CHALLENGES TOWARDS ACCESSING AN EMPLOYEE HEALTH AND AWARENESS CLINIC BY GAUTENG HEALTH CENTRAL OFFICE EMPLOYEES

by

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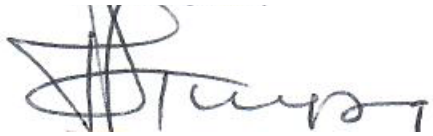

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ABSTRACT

Title: Challenges towards accessing an employee health and awareness clinic by Gauteng Health central office employees

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Access to health care services remains a huge challenge across the globe. Numerous research initiatives have been undertaken since the Alma-Alta Declaration which was aimed at ensuring that access to health care services is promoted and improved. The aim of this study is to investigate the access to health care services in the Employee Health and Wellness Clinic by the Gauteng Department of Health central office employees.

The complex nature of access to health care services is investigated in this study, mainly by looking at the challenges of access to health care services.

Qualitative applied research was conducted using collective case studies and person-to-person interviews as well as interview schedules to collect data. Different sampling methods were used to ensure that the participants were representative of the different buildings such as ORB, BOL and 11 Diagonal St., and included the nurses (key informants) that work at the clinic and employees (patients) who accessed the clinic in the past six months. Data analysis was by means of Creswell's model of data analysis and interpretation.

Quality of data was tested through a process called trustworthiness, using four constructs, that is transferability, credibility, conformability and dependability. Ethical considerations included avoidance of harm, informed consent, debriefing of participants, publication of the findings and researcher's competence.

The challenges in accessing health care services from different countries with specific reference to the geographical location of the health care service centres, the financial implications that hinder access to health care services, as well as the

structural challenges, the literature review also looked into the legislation that has been put in place to alleviate the challenges in accessing health care services. Lastly the benefits that access to health care offers to employees, with specific reference to productivity and benefits to the employer, such as the reduction of absenteeism.

The findings were presented in a thematic analysis. The themes included, accessibility and/or a lack thereof, marketing, management, and recommendations. Findings indicate that access to health care services are hampered by various elements, some of which are beyond the employees' control. For example, the clinic is awkwardly placed geographically, the clinic is not marketed and as a result many employees are not aware where the clinic is. The clinic does not have adequate equipment to assist as many patients/employees as it should, there is no running water and the toilets are considered to be dirty and unhygienic and result in a bad experience for employees who have access to the clinic.

Conclusions include the view that the geographic allocation of the Wellness Clinic is awkward and not conducive to providing proper care to employees who need private and confidential services, due to the noise caused by the security personnel outside the clinic. The fact that the clinic is not well equipped due to lack of proper space, poses a real challenge for the nurses who are expected to offer PHC services.

Recommendations include considering relocating the Employee Health and Wellness Clinic to a more accessible area, marketing and advertising the Wellness Clinic should be done on a regular basis, adequate infrastructure such as running water and good lighting must be prioritised as a matter of urgency, management should make sure that a healthy environment is provided as prescribed in the OHS Act of 1993 as amended.

Key terms: Primary health care, Access to health care, Biopsychosocial model, Employee Health and Wellness Clinic.

TABLE OF CONTENTS

DECLARATION OF ORIGINALITY ..... **i**
ACKNOWLEDGEMENTS ..... **ii**
ABSTRACT ..... **iii**
TABLE OF CONTENTS ..... **v**
LIST OF TABLES ..... **ix**
LIST OF FIGURES ..... **x**
ABBREVIATIONS AND ACRONYMS ..... **xi**
1. CHAPTER 1: INTRODUCTION TO THE STUDY **1**
1.1 INTRODUCTION 1
1.1.1 Key concepts 3
1.2 CONTEXTUALISATION OF THE RESEARCH TOPIC 4
1.3 THEORETICAL FRAMEWORK 5
1.3.1 Background 6
1.3.2 The biological influence on health 8
1.3.3 The psychological influence on health 8
1.3.4 The social/environment influence on health 9
1.3.5 Application of the biopsychosocial approach 10
1.3.6 Challenges of the biopsychosocial approach 10
1.4 RATIONALE AND PROBLEM STATEMENT 11
1.5 GOAL AND OBJECTIVES 12
1.5.1 Goal 12
1.5.2 Objectives 12
1.6 RESEARCH METHODOLOGY 13
1.7 CONTENTS OF THE RESEARCH REPORT 14
2. CHAPTER 2: LITERATURE REVIEW **15**
2.1 INTRODUCTION 15
2.2 EMPLOYEE HEALTH AND WELLNESS PROGRAMME(EHWP) 16
2.3 PRIMARY HEALTH CARE (PHC) 17
2.3.1 Services provided bythe Primary Health Care Clinic (PHC) 18
2.4 POLICY AND LEGISLATION PERTAINING TO WORKPLACE HEALTH AND WELLNESS PROGRAMMES 19
2.4.1 The application of the legalframework 21
2.5 ACCESS TO HEALTH CARE: HISTORICAL BACKGROUND 21

2.6 CHALLENGESTOWARDS ACCESSING HEALTH CARE 25
2.6.1 Internal challenges towards accessing Health Care 26
2.6.2 External challenges towards accessing health care 28
2.6.3 Financial implications/exclusion challenge(s) 28
2.6.4 Geographical challenges 29
2.6.5 Organisational challenges 31
2.6.6 Health promotion 37
2.7 OUTCOMES OF LACK OF ACCESS TO HEALTH CARE SERVICES IN THE WORKPLACE 40
2.7.1 Absenteeism due to Illness 40
2.7.2 Effects ofabsenteeismdue to Illness 41
2.7.3 Financial loss 42
2.7.4 Decreased productivity 43
2.7.5 Loss of staff morale and burnout 43
2.8 BENEFITS OF ACCESS TO HEALTH CARE SERVICE AND EHWP 44
2.8.1 Reduction in absenteeism 44
2.8.2 Increased employee performance and productivity 45
2.9 SUMMARY 45
3. CHAPTER 3: RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS 47
3.1 INTRODUCTION 47
3.2 RESEARCH APPROACH 47
3.3 TYPE OF RESEARCH 48
3.4 RESEARCH DESIGN 48
3.5 RESEARCH METHODS 50
3.5.1 Study population and sampling 50
3.5.1.1 Study population 50
3.5.1.2 Sampling methods and sample 51
3.5.2 Data collection 54
3.5.3 Data analysis 54
3.5.4 Quality of data 59
3.6 PILOT STUDY 62
3.7 ETHICAL CONSIDERATIONS 62
3.8 EMPIRICAL FINDINGS 66
3.8.1 Participant' demographics profile 66

3.8.2 Themes and sub themes 71
3.8.2.1 Theme 1: Accessibility and/or a lack thereof 72
3.8.2.2 Theme 2: Marketing 77
3.8.2.3 Theme 3: Management 80
3.8.2.4 Theme 4: Recommendations 81
3.9 SUMMARY 84
4. CHAPTER 4: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS 86
4.1 INTRODUCTION 86
4.2 GOAL AND OBJECTIVES 86
4.2.1 Objectives 86
4.2.2 Research question 90
4.2.3 Limitations of the study 91
4.3 KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS 92
4.3.1 Conclusions regarding the appropriateness of the research methodology 92
4.3.2 Key finding regarding the literature review of the study 93
4.3.3 Key findings and conclusions regarding empirical study 94
4.3.3.1 Theme 1: Accessibility and/or a lack thereof 94
4.3.3.1.1 Key findings 94
4.3.3.1.2 Conclusions 95
4.3.3.1.3 Recommendations 96
4.3.3.2 Theme2: Marketing key findings 96
4.3.3.2.1 Conclusions 96
4.3.3.2.2 Recommendations 97
4.3.3.3 Theme 3: Management 97
4.3.3.3.1 Key findings 97
4.3.3.3.2 Conclusions 98
4.3.3.3.3 Recommendations 98
4.3.3.4 Theme 4: Recommendations 98
4.3.3.4.1 Key findings 98
4.3.3.4.2 Conclusions 99
4.3.3.4.3 Recommendations 100
4.4 RECOMMENDATIONS FOR FUTURE RESEARCH AND POLICY .. 100
4.5 CLOSING STATEMENT 101

5. REFERENCE LIST 103
6. APPENDICES 112
6.1 APPENDIX A: FACULTY OF HUMANITIES ETHICS APPROVAL ... 112
6.2 APPENDIX B: GAUTENG DEPARTMENT OF HEALTH APPROVAL 113
6.3 APPENDIX C: LETTER OF INFORMED CONSENT 114
6.4 APPENDIX D: INTERVIEW SCHEDULE FOR EMPLOYEES 116
6.5 APPENDIX E: INTERVIEW SCHEDULE FOR NURSES 118
6.6 APPENDIX F: LETTER FROM EDITOR 120

LIST OF TABLES

Table 2.1: Legal framework on Employee Health and Awareness Clinic..... 20
Table 3.1: Participant demographic profile N=12..... 66
Table 3.2: Themes and sub themes 71
Table 4.1: Themes and sub-themes emerging from study 91

LIST OF FIGURES

Figure 1.1: Biopsychosocial model 7
Figure 3.1: Gender (n=12) 67
Figure 3.2: Medical aid (n=12) 67
Figure 3.3: Building occupied by the participants (n=12) 69
Figure 3.4: Participants' designation (n=12) 70

ABBREVIATIONS AND ACRONYMS

BOL	Bank of Lisbon
BPS	Biopsychosocial
DPSA	Department of Public Service Administration
EHWP	Employee Health and Wellness Programme
GPG	Gauteng Provincial Government
ILO	International Labour Organisation
OHS	Occupational Health and Safety
ORB	Old Reserve Bank
PHC	Primary Health Care
RSA	Republic of South Africa
WHO	World Health Organization

1. CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

In 1996, the new Constitution of the Republic of South Africa was adopted. According to clause 27.1 of the Constitution, “everyone has the right to access health care services” (RSA, 1996).Access to health care implies “timely use of services according to the need” (Jacobs, Ir, Bigdeli, Annear & Van Damme, 2011:2). The Constitution compels the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right to access health care (Cullinan, 2006).

In response and to ensure the compliance with the Constitution in realising the right to access the health care services, the Department of Public Service and Administration Republic of South Africa (DPSA) introduced the Employee Health and Wellness Programme (EHWP) to provide employees with holistic support to ensure risk management, occupational health, safety and productivity and well-being of government employees and their families (DPSA, 2012).

Employee Health and Wellness programmes are one of the most instrumental workplace strategies, which seek to ensure that employees’ health is well looked after. This strategy is influenced by − but not limited to the World Health Organization’s (WHO), Global Plan of Action on Workers Health 2008-2017, the International Labour Organization’s (ILO), Decent Worker Agenda in Africa 2007-2015 and the recommendations report of WHO’s Commission on Social Determinants of Health released in August 2008 (DPSA, 2008:5). The World Health Organization Global Plan of Action on Workers Health, 2008-2017 calls for effective interventions to prevent occupational hazards and to protect and promote health at the workplace (Wellness Management Policy [sa:14]).

Bearing in mind the above, the buy-in from the international organisations clearly indicates the importance of having the wellness workplace programme in all institutions as mandated. Clark, Warren, Hagen, Johnson, Jenkins, Werneburg and Olsen (2011:21) suggest that participation in wellness programmes can lower health

care costs and improve work productivity. Access to treatment on site can be easily facilitated if a wellness programme is accessible to employees (DPSA, 2008:8).

It is without a doubt that the Gauteng Department of Health has gone out of its way to ensure compliance with the Constitution of the Republic of South Africa, Act 108 of 1996 and its Bill of Rights to ensure that the right to access health care services is realised. The Employee Health and Wellness Programme also takes into consideration all international instruments that form part of international law and are relevant to the health and wellbeing of the workers (DPSA, 2012).

These include among others, the World Health Organization Workers Health Plan 2007-2015, the ILO Convention 187 of 2006 which provides a promotional framework for occupational health and safety. The compliance is evident through the establishment of Employee Health and Wellness by establishing a wellness clinic which functions as a primary health care service (PHC). The clinic has a staff establishment of two professional nurses, one medical practitioner and a social worker who comes to the clinic every Thursday to provide counselling and other psychosocial services.

The Gauteng Department of Health Central Office Clinic is meant to render medical and psychosocial services to employees and their close relatives. However, the accessibility to this clinic is questionable and results in poor utilisation. Access to health care services is usually constrained by expensive, inadequate or non-existent transport, by serious shortages of emergency transport, and long waiting times at the clinic and other health care services (South African Human Rights Commission, 2007). In this study the researcher investigated and filtered down the barriers that hinder the Gauteng Department of Health Employees from accessing the services rendered at the Wellness Clinic.

The researcher also investigated the challenges that are experienced by the nurses who work at the clinic in relation to access to the clinic by the employees, the external challenges, marketing of the programme/Wellness Clinic, and the kind of support that they receive or do not receive from the management of the Department of Health.

1.1.1 Key concepts

The following key concepts apply to this study and is described below:

- **Health WHO**

WHO compressively define health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (Van Rensburg, 2012:1). For the purpose of this study, health would mean a complete state of being psychologically and physically well of the employees at the Gauteng Department of Health Central Office.

- **Wellness**

Wellness is an active process through which organisations become aware of and make choices towards a more successful existence (DPSA, 2012). For both the individual and the organisation, the concept of wellness is one where active steps can be taken to reduce chronic disease and mitigate its debilitating impact on personal lives and organisational productivity (DPSA, 2012). In this study wellness is the programme that ensures that the employees of Gauteng Department of Health Central Office are able to access health care services while on duty.

- **Employee Health and Wellness Clinic**

An Employee Health and Wellness Clinic or Centre is staffed by a clinician(s) who is licensed to diagnose, treat, and prescribe for a wide variety of common illness and conditions. For any required treatment that goes beyond services offered, a referral can be sent to the primary health care physician. While the care centre offers a wide variety of preventative and primary health care service there are some primary, urgent, and emergency care procedures that are not available (Employee Health and Wellness Centre [sa:14]). In this study, the wellness clinic serves as the first step of medical help seeking. It functions as the primary health care for all Gauteng Department of Health Central Office employees.

- **Access to health care**

Jacobs, Bidgideli, Annear and Van Damme (2011) hold the view that there is no universal accepted definition for access to health care services. However, Peters, Garg and Bloom (2008:161) argue that access to health care implies to “the timely

use of services according to need." Access has four dimensions, i.e. availability, geographic accessibility, affordability and acceptability (O'Donnel, 2007 cited in Jacobs et al., 2011). In this study access to care would mean that health care services are readily available for all employees of the Gauteng Health Central Office to utilise at any time of need.

- **An employee**

An employee is any person (excluding the independent contractor) who works for another person or for the state and who receives or is entitled to receive any remuneration; and any other person who in a manner assists in carrying out or conducting the business of an employer, or a person appointed in terms of the Public Service Act of 1994 (Wellness Management Policy for Public Servants [sa:14]; Basic Conditions of Employment Act no. 66 of 1995 as amended). For the purpose of this study an employee refers to all individuals who are employed by the Gauteng Department of Health Central Office, whether as a professional, administration personnel, practitioner, manager or supervisor, Head of Department or MEC, regardless of the position or rank that they may or may not hold. The term employee in this study is used interchangeably with the word patient for easy reference.

1.2 CONTEXTUALISATION OF THE RESEARCH TOPIC

Access to health has been met with various challenges over time. To deal with such challenges in the workplace the Department of Public Service Administration (DPSA) has introduced various legislation and frameworks that enhanced the implementation of the Employee Health and Wellness Programme. This enforces the provision that each government institution must have a wellness centre or clinic that would make access to health care easier for employees while on duty. To date, access to health care by Gauteng Department of Health employees is 1.37% (Care Ways Report, 2018). The percentage presented in this section shows that the utilisation of the health care service and in particular the wellness programme is very low. This has prompted the researcher to investigate the low utilisation by linking it to challenges that employees encounter to accessing health care services.

The biopsychosocial approach which will underpin this study is subsequently discussed.

1.3 THEORETICAL FRAMEWORK

The biopsychosocial approach underpins this study. The reason for utilising this approach in the study is because the biopsychosocial approach focuses on the holistic view of an individual (medical, psychological and environmental) as a way of bridging the gap between illness and health (Ross & Deverell, 2012:13), this also serves as a motivation in promoting health-seeking behaviour. Health seekers would be more motivated knowing that they will be attended to holistically by the health care practitioners. The link between the study and this approach is that both the study and the approach seek to prioritise the holistic view of a human being. This is done by looking at the physical or biological state of a human that deals with tangible factors such as injuries, disability, as well as infections (The Biopsychosocial model… [sa:14]). The mental state is also closely related to the physical aspect because what affects the outside (physical/body) is likely to affect the inside (mental state) as well. For example, a traumatic injury such as an accident that can mostly harm a physical part such as a limb, can bring about psychological and social trauma. Emotional turmoil and negative thinking may result in depression which is the most precise mental condition for most cases (Dogar, 2007). Lastly, the social aspect of the biopsychosocial model deals with examining the social systems such as cultural, environmental and familial influences on the expression and experiences of illness (Dogar, 2007). These three aspects can play a vital role in influencing or discouraging access to health care.

This approach emphasizes that lack of access is not only due to physical limitations for example allocation, the building's accessibility, but also psychosocial, hence the biopsychosocial approach. For example, if an employee is sick physically, but still refuses or is unable to go to the Employee Health and Wellness Clinic, there must be a motive behind the unwillingness to access care. This lack of access could stem from psychosocial inability (mind over matter) which this research sets out to establish. The use of the biopsychosocial approach becomes very important as it is not only focused on physical wellness alone, but also on the psychosocial wellbeing of employees.

1.3.1 Background

In dealing with health, one needs to understand its origins and evolution. The "health" concept was first used before the 12th century and originates from the old English word "hale," which meant "free from defect, disease or infirmity," "wholeness," or being whole, sound or well(Dolfman,1973 and Lambert,1940). The World Health Organization took it a step further by comprehensively defining health as "a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity" WHO (1987:15). Access to biomedical treatment alone is not enough in an attempt to heal a person holistically, because the psychological and social being must equally be treated, as it contributes to suppressing or elevating the illness. The Wellness Programme has the competency to attend to the physical and psychosocial aspect of the employee; hence the biopsychosocial approach is fit for this study.

From this point onward the researcher acknowledges that accessing health care can also be factored through the wholeness of a person. One can seek help but if financially (socio-economic), they cannot afford health care services, they may be less motivated to show up at the clinic. If health care is physically not accessible, they may also refuse to seek medical attention until it's too late. For proper diagnosis and prognosis to be made the mental health, physical health, and environment must all come into play. Successful treatment is contingent upon accurate and comprehensive assessment and the matching of affected persons to the most appropriate treatment (The Biopsychosocial Theory …, 1996).

In the 19th century, diseases spread more rapidly causing epidemics that killed many people. During that time humankind discovered that diseases were passed from one sick person to others through unsanitary practices and unhealthy conditions. Lifestyle and standards of living still influence health or illness today. For example, in areas where there is poor service delivery, illness and disease are more common than in areas where there is good service delivery (Gauteng Department of Health [sa: 14]). This tells us that lack of holistic treatment maybe as a result of people undermining health care services because they may be fruitless if the environment that one is staying in is the main cause of the illness. Hence for people to access health care, the three areas of concern must be diagnosed and treated in a

biopsychosocial approach. Health promotion must also be done to give health education. Diseases such as HIV, cancer and tuberculosis are strongly influenced by socio-environmental factors because they are either as a result of behaviour or the environment (Ross & Deverell, 2012).

In 1977, Dr George Engel believed that “to understand and respond adequately to a patient suffering, and give them a sense of being understood, clinicians must attend simultaneously to the biological, psychological and social dimensions of illness” (Borrel-Carrio, Sucbman & Epstein, 2004:576). This belief was later developed into the biopsychosocial approach by Dr George Engel and John Romano (Engel, 1977), who saw it not only as a dynamic and interactional − but a dualistic view of human experience, whereby there is a mutual influence between mind and body (Borrel-Carrio, Sucbman & Epstein, 2004:576). Engel (1977) emphasised that the biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery. This theory was later known as the body-mind theory (Egger, 2013).

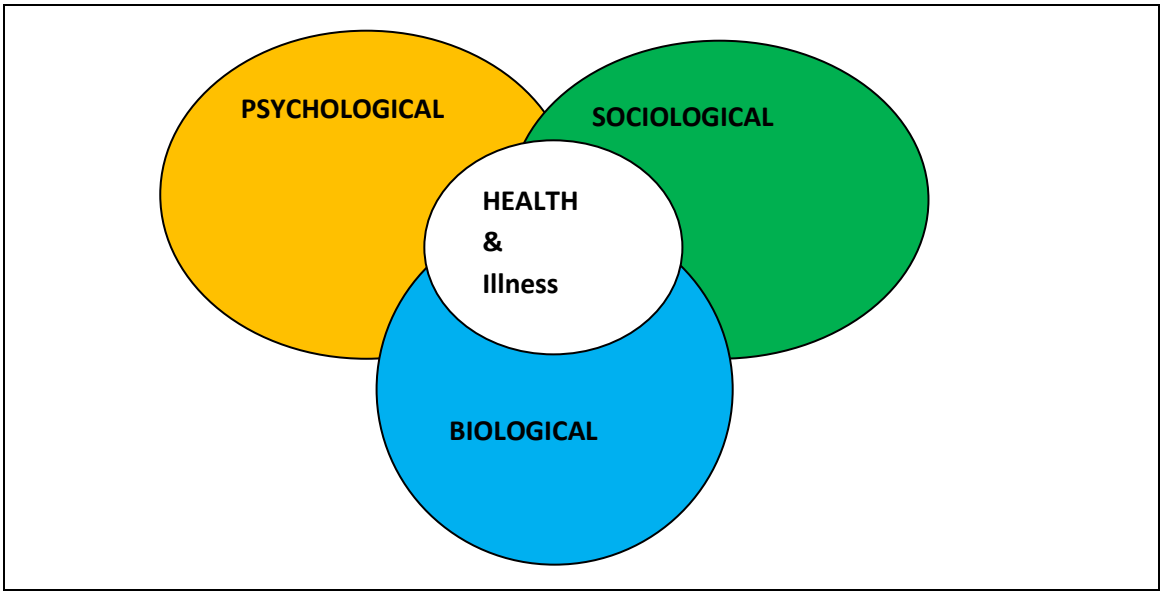

Figure 1.1: Biopsychosocial model

Source: (The Biopsychosocial model…, [sa: 14])

The above figure indicates how the biological, psychological and sociological factors overlap to determine the overall health.

In this section the researcher will explain how each element - biological, psychological and environmental − interacts or overlaps with each other in causing illness or contributing to health.

1.3.2 The biological influence on health

The biological system influences on mental health and mental illnesses are varied, and include genetics, infections, physical trauma, nutrition, hormones and toxins (The Biopsychosocial model…, [sa:14]). According to Lunt, Fox, Bowen Higgins, Crozier and Carter (2007), age, gender, ethnicity, early life stressors, previous injuries, medical treatment, and history of illness also forms part of the biological factor. Cooper, Billton and, Kakos... [Sa] add that neurology is also part of the biological factor and has a strong genetic influence. The biological system deals with the anatomical structural and molecular substance of disease and the effects on the biological functioning of the patient (Dogar, 2007).

1.3.3 The psychological influence on health

According to Egger (2013) the psychological definition of health focuses on the individual's experience of vitality and his habitual behaviour. Each person has a responsibility to gather knowledge relating to their own health and show adequate behaviour that promotes a healthy lifestyle.

