more information about this research, I may contact the researcher as indicated at the beginning of this document.

11.   AGREEMENT TO PARTICIPATE IN THE RESEARCH

My signature indicates that I have read, or listened to, the information provided above and that I received answers to my questions. I have freely decided to participate in this research and I know I have not given up any of my legal rights.

I hereby freely give my permission to participate in this research project.
This document was signed at _____ on the _____day of _____ 2016.

NAME: …………………………………………………………………………………

SIGNATURE: …………………………………………………………………………

SIGNATURE OF RESEARCHER: ………………………………………………………

APPENDIX 5: INTERVIEW SCHEDULE

Research title: Perceptions of Rand Water employees of access to worksite health care promotion programmes
The goal of the research is to explore the perceptions of Rand Water employees of access to worksite health care promotion programme services within Rand Water.

Section A: Background information

Gender	
Age	
Home language	
Number of years employed at Rand Water	
Work component within Rand Water	
Highest qualifications	
What does your job entail? Please include job position	

Section B: Knowledge and understanding of worksite health care promotion services rendered within Rand Water

1. What is your knowledge of the worksite health care promotion programme services within Rand Water? (What do you know about the worksite health care promotion programme services within Rand Water?)

Perceptions of employees on barriers to access health care services

1. What are the barriers you experience in accessing worksite health care promotion programme within Rand Water?
2. What are the general challenges for accessing worksite health care promotion programmes within Rand Water?
3. In your opinion, how does the worksite health care promotion programmes address your health needs?

4. What is your level of involvement in the planning of worksite health care promotion programme activities rendered within Rand Water?
5. To what extend does location play a role as an enabler or barrier to be able to access health care promotion programmes?
6. To what extend does language play a role in accessing worksite health care promotion programmes?
7. Do you experience problems with the times and schedules of worksite health care promotion programmes? If yes, please describe the problems that you have with the times and schedules of worksite health care promotion programme?
8. What is your view on the level of support given by managers in the effective execution of worksite health care promotion programmes?
9. In your perspective, to what extend are the providers skilful enough to coordinate the worksite health care promotion programmes within Rand Water?

Legislation and policies

1. Tell me about any health-related policy and procedures available in your department to deal with the health of the employees?
2. In your opinion, are those policies and procedures accessible to you?
3. How do the health policies get communicated to you?

General

1. Please provide your views that you would like to add regarding access of worksite health care promotion within Rand Water.
2. What do you recommend improving accessing worksite health care promotion services within Rand Water?

Thank you for your participation