

RESEARCH TOPIC

**THE MANAGEMENT OF
OCCUPATIONAL HEALTH AND
SAFETY SERVICES IN THE CLINICS
IN MAFIKENG AREA: NORTH WEST
PROVINCE: SOUTH AFRICA.**

BY

JOHANNES GABONEWE NTEBELE

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**Submitted in partial fulfilment of the requirements for the degree of
master of business administration in the graduate school of business and
government leadership in the faculty of commerce and administration
at the North West University: Mafikeng campus.**

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NOVEMBER 2004

ACKNOWLEDGEMENTS

The accomplishment of this study is the result of the generous and voluntary efforts of some special people dedicated to the concept of producing a comprehensive report on occupational health and safety.

Special thanks to the Almighty God, who has stood by me every step of the way through this study. By His Grace, I persevered and endured to enjoy the fruit of my toil.

Special thank also to my parents, Phineas and Ruth Ntebele (both of them are late), who have always encouraged me to pursue the route of education because this is a lifelong inheritance. Nothing would have delighted them more than to witness and share in my joy.

I also acknowledge the efforts and assistance of my friend Simon Molefe from Council for Geoscience: Mafikeng, in putting together information related to this study.

I am also indebted to the respondents to this study (i.e. the clinics' personnel in Mafikeng) who put away their valuable time to adequately complete the questionnaires sent out to them. You will be rewarded one time.

Above all my profoundest thanks to my fiancé Hetty Nkagisang Moletsane and my daughter Patience Ntshediseng Ntebele. You both have been my pillars of strength and your support has always been incomparable. You will always be on my mind.

Lastly let me say I am grateful to Dr. M. P. Maaga, my supervisor in this study. You have been my torch-bearer, leading the way throughout this journey. I appreciate your guidance a lot.

THANKS, GOD BLESS.

DECLARATION

I declare that the dissertation for the degree of Master of Business Administration at the North West University: Mafikeng Campus, hereby submitted, has not previously been submitted by me for a Degree at this or any other University, that it is my own work in design and execution and that all material contained herein has been duly acknowledged.

J.G. NTEBELE

ABSTRACT

The fundamental purpose of occupational health and safety is to avoid occupational diseases and injuries to the workers. Rendering these occupational health and safety services benefits the organisations in that time lost due to the worker(s) staying away from work treating the disease or injury is lessened. Productivity is also improved when the workers are healthy and working in healthy conditions. Lastly the organisations do not have to lose money in compensating the workers who have been disabled by the injuries and diseases sustained at work.

The purpose of this study was therefore to determine whether the occupational health and safety services were effectively managed in the clinics in Mafikeng area with special emphasis being to determine whether the occupational health and safety services were accessible to the health care workers in the clinics in Mafikeng area, whether the workers were benefiting from these services, and whether there was recording and reporting of the occupational diseases and injuries sustained by the workers to their employers for compiling valid and reliable statistical reports on them, and thereafter implementing appropriate remedial measures.

It is evident from the literature that global economic development of organisations revolves around offering effective and efficient occupational health and safety services to their workers. These workers should not only be taken as tools for production compromising their occupational health and safety. Disregarding this factor has unbearable socio-economic implications for the organisations, the workers, their immediate families and the country as a whole. Occupational health and safety for the health care workers should keep pace with developments around the world, to enhance their interest in their profession and their performance.

Structured questionnaires were used to gather information from the workers in the clinics in Mafikeng area. The study was a survey type and the method used for data collection was the structured self-administered questionnaires. A sample of one hundred and forty

(140) clinic personnel (clinic managers, professional nurses, enrolled nurses and enrolled assistant nurses), from a population of one hundred and fifty three (153) were selected at random.

The results of the study have indicated that the occupational health and safety services partially accessible to the workers in the clinics in Mafikeng area. Again only half of the respondents in the sample indicated that they benefited from these services. A large percentage of the respondents in the study indicated that there should be pre-placement medical examination of the workers, followed by periodic medical surveillance whilst the worker is still on duty and lastly exit medical examination when the worker retires or leaves employment.

Again what has been noted with great concern is the fact that occupational diseases and injuries are poorly recognised, poorly recorded and poorly reported. This could be attributed to fragmentation of the service and the legislation governing it. It has also come to light that there is lack of tracing of the source and cause of an occupational injury or disease to the type of work the worker is performing.

Much of the responses with regard to the findings stated above came from the professional nurses in the clinics, followed by the enrolled assistant nurses and lastly the enrolled nurses.

The following are some of the recommendations made based on what the study has revealed:

- ❖ Health care workers in the clinics should record and report work-related diseases and injuries sustained. This will enhance compilation of reliable and valid statistical reports, with a view to implement appropriate remedial measures.
- ❖ Managers of the occupational health and safety services should ensure at all times that the services reach out to all the workers in the clinics in Mafikeng, and that the workers benefit from these services in terms of being medically examined on regular basis and treated accordingly.

the workers benefit from these services in terms of being medically examined on regular basis and treated accordingly.

- ❖ Health care workers in the clinics in Mafikeng area should adhere to the legislation (Acts and Policies) governing occupational health and safety by adhering to the standard operating procedures in the workplaces.
- ❖ Fragmentation of the occupational health and safety services should be averted by drafting a common national policy encompassing all the departments dealing with occupational health and safety, such as Labour, Health, Mineral and energy Affairs, and Agriculture.

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CHAPTER 1

ORIENTATION

1.1 Introduction

Workers in South Africa spend at least eight (8) hours per day in formal employment in tens of thousands of factories, mines, on farms and in other places of work. Workers are often exposed to hazardous, and sometimes highly dangerous minerals, dusts, chemicals and other materials in the workplace. As a result of this, some of the workplaces remain hazardous environments that take a heavy toll on health and the economy in this country and other countries around the world.

Responsibility for the various aspects of occupational health and safety fall under a range of authorities and are governed by at least twenty-four pieces of legislation. These authorities include the Department of Health, Labour, Mineral and Energy Affairs, Agriculture, as well as the various provincial and local authorities. Their efforts are currently fragmented and insufficiently coordinated.

It is evident that the health authorities have some responsibility for the detection, treatment and rehabilitation of individuals suffering from an occupational injury or disease. In the past, however, no special effort was made to provide specifically for occupational health services to employees, except in two cases: the provision of some occupational health services to mainly white miners and the establishment of the National Center for Occupational Health in Johannesburg. The bulk of the occupational injuries and diseases are currently managed in the private sector and the various public sector health facilities in South Africa (Ross and Stanton, 2003).

The health and safety of workers is an important element in their workplace. Workers should feel safe, secure and valued at work, and as a result their productivity will be enhanced. That is why the International Labour Organisation (ILO) and the World Health Organisation

(WHO) have recognised the need to value the services of the working population by making provision for their health and safety at work with the provision of services such as occupational health for all categories of workers.

Against this background, it has become imperative to focus our attention on the management of the occupational health and safety services in the clinics in Mafikeng area.

Health care workers in the clinics in Mafikeng area handle and treat cases of different injuries and diseases on a daily basis. They also go to an extent of handling chemicals and solvents aimed at treating patients and rendering the working environment healthy and safe. It has never dawned in our minds whether these very same health care workers' health and safety at work is being taken care of. The mere fact that they render health care to the patients has disregarded their occupational health and safety.

At times a health care worker develops an unfamiliar condition or disease such as a consistent cough. He or she is booked off for some days so that he/she can be able to treat the condition and come back to work. The source and cause for this particular disease or condition is never traced back to the working conditions under which the health care worker performed his/ her duties. Again a health care worker can slip on the floor and injure his leg or arm. He will then be booked off to treat the injury and then come back to work. During the absence of the health care worker from work, there is man- hours lost and this contributes or has negative economic impacts to the organisation.

This is ascribed to poor occupational health and safety management at our clinics. There is no proper recording and reporting of occupational injuries and diseases. Due to poor coordination of the occupational health and safety services, injuries and diseases sustained by the health care worker cannot be ascribed to the conditions prevailing at their workplaces.

1.2 Statement of the problem

In this study focus is on the management of occupational health and safety services in the clinics in Mafikeng area. The extent to which the occupational health and safety service is accessible to the health care workers in the clinics and the awareness created regarding the existence of such a service was examined in this study.

Factors such as treatment of cases of occupational diseases and injuries of the clinic employees, the recording and reporting of such cases, with a view to determine their causes and sources, their trends as well as to compile valid statistical reports, are significantly valuable.

The improvement of the environmental working conditions for the workers to prevent them from contracting fatal diseases and injuries was looked at in this study. Knowing the environmental working conditions and occupational hazards to which the health care workers are exposed, assists in ascribing the injuries and diseases sustained to the conditions prevailing at their workplaces. This also enhances proper recording and reporting of the occupational hazards facing these health care workers with a view to improving the compilation of valid statistical reports and implementing appropriate remedial measures.

1.3 Importance of the study

The study is extremely necessary because its outcomes provide recommendations to resolving the problems of the fragmented occupational health and safety services delivery in the Mafikeng area. It also provides answers as to how the persons in organisations and institutions in the area feel about this problem, and whether the recommendations and criticisms made by different commissions of inquiry were heeded and if not, why. It also digs deep into the factors contributing to this fragmentation such as the different pieces of legislation dealing with occupational health and safety falling under different government departments. The recommendations arising from the analysis of the findings give guidelines on how to bring coordination to the delivery of the service, alleviate the problem of under-

reporting of occupational diseases and injuries, as well as improving the compilation of a comprehensive statistical report on the service.

1.4 Objectives of the study

- ❖ To determine whether occupational health and safety services are accessible to workers in the clinics in Mafikeng area.
- ❖ To establish the benefits of the occupational health and safety services to the workers in the clinics in Mafikeng area.
- ❖ To determine whether there is recording and reporting of occupational diseases and injuries at the clinics in the Mafikeng area.
- ❖ To determine whether the clinic employees know about the legislation (Acts and policies) governing occupational health and safety.
- ❖ To determine from the workers, whether they support the idea of the establishment of the National Occupational Health and Safety Council, which aims at drafting a national policy applicable to all departments dealing with occupational health and safety.