The psychological sphere of the biopsychosocial model includes potential psychological factors that may contribute to the development of a health problem (The Biopsychosocial model…, [sa:14]). These include lack of self-control, emotional turmoil, and negative thinking. Negative thinking may result in depression; one may try to cope with depression through alcohol abuse, which may cause damage (The Biopsychosocial model…, [sa:14]). For the purpose of this study, negative thinking can be associated with the clinic and such negative feelings can lead to a barrier towards accessing health care services at the Wellness Clinic.

Personalities, for example hostility and ambitiousness contribute to ischemic diseases, other variables affect the cause of hypertension, diabetes mellitus and cancer (Dogar, 2007). This means psychological factors may increase a biological predisposition by putting a genetically vulnerable person at risk of other risk behaviours (The Biopsychosocial model…, [sa:14]). According to Dogar (2007)

psychological, behavioural and social factors substantially affect consultation and compliance with treatment; as do the psychodynamic factors like motivation and personality on the experience and reaction to illness (Dogar, 2007).

1.3.4 The social/environment influence on health

Social systems examine the cultural, environmental and familial influence on the expression and experiences of illness (Dogar, 2007). This influence which people attach to illness and health, for example in some cultures death or sickness are considered to be due to evil spirits and are not treatable (Ross & Deverell, 2012). In certain black families a disabled child is associated with a curse placed on the family by a sangoma (Ross & Deverell, 2012).

In some instances, beliefs may impede medical care, such as the refusal of some religious groups (Jehovah's Witnesses) to accept a blood transfusion (Dogar, 2007), and in so doing health care services can be hindered. In such cases, Dogar (2007) suggests that physicians must welcome the collaboration of the religious counsellor. This can be a very difficult situation to execute given that South Africa is considered a diverse society. The religious counsellor may also foster or impose his or her own belief on the patient. That can be seen as suppressing one's right to practice their belief. This may further perpetuate refusal of health treatment, which can be a fruitless exercise or impose danger on the patient.

The link between the study and this approach is found in the DPSA framework (2012). This framework says the Employee Health and Wellness Programmes in the public service are rapidly transforming the nature of holistic support provided to employees to ensure risk management, occupational health, safety and productivity and wellness of government employees and their families and safety of the public service. Both the study and the approach seek to prioritise the holistic view of a human being (physical, mental and social) regarding accessing health care. This approach emphasises that the lack of access is not only due to physical limitations, for example location or the building's accessibility, but is also psychosocial, hence the bio-psychosocial approach. For example, if an employee is sick physically, but still refuses or is unable to go to the Wellness Clinic; there must be a motive behind the lack of access to care.

The lack of access to health care services could stem from psychosocial inability (mind over matter) which this research aims to establish. The use of the biopsychosocial approach is very important as it is not only focused on physical wellness alone, but also on the psychosocial wellbeing of employees. Hence health promotion as discussed in the preceding section must address the three factors. The growing body of empirical literature suggests that it is the combination of health status, perceptions of health, and socio- cultural barriers to accessing health care that influence the likelihood of patients engaging in health-promoting behaviours, like taking medication, a proper diet or nutrition, and engaging in physical activity.

1.3.5 Application of the biopsychosocial approach

This model expects doctors to be effective communicators, and ethical practitioners of the art and science of medicine who received adequate training in the study of the psychosocial aspects, alongside the biological determinants of health and disease. He/she is able to extend health care beyond the patient to include the family and community, and place as much stress on the prevention of illness and promotion of health as on treatment of the disease (Dogar, 2007).

The success of the patient's treatment depends on the incorporation into education and practice of a multi-disciplinary or interdisciplinary team, such as specialists from various disciplines. This means including family medicine, developmental and behavioural paediatrics, internal medicine, surgery, cardiac units, intensive care, physiotherapy, rehabilitation medicine, psychiatry, and social workers (Dogar, 2007).

The biopsychosocial approach has been used to help explain the diagnosis and the prognosis of a wide range of health conditions (Lunt et al., 2007). Of these health conditions or disorders, stress, anxiety and depression are particularly important factors in the workplace, especially in the occupational health domain due to the high prevalence and sickness absence rate they cause (Waddell & Burton, 2006).

1.3.6 Challenges of the biopsychosocial approach

It is very difficult to critique this theory because it seems like the solution to all the health conditions that have been there since the 20th century (Ross & Deverell, 2012). Using this theoretical framework, provides a better understanding that

psychologically defined events are part of salutagenic or pathogenetic processes (Egger, 2013). But, like any other medical procedure, there are advantages and disadvantages. In this section we discuss the challenges that face the biopsychosocial theoretical framework. Judging by how this model seeks to address health diseases, it clearly shows that various specialties are needed (Dogar, 2007).

With health care institutions crippled by staff shortages, this approach may not be as well executed as it should be, unless the medical practitioner is able to identify some areas of the biopsychosocial model and refer patients to institutions that offer the needed specialisation. According to Lunt et al. (2007), the biopsychosocial model is hampered by practical difficulties in being assimilated into all aspects of medicine. Secondly the lack of interdisciplinary work makes it difficult to link the needed services as fast as possible, and lastly, the lack of reducing complex interactions between biological, psychological and social factors into reliable models. The researcher suggests that on admission to hospital a registered nurse and a social worker should be available to assess the patient and identify all three spheres of the biopsychosocial framework. There afterward rounds with the identified specialists should take place so that treatment starts with an interdisciplinary approach.

1.4 RATIONALE AND PROBLEM STATEMENT

According to Fouché and De Vos (2011:79), “Before we can conduct or even design a research study, there must be a clear picture of the direction of the study.” This can be formulated or refined as the rationale and problem statement or research question is finalised.

With all the effort that the Gauteng Department of Health Central Office has put in place to bring the Employee Health and Wellness Clinic to the door-step of its employees, to ensure that employees’ health-related concerns are addressed, it is still not clear as to why employees are not accessing the services in large numbers.

This topic came about from the realisation of poor attendance on the Wellness Days held on a quarterly basis by the Gauteng Department of Health Employee Health and Wellness Clinic, as well as through Sister Zanele Mokone who is in charge of the clinic. She confirmed that less than 200 employees make use of the Wellness

Day(s) for physical assessments and other health related consultations. Fewer than 10 employees attend the clinic per day, which is very low for an institution that has the capacity for over 2000 employees.

Statistics at the clinic show that the 10 employees seen at the clinic per day include those that are coming for their monthly repeat medication for chronic illness. The fact that only a few employees access the clinic on a daily basis, signals that there could be a challenge, either with the employees' attitudes towards the Wellness Clinic or the clinic itself is not accessible to employees. This raised a reason for concern and prompted the need for this study. The geographical location of the clinic also raised concern, as the clinic is awkwardly placed far away from most employees, and has been relocated from one building to another without full consultation with employees.

Motivated by the mentioned facts as stated in this section, the research question for this study is as follows:

- What are the challenges towards accessing an employee health and awareness clinic by Gauteng Health Central Office employees?

To explore this question the goals and objectives of the study are provided.

1.5 GOAL AND OBJECTIVES

1.5.1 Goal

The goal of the study is to explore the challenges to accessing an employee health and awareness clinic by Gauteng Health Central Office employees.

1.5.2 Objectives

- To explore and describe all the services offered in the Gauteng Department of Health: Central Office Employee Health and Wellness Clinic.
- To determine the employee awareness with regard to services that are offered in the Gauteng Department of Health: Central Office Employee Health and Wellness Clinic.
- To explore if the Employee Health and Wellness services are marketed sufficiently to encourage the employees to access these health care services.

- To explore the internal, external and personal challenges that employees face regarding the services of the Employee Health and Wellness Clinic.
- To make recommendations to the Gauteng Department of Health to contribute to improved access to the Central Office Employee Health and Wellness Clinic.

1.6 RESEARCH METHODOLOGY

A qualitative research approach was followed in this study, which Fouché and Delport (2011:65) refer to as a "research method that elicits participant accounts of meaning, experiences or perception." The researcher elected this approach because it produces descriptive data in the participant's own spoken words. Applied research was pursued, which Leedy and Ormrod (2005:43) refer to as concerned with research projects which can inform human decision-making about practical problems. In this study access to health care is faced with challenges that need practical solutions, so that they can be resolved and therefore promote access to health care services.

The case study research design was followed, which Creswell (2007) refers to as concerned with the exploration of a bounded system that is characterised by time, context and/or place. The exploration and description of cases take place through a detailed, in-depth data-collection method, involving multiple sources of information such as interviews, documents, observation of participants, and archival records that are rich in context (Fouché & Schurink, 2011 and Leedy & Ormrod, 2005).

The study population has been drawn from the Gauteng Department of Health Central Office. Twelve employees formed part of the selected participants.

The sampling criteria for the 10 employees included the following:

- Participants must be employed by Gauteng Health Central Office; and
- Participants must have accessed the Employee Health and Wellness Clinic in the past six months as patients.

The sampling criteria for the two nurses as key informants included the following:

- Participants must have been working as nurses at the Employee Health and Wellness Clinic for the past year.

Two sampling strategies were used in this study. Firstly, a non-probability method was used because the odds of selecting a particular individual to participate in the study were not known (Strydom & Delport, 2011:391), and also because the researcher does not know the members of the population (Gravetter & Forzano, 2003:118). A purposive sampling method was used, because the researcher used his own discretion to sample the population that is composed of elements that contain most characteristic, representative or typical attributes of the population that serve the purpose of the study best (Strydom & Delport, 2011:391). Thirdly, probability sampling was used, namely stratified sampling to ensure the representation from each of the three buildings of the Department of Health Central Office. This kind of sampling is mainly used to ensure that the different groups or segments of population acquire sufficient representation in the study (Creswell, 2003:156).

After data was collected through the abovementioned sampling, the data was then analysed. Babbie (2001:10) defines data analysis as "a process of making sense of what has been observed or captured." This study followed Creswell's model of data analysis and interpretation (Creswell, 2007:150-155) as described and discussed in Schurink, Fouché and De Vos (2011:403).

The quality of data was tested through a process called trustworthiness. "Trustworthiness is established when findings as closely as possible reflected the meanings of the participants" (Lietz, Langer & Furman, 2010:444). The researcher utilised the four constructs of trustworthiness as proposed by the prominent qualitative researchers, Lincoln and Guba (1985) that are described and discussed in Schurink, Fouché and De Vos (2011:419). That is, transferability, credibility, conformability and dependability. The strategy that was used to compare the four constructs included member checking.

1.7 CONTENTS OF THE RESEARCH REPORT

Chapter 2: Literature review on challenges towards accessing health care services.
Chapter 3: Empirical findings, analysis and interpretation of data.
Chapter 4: Conclusions and recommendations.

The following chapter focuses on the literature review.

2. CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The political commitment to the health and wellbeing of the nation is enshrined in the South African Constitution, Act 108 of 1996 and the Bill of Rights. It is expressed as “Everyone has the right to an environment that is not harmful to their health or wellbeing,” and “Everyone has the right to have access to health care services, including, reproductive health care” respectively (RSA, 1996).

The Constitution informs us that access to health care services is not just a privilege but a human right issue. Bearing this in mind, it is without a doubt that the government departments, including the Department of Health have put strategies in place to elevate the access to health care as prescribed in the Bill of Rights and the Constitution for employees in a form of an Employee Health and Wellness Programme (EHWP).

The Employee Health and Wellness Programmes in the public service are rapidly transforming the nature of holistic support provided to employees to ensure risk management, occupational health, safety and productivity and wellness of government employees and their families and safety of the public service world of work (DPSA, 2012). With the EHWP strategy put in place by the Department of Health, the utilisation of the wellness clinic services is very low. This means that employees are not accessing the health care services as they should be. This paper will provide a discussion on the barriers towards accessing the employee health and wellness clinic at the Gauteng Department of Health Central Office.

Various views on barriers towards accessing health care services in general from various authors will be discussed, with the hope of providing recommendations to alleviate the said barriers and promote access to health care at the end of the study. The following section deals with the Employee Health and Wellness Programme to detail the full context of the investigation that the study is based on.

The legal framework, including the Constitution and the Bill of Rights guiding the health institutions, are also presented in this study for discussion. Once the

challenges and their effects have been discussed, the study investigates the benefits of accessing health care.

This chapter will explore the literature on investigations, discoveries and document challenges towards accessing health care services. The literature extends to the background that informs access or a lack thereof to health care services. Furthermore, the outcomes of the lack of wellness clinics or access to a health clinic, as well as the benefits of accessing Employee Health and Wellness Programmes or health care in general are discussed.

2.2 EMPLOYEE HEALTH AND WELLNESS PROGRAMME (EHWP)

To understand the history of Employee Health and Wellness Programmes one has to begin with knowledge of an Italian physician Bernardini Ramazzini (1633-1714), who is believed to be one of the first authors to write about the effects of employees' exposure to occupational diseases. He was interested in taking preventative measures to help improve employee wellbeing (History of Wellness Programme [sa:14]). However, the roots of the Wellness Programme pre-date the First World War (The Evolution of Corporate Wellness, [sa]:14). Ford and other manufacturers invested in these early programmes because they thought they'd see an increase in production with healthier employees (The Evolution of Corporate Wellness [sa]:14).In affirming this view Gillam, Yates and Badrinath (2009:221) agree that productivity is influenced by the health of individuals.

The Gauteng Provincial Government (GPG) EHWP, known as "Zinakekele" was initiated in 2004, following the Human Resource White Paper 2000's decision to implement seamless wellness programmes across GPG departments (Zinakekele: Employee Health and Wellness Programme Annual Report, 2015/16).

The Gauteng Department of Health (GDoH) has been recognised as a critical strategic intervention for wellness since 2007 (Wellness for all, 2008). The foundation work of the Employee Health and Wellness Programme from the years 2000 to 2003 focused on HIV and AIDS in the workplace, and the development of an integrated approach to employee wellbeing (Wellness for all, 2008).

In committing to dealing with challenges that emerge in the workplace, the government introduced a one-stop service centre called the Employee Health and Wellness Centre that caters for primary health care challenges (Clinic), occupational diseases or injuries as well as psycho-social challenges. The Employee Health and Wellness Centre is staffed with a clinician or a professional nurse in the GDoH: Central Office, who is licensed to diagnose, treat and prescribe for a wide variety of common illnesses and conditions (Wellness Centre…[sa:14]).

Although these steps are applied to ensure the health and wellbeing of the employees, it must be noted that employee wellbeing is the responsibility of the employer, but access to Wellness Clinic is the personal choice of the employees. However, it must be noted that in the South African context and workplace, conditions do not support optimal health and wellbeing (Wellness Management, 2008). Hence the DPSA (2008) stresses that there is a need to maintain an inclusive, barrier-free work environment that is accessible for all. The public service is mindful of barriers such as professional barriers (e.g. lack of advancement, mentoring and training opportunities), and psychological barriers (e.g. balancing work/family work expectations and sexual discrimination/harassment).

2.3 PRIMARY HEALTH CARE (PHC)

Primary Health Care originally meant the first care offered to a patient in need (Abatt & McMahon, 1985). In 1978 the Alma-Ata Declaration conference expanded Primary Health Care into:

> … an essential care based on practical, scientifically, sound and social acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford and maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care service (Dennill, 2012:4).

Primary health care in the context of this study is found in the GDoH Central Office Wellness Clinic which strives to rapidly transform the nature of holistic support

provided to employees to ensure risk management, occupational health, safety, productivity and wellness of government employees and their families (DPSA, 2012). The public health care sector is the main provider of Primary Health Care Services in South Africa. It is important that these services are provided in an equitable, effective and efficient manner (Reagon et al., 2003).

The Alma-Alta Declaration Conference responded to the feeling, internationally, that there was unacceptable inequality with access to health care. The conference was jointly sponsored by the World Health Organization (WHO) and The United Nations Children's Fund (UNICEF). This conference was seen as a means of achieving universally available health care and attaining health for all by year 2000 (Van Rensburg, 2012 and Dennill, 2012).

The Gauteng primary health care facility is managed by a staff member with a professional nursing qualification. The majority of primary health care facilities are open five days a week (Reagon et al., 2003). This view is supported in Dennill et al. (1995), who state that for primary health care to be effective, it must be based on a socio-ecological model in which health becomes a resource in everyday life. This context is based on the premise that health is a basic human right (Dennill et al., 1995).

2.3.1 Services provided by the Primary Health Care Clinic (PHC)

It is important that before the study can qualify or disqualify the Wellness Clinic as a PHC Clinic on the services rendered, we should look into the services that are mandatory for a PHC Clinic as recommended by the WHO, so that we can draw a comparison and contrast between the two.

The World Health Organization has defined eight elements of PHC that must be considered to make up a PHC Clinic. One must also note that not all eight elements are present in every health care programme (Abbat & McMahon, 1985; Dennill, 2012 and Dennill et al., 1995). The eight elements of primary health care:

- Health education;
- Nutrition;
- Immunisation;

- Maternal and child health and family planning;
- Water and sanitation;
- Control of endemic diseases;
- Treatment of common diseases; and
- Provision of essential drugs.

In a survey conducted in nine South African province district clinics in 2003, it was discovered that contraception, trauma care, STI treatment, and TB services were available in most of the facilities. Antenatal care, termination of pregnancy, HIV testing and counselling services and immunisation were available in just half of the PHC facilities. Few provided prevention of mother-to-child HIV transmission (PMTCT) and antiretroviral therapy (ARV) (Reagon et al., 2003).

This tells us that it will not always be the case that the clinic will be fully equipped, but some of the basic medications and instruments to treat and do minor operations must be available. Contrary to this view, in her Gauteng Health budget speech for the 2017 financial year, Dr Gwen Ramokgopa, MEC for Health, stated that “an ideal clinic is a clinic with good infrastructure, sufficient staff that practices Batho Pele principles, has adequate medicine supplies, and good administrative processes” (Gauteng Health Budget speech, 2017).

2.4 POLICY AND LEGISLATION PERTAINING TO WORKPLACE HEALTH AND WELLNESS PROGRAMMES

It is in the interest of the employees that they are furnished with the information that the Employee Health and Wellness Programme is not a “nice to have” type of programme, but it is a mandatory programme from the Department of Public Service and Administration (DPSA), that is enforced by various agencies, policies, legislation, the Constitution, and the Bill of Rights. Failure to implement the constitution can be considered a human rights violation. Table 2.1 below, gives an illustration of the policies, their functions and the enforcement agencies that keep the EHWP in line.

Table 2.1: Legal framework on Employee Health and Awareness Clinic

Act/policy	Function	Enforcement agency
Constitution of the Republic of South Africa 1996	To ensure that everyone has the right to an environment that is not harmful to their health and wellness	Department of Labour
Occupational Health and Safety Act no. 85 of 1993	Ensure a safe and healthy environment in the workplace	Department of Labour
Compensation for Occupational Injuries and Disease Act (COIDA) no. 130 of 1993	Provides for medical cover and compensation of occupational injuries or diseases in all work places	Department of Labour
Medicine and Related Substances Act no. 101 of 1965 as amended	Provides for authorisation permit to be issued to a nurse to dispense schedule 1-4 substance at workplace of health	Department of Health
White Paper on the Transformation of Care Systems in SA 1997	Gives directive on the provision of Occupational Health Act	Department of Health
National Health Act no. 61 of 2003	To provide a framework for structured uniform health system within the Republic of South Africa	Department of Health
Public Service Act and Regulation 1994 section 41	Mandates and guides HODS on requirements for managing HIV and AIDS in the workplace	Department of Public Service and Administration (DPSA)
Medical Scheme Act no. 31 of 1998	Assure that all employees have access to medical benefits	DPSA and Council for Medical Schemes
Employment Equity Act no. 55 of 1998	Ensures quality and non-discrimination in the work place	Department of Labour
Basic Conditions of Employment Act no. 75 of 1997	Regulate the relationship between employees, trade unions and employer	Department of Labour
Labour Relations Act no. 66 of 1995	Prevents unfair labour practice	Department of Labour

Table extracted from Wellness for All (2008:17)

2.4.1 The application of the legal framework

The Employees Health and Wellness Programme legal framework indicates that the Employee Health and Wellness Programme operates within the laws and policies of the country, and therefore it is not in any way trying to bypass the laws and policies of the country, but to also comply with the Acts and policies while representing the wellbeing of employees. Thus, the legal framework tabulated above enhances the scope of the Wellness Programme.

The Constitution of the Republic of South Africa and the Bill of Rights promotes the right to life and access to health care service respectively (RSA, 1996). In compliance with the Constitution and the Bill of Rights, the Wellness Programme implements those rights by ensuring the environment and access to health care through Wellness Clinics are realised and that the Occupational Health and Safety Act no. 85 of 1993 as amended, is in place and implemented. For example, if an employee gets injured or acquires an occupational disease while on duty, this Act combined with the Occupational Injuries and Diseases Act of 1993 (COIDA) comes into effect.

The injured or sick employee must be assisted through the Compensation for Occupational Injuries and Diseases Act (COIDA) no. 130 of 1993. And if the COIDA is not executed the Basic Conditions of Employment Act no. 75 of 1997 intervenes to assist the injured employee, and wellness through organised labour, such as trade unions, to ensure the right of the employee is realised. The legal framework is important for EHWP to ensure that not only the rule of law is upheld, but also to ensure that health care services are accessed by the employees − while they are on duty this Act comes into effect.

2.5 ACCESS TO HEALTH CARE: HISTORICAL BACKGROUND

Historically, access to health has always been met with difficulties in terms of policies and legislation, especially for black people during colonialism and the apartheid era. This is reflected in the Gluckman Commission report of 1944, where one of the disparities recorded was the shortage of health care services, blamed on both personnel and facilities' failure to provide health care services (Van Rensburg,

2012:85). This problem was illustrated by the average bed allocation to population ratio of 1:304 for white people and 1:1198 for the black population. These disparities were more severe for the black population, especially in creating poor health care.

This proves that access to health care was determined by the skin colour of the health care users. The commission further reported that health care serviced all sections of the people of the Union of South Africa, but services were poorly supplied to the under-privileged and the wealthier sections dominated by whites received good health care services (Van Rensburg, 2012).

Even if the health services are available in certain areas, but in many parts of the developing world access to health care is non-existent due to lack of resources, such as transport or to pay for the services and medication (Dennill, 2012). In these arguments we come to a realisation that even if the implementation can be done, there are still efforts needed to promote access and this can only be achieved if services are taken directly to the poor and vulnerable communities. It must also be known that offering health care services free of charge may not guarantee access but it can improve, as it is shown in the case of this study.

The 1978 the Alma-Ata conference adopted a slogan called “Health for All” (Van Rensburg, 2012). According to Dennill (2012:23) the Health for All was to be attained by the year 2000. Following on this Alma-Ata conference slogan, in 1994 when the ANC came to power, it introduced the so-called Presidential Lead Projects to “kick-start” the Reconstruction and Development Programme (RDP, Van Rensburg, 2012:124). The RDP championed the policy of free health care services, launched a month after the new government took office. Such free services were to be provided at all health care facilities (Van Rensburg, 2012:124).

The implementation of free Primary Health Care to all South Africans has brought about improved access to health. The second Kaizer Family Foundation survey of health care in South Africa discovered that 58% of South Africans named the free health care policy as the best thing to have happened to South Africa (Ijumba ...[Sa]).