1.5 Scope of the study

The study was conducted in thirty (30) clinics in the Mafikeng area. Each clinic has a staff complement ranging between three (3) and seven (7) employees. In these clinics there is a clinic manager, one or more professional nurse(s), enrolled nurse(s) and enrolled assistant nurses.

Some of these clinics are in the urban areas of Mafikeng, some in the peri-urban and the others are in the rural areas of Mafikeng. Most of these clinics are within easy reach from the urban centre. The furthest clinic is situated about one hundred and sixty two (162km) kilometers away from the urban center of Mafikeng.

1.6. The research design

1.6.1 Type of study

A survey method was employed in this study. It is a qualitative study which has made use of questionnaires. The study, on the other hand, does not emphasize the diverse aspects of a single case but rather the frequency or number of answers to the same question by different people. The different cases here lose their individuality, and thus become anonymous. Thus, one criterion for the quality of a survey will be how many questionnaires have been filled out and how large and representative the sample is (Bless & Higson-Smith, 1995:44).

1.6.2. Population

A population is a set of elements that the research focuses upon and to which the results obtained by testing the sample should be generalised (Bless & Higson-Smith, 1995: 87). In this study, the targeted population was one hundred and fifty three (153) workers in the clinics in the Mafikeng area. This population consisted of the managers of the clinics, the professional nurses, the enrolled nurses and the enrolled assistant nurses. Out of the 153 workers, only 140 responded.

1.6.3 Sampling

Basically, sampling means abandoning certainty in favour of probability. The subset of the whole population which is actually investigated by a researcher and whose characteristics will be generalised to the entire population is called a sample (Bless & Higson-Smith, 1995: 86).

The researcher has made use of a probability sample specifically random sampling, where each element in the population had the same chance, likelihood or probability of being chosen for the sample. The findings of the study have thus been generalised to the whole population

1.6.4. Data collection

The researcher has used structured questionnaires as the data collection method/tool. Self-administered questionnaires have been distributed to the respondents. Self-administered questionnaires gave respondents enough time to complete without being pressured, hence the choice of this approach. The language has been clear and the questions unambiguous. As respondents have been within easy reach, the researcher has issued the questionnaires personally instead of mailing them. The researcher has also attached a covering letter to these questionnaires indicating who he is, what the study entailed and requested the respondents to complete the questionnaire with full assurance that it will be treated with the strictest confidentiality.

1.6.5. Data management and analysis

After the completed copies of questionnaires were collected, data screening was done to detect errors of measurement. Data was captured, computerised and the Statistical Package of the Social Sciences (SPSS) was used, with the Chi-square as the data analysis technique. Frequency tables and bar-graphs were used to present and summarise aspects of the data in this study. An in-depth interpretation of the data presented on these tables and graphs was done with a view to come up with quality findings and draw up informed conclusions.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

When South Africa joined the Southern African Development Community (SADC) in August 1994, there was great optimism as countries in the region recognised that this move signaled a new opportunity for developing a meaningful regional economic community. Regional co-operation has become an important issue to enhance the promotion of peace, security and development throughout the region and also to promote concrete agreements in trade, investment and other areas of technical co-operation. Furthermore to create a stronger united basis for negotiation and to obtain more favourable trade and investment conditions in the face of globalisation and pressures from powerful northern hemisphere blocks such as North Atlantic Federation of Trade Authorities (NAFTA) and the European Union (EU), thereby dealing with the legacies of economic inequality and migrant labour. Also to build upon existing linkages between SADC country economies through regionally coordinated investment, economic restructuring and marketing strategies (Loewenson, 1996).

There are, however, factors that undermine regional co-operation, such as policies of unilateral restructuring of economies, with individual countries in the region being subject to national structural adjustment programmes that promote competing rather than mutually beneficial trade and investment strategies. Competition for foreign investment between SADC member states, separate bilateral trade agreements and vertical integration of SADC economies into the North can make the region secondary, undermining the potential of regional co-operation (Loewenson, 1997).

How have such economic trends and priorities been linked with occupational health development in the region? What is the role of regional co-operation in the promotion of

occupational health and safety practice in the region? This chapter aims to address the problem of occupational health and safety in South Africa, particularly in Mafikeng area.

2.2 The fragmented and uncoordinated management of the occupational health and services in South Africa

Fragmentation of occupational health services exists between various government departments, which is frequently the result of lack of legal and administrative coordination. Occupational diseases are also poorly ascertained. The Occupational Health Services (OHS) are provided in various ways in South Africa. With the exception of the mining industry and the large enterprises, small businesses and especially the informal sector are under-served or not being reached at all. Although some revision of occupational health legislation in South Africa has been seen in recent years, no single set of regulations or code of practice exists to govern the full function of an occupational health service. An enduring legacy of division exists between the mining and non-mining sectors in relation to occupational health and safety legislation.

To illustrate the problem of fragmentation of the occupational health and safety services, the Benjamin and Greef Commission of Inquiry into a National Occupational Health and Safety Council in South Africa concluded in 1997 that the practice of occupational health services in South Africa is uncoordinated, fragmented and a burden on resources, and that a coordinated approach to occupational health and safety and compensation is needed at all government levels (Industrial Health Research Group, 1995: 39).

This is further illustrated by the Erasmus Commission of Inquiry into occupational health which pointed out major deficiencies as far back as 1974, i.e. the inadequate health services, poor standards, inadequate statistics regarding conditions in the workplace, inadequate rehabilitation and compensation of the workers, and a gross duplication of legislation affecting occupational health (Industrial Health Research Group, 1995: 4).

2.3 Legislation (The Acts)

The Compensation for Occupational Injuries and Diseases Act of 1993 (COIDA) covers both injuries and diseases that occur out of and in the course of employment. Occupational diseases that are provided for in the COIDA are listed in Schedule 3 of the Act, but the Act also covers non-listed diseases, provided that sufficient evidence is presented to establish a cause-effect relationship. Occupational Diseases in Mines and Works Act, Act 78 of 1973 (ODMWA) on the other hand only compensates occupational lung diseases in mine workers (as listed in the Act), and any disease attributed by the Certification Committee to risk work.

The long procedure and the fragmented nature of the occupational health service is illustrated where the issue of compensation is to be addressed. Compensation for occupational injuries and diseases is governed by the Compensation for Occupational Injuries and Diseases Act 130 of 1993 (COIDA), which makes provision for payment of medical expenses, leave for temporary disability, compensation for permanent disability, and death benefits. Doctors who treat workers for occupational injuries and diseases, are required to submit the necessary claim forms for compensation by the Compensation Commissioner's Fund. Any occupational disease in turn has also to be notified to the Department of Labour (Labuschagne, 2003).

The Mines Health and Safety Act of 1996 (MHSA), which is the equivalent Act in the mining sector, includes procedures whereby the occupational medicine practitioner must report annually on the health status of the miner to an inspector of the department of Minerals and Energy Affairs. The practitioner also has to report to a health and safety committee, comprising of management and workers' representatives. Compensation for occupational diseases in the mining sector is provided for under the Occupational Diseases in Mines and Works Act of 1973 (ODMWA), whilst occupational injuries are insured by the Rand Mutual Assurance Company Ltd. (RMA), operating under license to the Compensation Commissioner. Occupational Diseases in Mines

and Works Act (ODMWA) only covers some occupational lung diseases while other occupational diseases such as noise induced hearing loss are covered by the Rand Mutual Assurance Company.

The present legislation i.e. The Occupational Health and Safety Act (Act No.85 of 1993) and its regulations, contains requirements for occupational health services in the non-mining sector. The core issue contained in this Act is that where a risk assessment indicates that the workers are exposed to a hazard, a programme of medical surveillance must be instituted by a qualified person e.g. an occupational health nurse or occupational medicine practitioner.

2.4 Administration of the Acts

Administration of the acts, COIDA and ODMWA, lies with the Ministry of the Department of Labour (Dol) and the Department of Health (DOH) respectively. The Compensation Commission (CC) in the Dol receives assessments from the employers and is responsible for adjudication of claims and making payments for compensation. The two Mutual Associations i.e. Federated Employers Mutual Assurance (FEMA) and Rand Mutual Assurance Company (RMA) are operating under a license granted by the Minister of Labour to operate compensation business but the Compensation Commissioner still gives guidelines and adjudicates on liability of some claims. Under ODMWA, the Director of the Medical Bureau for Occupational Diseases (MBOD) ensures adequate performance and quality control of benefit medical and postmortem examinations while the Compensation Commissioner for Occupational Diseases (CCOD) receives levies from controlled mines and makes payment for compensation and medical aid (Karen, 2002).

This goes to show that there are inadequate and fragmented occupational health services available to the public sector employees, with the exception of some parastatal organisations like Eskom, South African Airways (SAA) and Telkom, which provide comprehensive occupational health care to their employees. It has also come to notice that the health care workers (HCW), who are providing the services within the health care industry, have been identified as a neglected group with regard to the monitoring of their occupational

health status. This is ironic as one would assume that the service geared at the maintenance and restoration of health would monitor its workers' health, but this does not appear to have been the case.

Again, it has also come to notice that the division exists between the two government agencies dealing with occupational health and safety namely:- the health and safety inspectorate responsible for enforcement of the health and safety standards and the prevention of the occupational accidents and diseases, located at different government departments, e.g. Labour, Health, Mineral and Energy Affairs, and the compensation agencies located in separate departments, e.g. Health, Labour and Rand Mutual Assurance, which are responsible for compensating workers who have contracted occupational diseases/injuries, and the families of workers who are killed as a result. This division does not comply with the Reconstruction and Development Programme (RDP) as produced in the five year Programme of Action of the Ministry of Labour. Also, this division results in occupational health problems that are under-regulated and under-reported.