The patients' rights charter also emphasises that "everyone has the right to access health care services without discrimination, coercion or violence" (Health and Democracy…[Sa]; Cullinan, 2006). But certain authors and researchers have established that this right is provided under certain conditions. Dennill (2012:23) also concedes that the biggest problem faced to achieve health for all has been the inability to attain equity in health care or to establish health supporting environments. In response to this statement the Wellness Management emerged as a priority due to increasing recognition that the health and wellbeing of employees directly impacts on productivity of entire organisations. As employees are the life-blood of the organisation, it is vital to help them produce at their optimum levels (Wellness Management Policy, 2008).

- **What is access to health care?**

According to Peters, Garg and Bloom (2008), access to health care implies the timely use of service as per the individual need. To stretch this definition further, Valorie, Crooks, Gavin and Andrew (2009) state that access is the ability of an individual or group to obtain health services that they seek and which is available to them at the time of need.

In another view, access to health care is characterised by four dimensions, i.e. availability, geographic location, affordability and accessibility (Jacobs et al., 2011). In addition to these dimensions Dennill (2012:10) says health care services must be equitable, that is health care services must be accessible to all people. The health care services must also be effective, meaning it must do what it intended to do and lastly it must be efficient, that is the results should be proportionate to the input, in terms of the effort expended, money resources and time.

The dimensions to access health care are viewed in the South African Human Rights Commission (2007) and relegated to constrain the poor because of expensive, inadequate or non-existent transport, a shortage with regard to emergency transport and by long waiting times at the clinics.

Bearing in mind the mentioned dimensions, Valorie et al. (2009), see access to health care in two ways, the potential and realised access to health care. Potential access refers to "the degree to which population might make use of the existing

health resources, based on characteristics of available services" (Valorie et al., 2009). The second form is realised access, which deals solely with characterising how the population actually makes use of health services available at a specified time period (Valorie et al., 2009).

It seems like access to health care cannot be viewed in a blanket approach, because some specifications have to be met before the term access to health can be realised. The researcher holds the view that access to health care is when health care services are utilised as per the need of the patients. For the purpose of this study the Gauteng Department of Health Central Office employees must be able to access health care services while on duty at any time of need during working hours.

The access to health care in the light of the above indicates that many plans have been put in place to ensure that the historical restrictions on access are removed, and that health becomes free for all as per the Alma-Ata conference declaration (Dennill, 2012:23).The question that needs to be answered in this study is, are the Gauteng Health Central Office employees able to access the health care services freely and as needed? In answering this question, the researcher must bear in mind that the supply and demand of services must have a meeting point and collaboration to promote access (Jacobs et al., 2011).

It has been discovered in this section that the global community is aware of the need to promote access to health care, and measures have been put in place to promote access to health care, through the concept called free health for all. Some communities are now able to access health care services, but these services must also be linked to utilisation (Jacobs et al., 2011). Forty years later after the Alma-Ata Conference, the developing world still struggles to access health care services due to various challenges.

For the purpose of this study anything that limits the access to health care for the Gauteng Department of Health Central Office Employees, is considered a barrier in this study. The following sections will discuss some of the potential and realised barriers that are experienced by global health care seekers in accessing health care facilities.

2.6 CHALLENGES TOWARDS ACCESSING HEALTH CARE

Barriers can be defined as anything that hampers access to needed health care services (Jacobs et al., 2011). In the preceding section it was established that access to health care is a Constitutional Right and failure to comply with the constitution is presumably unconstitutional and can result in legal implications (Cullinan, 2006).This also means that man-made deliberate barriers towards access to health can be considered as a human rights violation.

Since 1994, there has been a great transformation in health care (The South African Human Rights Commission, 2007). On the other hand, Van Rensburg (2012) argues that more than three decades since the Millennium Development Goals (MDG), the Alma-Ata Declaration declared free health for all, but this is yet to be achieved in the majority of the developing countries, including South Africa.

Although measures such as the Constitution of the Republic of South Africa, that ensures right to access to health care (RSA, 1996), the Bill of Rights, the Health Act, the Patients' Rights Chatter, the DPSA Employee Health and Wellness strategic framework, the Wellness Management Policy, Batho Pele principles, and the Human Rights Commission have been put in place. There are still barriers that find ways to hinder access to health care.

Access to health care, especially for the poor is severely constrained by expensive, inadequate and non-existent transport (The South African Human Rights Commission, 2007). This is mostly true for poor black South Africans who live in informal settlements. The impact of social and economic determinants of health status and the existence of racial and ethnic health care access disparities is huge, multi-factorial models are being presented to explain the causes of such disparities (Carillo, Carillo, Perez, Salas-Lopez, Natale-Pereira & Bryon, 2011).

Depending on the population or sample, different authors hold different views when it comes to what the barriers are towards access to health care. In Jacobs et al. (2011), unwelcoming staff attitudes or poor interpersonal skills, lack of assertiveness and low self- esteem among the poor, stigma associated with the disease such as Tuberculosis (TB), are rated highly as challenges to accessing health care.

Monger (2011) says that stigma surrounding HIV/AIDS continues to be a growing obstacle to quality of life as well as accessibility to health care for those who are infected. At the end of the year 2006 the Centre of Diseases Control estimated that over a million people were living with HIV, but they were unaware of it due to fear of its stigma (Monger, 2011).

In a study conducted between Brazil and Colombia in 2014, it was learned that in Colombia the geographical location of health care services was considered a barrier to accessing health care more than it was in Brazil. Travelling times to reach health care services were significantly longer. Geographical access to health services is poorer in Colombia than in Brazil (Garcia–Subirats, Vargas, Perez, Paepe, Da Silva, Unger & Vazquez, 2014).

Furthermore, culture came into play in the literature as one of the barriers that is concerned with the low utilisation of health care services. Komaric, Bedford and Van Driel (2012) established that in instances where there is a lack of cultural diversity in the health care force, utilisation and access to health care were low.

2.6.1 Internal challenges towards accessing Health Care

It sounds like a cliché to say “experience is the best teacher of life” but, in reality, this can turn out to be true. Experience, attitude(s), and behaviour as well as beliefs, all form part of the internal barriers which intend to impede access to health care (Falasca, 2011:154). According to Ross and Deverell (2010:60), “attitudes are relatively stable patterns of mental views, opinions or interests, acquired through experiences over a period of time.”

In this paper we are dealing with the internal challenges first, because the researcher believes that motivation to access health care is mostly driven by the perceptions, experiences and attitudes towards health. In a study conducted by Price, Soares, Asante, Martins, Williams and Wiseman (2016), experiences have negatively influenced future decisions to seek hospital care.

In another study conducted in the Netherlands, 69% of undocumented women were reported to have obstacles with access to health care, because of fear, shame and lack of information regarding health care services (Schoevers, Loeffen, Van den

Muijenbergh & Lagro-Janssen, 2010). A lack of trust by users in their health care providers or the intermediates that link the population with these providers makes people reluctant to use the respective services (Jacobs et al., 2011).

The lack of trust by health care users could stem from the knowledge that health care service providers have been known to express feelings of anger, depression, frustration, despair and powerlessness at not being able to influence the course of diseases (Ross & Deverell, 2012). These frustrations can be taken out on health care users unintentionally and such behaviour can result in a particularly negative perception, attitude or experience that can in turn hinder future access to health care.

Van Rensburg (2012) describes health attitudes as pertaining to what people feel and experience regarding health, disease and care, for example scepticism about care in public hospitals. This knowledge proves that the internal conversation that one has before he or she seeks access to health services, plays a vital role in making that final decision. This means that attitudes can directly cause a person to act in a particular way (Maclachlan, 1997:12).

Personal attitudes that some people host towards public health play a big role in determining access to health care, for example the fact that public health is associated with bad service, long queues and shortage of medication and other health supplies, can bring about bad attitudes towards accessing health care (Van Rensburg, 2012).

The issue of first-hand experience with health care institutions by those who are seeking health care attention can strongly influence their behaviour to seek health care again or not, when they are ill. Maclachlan (1997) further cites that attitudes formed through direct experiences are stronger because such attitudes are held with more clarity, confidence and certainty. In agreement with Maclachlan (1997), Arksey et al. (2003), point out that the key barriers to health seeking behaviours include cultural/personal, as well as the recipient's attitude and preferences of care.

2.6.2 External challenges towards accessing health care

External barriers are characterised by the situation/s that make it physically difficult to achieve efficient health care services, for example lack of wheelchair ramps at access points for people with a physical disability (Huber, et al., 2008:110). Physical resources are very important for a well-functioning health care service. These resources are characterised by health service infrastructure such as buildings (Dennill, 2012). In this regard Dennill et al. (1995:6), says that health care services must be geographically, functionally, affordable, effective and efficient.

2.6.3 Financial implications/exclusion challenge(s)

Affordability of health care services relating to cost and prices were recognised as being borderline between accessing and a barrier to accessing health care (Jacobs et al., 2011). In the Kaiser Health Survey, it was recorded that in South Africa 73% of participants stated that when last ill they had consulted a health care provider. Of those who did not go to a health care service when they were ill, 66% said they did not seek care because they could not afford the service (Health & Democracy [sa:14]). Part of the reason why the services are constrained for the poor is due to financial limitations (South African Human Rights Commission, 2007).

Financial implications in health care are not only restricted to paying for health care services such as an administration fee or consultation fee, but also in a case where there is no medication in the health care facility. The doctor can write a prescription that can be given over the counter at any pharmacy, with the possibility of either paying a levy if one is on medical aid, or paying in cash (Prince et al., 2016).

Financial barriers to health care access arise in vulnerable populations when patients are uninsured or underinsured (Price et al., 2016). Research has proved that the impact of being uninsured or underinsured directly affects health care users by limiting access when ill, by going without a prescription, without medication, or foregoing recommended treatment (Carrillo et al., 2011). Another view is that individuals who are on medical aid or insured may nevertheless be subjected to other access barriers that are not as tangible as medical aid status (Carrillo et al., 2011).

Health care services that are rendered at the Gauteng Department of Health: Central Office Clinic are at no cost to employees. But financial barriers cannot be ruled out completely in this study because employees who are on medical aid which serves as a financial support towards their health care service, are more inclined to seek health care. This means that these employees have the choice of consulting any General Practitioner or a private hospital of their choice.

This can create a barrier in a sense that those employees who are on medical aid may feel that they are not receiving the best treatment, such as they would if they went to a private practice. They therefore may reject the services offered at the Wellness Clinic based on value for money. In this regard Engelbrecht and Van Rensburg (2012:513) state that public health care continues to lack infrastructure, has poor financial management of resources, tools of trade and staff shortages that compromise the quality of services delivered. Patients with sufficient financial resources would use private health care and such employees with access to medical aid would not consider utilising the Departmental Wellness Clinic.

Financial barriers are associated with decreased prevention, late presentation to health care, including self-referrals and decreased care which in turn result in poor health outcomes and health disparities (Carrillo et al., 2011). Utilisation of public health care services is largely associated with poor service; due to value for money. Possibly this may be the reason why the Gauteng Department of Health is not attracting many employees. This study will later look at the findings in this regard.

2.6.4 Geographical challenges

Geographical challenges can also be a factor in accessing health services, as Huber et al. (2008:28), state, a geographic variation in access to health is an important topic associated with patients' entry into the system. Evidence collected in different countries, points to significant regional differences which have the potential to limit access to care (Huber et al., 2008:29).

The Gauteng Department of Health Central Office Wellness Clinic is situated at an Old Reserve Bank Building (corner Fox and Simonds Street). This building hosts a handful of employees of the Department of Health Central Office institution. The largest number of employees is based at Bank of Lisbon building (corner Albertina

Sisulu and Prixley Seme Street).This building is situated about 600 meters away from where the clinic is situated. The third Gauteng Department of Health Central Office building which hosts the second largest number of employees is situated about 800 meters away from the clinic building.

The researcher brings the above information to the reader's attention to ensure the context of geographical variation is taken into consideration beforehand. In this study the setting of the Wellness Clinic will be regarded in context because employees who are based at the same building as the Wellness Clinic may not see any challenge accessing the clinic. Dennill et al. (1995:6), argue that for a health care service to be at a geographically reasonably accessible distance it should be around 5-10 kilometres away, as suggested by the World Health Organisation and transport should be available.

In many low and middle-income countries poor households are known to face a diverse range of barriers to using hospital services, such as distance to a facility, poverty, education, opportunity cost, cultural and social barriers. These are said not to be dependent on service provision or direct fees for service, but to significantly affect levels of utilisation, especially for vulnerable groups (Price, Soares, Asante, Martins, Williams & Wiseman, 2016:2).

In another study conducted in Burkina Faso it was established that the location of health care workers and facilities have an important dimension on the cost of care (Ensor & Cooper, 2004:23). Furthermore, a study conducted in Vietnam also proves that location is the main determinant of the delay between onset of illness and presenting for treatment (Ensor & Cooper, 2004:23).

The location of the Wellness Clinic in Gauteng's Department of Health has once sparked a dilemma when some employees preferred not to be seen going to the clinic, because of the stigma attached to it. This was one of the reasons external service providers like ICAS, Care Ways and Procare, as well as GEMS were brought in to provide an independent view on patient care and health services, especially psychosocial support to employees of the government in Gauteng. But other employees even opted to consult private doctors, rather than going to the staff Wellness Clinic for the same reasons relating to stigma. On the other hand, some

employees felt that if the clinic was within the premises, it would assist in curbing absenteeism of those who would take a day off to go to the doctor, but instead could make a quick stop at the clinic and save a leave day.

Another view was that the clinic was awkwardly placed. One has to go into the busy Johannesburg CBD and cross over traffic lights. The fact that someone could be going to the clinic while they are sick may pose a danger to their lives, in the sense that they may be knocked down by cars if they are absent-minded or feeling dizzy and fall while walking to the clinic. The five to 10kilometre radius prescribed by WHO becomes relevant if there is no transport, as in the case of the Department of Health Central Office.

2.6.5 Organisational challenges

These are organisational issues that are within the provider's organisation in general. This refers to rules and conditions or red tape in accessing health care. Patients (employees) can be faced with the limitations that are organisation-based, which can create challenges to accessing health care (Huber et al., 2008). Some of the organisational changes that were captured in Beech (2003:99) include waiting time and delays, subsequent delivery of that care, lack of services that allow pre-registration, excessive waiting time in waiting rooms and inadequate business hours.

- **Facility/infrastructure**

The domain of patients' rights sets out what a hospital or clinic must do to make sure that patients are respected, and their rights upheld, including access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, in accordance with Batho Pele Principles and the Patient Rights Charter (National Department of Health, 2011).

Another observation that was made by Reagon et al. (2003:12), was that the adequacy of waiting areas must be characterised by the availability of seating space, ventilation and lighting. The waiting times and queues must be managed to improve patient care, and seriously ill or injured patients must be attended to first (National Department of Health, 2011). The toilets were considered adequate if they had running water with hand-washing basins (Reagon et al., 2003:12).

The researcher is in agreement and adds that the cleanliness of toilets should also be prioritised. Dirty toilets may lead to patients' discomfort and can also bring about resistance to follow-up visits and treatment default. The Occupational Health and Safety Act, 1993, emphasises the importance of hygiene. This is also in line with the international consensus that seeks to address safety, health, environment, risk and quality as governance issues (DPSA, 2012).

The National Core Standards (NCS) further enforce that the health establishment is kept clean, including critical areas of public use (especially toilets) and areas for patient care (National Department of Health, 2011). Lastly, there is the consideration of providing the disabled with access to the facility through the use of ramps and wide opening doors (Reagon et al., 2003:12).

From the researcher's point of view this kind of barrier (facility barrier) is considered for two reasons. The first reason is that people may be less keen to attend the clinic, especially when they know that their audio-visual privacy will be compromised. Secondly, access for persons living with disability and using wheelchairs cannot be compromised. If the facility doesn't have a ramp or a lift, then it makes it difficult for them to access it.

The second reason is that people/employees may have visited the clinic and realised that the waiting area is not ventilated, or there is no adequate seating space, or both. This can create a barrier in a sense that employees may want to stay away from the clinic, fearing that they may catch some illness such as TB due to a lack of ventilation.

- **Health Care Services**

Service standards although generic within the public health care system, service users may hold different views (perceptions) on the quality of service received from the service provider (Ross & Deverell, 2012 and Prince et al., 2011). Service users are subjective in nature and would therefore express different views about whether the service is poor or of high quality. To settle the debate of quality of health care subjectivity Ijumba [sa:14] says the provision of quality primary health care service hinges on how the providers are trained and it requires multi-skilled workers who are prepared and have the time to upgrade their competencies regularly.

The judgment on whether the professionals conducted themselves in a good or bad manner is reliant on the provision of adequate medication, examination tools and quality health education as a necessary tool to avert poor delivery of service, even if the facility is managed by people who are well trained. This is one of the reasons why the study has used nurses who offer services at the wellness clinic as key informants.

Poor service can be experienced prior and after accessing the service. However, the researcher believes that a bad service experience can be more damaging once the client/patient receives it first-hand, because he or she may spread information about the bad service rapidly. This can result in many people, including the patient who experienced the bad service first hand being influenced to not utilise the service.

Also, a good experience can bring about promoting access to health care. Another view documented in Ijumba [sa:14] is that good interaction between patients and health care workers improve user satisfaction, patterns of utilisation, patient compliance and willingness to participate in service delivery.

The researcher believes that a good service requires more than just good interaction, but also the availability of resources such as adequate staff, because staff shortage creates many gaps in the service delivery of health care. The availability of drugs or medication is of paramount importance. “Initially pharmaceuticals were considered the answer to all health problems and much effort has been made to ensure that they are widely available to the people” (Baichoo, Mosaheb, Ramdoh, Ramphul & Soyfroo, 1994:1). Using this quote the researcher assumes the conclusion that the lack of medication can result in poor service in any health care sector.

- **Management/Organisational support**

The success of the EHWP strategy for promoting employee health and wellness in the public service depends on the extent to which pertinent organisational support is provided(DPSA, 2012).Participative management and quality circles are tools for enhancing the healthcare setting (Bezuidenhout, 2014). Managers influence the success of their organisations.

The successes with which an organisation achieves its objectives and satisfies the ever- increasing society depend on the competence of its managers. If managers do their jobs well, the organisation will be successful (Brevis, Vrba de Klerk, 1997). Managers' endorsement and active involvement from the top of the management structure is very crucial in the EHWP (Dickman, 2003).

In terms of the DPSA codes, final accountability regarding the availability and implementation of the wellness programme rests with the Head of Department (HOD) of Health (Gauteng Department of Health: Employee Wellness Policy Guidelines, 2006).

In this study management support is seen in two ways, one is for patients or employees and the other is for the Wellness Clinic. The two can determine whether the clinic is accessible or not. Both supervisors and managers can play a role in influencing employees to access the clinic when they are not feeling well, by identifying them as early as possible and referring them to the clinic.

On the other hand, if the clinic is unable to win the support of management, it may create a barrier to staff accessing adequate services. The lack of management support is usually due to a lack of proper communication, a lack of adequate consultation, which may be long and cumbersome, and which contributes to delays in addressing problems in reporting lines and an overly bureaucratic process (Human Rights Commission, 2007).

This is evident if management is not able to give enough or approve a budget for the clinic to make sure that the procurement of clinic resources is satisfactory, and, as a result, the clinic may be considered to be offering poor service. Good clinical management depends on the appropriateness of services supplied, the availability of equipment required, an adequate number of staff who are capable of providing a good service (Reagon et al., 2003).

Poor health care service can result in the development of negative attitudes by those who need to access the clinic for these services and can cause a barrier to accessing health care services because bad experiences impact negatively on future decisions to seek health care (Prince et al., 2016). This is also enforced in

the view of Van Rensburg (2012), that shortfalls, backlogs, inequalities and disparities still remain a characteristic of South African health care, resulting in poor service which is startlingly unequal, inequitable and inaccessible for certain groups, despite the claim of being theoretically accessible to all.

In the light of these factors, improvement of health care services should be founded on viable management structures and systems capable of supporting functions in a sustainable way (Van Rensburg, 2012). Ijumba ...[sa:14] also adds that enabling managers, and providing supervision that increases staff morale and motivation, and addressing issues related to structure and process will solve problems.

- **Marketing of health care services**

In an Employee Health and Wellness Programme, marketing can be seen as a communication strategy that is used to reach out to the employees regarding services that are rendered or available at the clinic. According to National Core Standards patients are given information on services and the time these services are available, key service areas are clearly signposted (National Department of Health, 2011). Communication is further defined as exchange of information and a cornerstone of every patient-practitioner relationship. It is essential that the practitioner must share as much information as possible to make the patient feel informed (Ross & Deverill, 2012).

In a study conducted in the Netherlands, 40% of undocumented women cited a lack of information as one of their personal obstacles in accessing care because they were not informed about their entitlement (Schoevers et al., 2010). This means that without information and knowledge on health care services offered at a clinic, accessibility to health care can be hindered and limited resulting in low or no utilisation.

Before the information can be presented to the potential health care users it has to be packaged in a particular way. Ross and Deverell (2012:79) highlight that “for communication to be effective it needs to be clear and understandable” − this is where the term “marketing” comes into play. Marketing is defined as the process of planning and executing the conception, pricing, promotion and distribution of ideas,

goods and services to create exchange that satisfies individual or organisational goals (Lamb, Hair, McDaniel, Boshoff & Terblanche, 2008:77).

One of the most effective marketing strategies that has been utilised to promote access to information is social marketing. According to Jacobs et al. (2011), social marketing is concerned with the use of marketing tools, concepts and resources to encourage positive behaviour change among those that are underserved. Social marketing has also been used by many health promoters to promote condom use (Jacobs et al., 2011).

The Gauteng Department of Health employees need to know what services are offered at the Wellness Clinic, but first they need to know if the Wellness Clinic exists in the first place. Due to the fact that employees come and go, some resign, retire, or are newly employed, some are transferred and so forth. The only way for them to know that there are services available at their doorstep is if they are informed about the Wellness Clinic and its services. The fact the clinic has been relocating from one building to the next makes it difficult for the employees to access it, as some of them are not aware of the relocation, hence marketing of the Wellness Clinic is important.

According to Rendall-Mkosi (2013:173) effective communication is central to all health related services, be it between co-workers, health care workers and the health beneficiaries. This communication may be in different forms, for example printed pamphlets, spoken messages from health care workers, TV programmes or messages embedded in stories (Rendall-Mkosi, 2013:173).

For employees to access the service they need to have knowledge of the services that are rendered at the Wellness Clinic. This can be done through health promotion days or through one of the aforesaid communication methods (Schoevers et al., 2010). Without the use of the mentioned communication means, employees may not be able to access the wellness clinic, not because they don't want to, but it could be due to lack of information regarding the clinic and its services. This takes us back to the research conducted in the Netherlands where 40% of undocumented women couldn't access health care services because they lacked information and were poorly informed about their rights to access health care (Schoevers et al., 2010).

To enable effective communication the health-care workers need to be able to express themselves clearly both in writing and verbally, as well as knowing the correct channels of communication, who to contact and when (Dennill et al., 1995:135). It is very important to communicate clearly who the clinic serves, because some employees may assume that the Wellness Clinic is just like any community clinic that is characterised by the same challenges as those of the public clinic, such as long queues, staff attitude, lack of medication and bad service. This can bring about negative attitudes, negative perceptions that can be invoked by past experiences from local health care services resulting in a barrier to access the clinic.

2.6.6 Health promotion

In the preceding section the researcher emphasised the importance of communicating the services that are available at the Wellness Clinic though the use of marketing. Marketing alone is not enough and cannot serve as the sole vehicle to motivate employees to access the employee Health and Wellness Clinic. But employees need to be conscious of their health and the importance of taking charge of their own health for them to reach out to health care services (Dennill et al., 1995).

Taking into consideration the definition by the World Health Organization that "… health is more than just the absence of disease, it is a sound condition of human beings which encompasses not only physical but also social and psychological wellness" (WHO, 2001). This means seeking help should not only be on the basis that one is ill, but most importantly, to prevent illness beforehand. This can mostly happen if employees are in charge of their health.

In this section the researcher will look into how valuable promoting access to health care is. In the context of this study, health promotion refers to activities that the Gauteng Department of Health Central Office Employee Health and Wellness Clinic uses to ensure that employees are health conscious and taking charge of their own health.

WHO (1987:12) defines health promotion as:

> … the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize

> aspirations, to satisfy needs, and change or cope with environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept, emphasizing social and personal resources, as well as physical capacities, therefore, health promotion is not just a responsibility of the health sector, but goes beyond healthy lifestyles to well-being.

Looking at the definition by WHO of health promotion, the first part refers to "the process of enabling people to take control over their health" (WHO, 1987). This is where the gist of definition is because the definition does suggest that people must take charge of their health, but they must be enabled to do so. According to Yeo (1993:233) "… enabling is based on the idea that in order to realize freedom and assume greater responsibility for their health, individuals may require help in the form of knowhow, resources and power to assume greater control."

Furthermore, to enable "is to assist, empower or support individuals or a group of people, to gain power, knowledge and skills in health matters" (Gauteng Department of Health…[sa:14]).This is where the Employee Health and Wellness Programme fits in, to provide the needed guidance and to enable health promotion. The WHO is concerned to "build healthy public policy and create a supportive environment" (Dennill et al., 1995). Also, Health Promotion supports living and working conditions that are safe, interesting, satisfying (Gauteng Department of Health…[sa:14]). Health and medical services must be re-orientated in order to meet consumer needs in a responsive and holistic way.

The Ottawa charter suggests that people must be assisted in leading a healthy lifestyle (Dennill et al., 1995). This can be done through three proposed strategies, i.e. Enabling − which deals with ensuring that equal opportunities and resources are distributed to ensure that all people regardless of their gender, race, or ethnicity achieve their full health potential (Randall-Mkosi, 2012:153). Also to empower people with knowledge, skills and attitudes so that they can make the right choices and pass these abilities on to others (Gauteng Department of Health…[sa:14]).

The second strategy is Advocacy − which deals with multifaceted conditions for achieving health favourably (Randall-Mkosi, 2012:153). To campaign, speak up for, and on behalf of, but most importantly to campaign for the healthy consumer and health itself (Gauteng Department of Health…[sa:14]). And lastly, Mediation − which

focuses on negotiating for, or intervening on behalf of and between groups that have power and influence and those that do not (Gauteng Department of Health…[sa:14]).

The study conducted by Gott and O'Brien (1990) encountered a frequent practice of referring to and interpreting health promotion and health education as one and the same. To support this view, Ewles and Simnett (1992) claim that without knowledge, people cannot make healthy choices about their own life. Health education evidently has been concerned about influencing health choices. The Gauteng Department of Health…[sa:14] adds that health promotion gives people access to information and education to improve their health and life skills. By doing so, it increases the choices available to people to take more control of their own health and their environments in order to make better health choices. For example, if people are educated about the signs and symptoms of a particular disease such as TB, they know that if they cough for more than two weeks then it's a reason for concern and they can therefore seek help to see if they have contracted TB.

Rendall-Mkosi (2012) states that health promotion is concerned with the creation of a supportive environment by carrying out on-going assessment of the health impact of the environment on health. Enable personal skills by providing information, education for health, and enhancing life skills. Re-orientate health services by expanding the health service to reduce curative care and shift to more preventative and promotive activities.

The absence of a Health Promotion programme can cause a barrier to accessing health care because health promotion gives people access to information and education to improve their health (Gauteng Department of Health…[sa:14]).In the light of this understanding, if people are not educated or informed about how to take charge of their health, the chances are that they may not participate in health care services such as screening and prevention of disease programmes and may only access health care when it's too late. To add to this the GDoH. [sa:14] states that health care needs to concentrate on prevention of health problems so that they do not occur in the first place. The health promotion serves to highlight some of the more common factors likely to increase ill health (Ross & Deverell, 2012).

This signals that for people to access health care in their numbers, certain strategies have to be in place. Also, the more people are aware of their health the better the chances are that they will consult health care services.

2.7 OUTCOMES OF LACK OF ACCESS TO HEALTH CARE SERVICES IN THE WORKPLACE

From the researcher's point of view, once the said precautions are not taken into consideration to promote access to health care services, there are consequences that may lead to the collapse of services in the workplace by exacerbating community communicable and non-communicable diseases. This section focuses on those areas that exist as a result of lack of access to health care.

2.7.1 Absenteeism due to Illness

Absenteeism is leave without permission by an employee with the intention to return to work, for example if the employee is off sick (Nel, 2012). According to Watkins (2005:7) "absenteeism is when an employee is not physically at work." Anderson (2009:13) says it is failure of an employee to show up for work as scheduled. This could include, for example, being off sick, taking extended tea/lunch breaks, doing shopping during work time, absenting oneself without leave (Munro, 2007).Absenteeism is also referred to as a habitual pattern of staying away from work. These patterns may be an indication of the challenges with psychosocial, medical or social adjustment to the work environment (EHWP Annual report, 2015/16). Absenteeism in GPG is measured through sick leave taken; application for long and short ill-health retirement; number of death and chronic illness risks (EHWP Annual report, 2015/16).

The Basic Conditions of Employment Act (Act no. 75 of 1997) stipulates that during every sick leave cycle, an employee is entitled to an amount of paid sick leave, equal to the number of days the employee would normally work during a period of six weeks. The Basic Conditions of Employment Act further states that an employer is required to pay an employee if he/she is too ill to work, provided a medical practitioner's certificate of not being fit to work is produced. Persons employed by the state are entitled to 36 working days normal sick leave with full pay.

The Compensation for Occupational Injuries and Disease Act (1993) states that if an employee is unable to work due to an accident or occupational disease, as defined in this Act, then any period of absence should not be taken from ordinary sick leave but as special leave. This makes it difficult to capture the exact number of days that the employer has lost due to occupational injuries (EHWP Annual report, 2015/16).

Pillay (2009) emphasises how personal factors, such as ill health, appeared to be a leading cause for absenteeism in the workplace. Opponents of mandatory sick leave argue that it will ultimately cost business more money and lead to increased retrenchments of employees (Cost of loss in productivity, 2013).

It is well documented in Belita, Mbindyo and English (2013:44) that “absenteeism as a result of illness in the workplace is one of the key reasons of staff shortage.” The health of an individual is bound to affect how often and how long they are away from their workplace in high-income settings. Studies have often focused on musculoskeletal and psychological (stress or burnout) disorders, with HIV accounting for more than 50% of the absenteeism in 2014, adding to caring for relatives or a family member that is sick (Belita, Mbindyo & English, 2013:44).

A data set of services rendered through telephonic counselling in the GPG EHWP was collected and analysed in an effort to understand the driving factors behind the increased absenteeism and other threats to productivity (EHWP Annual report, 2015/16). In this report it was recorded that in the past three years there has been a gradual increase in relationship and organisational problems, as well as stress, trauma, and bereavement problems. These challenges were found to be similar in all GPG departments (EHWP Annual report, 2016/2017).

2.7.2 Effects of absenteeism due to Illness

Absenteeism remains one of the top organisational challenges that GPG employees are presenting (EHWP annual report, 2015/16). The researcher believes that absenteeism due to illness, or absenteeism in general brings about many challenges, among which are loss in human capital and loss of money for the employer.

This can result in poor service delivery, and poor service delivery may also result in service delivery protests which can bring about public disobedience, such as looting of foreign nationals' shops or even burning of schools, as it was in Vuwani (Limpopo) in 2014. To second this belief the EHWP annual report (2015/16) says absenteeism does not only pose an economic risk to the employer, it also threatens the capacity of the state to deliver much needed services. This section deals with such challenges that can bring about collapse of services.

In the 2015/16 EHWP Provincial annual report it is reported that the incidence of injury or acquiring of occupational disease on duty per se have direct and indirect economic implications for the employer. The direct implications include the cost of medical treatment, retraining of employees who need reasonable accommodation following an accident. The indirect repercussions may include loss of productive time, increased absenteeism, and cost associated with recruiting new employees as a result of fatalities.

2.7.3 Financial loss

The Gallup-Heathway's wellbeing index surveyed 94 000 workers across 14 major occupations in the USA. Seventy seven percent of the surveyed workers were found to have some chronic illness such as asthma, diabetes, high blood pressure and other non-communicable diseases, and the total annual cost related to loss in productivity totalled $84 billion (Cost of loss in productivity, 2013).

The Occupation Care South Africa (OCSA) supplied the information that absenteeism costs the South African economy between R12-16 billion per annum. OCSA further says that on average, 15-30% could be absent from work on any given day and one day's absence can cost a company up to three days' worth of salary (Managing absenteeism, [sa]:14).

More than R65 million was lost between the GPG departments in 2012 due to sick leave (EHWP annual report, 2015/16). The Gauteng provincial treasury presented a112% increase which is more than the double amount in 2013 (EHWP annual report, 2015/16). This means that a lot of money is still being lost through absenteeism due to illness. This money that has been lost between the GPG

departments could have been channelled to better use and improved service delivery.

2.7.4 Decreased productivity

Workers who are physically and emotionally ill, will fail to be productive in the workplace and will be unable to carry out more demanding jobs (Barnett & Whiteside, 2006:262). Services such as EAP are of importance in helping to prevent poor productivity and remediate an individual, and a lack thereof will result in low productivity (Kirst-Ashman & Hull, 2007:74).

Productivity in GPG is under threat as a result of absenteeism (EHWP annual report, 2015/16). The loss of skill due to death for the year 2014 and 2016 was in positions such as educators, health care workers, and general workers. The death of employees within the professional band, including nurses, general workers, senior administrative staff, social workers etc., has the potential to paralyse GPG efforts in delivery of quality service delivery to its citizens (EHWP annual report, 2015/16).

2.7.5 Loss of staff morale and burnout

As already relayed in the preceding section of this paper, with staff size being reduced, causing long working hours and days, there are fewer opportunities to recharge and relax and greater responsibilities for the remaining employees. Ultimately, these changes in the workplace dynamic could cause reductions in staff morale and increased burnout (Lee, Scheunemann, Hall & Pyne...[sa:14]). Staff burnout could lead to the following adverse effects in the work setting: high rates of illness, low staff morale, increased use of alcohol and drugs, lower career satisfaction, high staff turnover, reduced quality of services, and poor customer outcomes (Moore & Cooper, 1996).

Loss of morale and staff burnout becomes a big challenge to professions such as nursing and social work, because these professionals will end up being subjected to bordering other professions as is currently happening in some of the public health care facilities. For example, the professional nurse will have to juggle two jobs at the same time i.e. being a social worker and providing counselling for the patient who suffered a traumatic injury. This can compromise the service due to lack of

competency, when one is trained to be a social worker but ends up administering medication which they were never trained for.

Employees may also find themselves overworked and suffer burn out resulting in taking unplanned leave. And the implication on the organisation is that there will be reduced productivity due to low staff morale, employees might end up using their vacation or sick leave, leaving their posts neglected (EHWP annual report, 2015/16).

2.8 BENEFITS OF ACCESS TO HEALTH CARE SERVICE AND EHWP

In one study conducted by Sieberhagen, Pienaar, and Els (2011:33), "Wellness of an employee can influence the wellness of an organization according to the EHWP annual report for 2015/16:10 "when the employees' problems are identified they undergo counselling that ultimately restores their job functioning thus improving their productivity." There are benefits for the organisation that prioritises and ensures that the working environment is conducive to employee wellness, which in turn increases staff morale and optimal performance (EHWP annual report, 2015/16). This is precisely why this study is investigating the access to health care because there is a great benefit behind the access to health care and a danger associated with lack of access to health care. This section looks into some of the benefits that the access to health care services can bring about.

2.8.1 Reduction in absenteeism

Once employees are healthy, their quality of life will increase, bearing on the return on investment to the employer. Quality of life (QL) is an important component of wellness and consists of both mental and physical wellness (Clark et al., 2013:61). Quality of life is also associated with health status, health behaviours and wellness.

Absenteeism caused by illness is one of the major problems in South Africa, crippling the economy through sick leave. This can be addressed once the employer provides for those who are sick while on duty with a reasonable solution; so that when they get better, they can be reintegrated back to their rightful work stations rather than be totally excluded from work due to minor illnesses. Employees may take a day off to go to their own health care provider of their own choice. But if health care services are provided on site at the workplace employees may be attended to

while on duty without taking a day off and then resume their duties as soon as they feel better.

2.8.2 Increased employee performance and productivity

The former minister of Public Service and Administration, Mr. Masenyani Richard Baloyi, made it clear when he was quoted as follows: “The high value public servants of the future will be characterized by a capacity for balanced and healthy living to ensure efficient service delivery” (DPSA, 2008:28). The integrated approach to the Employee Health and Wellness Programme recognises the importance of individual health, wellness and safety and its linkage to organisational wellness and productivity in the public service (DPSA, 2008:32).

It is clear that the implementation of the wellness programme in the workplace has some return on investment to both the organisation and the employees, as it promotes job satisfaction and health benefits for the employees (DPSA, 2008:28). This provides a winning formula for both parties’ i.e. the employer and the employee because when the employee’s health problems are identified in the work-place they go to the Wellness Centre where they can undergo counselling or treatment that ultimately restores their job functioning, thus improving their productivity (EHWP annual report, 2015/16). The concerted efforts to assist distressed employees is GPG’s drive for enhanced productivity in order to ensure a systematic contribution to the Gauteng economy (EHWP annual report, 2015/16).

2.9 SUMMARY

The literature review revealed that a lot has been put in place to promote access to health care, but there is still more that needs to be done. The challenges to accessing health care have been in existence since the beginning of time and still continue to be a major cause of late help seeking and “unnecessary deaths” among others. In response to the challenges towards accessing health care, an International Conference on Primary Health Care called the Alma-Ata conference was held in Kazakhstan, USSR in 1978.

In linking the study to a theoretical framework, a biopsychosocial approach and primary health care approach are used in this study. The reasons that are discussed in this study and for choosing this kind of theoretical framework is to enhance access

to health care services through looking at the holistic approach to attending to the patient. The study further looks at the services provided by the primary health care clinic.

The Employee Health and Wellness Programme (EHWP) is discussed in this study as the main focal point on the Gauteng Department of Health Central Office employees. The outcomes of the lack of access to health care service in the workplace is described. Absenteeism and its effects come out strongly in the sense that it causes decreased productivity, loss of staff morale and burnout. In this chapter it was also revealed that there are benefits to accessing health care services and EHWP, some of which are the reduction in absenteeism, improved employee performance and productivity.

The following chapter will focus on the research methodology and findings from the study.

3. CHAPTER 3: RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS

3.1 INTRODUCTION

This chapter will focus on the research methodology of the study firstly, and secondly on the qualitative research findings. The research approach, type and design are discussed in detail, followed by the research population, sampling method and sample. Thereafter the methods of data collection, data analysis, and quality of the data, the pilot study and ethical considerations are discussed.

The empirical results will be presented in this chapter through a thematic analysis using themes and sub-themes that were generated from the data analysis. Verbatim quotes from the participant interviews will be used to support the themes and sub-themes and this will also be substantiated through the literature.

3.2 RESEARCH APPROACH

The qualitative approach is followed in this study. Qualitative research involves careful observation of participants and often includes interaction with participants, usually accompanied by extensive note taking (Gravetter & Forzano, 2006:147). In its broadest sense a qualitative approach refers to the “research that elicits participant accounts of meaning, experiences or perception” (Fouché & Delport, 2011:65). It also produces descriptive data in the participant’s own written or spoken words (Fouché & Delport, 2011). In support of this definition, Sharan (2009:39) adds that the qualitative approach focuses on the meaning and understanding of a process using purposive sampling and data collection done via interviews and audio recordings, as well as through observation.

The observations and notes are then summarised into a narrative report that attempts to describe and interpret the phenomenon being studied (Gravetter & Forzano, 2006:147). This approach is typically used to answer questions about the complex nature of phenomena, often with the purpose of describing and understanding the phenomena from the participant’s point of view (Leedy & Ormrod, 2005).

The choice of this approach was motivated by the nature of the problem being investigated. The researcher has planned to focus on and understand the challenges that are linked to perceptions, experiences and physical challenges hindering the employees from accessing health care services in the Gauteng Department of Health Central Office Employee Health and Wellness Clinic.

3.3 TYPE OF RESEARCH

Applied research was pursued, which Leedy and Ormrod (2005:43) refer to as being concerned with research projects which can inform human decision making about practical problems. This kind of research is also intended to answer practical questions and solve practical problems (Gravetter & Forzano, 2006:41).

In the light of these explanations, the researcher is not planning to "reinvent the wheel," but focus on the practical problem that is faced by the Gauteng Health Central Office employees regarding access to health care services at the Employee Health and Wellness Clinic. Once this insight has been gained, recommendations will be made available to the Wellness Clinic in order to improve access to health care. This is the key motivation behind selecting this method, that is, to improve access to health care once the sources that limit access to the health care services are identified.

The solutions are therefore anticipated to be practical and applicable, based on what the research subjects and the literature recommend. Because the end results of the study should close the gaps that have been hindering access to the Employee Health and Wellness Clinic they should thereafter improve the utilisation of health care services.

3.4 RESEARCH DESIGN

The case study design was followed, where a particular individual or event is studied over a period of time (Leedy & Ormrod, 2005). Creswell (2007) refers to a case study as being concerned with the exploration of a bounded system that is characterised by time, context and or place. The exploration and description of cases takes place through detailed, in-depth data-collection methods, involving multiple sources of information such as interviews, documents, observation of

participants and archival records that are rich in context (Fouché & Schurink, 2011 and Leedy & Ormrod, 2005).

Furthermore, Fouché and Schurink (2011) are of the opinion that qualitative researchers make use of case study designs to immerse themselves in the activities of one person or a small group in order to obtain an intimate familiarity with their social worlds and look for patterns in their participants lives, words and actions in the context of the case as a whole. The purpose of a case study is to assist the researcher in gaining knowledge about the specific social issue (Fouché & Schurink, 2011:321), therefore this design serves the direct purpose of the research.

In its broad sense the case study design looks at an overall view of what the researcher wants to achieve. To downsize this term to fit the study, the researcher elected to use the collective case study design. “A collective case study design involves more than one case, which may or may not be physically collocated” (Mills, Durepos & Wiebe, 2010) which Fouché and Schurink (2011:322) refer to as an instrumental case study, extended to a number of cases. Cases are chosen with the intention of comparing their concepts and theories. The researcher agrees with a notion cited in Rule and John (2011:7) that collective case study design can be used to explore a general problem or issue within a limited and focused setting. This design is meant to focus on building the theory as well as to test it. This theory may bring about knowledge that can in turn bring about an influence in policy development (Fouché & Schurink, 2011:321) in the entire Department of Health. The collective case study design was utilised and is also applicable because it deals with experiences, attitudes as well as the understanding that individuals have about a phenomenon.

Two groups of participants from the Gauteng Health Central Office employees, the first being those who have been exposed and received services from the Employee Health and Wellness Clinic and the second group of participants was the nurses who have worked at the Wellness Clinic for the minimum of a year. The data of nurses who work at the Employee Health and Wellness Clinic and the employees who have been at the clinic in the past six months will be triangulated.

The goal of this study is to explore the challenges that the Gauteng Department of Health Central Office employees face in accessing Employee Health and Wellness Clinic health care services. Therefore, adopting a collective case study design can assist in bringing the achievement of the goal of the study by investigating the challenges these two groups face.

3.5 RESEARCH METHODS

This section deals with steps that were applied practically to collect the raw data. The steps include the type of targeted population that the data will be collected from, the type of sample, as well as sampling methods.

3.5.1 Study population and sampling

3.5.1.1 Study population

The target population is defined as a group of individuals who share at least one common characteristic (Gravetter & Forzano, 2006:129). In support of this definition the population for this study shares a common characteristic, which is being employed by the Gauteng Department of Health Central Office, where 2000 employees are employed. The population includes all employees regardless of their nature of work, rank, position, qualification gender or background. The target population included people from this population who have utilised/accessed health care services at the Gauteng Department of Health Central Office Employee Health and Wellness Clinic.

The entire population of clinic staff, namely two nurses were included as key informants. Thus, they need not be sampled, as they make up the whole population of key informants at the clinic. Key informants provided the researcher with information and insights relevant to the research question (Leedy & Ormrod, 2015). In Strydom and Delport (2011:394) key informants are identified as experts in a particular field of interest. For the sake of this study, the field of interest would refer to providing health care services to the Gauteng Department of Health Central Office employees through the Wellness Clinic.

Furthermore, the Gauteng Department of Health Central Office is spread across three buildings in the Johannesburg CBD, namely the Bank of Lisbon Building

(BOL), 11 Diagonal St Building and The Old Reserve Bank Building (ORB). Thus, the researcher saw to it that there was representation of participants from each building in the sample to give coverage to the group dynamics that each building was faced with by employees accessing health care services at the Employee Health and Wellness Clinic.

3.5.1.2 Sampling methods and sample

The following sampling methods and techniques were used in this study. Firstly, non-probability sampling was used in this study to recruit participants, as the odds of selecting a particular individual are not known because the researcher does not know the members of the population or the size (Strydom & Delport, 2011:391 and Gravetter & Forzano, 2003:118). This method was chosen as the researcher does not work at the clinic and therefore had no idea of the number of employees who attend the clinic, but it is also crucial that whoever is interested in participating in the study should be given an opportunity to do so provided they meet the requirements set out by the researcher.

The type of non-probability sampling used was purposive sampling. In a purposive sampling, people are chosen for a particular purpose (Leedy & Ormrod, 2005:206) the researcher used his own discretion to sample the population that is composed of elements that contain most characteristic, representative or typical attributes of the population that serve the purpose of the study best (Strydom & Delport, 2011:391). This form of sampling is used in qualitative research. Participants and sites are selected that can purposefully inform an understanding of the research problem of the study (Creswell, 2007:79).

This type of sampling was also used to try and minimise study bias and to get as much information as possible. Bias is any influence, condition, or set of conditions that singly can distort data, (Leedy & Ormrod, 2005:208) and with this view in mind, the researcher is well aware that this kind of sampling may have created a bias, since the sampling was based on employees who have already accessed the clinic in the past six months. The reason for this was because the researcher believed that employees who have accessed the clinic in the last six months, had adequate and recent information, coupled with their experience, informed by the challenges

that they experienced and the perceptions they had before and after accessing the clinic. However, it also provided an opportunity to minimise the manipulation of data since the participants were not known.

The inclusion criteria for selection were as follows:

- Employees of Gauteng Department of Health Central Office.
- Employees/patients who have accessed the Gauteng Department of Health Central Office Employee Health and Wellness Clinic in the past six months.
- Employees aged 18 years and above.
- Employees of any gender, race, culture.
- Employees who were willing to participate in the study voluntarily.
- Nurses who work at the Gauteng Department of Health Central Office Employee Health and Wellness Clinic in the past year (only the key informants).
- Persons able to read and write.
- Persons conversant in English, Tswana, Sotho, Xhosa and Zulu.