The inadequate and poor management of the occupational health and safety service is highlighted in the informal sector and many small-scale enterprises which are characterised by the struggle for survival. In this struggle, complete families are involved in the work-process. Especially worrying is the fact that children and the already retired are pulled into work. Women are often forced to join the workforce for economic reasons, although they might already have a heavy burden at home.

Another special vulnerable group are the migrant workers, often living in very poor conditions, not speaking the language spoken locally, and not covered by any legislation. In the worst case, they do not even have a legal status in the country. Also seasonal workers (mainly seen in agriculture) have special problems, since they are at different times of the year exposed to different hazards and there are hardly any protective measures in place for them.

The fragmented and poor management of the occupational health and safety service manifests itself in systems whereby big companies outsource their assembly work to other enterprises. The term usually used in this system is the “sweatshops” or “maquiladoras”. The working conditions in these “sweatshops” are generally bad. A definition that can be used is: “a sweatshop is a workplace where workers are subject to extreme exploitation, including the absence of a living wage or benefits, poor working conditions and arbitrary discipline”. Workers in sweatshop are predominantly women between the ages of 16 and 25 (World Health Organisation, 2000).

A remarkable fact is that there is a lot of advertisement on the internet for businesses to outsource their assembly work to sweatshops. They state the many business-advantages like the absence of labour unions, and low labour costs, which are definitely no advantages for the workers in the sweatshops or maquiladoras (World Health Organisation, 2000).

Occupational health and safety is not only an issue in small-scale enterprises in developing countries. In every work environment, occupational health and safety is important. And in most cases, as in the small-scale enterprises, the improvement of the occupational health situation is not without difficulties. There is a lot of underestimation of occupational diseases and injuries, and sometimes unwillingness to recognise occupational causes of health problems. The history of occupational health is that of a struggle between workers fighting for protection and preventive measures or compensation, and their employers seeking to deny or reduce their liability for work-related diseases and injuries. This conflict has greatly influenced statistical reporting, which explains the underestimation of occupational health and safety.

Any estimate concerning the number of occupational diseases is often an under-estimation, as reported cases are usually only a small portion of the actual amount of occupational diseases. The large number of reported cases is still a very small sample of what really occurs because few people with occupational diseases reach medical services. And even

when they reach medical services, they are rarely recognised and reported as resulting from an occupational exposure.

Under-reporting of occupational diseases and injuries means that their burden often is borne by the general health system. People with occupational disease and injuries visit the health center and hospital, and are treated. The uninsured workers and their families carry the economic burden of the occupational diseases and injuries. They are not covered by social security, and not recompensated for medical costs or lost income. This is especially the case in developing countries, where state based social security is covering very small proportions of the population (World Health Organisation, 2000).

2.5 Occupational Health Developments

Workplaces in Southern Africa have a high level of hazards. Many of the noise, heat, mechanical and ergonomic hazards that Southern African workers face on the job have long been identified and controlled in Europe and North America. However, Southern African workers are also exposed to new chemical, psychosocial and physical hazards that are emerging from new forms of industrial processes and work organisation. There are many multi national companies in the region, most of which have their parent companies in Europe and the USA, but there are also new entrants from South East Asia and China. While there are evident efforts to apply safety policies within some multinationals, many in reality use different standards in Africa and in the North. Chemicals banned or severely restricted in Europe are in common use in Southern Africa (Stanton et al, 1996).

The more advanced of our economies are becoming producers and exporters of hazardous processes and substances to poorer countries in the region which have less well-developed systems for dealing with the negative impacts. More than half of the working population are employed in agriculture and the informal or the small-scale sector, where work environments are often hazardous and unregulated. This sector has grown along with unemployment under economic liberalisation, and it is estimated that less than a quarter of working people will be in the formal sector by the turn of the century under the current

economic policies. This makes unemployment perhaps the leading occupational hazard in our region. The existence of child labour means that small children can also be exposed to hazardous work (Stanton et al, 1996).

Despite the clearly unsafe nature of workplaces in Southern Africa, occupational illness and injury is poorly monitored and rarely diagnosed as work-related. Workers are poorly informed about the health risks of their work, or are afraid of mentioning their health problems because of job insecurity. There is a rigid division in systems, laws and services between workplace health (or occupational health) and public health, despite the fact that the worker moves between these two environments and is affected by both. Hence occupational health issues are often partitioned between ministries of labour, health, mines, transport and environment, and social security systems. This is itself not a problem, but often the systems are not adequately co-ordinated (legally or administratively) and leave the worker or employer moving between many administrative authorities to solve a single problem. The situation is made worse when the state systems are weak (as they are in most of the region), and where third-party private 'inspection' systems exist without adequate linkage to or co-ordination with the national systems (Murphy, 2001).

Within this context there have been some major areas of occupational health (OH) progress. One sign of such progress has been an active process of legal reform in occupational health and safety law in most of the Southern African region. Three countries in Southern Africa have relatively recently enacted new health and safety laws (South Africa, Lesotho and Mauritius) and several countries have new health and safety laws in draft or as Bills (Malawi, Swaziland, Lesotho, Zambia, Tanzania, Namibia) (Murphy, 2001).

Firstly, the law has a broader vision of what occupational health and safety encompasses. The process of legal review in the region is widening the definition of occupational health and safety from the narrow 'work safety' concept of the old 'Factories Acts', to the broader concept of reducing risks to safety and health by ensuring the safe design, testing and choice of equipment, by establishing safe work environments and work organisation and by

adapting work to workers. This places obligation not only on employers and employees, but also on manufacturers, designers and importers of equipment. For employers, it implies the obligation to remove hazards at source, an obligation which is still only stated explicitly in South African and Lesotho laws and in draft regulations in Namibia. It further obliges employers to protect those not in their employment who are directly affected by hazards caused by their firms and to prevent environmentally damaging emissions. These laws give more focus to the occupational health and safety system, particularly the tripartite roles and responsibilities, and to providing a framework within which specific technical problems can be regulated and comprehensive occupational health services provided (promotion, inspection and prevention, occupational hygiene, medical surveillance, accident prevention and investigation, compensation and rehabilitation of injury, major accident prevention and disaster control) (Antonsson, 1991).

The laws also cover a wider range of 'workplaces and workers'. In the more recent legislation in the region, there is provision for coverage of all workplaces, a workplace being defined by the existence of (explicit or implied) contracts of employment. Thus legal coverage will be extended to small-scale and rural workplaces: i.e. beyond traditional 'factory' of older OHS law in the region. This raises the challenge of how occupational health standards will be promoted and enforced in new areas of coverage, such as small-scale enterprises. This challenge is not unique to Southern Africa nor to occupational health law, as the same issue is being faced in all regions and with respect to all labour standards. With the growth of small-scale or informal sector, it will become increasingly important to address this issue in order to avoid environmental damage and risks to health as well as to prevent the accidents occurring in the sector. There is, however, a growing recognition that punitive measures do not work in this sector without strong, appropriately oriented mechanisms for the promotion of such standards (Antonsson, 1991).

This has obvious implications for the inspection system, since the broader definition of OHS creates institutional challenges. Inspection systems should move away from inspecting workplaces only, to inspecting imported and manufactured equipment prior to installation,

including that contained in new investment proposals. Work environment inspection and regulation should be linked with regulation of the general environment. Environment Impact Assessment is increasingly being called for as a criterion for approval of new investments and this should include work environment standards. This type of centralised inspection system does not yet exist in the region. There is also a need to examine exporters obligations, as goods often flow from countries in the region with more developed systems that are more able to regulate standards, such as South Africa and Zimbabwe, to countries less able to do so because of poorer-quality producers or infrastructures, such as Mozambique and Malawi. As reflected in the recent debate over the Basle Convention on the export of hazardous waste, greater legal attention is being paid to exporters liabilities (Ashton et al, 1992).

The changing legislation also creates a more central role for the tripartite structure, and it affects the roles of the different parties. Inherent in this review of the concept of OHS is also a review of the roles of workers, employers and the state. The situation reflected in older laws is that of worker 'working safely', employers obeying standards and the state inspecting, regulating and enforcing standards. The creation in more recent law of bipartite employee/employer structures for the identification of hazards and implementation of standards grants recognition to the appropriate role of those at the workplace, particularly the workers, in identifying risks and ensuring safe work. Hence more recent law clearly provides the information on OHS risk and precautionary measures to be given to workers and their representatives. This is further reflected in new laws being developed in the region. For example, Mine Health and Safety Bill in South Africa aims to expand the amount of management-union contact, to enhance employee participation and control, and to require employers to report on health and safety regularly (Chapman et al, 1994).

This recognition of the need for informed participation derives from the recognition that workers are closest to and thus most familiar with the work process, hence the desire to locate preventive action as close to the shop floor as possible. This new central role of employees in OHS is, however, still not fully provided for in the laws of the region.

The right of employers and employees to bring in technical advisors is not explicitly provided for in most laws in the region. In addition, most laws, including some of the newer laws, do not go as far as providing workers with the right to refuse dangerous work and does not lay down procedures for rejecting dangerous work, despite the fact that this right to act has been identified elsewhere as a significant contributor to reduction of accidents and injury. The situation is made worse by the relatively weak protection of workers in the law against victimisation for reasonable OHS actions. Hence while there is greater recognition of the need for bipartite and particularly employee input into OHS action to reduce risks, the shift towards employee control of risks is still relatively limited. Given the current labour relations environment, unemployment levels and job insecurity, if the law is not strengthened in this area, it is unlikely that workers will take steps such as stopping dangerous work, unfortunately thus undermining their ability to avoid injury at work (Chapman et al, 1994).