To recruit participants, the researcher designed a poster inviting employees who met the criteria to participate in the study. The poster was placed at Central Office Employee Health and Wellness Clinic, as well as at other designated areas where it was visible to most employees within the Department of Health Central Office. Those who were interested in participating in the study were advised to leave their contact details in a sealed box that was clearly marked and placed at the inquiry desk at the Clinic. The researcher then collected the reply slips after two weeks. More than 30 reply slips were found in the box.

This meant that any of the 30 volunteers working at Gauteng Department of Health Central Office stood a chance of participating in the study, provided that they met the inclusion criteria:

Of the 30 replies, those who met the inclusion criteria had to be selected to represent each building. Thus **secondly, probability sampling** was used. Leedy and Ormrod (2005:199) refer to probability sampling as a sampling whereby the researcher can specify in advance that each segment of the population will be represented in the sampling. How accurately we can generalise the results from a

given sample to the population depends on the representativeness of the sample (Gravetter & Forzano, 2009:130).

To generalise the results of the study to a population, the researcher must select a representative sample (Gravetter & Forzano, 2009:130). After all 30 volunteers were brought together (in reply slips), the researcher followed stratified sampling. In stratified sampling the researcher samples equally from each of the layers in the overall population (Leedy & Ormrod, 2005:202). This is to ensure that the different groups or segments of the population acquire sufficient representation in the sample (Creswell, 2003:156 and Leedy & Ormrod, 2005:202).

Although in this study the representation was not done equally per building, due to the fact that one building hosts more employees than the others, nevertheless the researcher ensured that all Gauteng Department of Health Central Office buildings were represented. This was to try and avoid sampling error, which means a sample does not provide a perfectly accurate picture of its population (Gravetter & Forzano, 2009:437).

The geographical location came out strongly in the literature review as one of the barriers towards accessing health. The researcher believes that a full representation of each Gauteng Department of Health Central Office building could lead to interesting results and also allow the participants to speak on behalf of their own building regarding their challenges towards accessing health care services at the Gauteng Department of Health Central Office Employee Health and Wellness Clinic.

After the stratified sampling selection was concluded, the size of the sample was ten employee participants (two males and eight females), plus the two key informant nurses (two females), making a total number of twelve participants who were selected to participate in the study. Driedger, Gallois, Standers and Santesso (2006:1151), refer to a “minimum of 12 participants needed to create stability among the views in the sample.” All participants were given a copy of the informed consent letter to read through with the researcher and sign once everything was understood. Only then did the interviews commence.

3.5.2 Data collection

The data collection method that was utilised in this study is called a semi-structured one-to-one interview or open ended or guided interviews. Dicicco-Bloom and Crabtree (2006:314) define semi structured one-to-one interview as interviews that are organised around areas of particular interest, while still allowing considerable flexibility in scope and depth. Within the context of qualitative research, observation and interviewing are usually used to collect relevant data (Strydom & Delport, 2011:376). An interview is a social relationship designed to exchange information between the participant and the researcher (Greeff, 2011:364). An interview in qualitative research attempts to understand the world from the participant's point of view, to unfold the meaning of people's experiences, to grasp their lived world prior scientific explanations (Greeff, 2011:364). The researcher used an interview schedule with open ended questions to collect data. This was to guide the interview rather than dictate the process (Greeff, 2011:364). This method was of great help to the researcher, as he was able to probe for more information and it helped to connect with participants, thus gaining insight into their beliefs, experience, attitudes and views that they hold regarding the Gauteng Department of Health Central Office Employee Health and Wellness Clinic and its accessibility (Delport, Fouché & Schurink, 2011:352). A voice recorder was used to record the data, with the permission of the participants.

3.5.3 Data analysis

Patton (2002:43) states that qualitative data analysis is a process of transforming raw data into findings. This means that the raw data that has been collected through qualitative data collection methods is now reduced into small components to make sense of the findings. Of the same view Schurink, Fouché and de Vos (2011:397) describe data analysis as "the process of bringing order, structure and meaning to the mass collected data." The researcher supports the notion of unpacking the information to fit it into tangible facts that will make sense and illustrate the required changes that can be implemented to enhance the problem-solving strategies.

In attempting to analyse the data collected in the manner selected in the preceding section the researcher employed Creswell's model of data analysis and interpretation (Creswell,2007:150-155) as described and discussed in Schurink,

Fouché and de Vos (2011:403). The process of data analysis begins with preparing the data and organising the data. The researcher brought in all pieces of evidence collected during the interviews ranging from recordings, observations to field notes to start with the analysis.

- **Planning for recording of data**

The researcher planned a system to facilitate the recording of data collected, by colour coding the notes and descriptions according to their themes or sub-themes, defining categories for data analysis and planning for further data collection (Schurink, Fouché & De Vos, 2011:403). Secondly, the researcher used a voice recorder and took down the field notes afterwards and sometimes during the interviews.

- **Data collection and preliminary analysis**

Data analysis in qualitative inquiry necessitates a dual approach (Schurink, Fouché & De Vos, 2011:405). The first part involves data analysis in the field during data collection (Schurink, Fouché & De Vos, 2011:405). During this time the researcher was trying to capture the moments on the spot to ensure that proper data was gathered. This part of data analysis can be treated as pre-data analysis or the build-up since it is still in a "liquid form."

The second part of data analysis is also known as the office approach. The office approach may be conducted between visits to the field, prior to, as well as after, completion of data collections (Schurink, Fouché & De Vos, 2011:405). Generally, the office approach focuses more on pragmatics such assorting, retrieving, indexing and handling of qualitative data (Schurink, Fouché & De Vos, 2011:405).

- **Managing the data**

Managing the data is also known as the intensive data analysing phase. This is the first step in data analysis away from the data collection site (Schurink, Fouché & De Vos, 2011:408). In other words, managing data is a fairly mechanical process during which one gathers the entire material one has collected, and devises some or other system or files them Esterberg (2002:325).

At the early stage in the analysis phase the researcher organised the data into file folders, index cards, or computer files (Schurink, Fouché & De Vos, 2011:405). This might seem like an impossible task; however, the following guidelines extracted from Creswell's model of data analysis cited in Schurink, Fouché and De Vos (2011:408) was followed. This started with an inventory. Are field notes complete? Are there any parts that were put off to be written later and need to be finished, even at this late date, before beginning analysis? Are there any glaring holes that can still be filled by collecting additional data before the analysis commences? Are all data properly labelled with the notation system that will make retrieval manageable (dates, places, interviewee identifying information, etc.)? Are interview transcriptions complete? The researcher needs to get a sense of the whole.

The transition between field work and analysis discussed in the preceding sections is one point of transition between data collection and analysis, and transcribing interviews and notes (Schurink, Fouché & De Vos, 2011:405). When managing data, it is important to make backup copies of all one's data (Schurink, Fouché & De Vos, 2011:405).

Researchers are advised to put away one master copy somewhere secure for safe keeping (Patton, 2002:441). It is also wise to make copies of data that was collected, being certain to put one copy away somewhere for whatever reason so that it cannot be disturbed, lost or burned (Schurink, Fouché & De Vos, 2011:405).

Beside information getting damaged, it also important that information should be kept safe to avoid any leaks that may damage the reputation of the participants by exposing their identity. It is not only the collected data that must be kept safe. The consent forms that expose the names of the participants and their signatures must also be kept under lock and key. The voices in the voice recorder can easily be identified and be linked back to the participants ending in victimisation. Thus pseudonyms are allocated.

Field notes and interviews should be treated as the valuable material that they are. Protect them from damage or even theft (Schurink, Fouché & De Vos, 2011:405). The researcher placed the collected data and other study material into a lockable

Google account and iCloud where it will be kept at least 15 years, secondly a hard copy was also made in a form of a disc and stored in lockable safe box.

The researcher arranged the data in preparation for the actual analysis. The data was numbered according to the participant's pseudonym/fake alphabet names to protect their identity as stated in the consent form, until the last margin in preparation for the actual data analysis.

- **Reading and writing memos**

According to Kreuger and Neuman (2006:440) "memos are short phrases, ideas or key concepts that researchers write to themselves about the coding process, called analytic memos." After the sorting out and conversion of the data, the researcher continues the analysis by getting a feel for the entire database (Schurink, Fouché & De Vos, 2011:409). It is generally expected that the researcher will read the transcripts in their entirety, often several times to get immersed in the details, trying to get a sense of the interview as a whole, before breaking it down into parts (Schurink, Fouché & De Vos, 2011:409).

To the researcher, the first time of listening through the recordings gave a "foreign" experience in a sense that the researcher was worried and absorbed in how the interview was conducted and self-analysing and critiquing. The researcher then opted to do a pause and play to transcribe the interview verbatim. Then read through the verbatim account and started to familiarise himself with the data more thoroughly. The researcher made an extra pair of notes in the margins of the interview transcripts to start generating codes. The field notes were also added here.

- **Reducing the data**

Data reduction is the process whereby raw data is reduced into small manageable sets of themes to write into a final narrative (Schurink et al., 2011:409). Various authors argue regarding the definitions and description of coding and categorising. In this section the researcher will share some of the arguments that enhance the debate for categorising and coding.

- **Generating categories and coding the data**

On one hand Bogdan and Biklin (2007:173) argue that categorisation and coding can be regarded as two distinct steps. Coding is regarded as the identification and labelling of relevant topics of data, while categorisation involves reducing data to a small manageable set of themes in the final narrative (Schurink, Fouché & De Vos, 2011:409).

On the other hand, authors such as Flick,(2006); Kreuger and Neuman,(2006) and Grinnell and Unrau, (2005) argue that categorisation and coding are regarded as simultaneous activities, for example coding is a combination of identifying meaning units, fitting them into categories and assigning codes (Schurink, Fouché & De Vos, 2011:409).

In the light of the above arguments the researcher supports the view that says coding and categorising are intertwined, because to code the information one needs to break it down into categories such as abbreviations of key words, coloured dots or numbers (Schurink, Fouché & De Vos, 2011:409). The same applies to categorisation because information needs to be grouped into particular concepts, whether by means of naming them or underlining them (Schurink, Fouché & De Vos, 2011:409). In this case, themes were generated.

At this stage of data analysis, category formation represents the heart of qualitative data analysis (Schurink, Fouché & De Vos, 2011:409). It seems like the analytic process demands a heightened awareness of the data, focused attention onto it, and openness to the subtle, tacit under-currents of social life (Schurink, Fouché & De Vos, 2011:409).

Identifying salient themes, recurring ideas or language and patterns of belief that link people and settings together is the most intellectually challenging phase of data analysis and one that can be integrated in the entire endeavour (Schurink, Fouché & De Vos, 2011:409). The researcher broke down the data into smaller components, namely themes for analysis purposes by means of coding, and labelling in the margins.

3.5.4 Quality of data

Trustworthiness is established when findings reflect meanings by the participants as closely as possible (Lietz, Langer & Furman, 2010:444). The researcher utilised the four constructs of trustworthiness methods proposed and used by two prominent qualitative researchers, Lincoln and Guba (1985) that are described and discussed in Schurink, Fouché and De Vos, (2011:419). That is, transferability, credibility, conformability, and dependability because they are believed to reflect the assumptions of the qualitative paradigm more accurately.

- **Transferability**

Transferability is defined as an extent to which it is possible to generalise the data and context of the research study to the broader populations and settings (Terreblanche, Durrheim & Painter, 2006:91). Transferability is achieved by producing detailed and rich descriptions of contexts (Terreblanche, Durrheim & Painter, 2006:91). The researcher invited full representations of the population by ensuring that the sample is represented by different Gauteng Department of Health Central Office employees who are based in various buildings. This was designed to explore unique challenges that are experienced by employees as a result of the building in which they are stationed. For example, on one hand there are employees who feel that the Employee Health and Wellness Clinic being far from their workstations works at their advantage in terms of managing confidentiality and privacy. On the other hand, there are some who feel extremely disappointed at the location of the Employee Health and Wellness Clinic away from their work stations as it adds a danger to their lives. This makes it difficult to generalise findings based on a single building representation.

The transferability criteria in this study included solid results such as descriptions furnished with direct quotes from the participant's interviews as well as substantiation in the literature.

- **Dependability**

Dependability refers to a degree to which the reader can be convinced that the findings did indeed occur as the researcher said they did (Terreblanche, Durrheim & Painter, 2006:91). The researcher considers dependability as involving

scrupulous application of most of the research principles and ethical considerations such as the publication of the results to produce a true value of the study.

If by any means the results are suspected to be distant from the truth, an opportunity should be afforded to repeat the study to see if the results will come close to the original, provided the study is done with the same participants under the same circumstances. To further prove the dependability of this study, the researcher made use of a voice recorder and saved the recordings to make them accessible at any given point, as well as the semi-structured interview schedule to ensure uniformity of the interviews. The research is also logical, well documented and can be audited (Schurink, Fouché & De Vos, 2011:419), as the researcher saved all data, field notes and transcriptions, and thus left an audit trail.

- **Credibility**

Credibility deals with the question of "how congruent are findings with reality?" (Shenton, 2004:64). Credible research produces findings that are convincing and believable (Terreblanche, Durrheim & Painter, 2006:91). In the researcher's view this is the kind of proof that should go beyond reasonable doubt. The relationship between the true reflection of the research and the reality of what was investigated must tally.

The researcher interviewed 12 participants, all with personnel (employment) numbers as proof that they work for the Department of Health Central Office. Prior to the interviews the researcher visited the potential participants at their work stations unannounced to make sure they were still willing to take part in the study and to schedule appointments. A voice recorder was used for all 12 participants during the interviews and they were guided by the semi-structured one-to-one interview schedule. In addition to that, the interviews were transcribed verbatim. This enables anyone (permitted) to take a transcribed interview to match it with the voice recordings of the interview to test the credibility and trustworthiness.

Although resources can be limited to produce the identical results, it must reflect the reality of what was being investigated and what was found after investigation. This is where the researcher used reflexivity to eliminate the exaggeration of results to fit in with the researcher's biasness, which will be discussed later in this study.

- **Conformability**

The concept of conformability is the qualitative investigator's comparable concern about objectivity (Shenton, 2004:64). It is said that in this regard steps must be taken to help ensure as far possible that the report's findings are the results of the experiences, views and ideas of the participants, rather than the characteristics and preferences of the researcher. Although it has been proven to be difficult in a qualitative study it must be able to be confirmed by another study (Schurink, Fouché & De Vos, 2011:421).

The researcher kept track of his feelings through the use of reflexivity awareness. Reflexivity involves deconstruction of who we are and the ways in which our beliefs, experiences and identity intersect with that of a participant (Lietz, Langer & Furman, 2010:446), by making use of a reflection journal to jot down feelings and supervision sessions, as well as the self-acknowledgement of holding the social work principles of allowing the diversity of the participants to play out without any hindrances.

The researcher's competence was also another edge in producing the true value of the study. The researcher is employed by the Gauteng Department of Health Central Office however, the researcher's duties at Gauteng Health is to coordinate the Tuberculosis (TB) programme at Central Office to all Gauteng Department of Health institutions such as hospitals, specialized services, colleges and district offices outside the Central Office where the study was conducted.

Member checking was one of the productive methods in promoting trustworthiness that the researcher applied in this study. The researcher opened up an opportunity for participants to either add important information that could have been left out in the interview or subtract unnecessary information, especially the information that could expose the participant to harm (Lietz, Langer & Furman, 2010:453).The researcher went back to participants after transcribing the interviews and interpreting of the data to check that the themes truly reflected what they had shared in the interview.

3.6 PILOT STUDY

A pilot study is said to be a try-out of a particular procedure, measurement instruments or methods of analysis (Leedy & Ormrod, 2005:110). This is done before the initial project or study commences. It serves as a skeletal review and offers the researcher an opportunity to reflect on the bigger picture of the entire study. Two participants, male and female were interviewed in the pre-test for the pilot study before the actual study could commence. The purpose of the pilot study was to investigate the feasibility of the initial study.

The researcher experienced a number of challenges during the pilot study. The first participant took an urgent call from her supervisor during the interview and was forced to leave during the interview, but came back later to finish it. This caused stress by the researcher. Following that challenge the researcher mentioned the name of the second participant of the pilot study during the voice recording, instead of using the pseudonym. The researcher was, however, more relaxed and able to pay more attention. The pilot study helped the researcher to make minimal adaptations to the questions in the interview schedule. The information gathered here merely provided direction to the main study. The lesson learned was to advise the participants to switch off their cell phones before the interview commenced and to also provide water to participants as the interview took more than 30 minutes per participant.

3.7 ETHICAL CONSIDERATIONS

To align this study with Social Work principles and values, the researcher upheld and adhered to the honesty and integrity of the profession, by ensuring that no harm occurred to participants during the study. This study is based on mutual trust, acceptance, cooperation, promises and well accepted conventions and expectations between all parties involved in the research (Strydom, 2011:113). The researcher underpinned the following ethical consideration to ensure compliance with research ethics:

- **Avoidance of harm**

It is considered a basic requirement for social research to avoid all keep physical harm to participants (Babbie, 2007:12). Even though it is not possible to avoid harm

completely, the researcher ought to try his or her best to ensure that physical harm is avoided (Babbie, 2007:12).

Considering the abovementioned view, the researcher ensured that interviews were held in a boardroom which was a safe environment with privacy and confidentiality. The researcher thoroughly informed the participants of the content of the study to ensure that they understood what they were involving themselves with and signing consent for. This is to ensure that emotional harm that may occur during the study is kept at a minimum once participants know the risk.

The researcher had a plan in place in case emotional harm occurred, that is, to refer the participants to the Department of Health (GPG) external service provider Care Ways for counselling if needed. Luckily in this study no harm was experienced and the need to refer the participants to ICAS was eliminated completely.

- **Informed consent**

No participant was coerced into participating in this study. Informed consent was obtained from all participants to take part in the study (Neuman, 2003:124). It was stated in the letter of informed consent that the participation was voluntary, and that participants had the right to withdraw from the study whenever they felt uncomfortable. Graventter and Forzano (2008:108) also agree that informed consent requires the investigator to provide all available information about a study so that an individual can make a rational decision to participate in the study. The letter of informed consent consisted of the following information as extracted from Leedy and Ormrod (2005:101):

- A brief description of the nature of the study.
- A description of what participation will involve in terms of activities and duration.
- A statement indicating that participation is voluntary and can be terminated at any time without any penalties.
- A list of any potential risk that a participant may encounter.
- The guarantee that all responses will remain confidential.
- An individual or office that they may contact, should they have a concern about the study.

- Interviews will be recorded.
- The data will be stored for 15 years.
- A place where the participant should sign indicating agreement to participate.
- Only once the participant(s) have signed, will the interview commence.
- There will be a separate letter for nurses and for the employees as discussed in the data collection section.

- **Violation of privacy/anonymity and confidentiality**

Under no circumstances should a research report, either orally or in writing, be presented in such a way that others become aware of how a particular participant responded or behaved (unless permission is granted by that particular person) (Leedy & Ormrod, 2005:102). This point had already been emphasised in the preceding sections. For the sake of this study the researcher ensured the information was handled in a strictly confidential manner, the same goes for the publication of findings. No participant's name appeared in any of the responses. Participants were given pseudonym/fake alphabet letter names such as participant Mr. A or Ms. B and their original identifying information was not used. The information was be kept under lock and key for quality control purposes.

- **Voluntary participation**

Participants were fully aware that participation was voluntary and that there would be no compensation awarded for participating in the study. The participants were also informed that they were free to withdraw from the study whenever they experienced any discomfort as advised in the consent form. If participants were coerced or misled into participating in the study, the results could be skewed in a certain direction, and not be a true and unbiased reflection of the study. In this study the researcher applied the principle of giving brief information as to what was to be studied, without giving too many details of the goals of the study (Strydom, 2011:116), to make sure that participants knew what they were committing themselves to.

- **Debriefing of participants**

Debriefing is done at the time during which the research participants are afforded an opportunity after the study is completed to work through their experiences and

the consequences that come with it, and where they can have their questions and misconceptions corrected (McBurney, 2001 cited in Strydom, 2011:122). The researcher utilised the debriefing session after the interview to rectify any misconception that may have occurred in the minds of the participants during the study (Strydom, 2011:122). Participants were given an opportunity to share their thoughts and experiences to get their questions answered with facts and have misconceptions removed. Fortunately, there were no signs of trauma at play during these debriefing sessions.

- **Publication of the findings**

The researcher holds a view that the publication of the findings is one of the key elements of the research. This is where the work that has been done is unleashed into the public domain for the respondents, colleagues and even those that are affected by the outcomes to peruse, so that the needed changes as recommended in the paper can be initiated. A manuscript will be sent to a scientific journal for possible publication. The report is available at the University of Pretoria library.

The researcher is ethically obliged to ensure that the investigations are done correctly and that no one was deceived (Strydom, 2011:126). In this study the researcher made sure that no participant's name was used or published when the findings were reported, to ensure that confidentiality and privacy is maintained. The researcher compiled the report in the form of a mini-dissertation, as accurately and as objectively as possible to eliminate fabrication and falsification of data (Strydom, 2011:126). It is available at the University of Pretoria library.

- **Researcher's competence**

The researcher is a professional social worker registered with South African Council of Social Service Professions (SACSSP), abiding by a code of ethics and thus is competent in conducting these interviews. He has completed a research project and report in the final year of his BSW Degree, as well as the research methodology module MWT864 of this programme and is thus knowledgeable of the research methods, with some research experience. The researcher will be supervised throughout the research study.

3.8 EMPIRICAL FINDINGS

In the research report, researchers synthesise their discoveries and findings for public consumption (Schurink, Fouché & De Vos, 2011:429). The report is thus a critical stage in the transformation of data into knowledge (Schurink, Fouché & De Vos, 2011:429).

This section deals with the presentation, analysis and interpretation of qualitative data that was collected through semi-structured interviews and voice recordings that were transcribed. The researcher will first introduce the participants through biographic profiling for both employees and nurses. The findings will later be repackaged into themes to allow for logical flow and to make sense through groupings of information before we can arrive at the conclusive results. This will be presented by means of a thematic analysis.

3.8.1 Participant' demographics profile

The following table displays the demographic profile of participant.

Table 3.1: Participant demographic profile N=12

Participant (pseudonym)	Gender	Medical aid holder	Building/work stations	Rank
Ms. AO	Female	Yes	Old Reserve Bank	Deputy Director
Mr. RM	Male	Yes	Bank of Lisbon	Library Assistant
Mr. B	Male	Yes	Bank of Lisbon	Admin Clerk
Mr. F	Male	Yes	Bank of Lisbon	Admin Clerk
Ms. V	Female	No	Bank of Lisbon	Admin Clerk
Ms. E	Female	No	Bank of Lisbon	Admin Clerk
Ms. P	Female	No	Old Reserve Bank	Admin Officer
Ms. T	Female	Yes	Bank of Lisbon	Admin Clerk
Ms. S	Female	No	11 diagonal	Admin Officer
MS. L	Female	NO	Bank of Lisbon	Admin Officer
Nurse A	Female	Yes	Old Reserve Bank	Professional Nurse
Nurse B	Female	Yes	Old Reserve Bank	Professional Nurse

The following pie charts provide a comprehensive analysis on the biographic details of participants as depicted in the table.