The new and proposed legislation calls for a change in fragmented administrative systems. These changes in the scope and conceptual approach of OHS law create a challenge for administrative services that reflects the change. The current administrative division of inspection services, occupational health services, compensation services, mine safety and environmental health between ministries of labour, health, mines, environment, and local government acts as an impediment to a more unified tripartite system, and it will continue to do so unless mechanisms for co-ordination are developed and implemented in both law and practice. The law in the region is often silent on this issue. The law that most explicitly recognizes the various authorities and the need to incorporate and co-ordinate their input is the draft Zambian OHS Bill, which identifies all the related inspection services recognised under other laws, assigns them the role of 'authorised officers' and gives them powers in terms of the OHS Bill. There is a clear trend in the region towards the development of comprehensive OHS law -combining prevention, promotion, inspection and OH service roles-that signals a policy intention of greater unification and co-ordination of the OHS system. There is a corresponding need for legal and administrative provisions that will make this policy a practical reality (Labuschagne, 2003).

2.6 Implications for Occupational Health Practice

These trends imply areas for further development for occupational health practice, complementary to existing work, to make OH practice relevant to economic change and to ensure that economic change is consistent with the goals of healthy and safe work.

There is an obligation on all parties to be more capable of intervening in rapidly changing work processes to reduce risks. Identifying the kinds of technology, substances, processes and work organisation that reduce risks is becoming even more relevant, particularly as there is often a synchrony with product quality and process efficiency. This not only applies to large enterprises but may be even more important for small and medium-sized enterprises. If information is provided by manufacturers and importers, this will lessen the burden on those at the workplace. The capacity of inspection and standards-setting systems to identify safe technologies and processes and to avoid the marketing and use of hazardous processes will lessen production and health problems further down the line (Farnsworth et al, 1994)

It is also important to extend the definition of risk beyond the worker to the importer, and to consumers and the public, who may be exposed to risks. States and enterprises will need to be cognisant of this liability and will need to take measures to respond to it. This requires new management approaches. The democratisation of working life in many parts of the world has challenged the assumption that change in production should be a product of technical inputs and high-level decision-making. Swedish working life research has demonstrated that machine pacing, isolation, piece rate pay, and authoritarian management systems have had negative social and psychological consequences for working people and have undermined productivity (Mabope, 1995). Examples of quality control circles in Japan, and team production in Germany and Sweden have led to a closer examination in many countries of the role and impact of worker participation in the organisation of work as a critical factor in determining productivity, work satisfaction, health of workers and competitiveness of the enterprise. In the final analysis there is an economic, social and

health motivation to move away from authoritarian to participatory systems. While this is increasingly reflected in the law, it is often implemented in a half-hearted or piecemeal manner which undermines the positive practical effect of the policy (Mabope, 1995).

This policy extends to setting up bipartite and tripartite systems and ensuring their functioning and authority. As rapid change takes place in production, with much outcontracting, new forms of work organisation and production interactions, standards of good practice will be important in order to regulate relations between employers and labour, producers and their markets, and producers and consumers, both nationally and internationally. These standards will not be acceptable unless the process by which they have been achieved is acceptable. In occupational health, this demands effective and representative bipartite and tripartite structures that include those affected by the standards. Debate has arisen about independent standard setting and enforcing bodies (or what is sometimes termed 'third party verification'). For example, there is currently a debate about whether the International Standards Organisation (ISO) should develop a management occupational health and safety standard, the problems cited including the relationship to the normal setting tripartite standard-setting process, the legal status of the certifying system (in relation to national laws) and mechanisms for ensuring compliance. There is a need for a clear debate and position on all such 'third party certification systems' and their relationship to national standards, tripartite standard-setting mechanisms and state inspection authorities (Mabope, 1995).

The development of effective systems requires also a regional approach, and having begun with the region, conclusions will be made with a few words on this topic. In a process of 'globalisation' that encourages competition between the economies of Southern Africa, there is a significant possibility in a capital-starved situation that competition will be based on cheap labour policies, on compromises with regard to labour conditions and rights, including occupational health standards, and on unsustainable financial and other inducements to foreign companies, such as those being created in the tax-free and duty-free Export Processing Zones (EPZ). EPZs have been documented in many parts of the world as having

negative implications for labour and environmental standards. Should this happen, it may create cheap options for short-term investment, but it is a longer-term recipe for high health and environmental costs. This is not only an issue of cross-border flows of hazardous substances, wastes, pollution and major accident risks but also one of investment options in the region being made on the basis of unacceptable differences in basic rights to health and safety (Ramantsi, 2002).

There has been pressure within the SADC Employment and Labour Sector for a commitment among SADC member states to have a common occupational standard in the region, particularly as the SADC becomes more economically integrated and there is a greater flow of labour, goods and services between Southern African countries. Such a commitment is made more feasible by the fact that the basic legal standards for OHS in the region are becoming more similar. Attention has also been drawn to an immediate need to focus on issues that have immediate cross-border implications in the region – particularly in relation to hazardous processes – such as liabilities for control of OHS risks of importers, exporters and transporters, establishment of a common information and labeling system for hazardous substances, prevention of environmental emissions and control of risks in major hazard installations. Such co-operation between SADC member states in sharing information, skills and strategies in a harmonising standard is not impossible. The process of legal reform in OH has itself been one example of the spillover in positive gain across the region, with the laws drafted in one part of the region being used as a primary source of input for laws being drafted in other parts (Ross and Stanton, 2003).

This is a period of substantial change. In occupational health law and practice, there are now trends towards a more comprehensive, co-ordinated and participatory system. These challenges on their own create a basis for regional co-operation and exchange of experience. However, the application of such occupational health changes is built on a model of production and management that widens the basis for decision making, recognises the contribution of those in the workplace and requires information to support workplace-level

decision-making. This is a production model that emphasises skills and information on the shop floor.

Many of the product quality standards are recognising this approach towards competitive production. However, the approach, and thus good occupational health practice, cannot thrive in a region where there is economic competition based on declining labour and health standards, where inequalities are exacerbated, unemployment and labour migration pressures intensified, and conflict around production increased. Forms of economic co-operation that provide a stronger framework for SADC economies, individually and collectively, to meet the challenges of integration into the global economy thus also make good occupational health sense at both regional and national level (Ross and Stanton, 2003).

The regulation and promotion of occupational health and safety is the responsibility primarily of three government departments: - Labour, Health, Mineral and Energy Affairs. Several other departments, most significantly Transport, Environment, Water Affairs, Agriculture and Safety and Security have responsibility for aspects of occupational health and safety or regulate matters that impact upon occupational health and safety. This has resulted in a fragmentation of occupational health and safety policy and enforcement, inadequate coordination between government agencies and an inconsistent body of legislation. No single institution within the state has either the capacity, or the responsibility, to assume the leadership role in developing and implementing an overall health and safety policy applicable to all sectors of the economy.

Each department has developed different approaches to the regulation of health and safety. There is a lack of commonly understood demarcations between the functions of the different departments. This has significantly reduced the capacity of the state to regulate both environmental and occupational health. It has also prevented the optimal utilisation of the inspection resources within the different government agencies.

The absence of an overall policy has further prevented the development of a synergistic relationship between South Africa's health and safety prevention and compensation agencies (Department of Health, 1996).

2.7 Management Issues

The Minister of Labour in 1996 said the provision of an efficient occupational health and safety service in South Africa, including compensation for injured and diseased workers, is severely hampered by lack of an overall national management and implementation strategy in this field (Pantry, 1995:108). It is further hampered by the fragmentation of responsibility across various government departments. A consequence of this lack of coordination and fragmentation is that occupational health and safety problems are under-reported and under-regulated. As a result we do not have a clear picture of the state of occupational health and safety in the country and the full extent of loss of life and health problems caused by workplaces are effectively not known.

Pantry (1995) also contends that management issues are a contributory factor to the ineffective and uncoordinated service delivery of occupational health and safety. The author further contends that research programmes completed by the Health and Safety Executive's Accident Prevention Advisory Unit (APAU) in the 1980's found that 70 % of accidents were due to management failures (HSE, 1985). In successive Health and Safety Commission (HSC) reports, references were made to high standard of managerial control as key to high standards of occupational health and safety (Franco, 1999).

The importance of managing occupational health and safety is reflected in the publication by the Health and Safety Executive (1991) of *Successful Health and Safety Management*. The concept of managing and auditing health and safety is slowly gaining momentum. The philosophy is based on the concept that well-managed organisations are safe organisations. A great deal of the guidance on managing health and safety as any other function is based on Total Quality Management (TQM). Total Quality Management can be defined as philosophies and company practices that aim to harness the human and material resources of

an organisation in the most effective way to achieve the objectives of an organisation. In British Standards (BS) 7850 this traditional view of TQM is indicated as a philosophy which recognises that business objectives, customer satisfaction, environmental considerations, and health and safety are interdependent. The philosophy of TQM can be applied to any organisation (Pantry, 1995: 115).

The challenge for those health professionals working to reduce the incidence of occupational diseases may well be to recognise the merits of working as facilitators, that is, as health professionals continuing to work to enable managers to establish adequate policies, appropriate organisation for the implementation of such policies and accountability at the highest level. The objective is for managers to manage the reduction of the incidence of occupational ill health. The next management steps are to measure the effectiveness of the systems through the collection of data and the implementation of monitoring and auditing programmes. For the health profession also will mean moving away from the pure medical model to a risk management models. Health professionals and the government must not ignore the half of the workplace in South Africa that does not have the benefit of working for an employer who provides professional health care. It can be argued that it is this population who are most at risk (Pantry, 1995: 121).

2.8 Health Surveillance Records

According to Pantry (1995), there is a large amount of duplication of health surveillance programmes. This risk of duplication of health surveillance appears unlikely to be changed. For example, the Health and Safety (Display Screen Equipment) Regulations 1992, regulation 5 requires eyes and eyesight tests to be provided on request to defined users of the display screen equipment. This can result in the mobile workforce being examined several times in a short timespan as there is little referral or sharing of information or records between companies.

If directed research and subsequent strategies for the prevention of occupational disease are to be progressed, then access to factual practical information is essential. For 50 % of the working population, there are health surveillance records held by employing organisations.

For employees working under the health surveillance programmes required by the Control of Substances Hazardous to Health Regulations (Act of 1988) and related amendments, there may be the results of environmental and biological monitoring. Many organisations implement specific projects directed to their own unique problems. A large amount of valuable information and data has been produced but little of it is available to other interested parties (Pantry, 1995: 118).