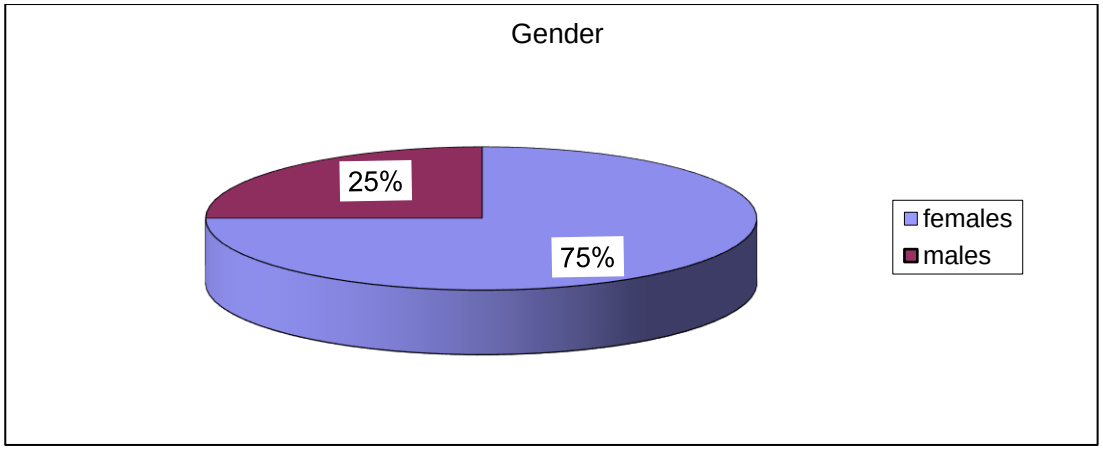

Figure 3.1: Gender (n=12)

The above pie chart indicates the gender of participants, with 25% male and 75% female including the nursing staff who work at the Employee Health and Wellness Clinic. The study targeted 50% participation per gender, but due to minimal interest from male participants, the numbers failed to balance. Studies comparing men and women are inadequate in explaining the process involved in men's help-seeking behaviour. However, the growing body of gender-specific information highlights a trend in men who delay help-seeking when they become ill (Galdas, Cheater & Marshall, 2005:616). The researcher can then conclude that these numbers are justified and maybe able to give an accurate representation of both males and females in the Department of Health in general.

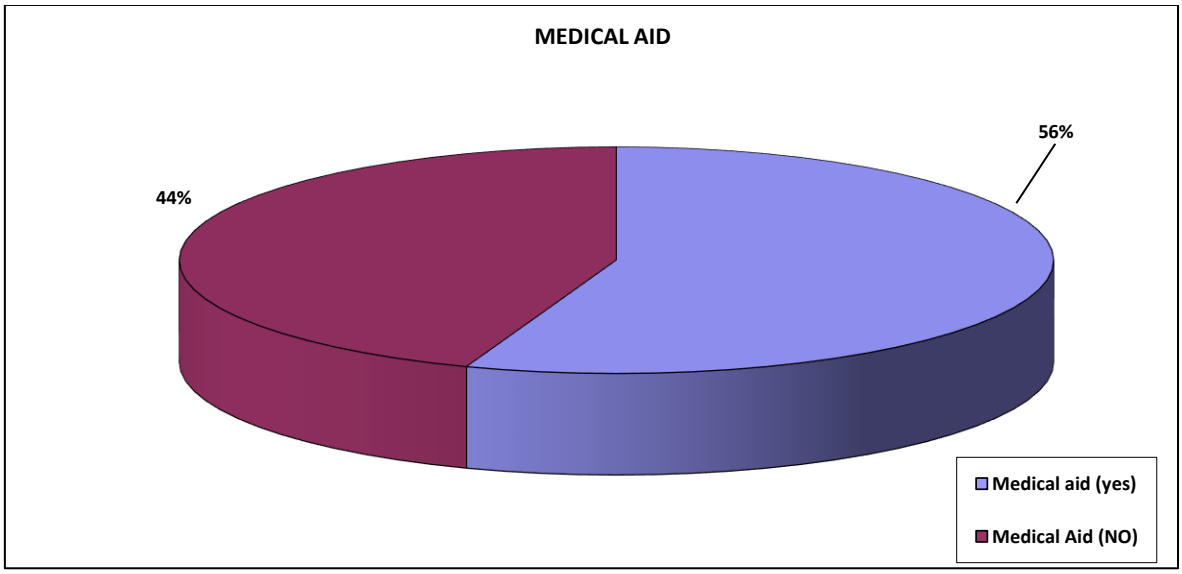

Figure 3.2: Medical aid (n=12)

Figure 3.2 depicts the number of participants that are on medical aid and those that are not. Of twelve participants, two were nurses who are included in the biographic profiling.

The reason behind this investigation was because the researcher wanted to establish whether the employees have any other option except the Employee Health and Wellness Clinic.

The researcher also wanted to deny or confirm the view that people who have medical aid do not use public health services. This notion was also highlighted in the National Health Plan of South Africa as prepared by the ANC (1994:16) that the private and public sectors are seen as being in opposition to each other. In the sense that health care services that are offered at private hospitals are a direct opposite of offerings in public health care facilities.

This investigation revealed that access to the Employee Health and Wellness Clinic has little to do with being a medical aid member or not. However, it must be emphasised that those who do not have a medical aid consider the Employee Health and Wellness Clinic as the only option for health care services some of the participants consider the public health local clinic as the second opinion. But given the fact that they have to absent themselves or put in for sick leave from work and endure the endless long queues at the local public health clinic makes it difficult to consider this option as a realistic solution for health care.

Medical aid beneficiaries have better options for accessing health care services as they are not limited and may consult private doctors or local general practitioners and private hospitals. However, they also have to take sick leave if they cannot take their lunch break consult a private doctor that does not have long queues as at the public local clinic.

The following demographic profiling deals with the number of participants per building as discussed in the previous section on sampling.

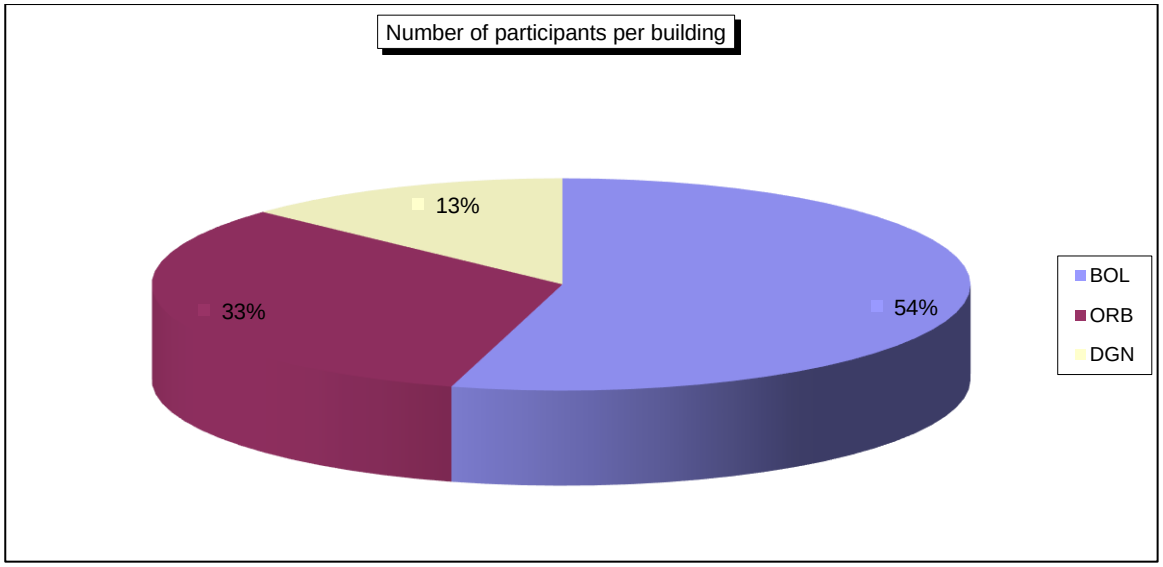

Figure 3.3: Building occupied by the participants (n=12)

Figure 3.3 depicts the estimated percentage of participants per Central Office building where they work. The reason behind selecting the sampling in this manner was to ensure that there was representation for every building occupied by the Gauteng Department of Health Central Office employees. It was also submitted earlier in this study that the Bank of Lisbon Building (BOL) is occupied by almost 80% of the employees and had 54% of the participants followed by 11 Diagonal Street with 13%. The Old Reserve Bank Building (ORB) has the smallest number of sampled employees but its sample was bigger than the Diagonal Street building as it was represented by 33% of the participants. The reason for a bigger representation from this building was because the key informant nurses who work at the clinic are based at the ORB. Bearing this in mind, the highest number of respondents that showed interest in this study were from the BOL building because it hosts the biggest population size hence the bigger sample. The ORB population showed the second highest interest in the study. This was directly opposite to the BOL because they have the least number of employees yet they have managed to attract the more respondents than the Diagonal building.

The following figure represents the demographic job profiling of the participants'.

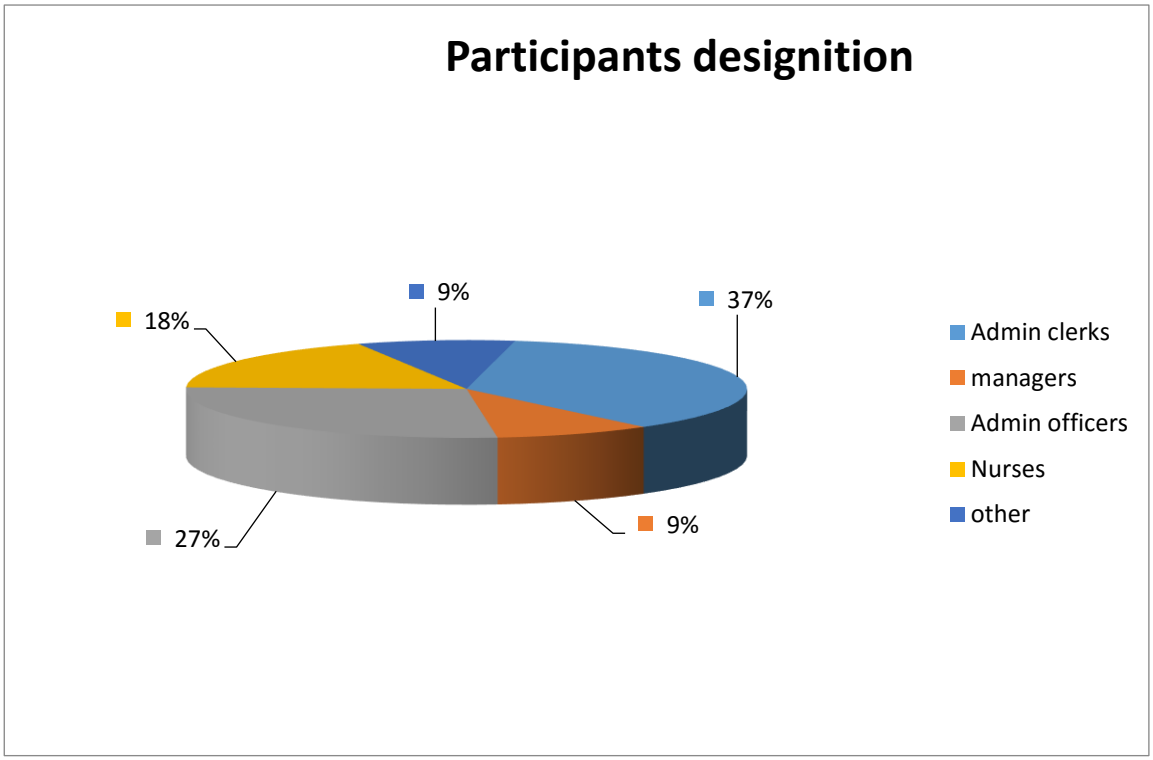

Figure 3.4: Participants' designation (n=12)

Figure 3.4 depicts the job profile of the participants in this study. In this illustration the largest group consists of 37% Administration Clerical personnel. Part of the reason for such a large percentage is that the Central Office is an administration office with more administration clerks than any other occupation; therefore most of the employees who participated in this study were administration clerks. The second largest group was comprised of administration officers at 27%. They are senior to administration clerks in terms of salary level.

The third largest group of participants at 18% included the two key informant nurses who work at the EHWP Clinic. The pie chart shows that managers comprise 9% of the sample. This is a true reflection of the minimal participation of managers in the wellness programmes in general, which is a grave concern. This will be discussed later. The researcher was happy to have had some representation from managers in order to obtain their views at that level. A further 9% on the pie chart was represented by a library assistant who brought another view to the study.

This profiling was meant to measure participation in representation by rank so that we can draw conclusions about the mostly likely patients to be seen at the Wellness

Clinic amongst the employees. Most importantly, this section was used to measure the level of attendance by supervisors and managers in terms of their numbers. In this study it has already been established that managers do not support the EHWP and the Wellness Clinic. This pie chart analysis supports this statement. Based on these results the researcher concludes that the Wellness Clinic is not fully supported by management. It must also be noted that this representation didn't form part of sampling and was done on a voluntary basis.

3.8.2 Themes and sub themes

This section provides a thematic analysis of the themes and sub-themes generated from the data that emanated from the interviews during data collection. The results will be discussed using direct quotations from the participants to support the themes and sub-themes. Literature substantiation was used to support these themes and sub-themes as a means of validating and strengthening the views of participants regarding the barriers towards accessing the Employee Health and Wellness Clinic by the Gauteng Department of Health Central Office employees.

Table 3.2: Themes and sub themes

Theme	Sub-theme(s)
1. Accessibility and/or a lack thereof	1.1. Access to health care options/opportunities 1.2. Supervisor's referrals to the Employee Health and Wellness Clinic v/s self-referrals 1.3. External challenges 1.4. Internal challenges 1.5. Structural challenges
2. Marketing	2.1. Knowledge about the Employee Health and Wellness Clinic 2.2. Advertising.
3. Management	3.1. Participation of management in wellness programme 3.2. Management Support
4. Recommendations	4.1. Marketing strategies 4.2. Way forward

3.8.2.1 Theme 1: Accessibility and/or a lack thereof

This theme is concerned with the options that the participants have to accessing health care, but more importantly the barriers that prevent employees from accessing the Employee Health and Wellness Clinic. These are described under sub-themes: Access to health care options/opportunities, external challenges, internal challenges and structural challenges.

Sub-theme 1.1: Access to health care options/opportunities

This sub-theme begins by revealing the number of participants who subscribe to a medical aid and those that do not. Figure 3.2 reveals that 56% have a medical aid, while and 44% do not. Out of the 56% that are medical aid members, 12% were the key informant nurses who work at the Employee Health and Wellness Clinic. This leaves the study sample with 44% as medical aid members and 44% without medical aid. The majority still prefer the Wellness Clinic for different reasons.

The following are some of the participant's views regarding being or not being medical aid members:

> I do not have a medical aid, but I have an option to go to my nearest local government Clinic, but due to the nature of my work…it would prove to be difficult for me to attend to the local Clinic during the day or in the morning. Because if I want to make it on time at the local Clinic I have to wake up as early as 4 am just to be attended at around 8am or 9am, hence the Wellness Clinic is the best option for me.
>
> I have a medical aid and I also have a family General Practitioner (GP), meaning I can make an appointment and attend to my GP without having to queue like it happens in the public hospital. But the Wellness Clinic is very convenient for me (Ms.AO).
>
> I have a special doctor for the condition that I am suffering from, and I also have Gems medical aid. But the reason I am attending the Wellness Clinic is because I noticed that the same services that are available at private hospital or doctor are the same services that are rendered at Staff Clinic (Mr. F).
>
> I have no medical aid and I have two options that I can use to seek help. On one hand I have my nearest local clinic that is characterized by long queues but at the end of the day I am able to get the medication, on the other hand I have the Wellness Clinic that has no queues and no medication (Ms. V).
>
> I don't have any other option except the Wellness Clinic because I don't have a medical aid (Ms. S).

The above quotations proved that having a medical aid or not, played a minimal or no role at all in ensuring that employees attended the Wellness Clinic because those

that do have a medical aid still attended the Clinic for various reasons including those that are quoted above. The Clinic is more convenient to most of the employees which is what was advocated in Reagan, Irlam and Levin (2003:IX), citing that it is important for services provided by the public sector are delivered in an equitable, effective and efficient manner.

Sub-theme 1.2: Supervisor's referrals to Wellness Clinic vs self-referrals

Management buy-in has always been a challenge when it comes to the Employee Health and Wellness Programme (EHWP) in general. The participation of supervisors in the Wellness Programme has always been low according to sister Zanele of the Wellness clinic.

This section therefore deals with the involvement of supervisors in referrals. Supervisors are seen as the first contact of the employees prior to accessing the Wellness Clinic, therefore the supervisors and managers are expected to advocate for the Wellness Clinic as a means of curbing absenteeism in the workplace due to illness.

This sub-theme reveals that out of the 10 participants who were interviewed, only two were referred by their supervisors, the other two were alerted by colleagues, and six of them were self-referrals. This means that the supervisors and managers who are supposed to be the first point of contact for the Wellness Clinic are either not aware of the Clinic or do not want to recommend it to subordinates. This creates a gap in the system because the supervisors need to account for the whereabouts of their subordinates during working hours, but should also to be able to ensure that their subordinates are healthy while on duty.
Some of the responses from the participants in this regard included:

> I was not referred by my supervisor, I heard about the Wellness Clinic from my colleague (Ms. P).
>
> I was advised by my supervisor when I fell ill (Mr. RM).
>
> I was referred by a colleague but my supervisor was also aware when I went to the Clinic but he did not play any role in influencing my decision to go to the Clinic (Mr. B).
>
> Very few patients/employees are referred by their supervisors, most are self-referrals (Nurse A).

> It was out of my own accord, but I mostly go to the Clinic for family planning (Ms. L).

The supervisor provides leadership, emotional and psychological support to his or her staff as a means of preventing worker burnout and to enhance motivation and job satisfaction (Lewis, Pakard & Lewis, 2007:12). With this view in mind the researcher believes that if the supervisors can encourage the help-seeking behaviour to their subordinates the Wellness Clinic would be much more popular and accessible because as far as this study is concerned the supervisors and managers are failing to encourage their subordinates to utilise the Wellness clinic.

Sub-theme 1.3: External challenges

External challenges are challenges that are physical and visible to the Gauteng Department of Health Central Office employees. Some of those challenges are dealt with in this section. The sub-themes that kept on "popping up" during the interviews included, the distance to the Clinic, the infrastructure, privacy, and lack of clean toilets.

Participants were very clear regarding the physical barriers that they had experienced before and after accessing the Clinic. The following reflect some of the participants' dissatisfactions:

> There were no challenges per se before accessing the Clinic because my work station is in the same building with the Clinic. I experienced challenges when I accessed the Clinic. The toilet is dirty and not user friendly, the confidentiality at the Clinic is compromised. When one is sitting at the waiting hall way he or she can hear what the consultation is about in the consultation room, hence when I go inside I speak in a very soft voice. I have notified the nurses about this and nothing is being done about it. I was diagnosed with urinary tract infection and the nurse told me to take urine jar and go to urinate in it at the toilets so that she can do the urine test. She admitted beforehand that the toilets are dirty so I needed to be careful. This made my experience horrific because the toilet exposed me to other infections; I suspect the toilet made my illness to prolong from healing (Ms. P).
>
> The problem with the Clinic is that it is too far from my work station (Mr. RM).
>
> The Clinic is too far, the distance was a challenge and I was not sure if they are well equipped to attend to my illness (Mr. F).
>
> I have experienced massive challenges (Ms. E).
>
> The Clinic is too far and the toilets are dirty (Ms. V).
>
> Before going to the Clinic I had to request for a permission from my supervisor and submit my work before hand, the clinic is far and being sick as I was it was

> very difficult to walk to the Clinic. When I finally arrived at the Clinic I had to wait for a long time because someone was being attended (Ms. S).
>
> The Clinic is awkwardly placed with no signage and distance is one of the key concern to most employees. Once the employees access the clinic more challenges become inevitable. The toilets are smelly like no body's business, the security guards are making noise, the facility itself is not encouraging, there's no privacy, the situation is appalling (Nurse A).
>
> The Clinic is not accessible to the majority of the employees; the clinic is located at about +-1.2 kilometres away from the employees work stations, the Clinic doesn't even have a basin to wash hands in between patients. This can easily cause cross infections and harm the employees (Nurse B).

The above findings provide the impression that most of the participants including the nurses do not think that the Clinic is physically accessible. This contradicts the findings recommended by Reagon et al. (2003:35), that the quality of the physical infrastructure is an important determinant of the functioning of services, and of client and staff satisfaction with the health services, because in this case nurses and employees, or service users feel that the infrastructure and more especially the toilets are in a bad state.

The distance challenge came out as one the most prominent themes. The Clinic is too far for most employees. Distance has the potential to limit accessing health care services (Huber et al., 2008:29). The geography of the health care service can pose access hurdles for people at risk (European Commission, 2008:47). The researcher noted that the distance issue is more of a negative attitude and behaviour problem, because all the participants interviewed, exaggerated the distance by more than a kilometre, when the actual distance is less than 900 meters as per google maps and WhatsApp location.

Sub-theme 1.4: Internal challenges

Most participants were worried about the privacy, confidentiality and about the public health service in general. Below are some of the responses gathered from the interviews in this regard:

> I fear that my health records may be leaked to other employees, I did not want my information to be up for public scrutiny (Mr. B).
>
> The fear of information being displayed from other employees (Mr. F).
>
> I always imagined our Clinic in the same light with the local public Clinics, with long queues (Ms. E).

> The distance to the Clinic always gave negative feelings (Ms. S).
>
> I was worried about opening up to a stranger about my illness (Ms. L).

Most respondents only developed a negative attitude after they had accessed the Clinic, compared to those who had negative attitudes by associating the Wellness Clinic with public health care. The fears that are expressed above are justified in a sense that employees do not really want to share their private life with anyone except professionals. If trust is not established with the professionals working at the Clinic it means that insecurities can create a barrier to accessing the Employee Health and Wellness Clinic again.

Experience, attitudes, and behaviour as well as beliefs, all form part of the internal barriers which impede access to health care (Falsca, 2011). Fear has created the negative attitude of most of participants towards accessing the Wellness Clinic. Attitudes towards health are described as pertaining to what people feel and experience regarding diseases and care, for example scepticism about care in public hospitals (Van Rensburg, 2012:10).

Sub-theme 1.5: Structural challenges

Almost all the participants including the nurses found the facility where the Clinic is based appalling and confronted with challenges such as being badly situated geographically, the privacy, dirty toilets, lack of running water or hand washing basins, as well as lack of emergency equipment and a shortage of serious medication. The following views were expressed during the interviews:

> The Clinic is too small, there's also a need for more staff to be employed at the Clinic (Mr. RM).
>
> I can't say the Clinic is fully equipped because there are few consultation rooms, to attend the staff which results in long waiting periods (Mr. B).
>
> My colleague went to the Clinic to consult, she was suffering from an ear and she was told to go buy her own medication, so the Clinic doesn't have medication (Ms. V).
>
> The Clinic is too far, the distance was a challenge and I was not sure if they are well equipped to attend to my illness (Ms. L).
>
> The Clinic is not well equipped because most of our equipment are packed away because we are not sure where to unpack it, the place is so small plus we don't even know when are we going to move to the next building (Nurse B).

> There's a lack of management support, I have been writing submissions to management regarding the challenges that were are faced with in this Clinic, but they don't even bother responding (Nurse B).
>
> We are unable to treat injuries due to lack of capacity (Nurse A).
>
> We don't even have telephones or basins to wash our hands (Nurse A and Nurse B).