When a company closes, the records are often destroyed. The Health and Safety Executive (HSE) will not take them, the professional advisory bodies have a concern regarding confidentiality but provide little practical advice in respect of the retention of records. The end result is that 50 % of the workforce through their working life have health examinations which are used by their current employer. The real value of a life occupational record, showing exposures, type of work, preventive strategies, result of biological monitoring and environmental exposures is lost due to the very nature of the legislation, the fragmented control of records and the personnel bias of a high proportion of health surveillance programmes. This retained health surveillance data is often used by employers in cases of litigation. But surely the real benefit to society is the reduction of the risk and incidence of occupational diseases. The employee's previous exposure is key to this objective (Pantry, 1995: 121).

2.9 Specifying the problem of workers in Small-scale Enterprises and Informal sector

Until now, the document has focused on health in general. Numbers at a global level show the drama of occupational deaths, diseases and injuries. For small scale enterprises and the informal sector, the situation is if possible even more dramatic.

Generally, workers in these sectors are not covered by any legislation. Nobody is responsible for the health and safety of the workers. In many small-scale enterprises, the rule is a complete lack of preventive measures, leading to a large number of uncontrolled hazards. Routine inspection and surveillance being practically non-existent, poor working conditions in very small and informal enterprises are seldom uncovered. In a few cases, such

situations are brought to light by special studies or because some frequent or recurrent health impairment is remarked by health professionals and traced back to a specific hazardous exposure. The risks, however are not less. Very often, toxic chemicals (such as pesticides, solvents, and lead) are handled under extremely poor working conditions, obsolete second hand equipment and improvised tools are used, housekeeping and storage of materials are chaotic. Cases of severe intoxication, and even deaths, have been reported among persons working in very small enterprises or at home, with substances which require carefully controlled conditions of use, or, should not be used at all, as is the case of benzene as a solvent (Antosson, 1991)

As discussed earlier, it is not only the health and safety situation of these workers that is worrying: their general living situation, associated with poverty, makes the situation worse, making them even more vulnerable to diseases and poor health. Also, the hazards do not only affect workers, but the whole family.

It is quite common still to find workers in developing countries, without access to general health services (this might be lack of access due to distance, lack of resources, or lack of time). Within that context it is obvious that these uninsured workers have hardly ever any access to (preventive) occupational health services. This also leads to a very limited coverage by the national health surveillance systems. Most diseases and injuries caused by work will not be registered as such.

However, data obtained through isolated investigations in different parts of the world have given evidence that the global magnitude of health problems among such workers is tremendous. It is not unjustified to presume that under-reporting of occupational diseases increases as the size of the enterprise decreases, being practically the rule in small-scale enterprises (Lunn and Waldron, 1991).

Small-scale enterprises in the informal sector have certain characteristics. These characteristics make hazards, exposition and health outcomes different and frequently more

severe than those of workers in the formal sector of the economy. Although the magnitude and character of risks in this sector are not thoroughly known, it is generally accepted that the occupational risks and hazards for workers in small-scale enterprises in the informal sector are higher than for workers in the formal sector. Despite the magnitude and the problems of small-scale enterprises, few interventions have been successful in improving working and or living conditions of this group (Bailey, 1982).

Jeffrey Sachs, director of the Centre for International Development, the Galen L. Stone, professor of International Trade at Harvard University, and chairman of the WHO Commission on Macroeconomics and Health (CMH) states that many poor countries need external help when setting up national health services because they do not have the money to set such a system up themselves.

If this is true, and a ministry of health in a country is not able to create and maintain a national health system, it is not likely to be able to support the occupational health system in the country. Therefore, to improve the occupational health situation in a country, money from another source or the informal sector (as we shall see, one of the constraints of the informal sector is lack of money) is needed. It could be money from the private sector, or other sectors of the government.

There are many problems in improving the occupational health situation in small-scale enterprises, having to do with the characteristics of this sector. Common problems are found both across the industry sectors, regardless of technical skills and exposures, and in developing and developed countries. Nevertheless, differences are huge between sectors and countries.

2.10. Health Care Workers- A Previously Neglected And Presently Vulnerable Occupational Group

In 1700 the first systematic works demonstrating the association between occupational health and safety were published in Bernard Ramazzini's works de 'Morbis Artificum' (Sekudu, 2002). Ramazzini described the effects hazards have on the health of over 50

categories of workers and suggested ways in which these effects could be reduced. Despite these early findings, there has been poor management internationally of occupational health with insufficient emphasis placed on the preservation of workers health (Sekudu, 2002: 4).

2.11 Health care facilities as occupational settings

Health care settings are workplaces where health care is rendered to clients. These facilities have been identified among the most hazardous occupational settings as a result of the activities and the diverse nature of hazards encountered in these environments. The numerous activities conducted in health care settings result in diverse hazards, many of which are obvious (i.e. radiation exposure), but also others which are not (i.e. the psychosocial hazards associated with shift work and stress). The Health Care Workers (HCW) providing services within the health care industry have been identified as a neglected group with regard to the monitoring of their occupational health status.

As far back as 1945, Gieger wrote of this neglect (Wilkinson et al, 1992). Prior to the 1950s little serious research was conducted into the occupational hazards associated with health care settings. This occurred despite references to adverse health effects experienced by HCW dating as far back as Ramazzini's classical works. Felton (1990) reports that in the beginning of the twentieth century HCW experienced a high morbidity and mortality rate as a result of the infections and diseases they were exposed to through the routine care of patients. The control of hazards was poor and little emphasis was placed on safety management, a situation that persisted late into the same century. Wilkinson et al (1992) consider this to be an ironic situation, as one would assume that a service geared to the maintenance and restoration of health would monitor its workers health, but this does not appear to have been the case. Many of the hazards to which the health professional was exposed remained unchallenged by investigation and control.

There are reasons cited as contributing to lack of investigation into the hazards of the health care setting such as; that the health care workers are presumed to be safe from harm due to the knowledge they have regarding health, and that the health care settings (clinics) are presumed to be safe places to work in. The other reason cited is that there is lack of

presumed to be safe places to work in. The other reason cited is that there is lack of awareness and coordination of occupational health services within the clinic setting, and that the clinic management has focused attention on providing a safe environment for the patients and not the workers (Ramantsi, 2002).

The recognition of the deficiencies in occupational health management in health care facilities prompted the development, in 1957, of the first guidelines on occupational health for those employed in health care settings (Ramantsi, 2002). These guidelines were formulated to assist with the development of programs that would provide for the health and safety of HCW. They were not enforceable, but were written as recommendations for activities that should be conducted within the context of a health care setting to ensure that the health care worker was protected. Other than the introduction of immunisation programs in 1964, they remained unchanged for many years. In 1964, Mammen (cited in Felton, 1990), surveyed hospitals and found that these environments presented many physical hazards to employees. The report of this survey suggested that the thread to health posed by these hazards could be corrected by, “an enlightened management which would procure for its employees the benefits to be derived from good occupational medicine, industrial hygiene engineering and a safety program”(Felton, 1990). Despite the development of the guidelines and the subsequent works revealing the lack of organisation of occupational health programs, little was implemented to rectify the deficiencies in occupational health management for HCW.

The definitive study into occupational health in hospital settings was conducted in 1972 by the National Institute of Occupational Safety and Health (NIOSH) (www.cdc.gov/niosh/hcworld2.html). This survey conducted in 2600 hospitals of varying sizes, across the USA, revealed that 65% of the smaller hospitals lacked occupational health and safety programs whereas only 30% of the larger hospitals lacked such programs. It was also found that only 39% of the hospitals implemented immunisation programs and only 18% of the surveyed hospitals offered employee in-service training on hazard awareness. The result of which is poor occupational health facilities for HCW. The findings of this

survey led to the development by NIOSH of guidelines for the management of occupational health in health care settings. These guidelines did not only focus on activities which should be conducted to ensure that workers were not adversely affected by hazards within the health care setting, but included recommendations on how to identify and control the hazards to which the health care worker is potentially exposed (Rogers, 1997).

With the introduction of the Occupational Safety and Health Act (1970) in the USA an increase in awareness in most industries regarding hazard control and the management of workers' health was reported but not so in the hospital setting (Smook, 2002). A similar situation to that which existed in the USA is reported by Litchfield (1995) to have existed in the United Kingdom with the promulgation of the Health and Safety at Work Act 1974. He states that most large employers were promoting worker well being within the workplace but the National Health Service, which employed in excess of 800 000 workers, had not followed suit. A study conducted in South African hospitals in 2000 found that a similar situation exists to date in these hospitals i.e. little attention is given to the occupational health status of professional nurses (Harrington, 1990). It thus appears to be a common feature that managers of health care facilities are neglecting to ensure a healthy and safe working environment for the HCW employed in these facilities while they continue to concentrate on ensuring a safe environment for patients. Lunn and Waldron (1991) believe that the service rendered by the health care worker is dependent not only on the professional expertise of these professionals but also on the maintenance of their health and safety. If this is the case then it would follow that a lack of health management of HCW would result in ill health in this group with a concomitant decrease in quality of service.

2.12 Health Care Workers (HCW) as an occupational risk group

HCW are a diverse group of employees employed to render services in manifold settings. Their workplace environments are unique because the health care worker is exposed to hazards which are similar to those of other work settings as well as to hazards which are considered unique to the health care setting. Studies conducted in hospital settings have identified a variety of hazards to which hospital workers are exposed, to varying degrees at

one time or another. The adverse health effects include conditions such as adverse pregnancy outcomes, sprains and strains, back injury, leukemia and occupational asthma. Harrington (1990) reports that the nurses comprise the largest subgroup of HCW and despite the known effects that exposure to these hazards may cause, few epidemiological studies of this group have been undertaken.

Authors have identified hazards that make the health care setting unique with regard to hazard exposure. Farnsworth, Cox, and Ferguson (1994) are of the opinion that the exposure to infectious agents, which are categorized as biological hazards, is what makes the HCW exposure unique compared to other work settings.

Conant (1994) shows support for Farnsworth et al's opinions. Conant goes further and describes the exposure to infections, the risk of needle stick injuries and the exposure to reagents as exposures that make the health care setting characteristically different to other workplaces. Lowenthal (1994) supports these statements and goes on to state that hospitals are becoming more dangerous places to work because of the introduction of new technology, the emergence of new diseases and the re-emergence of old diseases due to resistance to available drugs.

Despite the documented hazards of working in a hospital, the implementation of adequate health and safety programs has not kept up with the increase in awareness of these hazards.

Levy (1998) and NIOSH state that reasons for this lack of progress in developing programs specifically for hospital staff are said to relate to the issues that the hospitals are traditionally orientated towards curative services and not preventive services and thus staff are not as cognisant of prevention strategies. Again it is believed that hospital staff are health professionals they are capable of looking after their own health without assistance. The high turnover of staff in these environments impedes the implementation of the occupational health and safety programs. There is also a belief that implementing such programs is expensive.

In 1988 Salvage and Rogers were discouraged by the lack of information for nurses regarding health and safety at work in British hospitals (Harrington and Gill, 1983). This prompted the writing of a book entitled "Nurses at risk". Many changes have taken place in the provision of health care and nursing subsequent to the publishing of this book. Ten years later when the same authors conducted investigation in order to update the contents of the book, they found the persistence of many of the previously acknowledged hazards (e.g manual handling causing back injury) and an escalation of new hazards. Cited examples of new hazards within the hospital setting are: an increased use of gluteraldehyde and an increase in the incidence of latex allergies. Both of these hazards have developed as a direct result of improved technology and the emergence of new diseases. These findings support Lowenthal's belief (1994) that the hospitals are becoming more dangerous places in which to work as a result of new technology. Rogers (1997) is of the opinion that an increase in the number of occupational injuries and diseases in the health care setting is likely due to increasing demands placed on HCW as a result of organisational structures. This is concerning as Harrington (1990), has shown that there is already a high rate of both absenteeism and accidents within the health care worker population and, to date, neither of these problems has been adequately investigated.

The Minister of Health's Committee on Occupational Health reported in 1996 that within the hospital setting occupational health services for HCW were largely underdeveloped and to date remain underdeveloped. The large number of HCW employed in health care settings are thus not provided with sufficient protection of their occupational health and safety. Through the author's personal experience and the reported experience of students and colleagues it appears that there is a lack in the provision of occupational health management for nurses and other HCW in the hospital setting. Many hospitals do have a facility providing for the health of their staff. However, the facilities are usually staffed by personnel who do not have a background in occupational health, and services rendered are, from an occupational health point of view, rudimentary in nature. The services concentrate on the more obvious hazards such as manual handling of patients and immunisation

programs for biological hazards. Implementation of occupational health service for HCW has been a slow process. In South Africa as recently as 1999 the underdevelopment of these services was noted (Waldron, 1991). There is no doubt that employment in the health care industry can be hazardous.

2.13 Controlling exposure to hazards

Considering the detrimental effects that these hazards have been shown to cause in exposed workers, it is evident that there is a need to protect the health care worker. Protection of workers from exposure can be achieved through the development of stringent occupational health programmes and the implementation of recognised methods of control. There are numerous techniques that can be implemented to reduce the potential risks associated with hazards. Included in these control methods are engineering controls, administrative controls and personal protective equipment. The OHS Act of 1993 is not prescriptive in determining which control method should be implemented. What the OHS Act does stipulate is that management has a duty to identify hazards within the workplace and that the most practicable method of control is implemented to reduce the associated risk.

2.13.1 Engineering controls and work practices

Engineering controls are the first choice of hazard reduction, as these are the most permanent methods for reducing the hazard. They often require design adjustments and are generally expensive to implement, and in many situations not financially practicable. Techniques used include, automation, enclosure or ventilation. Examples of these engineering controls are scavenger devices which are placed onto anaesthetic machines to reduce the release of waste anaesthetic gases into the operating room. There are also automatic washers used for cleaning instruments, and mechanical aids for the lifting of patients (Smook, 2002).

2.13.2 Administrative controls

Where engineering controls cannot be implemented, administrative controls must be used. These reduce worker exposure through job rotation, work assignment, time away from

hazards and education and training about the hazards and the associated health effects of exposure. A control method that may be implemented at an administrative level is a safe work procedure to ensure that activities are performed with the list risk to employees e.g. not leaving the lids off gluteraldehyde containers when not in use (Smook, 2002).

2.13.3 Personal protective equipment

Personal protective equipment (PPE) should be the last means chosen for controlling exposure to a hazard and should only be used when engineering and administrative controls do not reduce the risk posed by the hazards to an acceptable level. PPE only provides a barrier between the person using it and the hazard. The motivation for resorting to PPE as a last means of hazard control is based on the fact that no matter how effective the PPE is at providing a barrier between the worker and the hazard, it will only be as effective as the person using it. Examples of PPE that may be used in the health care setting include lead aprons for staff exposed to non-ionising radiation, and gloves, gowns, aprons, face shields and the eye protection to protect against biological hazards. There are also laser goggles and the glasses to protect against non ionising radiation (World Health Organisation, -2000).

2.14 Conclusion

In acknowledgement of the risk that the health care workers (HCW) face in their working environment a number of organisations and committees established guidelines for the management of the developed and new diseases that have emerged. These guidelines have been revised to ensure the protection of the health care worker from the adverse health effects that are associated with these new hazards e.g. HIV and latex allergy. The guideline set out minimum standards which should be applied and it is suggested that they be adjusted according to local risk factors such as prevailing diseases rates and staff turnover. Aspects included in these guidelines are that there should be pre-placement and periodic health assessment of all employees by a professional knowledgeable about the hazards to which workers may be exposed. Pre-placement medical examinations should be tailored to collect health information from the worker specific to the hazards to which the worker will be exposed. There should also be infection control through immunisation programs for

biological hazards including diphtheria, polio, tetanus, mumps, hepatitis B, rubella and influenza. The program should include an annual review of the health of these workers who are regularly exposed to infectious conditions. Again there should be prompt diagnosis and treatment of occupational illnesses and injuries to reduce disability and lost time associated with these conditions. Lastly there should be periodic environmental surveillance must identify potential hazards, evaluate the nature and extent of exposure, and recommend effective control measures (Wilkinson et al, 1992).

Health education should be given to each worker regarding exposure risk, safe work practices and accident and incident reporting. If the records and training are coordinated through the employee health service, the education can be reinforced at each subsequent visit. Individual and confidential health and safety records should be kept for each health care worker. These records should record all exposures, health assessment reports, treatments, immunization, investigations and injuries and illnesses reported (Chapman and Lipton, 1994).

CHAPTER 3

PRESENTATION OF DATA, ANALYSIS AND INTERPRETATION

3.1. Introduction

This chapter now reports on the empirical investigation conducted to gather information/data regarding the management of occupational health and safety services in the clinics in Mafikeng area. The accessibility of the service to the clinics' staff, the recording and reporting of cases of occupational diseases and injuries were the factors examined in this study.

3.1.1 Respondents

Out of one hundred and fifty three (153) questionnaires distributed throughout the area of Mafikeng, only one hundred and forty (140) clinic personnel responded. This indicates 93% of participation by the workers in this study.

3.2. Section A: Biographical Data

In this section, frequency tables and bar-graphs have been used to present objective information from the respondents on factual questions asked, such as their social background or related personal data.

3.2.1 Table1: Frequencies and Percentage Distribution by Gender

Gender	Frequency	Percent
Male	25	17.9
Female	115	82.1
Total	140	100

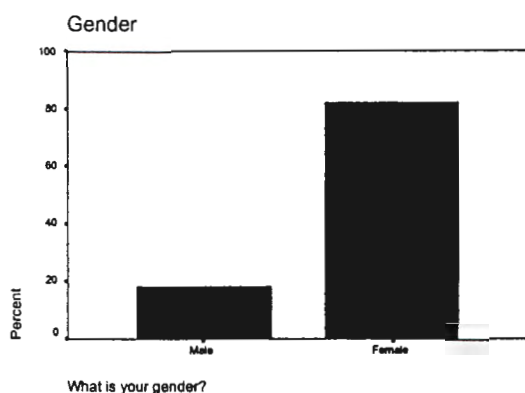


Figure 1: Percentage Distribution by Gender

The above table and graph indicate that one hundred and fifteen (115) females out of a sample of one hundred and forty (140), took part in this study. This constituted 82,1% of the sample. It therefore indicates that more females than males participated in this study.

Table 2: Frequencies and Percentage Distribution by Age

Age(yrs)	Frequency	Percent
21 - 25	2	1.4
26 - 30	8	5.7
31 - 35	25	17.9
36 - 40	37	26.4
41 - 45	36	25.7
46 - 50	19	13.6
51 - 55	9	6.4
56 and Over	4	2.9
Total	140	100

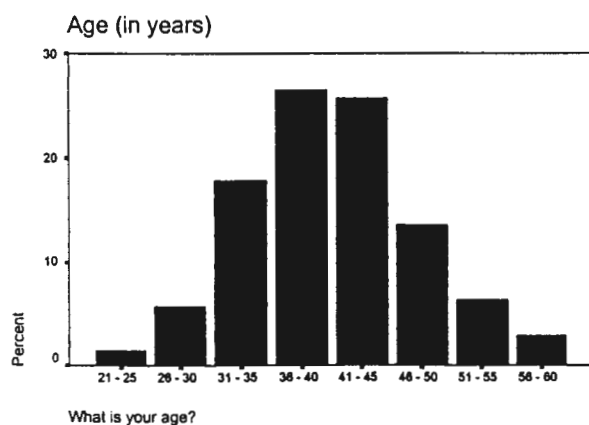


Figure 2: Percentage Distribution by Age

The above table and graph indicate that the greatest percentage of the respondents are within the age range 36-40 years old, and this makes 26,4% of the sample. This is followed by those within the age range of 41-45 years who make 25,7%. Little response came from those within the age range of 21-25 years old who make 1,4%, followed by those within the age range of 56-60 years old who make 2,9% or 3,0%. This implies that respondents between the ages 36 and 45 years old participated the most in this study.