Consultation rooms are considered adequate if they contained examination couches, working examination lights, hand washing basins with running water and soap, and both audio and visual privacy (Reagon et al., 2003:29). According to this definition, the Clinic is not adequate or fit to host patients because it does not have the listed requirements. This is not only causing the frustration of the patients, but also the nurses that work at the clinic. Although some of this equipment has been bought by the Gauteng Department of Health it is of no use if it is still packed away due to lack of adequate space at the clinic. Most participants felt aggrieved by the Clinic and its lack of resources to attend to basic patient health care needs. This can be linked to the biopsychosocial model as a restriction to patient care which results in other biological factors, such as illness that could and can be avoided if treated from the outset, but due to lack of resources the treatment may be delayed and result in unintended poor treatment.

3.8.2.2 Theme 2: Marketing

Without the knowledge of the whereabouts of the Clinic or the nature of services that are rendered at the Clinic it is difficult if not impossible to seek help at the Clinic. As recorded in the preceding sections, the Clinic has relocated from one building to the next since 2013, therefore most of Central Office employees have no knowledge of the current whereabouts of the Clinic, especially those who are not on chronic medication. This theme focuses on marketing or communication strategies and the lack thereof under the following sub-themes: Knowledge about the EHW Clinic and Advertising.

Sub-theme 2.1: Knowledge about the EHW Clinic

On the question of the Clinic's efforts to market the services that are available, the responses were:

> No, the Clinic needs to adopt the strategy of making sure that there are posters hanged on the lifts for the whole year to advertise the services (Ms. P).

> No, if the Clinic was in this building (BOL) we wouldn't even need those marketing strategies (Mr. RM).
>
> No it's not enough (Mr. B).
>
> Not at all (Ms. V).
>
> Not doing enough as someone who works at human resource directorate I always encounter staff members who are told to come to staff office to sign leave without pay forms. Some of these employees are junior staff members, they are not earning much. At one point I had to intervene and asked one woman who always had leave without pay. I confronted her and she told me that her child was critically ill and there's no one to take care of her at home so I have to absent myself to go take care of my child she said. As an HR Practitioner I advised her to make use of wellness, days later she came to thank me later cause her child was then referred to hospice through Wellness Clinic (Ms. E).

An overwhelming majority of participants believe that the Clinic is not doing enough to market its services. This turns out to be a barrier to accessing the Wellness Clinic. Crooks and Andrews (2009:45) state that realised access is concerned with solely characterising how a population actually makes use of the health care services available at a specific period. Without knowledge of the services, it will be difficult for employees to realise access to health care. Without realised access to health care services the employees of the Gauteng Department of Health are only subjected to potential access to health care services.

The participants were asked about their knowledge of the health care services that are rendered at the Clinic, with the following responses:

> I heard about the Clinic through the word of mouth from a colleague (Ms. P).
>
> There's no marketing happening, the only marketing that we know of is when there are awareness days and Wellness Days, such as World TB Day, World Aids Day, this kind of information is hanged inside the lifts. Even the people that are in this very same building where the clinic is are not aware of the services that are rendered at the Clinic (Ms. P).
>
> I heard about the Clinic from a colleague. The only thing I know of is Wellness Days (Mr. B).
>
> No at the moment I have no idea but I know about their events and I have also heard from a colleague that you can receive counselling at wellness Clinic but other than that I have no clue (Mr. F).
>
> I know they offer counselling, medical health, I heard about them from my supervisor (Ms. V).
>
> I heard about Wellness from the previous institution that I worked at, but not from Central Office (Ms. E).

> I don't know of any other services offered at the Clinic except for those that I go for, which is family planning or flue (Ms. T).
>
> NO it's even difficult to access condoms (Ms. S).
>
> I asked around about the Clinic (M.L).
>
> The wellness Clinic was only advertised when it was initially established back in 2009. The Clinic was advertised through intranet and pamphlets (Nurse B).

In light of the above quotes, the researcher concludes that the knowledge about the Clinic being available to Central Office employees is not coming from the Clinic per se but either from a colleague or someone who has been to the Clinic before. There could be more people who are not even aware that the Clinic exists. Rendall-Mkosi (2013:173) emphasises effective communication as central to all health-related services. It seems like the Wellness Clinic does not share this view and, even if it does, it is not doing enough to effectively communicate its services to employees, because only handful know about what services are offered at the Clinic. Those that know about the services were not informed by the Clinic but mostly by hear-say. This theme firmly confirmed that marketing through communication is a challenge.

Sub-theme 2.2: Advertising

This section looks at advertising as a sub-theme, with some of the views that were captured during the interviews:

> The Clinic is not marked at all from outside (Nurse A).
>
> At times you go to the Clinic and you find that it is closed without any notification (Ms. P).
>
> The Clinic is not doing well in terms of advertising, maybe it's because they are not well equipped so they don't want to raise expectations (Ms. AO).
>
> The Clinic has awkward operating hours which are not well communicated, for example in the afternoon is family planning and if you go during that time presenting with something different you will be turned away (Ms.AO).
>
> The only advertising that we do is through word of mouth to those that comes to the Clinic (Nurse A).

Rendall-Mkosi, (2013:173) says advertising includes different forms of communication, for example printed pamphlets, spoken messages from health care workers, television programmes, messages embedded in stories. None of these advertising methods has been used to communicate to the employees about the

Clinic. The participants found the lack of advertising as one stumbling block preventing employees from accessing the Clinic. This theme links with the biopsychosocial model because the model advocates that there is a need to communicate clinical evidence to foster dialogue (Borrel-Carrio, Sucbman& Epstein, 2004:576). Without communicating the services through marketing and advertising it will be difficult to encourage employees to utilise services that they are not even aware of. It is of vital importance that services that are rendered at the Wellness Clinic be communicated to the employees so that they can make an informed decision to access and utilise the Wellness Clinic.

3.8.2.3 Theme 3: Management

Management includes the top management at Central Office from the MEC for Health, the HOD, the CFO, Deputy Director Generals, Chief Directors, Directors and Deputy Directors. Over the past years, management has been seen to be compromised by a mixed bag of attitudes. On the one hand management has been seen to be pro-wellness, because it sought to have healthy employees who strengthened service delivery. On the other hand, EHWP coordinators have complained about a lack of management support at their respective institutions.

Sub-theme 3.1: Participation of management in EHWP

Management has been viewed in the past as using the EHWP as a means of wanting to punish employees. For example, employees who absent themselves from work for different reasons, including alcohol abuse, are referred to the EHWP as means of obtaining reports from them for management to use against these employees in preparation for labour relations suspension or dismissal of employees procedures. Thus, EHWP is not very popular as a result. Some quotes that reflect this are:

> Very few are referred by their supervisors (Nurse B).
>
> I'm not sure if my supervisor knows about EHWP (Ms. V).
>
> There are very few supervisors that come to our Clinic; if they do come they turn a blind eye to our challenges (Nurse A).
>
> I'm not sure I have never seen senior managers at the events (Mr. B).

Sub-theme 3.2: Managerial support

This sub-theme focuses on the extent of managerial support of the employees attending the clinic as well as the support by management towards the Clinic. The following are some responses:

> Very few are referred by their supervisors.
>
> There's no relationship between us and the management because we have not yet settled.
>
> There's no management support, we have written a submission to request the Pap smear screening, the submission have been sitting with the management for two months now without any feedback.
>
> The management has been turning a blind eye, because some of them have consulted at the clinic and they are aware of our challenges. For example, the administration block is smelly and they know about but it seems like they don't care.

Bezuidehout (2014:20) believes that participative management and quality circles are tools for enhancing excellence in health care settings. The lack of participation of management in supporting the Wellness Clinic makes it difficult for the Clinic to run adequately, which in turn causes employees to report having bad experiences. Once bad experiences are common, it becomes difficult for employees to go back to the Clinic to consult, hence they opt for alternatives to the Wellness Clinic. Some of these options may include staying away, defaulting or losing hope in the health care system. As illustrated in the biopsychosocial model, behaviour, thoughts and feelings may influence the health state (BMJ, 2018:324). If one thinks negatively about the health care system, that person has a greater chance of being demoralised about contacting a health care services centre until it's too late.

3.8.2.4 Theme 4: Recommendations

This theme revealed that accessing the Employee Health and Wellness Clinic comes with a lot of barriers that range from the location of the Clinic, the structural challenges, management of the department, marketing and advertising as well as the experiences held by health care service users. However, most participants still believe that the Employee Health and Wellness Programme is a solution for most of the Central Office employees and therefore they would rise above the challenges. That is, if few things could be put in place, over 60% of the participants said that

they would refer a colleague to the Clinic in future and that they would utilise the Clinic again in future should they require medical attention.

This section gives detailed responses from the beneficiaries of the programme who are the employees of the Gauteng Department of Health Central Office. The nurses, as the custodians of the programme, were also interviewed so that they could share their side of the story on how to make the Clinic more accessible and functional to employees. Their comments were integrated into this section. Some of the responses are recorded below:

Sub-theme 4.1: Marketing strategies

It was established that the marketing and advertising of the clinic and its services is very poor according to the participants. These are some recommendations given by participants on marketing strategies:

> Make use of desk drops, have pop up messages in our emails create awareness about the Clinic, put up daily notice in notice board (Ms. AO).
>
> Advertising by means of posters, and campaigns (Mr. RM).
>
> Make use of Facebook and posters (Ms. V).
>
> Make use of the intranet.
>
> Intranet and information giving (Ms. T).
>
> Flyers, door to door campaigns, memorandums, and road shows to do desk drops (Ms. S).
>
> Have an open day at the foyer of Bank of Lisbon building and have sort of a directorate to directorate's road show (Ms. L).
>
> Wellness campaigns on quarterly basis (Nurse A and Nurse B).
>
> Make use of staff bulk email (Mr. F).

Marketing is defined as the process of planning and executing the conception, pricing, promotion and distribution of ideas, goods and services to create an exchange that satisfies individual or organisational goals (Lamb, Hair, McDaniel, Boshoff & Terblanche, 2008:77). These methods can surely bring about the awareness among employees accessing the clinic. Different sources of marketing and adverting ideas were found in this theme. But most of the participants emphasised making use of posters and emails to market and advertises the clinic.

The use of the intranet was seen as vital, since everyone in the department is able to access the intranet, which is one of the biggest communication tools in the department. These are tried and tested methods that have been used before by departments to mobilise employees to attend campaigns and Wellness Days, including labour union meetings.

Sub-theme 4.2: Way forward

The following quotes show the ideas of participants on the way forward:

> Bring the Clinic to bank of Lisbon ground floor.
>
> Introduce the suggestion box to assist with improvements (Ms. AO).
>
> Have a settled environment with communication tools such as phones in case of emergency (Nurse A).
>
> To move to a place where most of employees are based like Bank of Lisbon, where there will be running water, a building where we can a crèche or kindergarten for employees children, have a food pharmacy whereby healthy food can be sold to employees and also have a gym to promote healthy life style (Nurse B).
>
> There should be more medication at the Clinic to cater for everyone (Ms. V).
>
> Relocate the Clinic and employ more staff, have more resources and offer more services (Ms. P).
>
> … bathrooms must be cleaned and have toilet papers, Improve the standard of privacy, have a pool phone were staff can call in to make appointments security guards at the Clinic need to be educated to respect the patients that goes to the Clinic and to keep their noise level at minimal (Ms. S).

Centralisation of the Wellness Clinic was on top of the list for most of the participants including those based in the same building as the clinic. Most participants feel that the clinic is not accessible, even though it offers free health care services. The state and condition that the clinic is in not acceptable, because there is no running water, the security guards at the clinic make a lot of noise making it difficult for confidential consultations and the toilets are smelly and dirty.

The participants agree with Reagon et al. (2003:29), that toilets for staff and patients are considered adequate if they have a hand washing basin with running water and soap, the same should apply to the consultation room. According to the participants the toilets are dirty, without soap and there are no toilets for disabled persons. The nurses also complained that there is no hand washing basin and running water in

the consultation room or proper lighting. The only solution is to relocate the clinic away from all these challenges.

This links with the BPS model, in a sense that it has created a gap in attending the patients/employees' holistic treatment, because the patient may come presenting with a different illness, but once they access the clinic, they may contract other illness. One participant stated that the lack of cleanliness of the toilets may have exposed her to other infections. This then tells us that psychologically the patients are affected, as well as physically and therefore the intervention should be from a biopsychosocial perspective. Secondly the lack of cleanliness may bring about other biological factors that are discussed in biopsychosocial model. These biological factors also include exposure to illnesses related to hygiene and cross infections because the nurses are unable to wash their hands in between attending to patients.

3.9 SUMMARY

This study is based on the qualitative research approach exploring, describing and confronting the challenges that are faced by the Gauteng Department of Health Central Office employees to access health care services at the Employee Health and Wellness Clinic. The research methodology was described first. This was followed by the empirical findings, discussed under various themes, which were generated from the data. These themes included accessibility and/or the lack thereof; marketing; management; and recommendations.

Accessibility or the lack thereof was based on looking at the things that enabled access to health care, and also at the limitations or the challenges that hindered access to health. It was then established that the geographic site of the Clinic was viewed by most participants as awkwardly placed and far from most of their work stations.

Marketing was summarised as not being as effective as it should have been, because most of the respondents in the study had never heard of the clinic or the services it rendered through any marketing strategies. They had mostly learned about it through word of mouth from colleagues and not from the wellness clinic itself.

Management support in the Wellness Clinic is considered poor for both the patients/employees and the nurses that work at the clinic. Very few employees are referred to the Clinic by their supervisors. In other words, most supervisors and managers are not encouraging employees to utilise the Wellness services. For the nurses at the Clinic managerial support is considered poor because the approval of submissions and requests to improve services at the clinic are being turned down without any valid reasons being provided.

The recommendations have been made by the employees and the nurses based on the identified themes. It was recommended that the Clinic be moved to a more convenient and accessible building. Some of the marketing strategies include making use of bulk emails, posters and Wellness open days. Managers and supervisors are encouraged to make use of the Wellness Clinic and also to establish the relationship with the Wellness Clinic so there is a link between the referrals and the clinic in order to maximise accountability and support to employees who are sick.

The next chapter focusses on the summary, conclusions and recommendations.

4. CHAPTER 4: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The previous chapter presented the findings of the study, as captured from the participants during the interviews which were transcribed verbatim. These findings were integrated with the literature in order to substantiate the findings. In this chapter the summary focusses on how the objectives and goals were met and how the research question was addressed. The key findings, conclusions and recommendations are then provided.

4.2 GOAL AND OBJECTIVES

The goal of the study was: to explore the challenges of accessing an employee health and awareness clinic by Gauteng Health central office employees. This goal was achieved through the attainment of the following objectives.

4.2.1 Objectives

Objective 1: To explore and describe all services offered in the Gauteng Department of Health Central Office Employee Health and Wellness Clinic

It was important for the researcher to establish knowledge pertaining to the kind of health services that are offered at the Wellness Clinic before examining the reasons regarding the access or lack of health care services offered at the Wellness Clinic. This was to discover if the services offered at the clinic are known to the employees or not, and to also understand if the services meet the needs of employees.

The literature review in chapter two assisted with the investigations regarding the type of services that should or should not be offered at the wellness clinic. The literature looked into employee health and wellness, the policy and legislation, health and wellness programmes and primary health care. Furthermore, it focused on the access to health care services and global trends regarding challenges accessing health care. The Employee Health and Wellness Clinic is classified under primary health care and the following services are offered at the EHWP Clinic; emergency medical and first aid services, management of injury on duty, needle stick injury, vaccinations, management of chronic conditions, family planning and

dispensing of medicine as well as offering counselling services through the external service provider.

Theme 1: Accessibility or a lack thereof, partly addresses this objective, by exploring and describing all services offered in the Gauteng Department of Health Central Office Employee Health and Wellness Clinic. It was divided into five sub-themes namely: Access to health care options/opportunities, supervisor's referrals to the Employee Health and Wellness Clinic v/s self-referrals, external challenges, internal challenges, and structural challenges.

The Biopsychosocial approach grounded this study because the study setting was at the Employee Health and Wellness Programme, Employee Health and Wellness Clinic. The findings showed three spheres were focused on by the Employee Health and Wellness Clinic, namely the bio or physical wellness, which is focused on under the medical clinic, also known and the Employee Health and Wellness Clinic, and the psychological and social, which is catered for under the EAP banner, (now known as Wellness Management). It is outsourced to a service provider known as Careways, which is also based at the Wellness Clinic. It was established in this study that access to health care is not only relating to physical challenge, but also the psychological and socio-economic. Hence the study focused on the biopsychosocial model and addressed these components in an integrated manner.

This objective was achieved from both the literature review and through findings in the themes discussed in chapter 3, where various aspects of the services were explored and described. The researcher became fully aware of the services that are supposed to be rendered at the Wellness Clinic and that the services that are offered at the Wellness Clinic are needed by the Gauteng Department of Health Central Office.

Objective 2: To determine the employees' awareness regarding to all services offered at the Employee Health and Wellness Clinic

The literature review was firstly consulted to assist the researcher in addressing this objective by contextualising the challenges that are hindering access to the wellness clinic by the Gauteng Department of Health employees and focused on the following topics: internal and external barriers to accessing health care services, outcomes of

lack of access to health care services in the workplace, as well as the benefits of access to EHWP health care services. The legal framework pertaining to wellness also formed part of literature review and the Department of Health was found to comply with the legislative framework. The biopsychosocial theoretical framework underpinning the study assisted with a better understanding of the phenomenon being studied.

This objective focused on the awareness of the participants regarding the services that are offered at the Employee Health and Wellness Clinic, as discussed in theme 1. Accessibility or a lack thereof, partly addressed this objective with five sub-themes namely: Access to health care options/opportunities, supervisor's referrals to the Employee Health and Wellness Clinic v/s self-referrals, external challenges, internal challenges, and structural challenges.

It was found that most of the participants in this study had no idea or had minimal knowledge of what services are offered at the Wellness Clinic and some only used the services when they were sick or when they needed their chronic medication. Some participants expressed a fear of the unknown, ranging from, but not limited to, being turned away for not falling under the category of who and what is the Clinic was equipped to treat. Hence, they decided to rather use other alternatives like private doctors. Lack of awareness was classified as one of the main reasons why there was a delay in seeking health care at the Employee Health and Wellness Clinic. These findings are discussed in detail in Chapter 3 under the themes that emerged from the study, as depicted in Table 4.1.

Participants emphasized that the awareness of the services offered at the Employee Health and Wellness Clinic was lacking, due to limitations in the marketing and advertising strategies.

This objective was achieved, as the study established that some employees know about the services that are rendered at the Employee Health and Wellness Clinic, but the majority of employees are not aware of these services.

Objective 3: To explore if the Employee Health and Wellness services are marketed sufficiently to encourage the employees to access these health care services

The theme on marketing, theme 2, addressed this objective. It was divided into two sub-themes, the knowledge about the wellness clinic and advertising of the wellness clinic. It was found that marketing forms a huge part of creating awareness about services rendered at the Employee Health and Wellness Clinic. The literature review showed that marketing forms part of a communication strategy and that lack of information was one of the major challenges towards accessing health care services. Participants confirmed that the services offered at the Wellness Clinic are not known to the employees, as a result of a lack of marketing and advertising strategies.

This objective was achieved, that insufficient marketing of the services of the Employee Health and Wellness Clinic was done, and participants were not aware of the services rendered. The key informant participants also confirmed that the last time proper marketing of the Employee Health and Wellness Clinic was done, was back in 2009 when the Clinic was first introduced to the Gauteng Department of Health Central Office employees.

Objective 4: To explore the internal and external challenges that the employees have of the services of Employee Health and Wellness Clinic

This objective helped the researcher to gain insight into the practical challenges that are faced by the Gauteng Department of Health Central Office employees, by exploring the internal, external and structural challenges in the Gauteng Department of Health Central Office. This objective was achieved by theme 1: Accessibility or a lack thereof, partly addressed this objective with five sub-themes namely: Access to health care options/opportunities, supervisor's referrals to the Employee Health and Wellness Clinic v/s self-referrals, external, internal and structural challenges.

External challenges, such as the geographical location of the Wellness Clinic. The infrastructure was poor, with the Employee Health and Wellness Clinic found to be awkwardly placed and far from most of the employees at Central Office. Structural organisational challenges, included the state of the facility (Clinic) to be appalling,

with lack of running water and dirty toilets. External challenges were the most dominant challenge of accessing the employee health and wellness clinic.

The internal factors included fear of the unknown, negative perceptions of the Wellness Clinic, bad experiences accrued from the Wellness Clinic, as well as a negative attitude towards public service in general. The negative perceptions about the Wellness Clinic were accumulated before and after accessing the health care services at the Wellness Clinic.

Management and organisational support, as found in theme 3: Management, was discussed under two sub-themes namely, participation of management in the wellness programme and management support for the Wellness Clinic. It was found that management participation and support was recorded to be low, with most employees referring themselves to the Wellness Clinic without the knowledge of their supervisors. The Wellness Clinic failed to implement some critical decisions, due to lack of management support.

This objective was achieved because the study was able to explore the external and internal challenges that the Gauteng Department of Health Central Office employees are faced with.

Objective 5: To make recommendations to the Gauteng Department of Health that will contribute to improved access to the Central Office Employee Health and Wellness Clinic

This objective was achieved through theme 4: Recommendations, with two sub-themes namely: marketing strategies and way forward to improve access to health care services. Practical recommendations were made, such as promotion of access to health care services at the Wellness Clinic by marketing and advertising the services offered at the Wellness Clinic and relocating the Wellness Clinic to a more accessible and convenient location.

4.2.2 Research question

The research question of this study was:

What are the challenges towards accessing an employee health and awareness clinic by Gauteng Health central office employees?

The research question was answered through the themes and sub-themes as discussed in chapter 3, and shown in Table 4.1 below:

Table 4.1: Themes and sub-themes emerging from study

Theme	Sub-theme (s)
1. Accessibility and/or a lack thereof	• Access to health care options/opportunities • Supervisor's referrals to the Employee Health and Wellness Clinic v/s self-referrals • External challenges • Internal challenges • Structural challenges
2. Marketing	• Knowledge about the Employee Health and Wellness Clinic • Advertising
3. Management	• Participation of management in wellness programme • Management Support
4. Recommendations	• Marketing strategies • Way forward

4.2.3 Limitations of the study

The following limitations were found in this study:

- This study focused only on participants who are employees of the Gauteng Health Central Office that have accessed the Employee Health and Wellness Clinic in the past 6 months. Thus, these findings cannot be generalised, but similar results could be expected from other province offices with similar circumstances.
- Participants could have included employees who have never accessed the Employee Health and Wellness Clinic, which could have yielded interesting findings regarding their opinion on barriers to access.

4.3 KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

In this section the researcher will discuss the conclusions from the research methodology, literature review and the key findings, conclusions and recommendations from the empirical findings. Thereafter recommendations for future research will be made.

4.3.1 Conclusions regarding the appropriateness of the research methodology

The nature of this study was a qualitative approach. This approach was utilised to assist the researcher in understanding the practical challenges that the employees of the Gauteng Department of Health Central Office have experienced when it comes to accessing health care services at the Wellness Clinic. This approach further enabled the researcher to understand the study phenomenon from the participant's own account of experiences and perceptions. Applied research was pursued because it is concerned with research projects which can inform human decision-making about practical problems. In this study access to health care is faced with challenges that need practical solutions, so that they can be resolved and therefore promote access to health care services.

The researcher used semi-structured one-on-one interviews to collect data. This method assisted the researcher to capture the needed information using open-ended questions and allowing the participants to express themselves freely. The interviews were recorded on a voice recorder with the permission of the participants to allow easy retrieval, data management and analysis. This also helped the researcher to generate the themes and sub-themes from all 12 interviewed participants.