Table 3: Frequencies and Percentage Distribution by Marital Status

Marital Status	Frequency	Percent
Married	74	52.9
Single	39	27.9
Divorced	23	16.4
Widowed	3	2.1
Other	1	0.7
Total	140	100

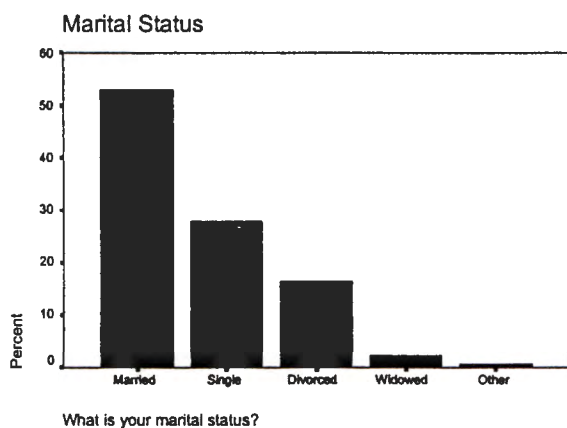


Figure 3: Percentage Distribution by Marital status

The table and graph above indicate that seventy four (74) out of one hundred and forty (140) respondents are married persons. This makes 52,9% (53%) of the population. The frequencies and percentages drop further down from single persons 27,9% (28%), divorced persons (16,4%), widowed persons (2,1%) to others who might be separated or

co-habiting (0,7%). Therefore clinic staff who are married responded the most in this study. This variable in any case does not have any impact on this study. It simply indicates the marital status of the respondents in this study.

Table 4: Frequencies and Percentage Distribution by Position in the Clinic

Position	Frequency	Percent
Manager	23	16.4
Professional Nurse	64	45.7
Enrolled Nurse	23	16.4
Enrolled Assistant Nurse	30	21.4
Total	140	100

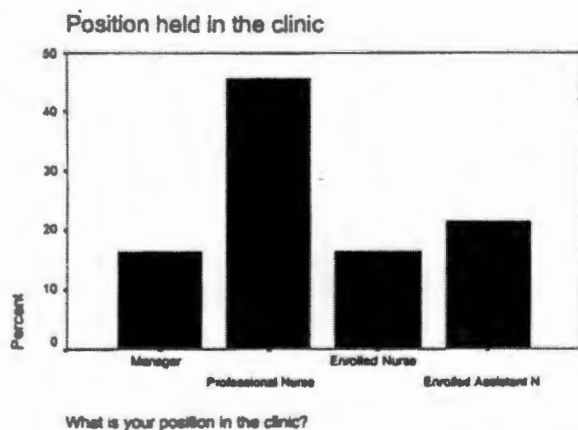


Figure 4: Percentage Distribution by Position in the clinic

The table and graph above indicate that the larger percentage 45,7% (46%) i.e. 64/140 are professional nurses, followed by enrolled assistant nurses (21,4%) i.e. 30/140. The managers of the clinics and the enrolled nurses have equal percentage distribution (16,4%) i.e. 23/140 each. Therefore the professional nurses participated the most in this study than the clinic managers who are known to be in the minority.

Table 5: Frequencies and Percentage Distribution by Duration in the Position

Duration (yrs)	Frequency	Percent
Less than 6yrs	37	26.4
6 – 10	53	37.9
11 – 15	31	22.1
Over 15yrs	19	13.6
Total	140	100

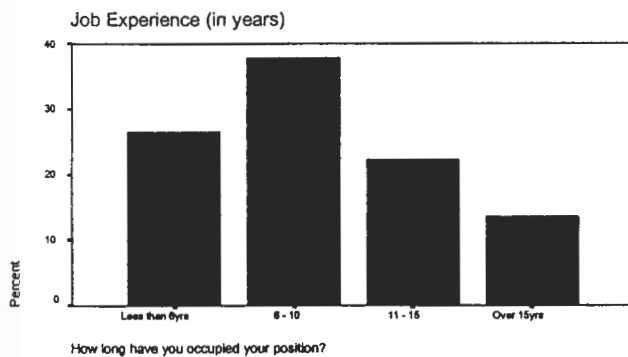


Figure 5: Percentage Distribution by Duration in their position

The above table and graph indicate that respondents who have occupied their positions for 10 years or less constitute the larger percentage of the sample (37,9%) or (38%), i.e. 53/140 respondents have participated in this study. Ironically those who have held their positions for 15 years and above constitute 13,6% i.e. 19/140 respondents. This indicates the level of interest shown by the workers who are not long in the service in matters of occupational health and safety. This also clearly indicates the awareness in matters of occupational health and safety at an early stage in the positions.

Table 6: Frequencies and Percentage Distribution by Language Spoken

Language	Frequency	Percent
Setswana	121	86.4
English	16	11.4
Afrikaans	1	0.7
Other	2	1.4
Total	140	100

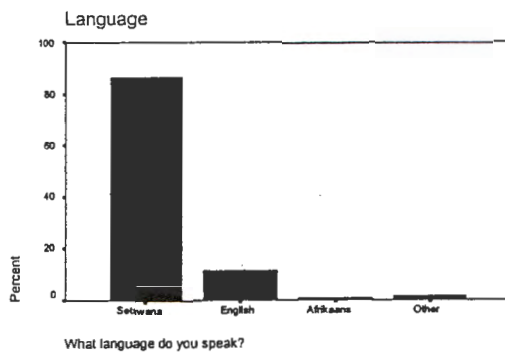


Figure 6: Percentage Distribution by the Language spoken

The table and graph above indicate that the largest percentage (86,4%) of the respondents in this study speak Setswana i.e. 121/140. Only (0,7%) of the respondents speak Afrikaans, i.e. 1/140. This is an indication that the study was undertaken in an area where the language spoken is predominantly Setswana.

Section B: Assessing the workplace conditions

In this section the responses as to whether the occupational health and safety services are accessible to the workers are assessed and presented.

Table 7: Frequencies and Percentage Distribution: Occupational health and safety conditions for health care workers

STATEMENT	SA		A		U		D		SD	
	f	%	f	%	f	%	f	%	f	%
B.1. Health care workers in the clinics in Mafikeng are safe from harm due to the knowledge they have regarding occupational health and safety.	29	20,7	40	28,6	3	2,1	40	28,6	28	20
B.2. Health clinics are safe places to work in.	9	6,4	42	30	11	7,9	50	35,7	28	20
B.3. There is lack of awareness of occupational health and safety services amongst the workers in the clinics in Mafikeng area.	20	14,3	59	42,1	11	7,9	36	25,7	14	10
B.4. The health district management has focused attention on providing a safe environment for the patients and not for the workers.	16	11,4	33	23,6	14	10	65	46,4	12	8,6

Statement B.1. in Table 7 above shows that 49,3% of the respondents either agreed or strongly agreed that the health care workers in the clinics in Mafikeng are safe from harm due to the knowledge they have regarding occupational health and safety, whereas 48,6% of the respondents disagreed or strongly disagreed with the statement. Only 2,1% were undecided. This indicates that a negligible percentage of the respondents regard health care workers as safe from harm due to the knowledge they have on occupational health and safety.

Statement B.2. above shows that 36,4% of the respondents either agreed or strongly agreed that the health clinics are safe places to work in, whereas 55,7% of the respondents disagreed or strongly disagreed with the statement. Only 7,9% of the respondents were undecided. This indicates that most of the respondents did not regard health clinics as safe places to work in.

Statement B.3. above shows that 56,4% of the respondents either agreed or strongly agreed that there is lack of awareness of occupational health and safety services amongst the workers in Mafikeng whereas 35,7% of the respondents disagreed or strongly disagreed with the statement. Only 7,9% of the respondents were undecided. This is an indication that most of the respondents agree that there is lack of awareness of occupational health and safety services amongst the workers in the clinics in Mafikeng area.

According to Statement B.4. above 35,0% of the respondents either agreed or strongly agreed that the health district management has focused attention on providing a safe environment for the patients and not for the workers, whereas 55,0% of the respondents disagreed or strongly disagreed with the statement. Only 10% of the respondents were undecided. This is an indication that the majority of the respondents are not of the view that the health district management has focused attention on providing a safe environment for the patients than to the workers.

In conclusion, Table 7 above indicates that a significant majority of the respondents regard the accessibility of the occupational health and safety services to the health care workers as still not satisfactory though the health district management has focused attention on providing a safe environment more to the workers than to the patients.

Section C: The value of the occupational health and safety services to the workers

This section evaluates the rendering of the occupational health and safety service to the workers in the Mafikeng area.

Table 8: Frequencies and Percentage Distribution: Evaluating the services of occupational health and safety

STATEMENT	SA		A		U		D		SD	
	f	%	f	%	f	%	f	%	f	%
C.1. Clinics in Mafikeng are traditionally orientated towards curative services and not preventive services.	11	7,9	38	27,1	15	10,7	54	38,6	22	15,7
C.2. Clinic staff in Mafikeng are professionals, therefore they are capable of looking after their own health without assistance.	9	6,4	29	20,7	11	7,9	60	42,9	31	22,1
C.3. The high turnover (resignations and transfers) of staff in the clinics, makes it difficult to develop occupational health and safety programs for them.	19	13,6	28	20	27	19,3	46	32,9	20	14,3
C.4. Implementing occupational health and safety programs for staff is expensive.	5	3,6	9	6,4	25	17,9	70	50	31	22,1

According to Statement C.1. in Table 8 above, 35% of the respondents either agreed or strongly agreed that the clinics in Mafikeng area are traditionally orientated towards curative services and not preventive services, whereas 54.3% of the respondents disagreed or strongly disagreed with the statement. Only 10.7% of the respondents were undecided. This indicates that the majority of the respondents do not agree that the clinics in Mafikeng area are traditionally orientated towards curative services and not preventive services.