Firstly, non-probability sampling was used because the odds of selecting a particular individual to participate in the study were not known. Purposive sampling was used, because the researcher used his own discretion to sample the population that is composed of elements that contain most characteristics, representative or typical attributes of the population that served the purpose of the study. Secondly, probability sampling was used, namely stratified sampling, to ensure the representation from each of the three buildings of the Department of Health Central

Office. This kind of sampling is mainly used to ensure that the different groups or segments of population are well represented.

After data was collected through semi-structured one-on-one interviews which were voice recorded, it was transcribed and analysed. In analysing the data this study followed Creswell's model of data analysis and interpretation. The quality of data was ensured through a process called trustworthiness, using constructs such as credibility, transferability, dependability and conformability and various strategies such as member checking and reflexivity to ensure trustworthiness. The research methodology that was applied in this study gave assurance that the quality of the study was of a good standard.

4.3.2 Key finding regarding the literature review of the study

It has been established in this study that the challenges towards accessing health care are not only fixed into physical, but also psychological and social barriers. The theoretical framework that was found to be fit for this study was the biopsychosocial theoretical framework, because it deals with the examination of three spheres that make up a holistic person, which is the biological/physical, psychological as well as the social and surroundings that people live or work in.

The theoretical framework assisted the researcher with the assessment and evaluation of the challenges that employees of the Gauteng Department of Health Central Office are faced with regarding access to the Wellness Clinic. In the literature review it was established that physical challenges had a direct psychological impact on the lack of access to Wellness Clinic, for example employees who felt that the geographic siting of the clinic was awkwardly placed and far from their work stations showed negative perceptions towards the clinic. In dealing with the challenges the researcher needed to look into both sides of the impacts.

The literature review indicated that access to health care services has been a challenge for many communities over many years to an extent that an Alma-Alta conference was called to address the access to health care services. Some of the challenges that were discovered in the literature include but are not limited to geographical allocation of the services, financial challenges, professionalism, and

infrastructure at the public health care institutions, negative perceptions and lack of proper medical care services.

The study concluded that the employees in Gauteng Department of Health Central Office are experiencing challenges in accessing health care services at the Wellness Clinic. It can be concluded that the literature used in this study showed a true reflection of what is experienced by the Gauteng Department of Health Central Office employees. The researcher can further conclude that the challenges that are experienced by the Gauteng Department of Health Central Office employees are not unique, as they are experienced in many countries according to the literature.

The next section will look into the key findings and recommendations of the empirical study.

4.3.3 Key findings and conclusions regarding empirical study

The following key findings and conclusions are discussed per theme as emerged from the empirical study:

4.3.3.1 Theme 1: Accessibility and/or a lack thereof

4.3.3.1.1 Key findings

- The study revealed that the EHWP is a well legislated programme which is in line with the highest rule of the law in the country, namely the Constitution. Anything that hinders employees from accessing health care service at their wellness clinic can be labelled unconstitutional. The literature review in chapter two found access to health care services in the workplace as one of the best returns on investment that the employer can achieve. Benefits such as increased productivity, high staff morale, reduction of absenteeism due to illness, improved service delivery, as well as cost containment were identified in this study.
- On the contrary, if access to health care while on duty is limited, the employer is bound to suffer the consequences of absenteeism due to ill health, which can directly cripple the employer financially and affect service delivery severely. Secondly, productivity and staff morale will decrease due to staff shortage and lack of skilled experienced workers who might be seeking health care services outside the workplace.

- Looking at accessibility, it was established that most participants showed disappointment because the clinic is awkwardly placed and characterised by many challenges, ranging from lack of signage to mark the clinic, poor infrastructure such as the state of the toilets, lack of running water and hand washing basins and lastly the geographical allocation of the clinic at a distance for most of the employees.
- The nurses and the employees who participated in the study, indicated that the clinic is not accessible to most employees and, for those who are able to access it, some of them do not come back for future consultations due to dissatisfaction, emanating from the noise that is made by security guards outside the clinic (this compromises consultation confidentiality as patients have to speak louder while in consultation rooms to overcome the noise coming from outside the clinic). Lastly, there is the poor state of the clinic toilets.

4.3.3.1.2 Conclusions

This theme investigated the accessibility of Employee Health and Wellness or the lack thereof. The investigation discovered that most participants showed dissatisfaction regarding Clinic accessibility. Even those who managed to access the Clinic divulged that they had a negative experience relating to the infrastructure at the Clinic, among others, dirty toilets and a foul smell in the rest of the Clinic. The nurses also confirmed that the Clinic is awkwardly placed and not accessible to a lot of employees.

The biopsychosocial model can be used to link to the psychological negative impact that in turn can result in biological harm because once the patient develops a negative attitude towards the health care service centre based on what he or she saw (dirty toilets) or struggles to find an awkwardly placed health care service centre, he or she may be reluctant to come back for a treatment follow-up as recommended by the health care practitioner thus prolonging the illness or causing further harm.

The Biopsychosocial approach is a dualistic view whereby the mind and the body influence each other (Borrel–Carrilion, Sucbman & Epstein, 2004:576) hence the mind and the body must be treated equally by removing the psychological or

physical barriers that may influence the mind otherwise in order for treatment of the body to take place.

4.3.3.1.3 Recommendations

The researcher recommends that:

- The Clinic must be moved to a central and accessible place where most of the employees can easily access it.
- The clinic must be placed in a more secluded area, far from support staff such as security guards, to ensure that the noise level from outside the consultation rooms is kept at a minimal level.
- The clinic must be fully equipped with medical equipment, good infrastructure, clean toilets and have clearly marked signage to inspire confidence in the health care users as well as the health caregivers.

4.3.3.2 Theme 2: Marketing key findings

On marketing and advertising the services that are offered at the clinic, the study revealed that the Clinic is not doing enough to market the services that are offered to Central Office employees. Some participants went as far as linking the lack of marketing of services to the geographical location of the clinic. The following quote was recorded from one of the study participants “if the clinic was in this building (BOL) we wouldn’t even need those marketing strategies.” Advertising of the clinic was also considered as non-existent, in another participant’s words “the clinic is not doing well in terms of advertising its services, maybe it’s because they are not well equipped so they don’t want to raise expectations.” This tells us that some of the employees do understand the reasons why marketing and advertising of the clinic is not at its optimal level.

4.3.3.2.1 Conclusions

Marketing of the Wellness Clinic was found to be inadequate, as reflected by the participants in this study. Most of the participants are not even aware of the services that are rendered at the Wellness Clinic and this is one of the reasons why they struggle to take the help-seeking step. The participants had built up their own narrative about the Clinic, indicating mostly negative attitudes. The Biopsychosocial

model can be linked to the emotional turmoil, and negative thinking may result in depression which is the most precise mental condition for most cases (Dogar, 2007).

Lastly the social sphere of the Biopsychosocial model deals with examining the social systems such as cultural, environmental and familial influences on the expression and experiences of illness (Dogar, 2007). The researcher holds the view that marketing of health care services has a way of moulding a positive thinking in patients depending on the product that is being marketed. For example, if the Wellness Clinic could market the counselling services and state that the counselling services are free, private and confidential, some of the employees who have been afraid to go to the Wellness Clinic because they thought their private life may be exposed to fellow colleagues may be motivated to attend and utilise the said services

4.3.3.2.2 Recommendations

The researcher recommends that Marketing and advertising of the Wellness Clinic should be done on a regular basis through some of the following strategies:

- Desk drops;
- Pop-up messages surrounding the clinic service;
- Wellness campaigns;
- Open days on a quarterly basis; and
- Posters to communicate the information about the clinic.

Ongoing activities that promote access to the health care services must be encouraged, given that single isolated promotions or initiatives with no follow up do not constitute a comprehensive approach to employee health and wellness.

4.3.3.3 Theme 3: Management

4.3.3.3.1 Key findings

The study established that Gauteng Department of Health Central Office management is not doing enough to support and encourage employees to utilise the EHWP service or the Wellness Clinic. The key informants also cited that support from management is at its lowest because most of the requests that they have made

to management to assist with the resources that are needed at the Clinic were turned down or ignored. The participation of management during Wellness days continues to be is very low. In this study, only one manager at the Deputy Director level volunteered to participate in this study. This reveals evidence of the lack of interest in Wellness Clinic related activities.

4.3.3.3.2 Conclusions

Given the evidence provided in this study, it is clear that the Gauteng Department of Health managers are not supporting the Wellness Clinic services, either by participating in wellness days, consulting at the clinic or encouraging their subordinates to utilise the Wellness Clinic. The biopsychosocial model emphasises the importance of a multi- disciplinary approach to ensure that holistic treatment is offered.

4.3.3.3.3 Recommendations

- It is recommended that managers be advised of the importance of the utilisation and access to the Wellness Clinic.
- Managers need to encourage their staff members or lead by example in attending the Wellness Clinic.
- Managers must support Wellness Clinic activities, including taking action of the requests that are made by the health caregivers at the Wellness Clinic.

4.3.3.4 Theme 4: Recommendations

4.3.3.4.1 Key findings

This theme discussed the recommendations by the key informant nurses and the employees. It was important that the beneficiaries and the custodians of the Clinic found a common ground in the midst of all the troubles that are discussed in the previous themes. One of the most important things that the researcher picked up in the entire study is that no matter how bad the experiences of those who had accessed the Clinic was, when they were asked if they would utilise the Clinic again, the answer was yes for 9 out of 10 participants. Therefore, their recommendations are of vital importance to ensure that the accessibility of the Clinic is promoted.

- The participants feel that the Clinic must be relocated to a centralised place where every employee will be able to access health care services. The toilets' cleanliness or lack thereof was another challenge that the participants felt must be resolved as soon as possible, to eliminate the horrible experiences that brings about doubtful follow-up visits.
- The noise that is made by the security guards at the Clinic is described as one of the most annoying challenges, an issue that is not only affecting the nurses, but also affecting the patients. The patients are obliged to speak louder while in the consultation room because the noise that is coming from outside makes it difficult for a sick person to speak softly, which in return compromises their privacy and confidentiality. The louder the patients speak the greater the chances are that someone outside may hear what they are consulting about. The participants are very clear that the security detail must be told to keep quiet at the Clinic immediately.

4.3.3.4.2 Conclusions

The clinic is awkwardly placed and out of reach for most employees. The noise that is made by the security personnel near the consultation rooms is annoying and creates a number of unethical challenges, such as compromising the privacy and confidentiality of patients as they have to speak louder inside the consulting rooms to match the noise that is made by the security guards. This can be linked to the Biopsychosocial model because it adds to the psychosocial challenges at the clinic. From this conclusion we learn that the environment is not conducive to providing proper care to employees who need private and confidential services due to the noise that is caused by security personnel outside the Clinic. This becomes a psychological problem because it causes negative thinking about the Clinic. The mentioned challenges may also result in patients who suffer from the so-called private illnesses such as STIs to stay away from the clinic due to fear of embarrassment that the clinic may cause them to reveal their illness during consultations, if the security personnel continue to be noisy, thus forcing them to speak louder about their illness which can then be overheard in the waiting room.

4.3.3.4.3 Recommendations

Given the facts presented in the findings of this study, the following recommendations are needed to deal with the barriers towards accessing health care services at the Gauteng Department of Health Employee Health and Wellness Clinic:

- The location of the Employee Health and Wellness Clinic should be central to all employees for easy access.
- Marketing and advertising of the Wellness Clinic should be done on are gular basis
- It is recommended that the Clinic should be relocated to an area where there is adequate infrastructure such as running water and good lighting.
- Management should make sure that a healthy environment is provided. The Gauteng Department of Health must promote access to health care services to ensure healthy working conditions for its employees.
- Managers and supervisors must form the integral part of health promotion in the Department of Health. Supervisors and managers must lead by example during the wellness days, they must assist in identifying employees that are not performing at their optimal level due to stress or any other work-related problems, continuous absenteeism due to illness, monitoring of sick leave utilisation. Such employees must be assisted through referral to the Wellness Clinic.
- The Clinic must create a pledge in a form of a poster declaring its confidentiality and privacy practices.

4.4 RECOMMENDATIONS FOR FUTURE RESEARCH AND POLICY

The study explored the challenges in accessing an employee health and awareness clinic by Gauteng Health central office employees. The study was limited to only the Gauteng Department of Health Employee Health and Wellness Clinic and Central Office Wellness Clinic, with the inclusion of those who had only accessed the Clinic in the past six months.

- A future study must be extended to the employees who have never accessed the clinic before, as well as to the other wellness centres within the Department

of Health. This will assist in identifying the challenges that are hindering employees from accessing and utilising the Wellness Clinic in the Gauteng Department of Health.

- These findings and recommendations will be made available to the Gauteng Department of Health Provincial Monitoring and Evaluation Directorate, as well as the Policy, Planning and Research Unit in order to influence the policy direction of EHWP in the Department of Health and subsequently elevated to the DPSA.

4.5 CLOSING STATEMENT

The access to health care services is faced with many challenges. Although a lot of work has been done to alleviate these challenges to accessing health care services, there is still a lot that needs to be done. On the 5th of September 2018 the Gauteng Department of Health, Bank of Lisbon building caught fire, resulting in the death of three fire fighters. The cause of fire has been linked to non-compliance with statutes, section 38(2) of Occupational Health and Safety Act, Act 85 of 1993 of the National Building Regulations and Building Standard Act, Act 103 of 1977 and section 4(1) of the Government Immovable Asset Management Act of 2007, which had all been contravened. As a result, the Democratic Alliance called on the Gauteng MEC for Health, Dr. Gwen Ramokgopa and the Gauteng MEC for the Department of Infrastructure Mr. Jacob Mamabolo to resign because this amounted to culpable homicide, claiming that their negligence had led to this tragedy (News 24, 30 October 2018).

These are some of the consequences that the departments are faced with for non-compliance with legislation. The challenge that the Gauteng Department of Health is faced with is the low utilisation of its health care services, which is linked to the state of the clinic facilities and the building it is housed in, as well as personnel's inability to access the services far from other buildings. The inability to access health care services was found to be due to lack of good marketing strategies, poor knowledge of the services rendered at the Gauteng Department of Health Central Office Employee Health and Wellness Clinic, poor infrastructure, and the geographical location of the Employee Health and Wellness Clinic.

It is important that the Gauteng Department of Health Central Office management must support the Employee Health and Wellness Clinic.

The Employee Health and Wellness Clinic should also encourage employees to make use of the health care services that are offered. The Clinic must also be marketed in all buildings of the Department of Health, and finally the clinic must be relocated to a more convenient and accessible location, to ensure that all employees are able to access the clinic and are able to utilise the services offered.

5. REFERENCE LIST

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6. APPENDICES

6.1 APPENDIX A: FACULTY OF HUMANITIES ETHICS APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

8 August 2017

Dear Mr Nkagisang

Project:	**Challenges towards accessing an employee health and awareness clinic by Gauteng Health central office employees**
Researcher:	**J Nkagisang**
Supervisor:	**Dr C Carbonatto**
Department:	**Social Work and Criminology**
Reference numbers:	**15254373 (GW20170502HS)**

Thank you for your response to the Committee's correspondence of 22 May 2017.

The **Research Ethics Committee** notes that the outstanding permission from the *Gauteng Department of Health* was submitted as requested and has therefore given **final approval** for the above application at an *ad hoc* meeting on 8 August 2017. 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 and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

cc: Dr C Carbonatto (Supervisor)
Prof A Lombard (HoD)

Research Ethics Committee Members: **Prof MME Schoeman (Deputy Dean)**; Prof KL Harris; Dr L Blokland; Ms A dos Santos; Dr R Fasselt; Ms KT Govinder; Dr E Johnson; Dr C Panebianco; Dr C Puttergill; Dr D Reyburn; Dr M Taub; Prof GM Spies; Prof E Taljard; Ms B Tsebe; Dr E van der Klashorst; Dr G Wolmarans; Ms D Mokalapa

6.2 APPENDIX B: GAUTENG DEPARTMENT OF HEALTH APPROVAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

University of Pretoria Ethics Committee

Re: Permission for research proposal

This serves to notify you that that the Department of Health grants permission for the research proposal of Thabo Nkagisang on " Challenges towards accessing an Employees Health and Wellness Clinics by Gauteng Department of Health" to be conducted amongst Gauteng Health employees.

Kind Regards

Dr Bridget Ikalafeng

Research and Epidemiology Manager

Date: 2017/02/01

6.3 APPENDIX C: LETTER OF INFORMED CONSENT

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work and Criminology

Researcher: Mr. Thabo Nkagisang
Contact: 079 502 5497
Email: thabojnkagisang@gmail.com

LETTER OF INFORMED CONSENT

TITLE OF THE STUDY: Challenges towards accessing an Employee Health and Wellness Clinic by Gauteng Health Central Office employees.

PURPOSE OF THE STUDY: To explore the challenges that the Gauteng Department of Health employees face in accessing Employee Health and Wellness Clinic health care services.

PROCEDURES: This document serves to inform you as a potential participant to make an informed decision to participate in the research study. Participation is completely voluntary and you can withdraw at any time you feel uncomfortable without any consequences imposed on you by the researcher. You will be expected to partake in a 30 minutes one-on-one interview session with the researcher and if need arises a follow up session may be requested. The researcher will use an interview schedule to guide the session with an intension to probe further. A voice recorder will be used with your permission to record the interview, for data capturing purposes. The focal point of the session(s) will be to explore the challenges that Gauteng Department of Health Central Office employees faces towards accessing health care services at the Employee Health and Wellness Clinic. The data will be stored for 15 years at the university as required for archival purposes and may be used again with your permission during this period for further research.

RISKS: You should note that there is a possibility that emotional discomfort may occur due to the fact that you may have to discuss your personal experiences as an employee regarding the challenges experienced in: 1) accessing health care services as an employee or, 2) providing the access to services as a nurse, at the Gauteng Department of Health Central Office Employee Health and Wellness Clinic. A debriefing will be held with you by the researcher after the interview, should you need a further counselling, an appointment will be organized with an external service provider (Procare) on site to provide a neutral emotional resolution and restore calm.

BENEFITS: You must take note, that there will be no financial benefits that can be expected from this study, however as employees of Gauteng Department of Health you may benefit

later in the study once recommendations are submitted to improve access to health care services at the Wellness Clinic.

PARTICIPANTS' RIGHTS: You may withdraw from participating in this study at any time during the interview and withdrawal from the study will not have any negative implications for you.

CONFIDENTIALITY: The data collected in this study using a voice recorder and field notes will remain confidential. No names will be mentioned, you will be given an alphabet letter as a false name to protect your identity and the data will not be linked to your name or identity. The results may be published in a professional journal or presented at professional conferences, but will never be linked to any of the participants identity.

I …… (Name and Surname) hereby give consent to

Participate in this research

I hereby declare that I was not coerced into participating in this study; I have read and fully understand the contents of this letter and by signing I agree to participate voluntarily.

Participant signature ……..Date……..

Researcher's signature ……..Date……..

6.4 APPENDIX D: INTERVIEW SCHEDULE FOR EMPLOYEES

INTERVIEW SCHEDULE FOR EMPLOYEES

1. Accessibility and/or a lack thereof

1.1 When last did you access to the Employee Health and Wellness Clinic? If you are a chronic patient, how long have you been attending to the clinic?

1.2 What other options did you have besides the EHWP Clinic? If there were others options besides Employee Health and Wellness Clinic, what were they?

1.3 Were you referred by your immediate supervisor or was it out of you own volition?

2. Internal and External challenges

2.1 Tell me about any challenge(s) have you experienced before you could access the Employee Health and Wellness Clinic?

2.2 Please tell me about your personal challenge(s) in accessing the Employee Health and Wellness Clinic

2.3 What about workplace challenges that you have experienced?

2.4 Does your supervisor encourage you and/or your colleagues to make use of the Employee Health and Wellness Clinic to access health care services? If not, are there any reason(s)?

2.5 What was your attitude about the Employee Health and Wellness Clinic before you could access it? If it was negative, why?

2.6 What is your personal experience in terms of the treatment from the staff at the Employee Health and Wellness Clinic?

2.7 According to your personal opinion, what would you like to see happening to curtail the barriers and the challenges that employees like yourself came across?

3. Structural challenges

3.1 How far is the clinic from your working station?

3.2 Is the building where the clinic is situated accessible?

3.3 Do you think the clinic is well capacitated to assist all employees that require medical attention? If yes, why do you think so?

3.4 Does the Employee Health and Wellness Clinic practice a privacy and/or confidentiality protocol?

4. Marketing of the Wellness clinic

4.1. How did you hear about the Wellness Clinic?

4.2. Do you know of any health care services that are provided at the Employee Health and Wellness Clinic?

4.3. Do you know of any marketing strategies that can be implemented to encourage employees to access health care services? If so, at what so at what stage can they be implemented?

4.4. Do you think the clinic is doing enough to market the services that are available for the employees?

5. Conclusion and Recommendations

5.1. Are you planning to utilise the Employee Health and Wellness Clinic services in the near future? If yes, why?

5.2. Would you encourage any of your colleagues to utilise the Employee Health and Wellness Clinic?

5.3. What steps do you think should be done to further improve accessibility to health care services at the Employee Health and Wellness Clinic?

6.5 APPENDIX E: INTERVIEW SCHEDULE FOR NURSES

INTERVIEW SCHEDULE FOR THE NURSES

1. Background information

1.1. How long have you been working at the Wellness Clinic?

1.2. How many patients and/or employees do you see per day?

2. Access to the clinic

2.1. Do you think the wellness clinic is freely accessible to the employees?

2.2. What could be the challenge(s)?

2.3. Have you received any complaint(s) in terms of access to health care services at the wellness clinic per se? If yes, please provide instance(s).

3. Internal and external challenges

3.1. What kind of challenge(s) have you encountered as a health care worker that hindered you from providing efficient and effective health care service(s)?

3.2. What sort of complaint(s) have you received from employees regarding access to Wellness Clinic?

3.3. What attitude(s) have you diagnosed from the employees as a result of the aforesaid?

3.4. Do you think the clinic well equipped to provide necessary health care services to the entire Gauteng Health Central Office employees?

4. Marketing of the programmes/Wellness Clinic

4.1. What steps have you taken in ensuring that Gauteng Health Central Office employees are aware of the services that are rendered at the Wellness Clinic?

4.2. What do you do to market the services to encapsulate staff access to health care services at the Wellness Clinic?

4.3. How often do you market the Wellness Clinic health care services?

4.4. What sort of marketing strategies do you have in place to improvise your services?

4.5. Are those strategies efficient and effective? If not, what kind of strategies would you like to implement in future?

5. Management support

5.1. How often do you attend to employees who are referred by their supervisors to seek health further attention?

5.2. Are you receiving any support from management to deal with access challenge(s) experienced by the employees? If yes, what sort of support have you received?

5.3. What sort of support will you need to render health care services at the Wellness Clinic?

6. Conclusions and recommendations

6.1. What improvement(s) would you like to see in terms of promoting access to Wellness Clinic?

6.2. What recommendation(s) would you like to make?

6.6 APPENDIX F: LETTER FROM EDITOR

Mrs J E de Wet
P O Box 781510
SANDTON
2146

8 February 2019

To whom it may concern

This is to confirm that I have edited the Master's dissertation entitled **'Challenges towards accessing an employee health and awareness clinic by Gauteng Health central office employees'** by Thabo J Nkagisang.

Please note that language, style, punctuation, spelling and paragraphing were the only aspects of the work that were edited and that no other alterations were made to the student's content in any way whatsoever. References were also edited in accordance with the style guide provided. I am not accountable for any changes made to this document by the author or any other party subsequent to my edit.

Yours faithfully

J E de Wet (Mrs)

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