According to Statement C.2. above, 27,1% of the respondents either agreed or strongly agreed that the clinic staff in Mafikeng are professionals, therefore they are capable of looking after their own health without assistance, whereas 65,0% of the respondents disagreed or strongly disagreed with the statement. Only 7,9% of the respondents were

undecided. This indicates that the majority of the respondents still expect the occupational health and safety services to be offered to them rather than taking care of their own health.

According to Statement C.3. above, 33,6% of the respondents either agreed or strongly agreed that the high turnover (resignations and transfers) of staff in the clinics makes it difficult to develop occupational health and safety programs, whereas 47,2% of the respondents disagreed or strongly disagreed with the statement. Only 19,3% of the respondents were undecided. This is an indication that the clinic staff still expect the occupational health and safety programs to continue despite the resignations and transfers of some of their colleagues.

According to Statement C.4. above, 10% of the respondents either agreed or strongly agreed that implementing occupational health and safety programs for staff is expensive, whereas 72,1% of the respondents disagreed or strongly disagreed with the statement. Only 17,9% of the respondents were undecided. This indicates that the majority of the clinic staff regard their health and safety at work as crucial, valuable and not to be gambled with. Money should not come before a person's life.

In conclusion, Table 8 above indicates that a significant majority of the respondents still confirm the importance of rendering the occupational health and safety services to the workers at the clinics. The staff turnover and cost implications should not be the impediments to offer an effective service to the workers.

Section D: Expectations of workers about the type of the occupational health and safety service to be rendered

In this section the various services of occupational health and safety are presented. These are the expectations of the workers at the clinics on the type of services to be offered to them.

Table 9: Frequencies and Percentage Distribution: Safe-guarding the health and safety of the workers

STATEMENT	VI		I		U		Un		V/Un	
	f	%	f	%	f	%	f	%	f	%
D.1. There should be pre-placement medical examination of all employees in the clinics in Mafikeng by a professional knowledgeable about the hazards to which the workers may be exposed.	97	69,3	33	23,6	5	3,6	2	1,4	3	2,1
D.2. There should also be periodic health assessment of all employees in Mafikeng specific to the hazards to which the worker could be exposed.	90	64,3	44	31,4	4	2,9	1	0,7	1	0,7
D.3. There should be infection control through immunisation programs for biological hazards such as diphtheria, hepatitis B, rubella and influenza.	78	55,7	43	30,7	15	10,7	1	0,7	3	2,1
D.4. There should be prompt diagnosis and treatment of occupational diseases and injuries to the clinic staff to reduce disability and lost time associated with these conditions.	86	61,4	42	30	7	5	2	1,4	3	2,1
D.5. There should also be periodic environmental inspections conducted in the clinics in order to provide an on-going evaluation of the health and safety hazards.	95	67,9	38	27,1	2	1,4	3	2,1	2	1,4

Statement D.1. of Table 9 above shows that 92,9% of the respondents either rate the statement that there should be pre-placement medical examination of all employees in the clinics in Mafikeng by a professional knowledgeable about the hazards to which the workers may be exposed, as important or very important, whereas 3,5% of the respondents rated it as unimportant or very unimportant. Only 3,6% of the respondents were undecided. This clearly indicates that base-line information on an employee's medical state should be known before being placed in a particular area to work in.

Statement D.2. above shows that 95,7% of the respondents rate the statement that there should be periodic health assessment of all employees in the clinics in Mafikeng specific to the hazards to which they could be exposed, as important or very important, whereas 1,4% of the respondents regard the idea as unimportant or very unimportant. Only 2,9% of the respondents were undecided. This indicates that the workers should be continuously examined whilst on duty to determine the extent to which the hazards at work affect them.

Statement D.3. above shows that 86,4% of the respondents regard the idea that there should be infection control through immunisation programs for biological hazards such as diphtheria, hepatitis B, rubella and influenza as important or very important, whereas 2,8% of the respondents regard the idea as unimportant or very unimportant. About 10% of the respondents were undecided. This indicates that the overwhelming majority of the respondents are in favour of infection control programs being offered to the workers as a preventive measure against diseases.

According to Statement D.4. above, 91,4% of the respondents rate the statement that there should be prompt diagnosis and treatment of occupational diseases and injuries to the clinic staff as important or very important, whereas 3,5% of the respondents say the idea is unimportant or very unimportant. About 5,0% of the respondents were undecided. This indicates that the overwhelming majority of the respondents say that occupational diseases and injuries should be avoided at all costs to reduce disabilities and lost time associated with their treatment.

Statement D.5. above shows that 95% of the respondents rate the statement that there should be periodic environmental inspections conducted at the clinics, as important or very important, whereas 3,5% of the respondents rate this as unimportant or very unimportant. Only 1,4% of the respondents were undecided. This indicates that the overwhelming majority of the respondents are in favour of the idea in order to provide an on-going evaluation of the health and safety hazards at work.

In conclusion, according to Table 9 above, the overwhelming majority of the respondents prefer that their health and safety at work should be safe guarded. This should be carried out by conducting pre-placement medical examination of the workers, followed by periodic medical examination whilst on duty and lastly exit medical examination when the worker retires or leaves employment.

Section E: Survey of opinions on the management of the occupational health and safety service in the clinics in Mafikeng area

In this section, opinions of the workers in general (all categories) with regard to the management of the occupational health and safety service in the clinics in Mafikeng area, are sought and presented.

Table 10: Frequencies and Percentage Distribution: Expression of opinions regarding the delivery of the services

STATEMENT	YES		NO		Do not know		Undecided	
	f	%	f	%	f	%	f	%
E.1. In your opinion would you say the occupational health and safety services of the Department of Health are accessible to the workers in the clinics in Mafikeng area?	71	50,7	51	36,4	12	8,6	6	4,3
E.2. In your opinion would you say the services of occupational health and safety in Mafikeng are beneficial to the staff members?	71	50,7	36	25,7	19	13,6	14	10
E.3. Do you treat cases of occupational diseases and injuries in your clinic?	64	45,7	40	28,6	19	13,6	17	12,1
E.4. Do you record cases of occupational diseases and injuries in your clinic?	53	37,9	69	49,3	14	10	4	2,9
E.5. Do you report cases of occupational diseases and injuries from your clinic to the employers?	50	35,7	73	52,1	13	9,3	4	2,9
E.6. Do you know the legislation (Acts and Policies) governing the occupational health and safety in your workplace?	81	57,9	48	34,3	8	5,7	3	2,1
E.7. Would you say the Department of Health, Labour, Agriculture, Minerals and Energy Affairs should draft a common national policy applicable to all sectors dealing with occupational health and safety?	109	77,9	5	3,6	16	11,4	10	7,1
E.8. Would you say this national policy will curb the fragmented service delivery of occupational health and safety in Mafikeng?	95	67,9	2	1,4	28	20	15	10,7

Statement E.1. of Table 10 above shows that 50,7% of the respondents said Yes the occupational health and safety services are accessible to the workers, whereas 36,4% said No to the statement and 8,6% of the respondents did not know. Only 4,3% were undecided. This is an indication that the services of occupational health and safety are accessible to the workers in the clinics in Mafikeng area though not entirely. This can be attributed to lack of knowledge about what the service entails.

Statement E.2. above shows that 50,7% of the respondents said Yes they benefit from the services of occupational health and safety rendered to the clinic staff, 25,7% said No and 13,6% did not know. Only 10% of the respondents were undecided. Again it cannot be said that a greater percentage of the workers benefit from the service. This can once again be attributed to the fact that workers might not have a better knowledge about what the service entails.

Statement E.3. above shows that 45,7% of the respondents said Yes they do treat cases of occupational diseases and injuries in their clinics. 28,6% said No and 13,6% of the respondents did not know. Only 12,1% were undecided. It can also be deduced from a low percentage of the respondents who said Yes to the question that these workers are not fully aware of what the service of occupational health and safety entails.

Statement E.4. above shows that 37,9% of the respondents said Yes they record cases of occupational diseases and injuries in their clinics. 49,3% said No and 10% said they did not know. Only 2,9% of the respondents were undecided. This is an indication that fewer or improper recording of cases of occupational diseases and injuries takes place at the clinics. This results in invalid and unreliable statistical reports on cases of occupational diseases and injuries.

Statement E.5. above shows that 35,7% of the respondents said Yes they report cases of occupational diseases and injuries from their clinics to the employers. 52,1% said No and 9,3% said they did not know. Only 2,9% of the respondents were undecided. This is an indication that more cases of occupational diseases and injuries could occur but are not reported. This results in poor, unreliable and invalid statistical reports on cases of occupational diseases and injuries.

According to Statement E.6. above, 57,9% of the respondents said Yes they know the legislation (Acts and Policies) governing occupational health and safety in their clinics. 34,3% said No and 5,7% said they did not know. Only 2,1% of the respondents were

undecided. This is an indication that more than half of the respondents had knowledge about the legislation on occupational health and safety but were not implementing it stipulated.

According to Statement E.7. above, 77,9% of the respondents said Yes the department of Health, Labour, Agriculture and Minerals and Energy Affairs should draft a common national policy on occupational health and safety. 3,6% said No and 11,4% said they did not know. Only 7,1% of the respondents were undecided. This indicates that the majority of the respondents prefer only one common national policy that will affect all these departments, should be drafted, rather than each department having its own separate pieces of legislation on occupational health and safety.

According to Statement E.8. above, 67,9% of the respondents said Yes this national policy will curb the fragmented service delivery of occupational health and safety in the clinics in Mafikeng area. 1,4% said No and 20% said they did not know. Only 10,7% of the respondents were undecided. This is an indication that the majority of the respondents agreed that the service of occupational health and safety is fragmented and needs to be brought under one agency that will respond to or address all matters related to occupational health and safety in the country.

The overall conclusion that can be drawn from Table 10 above is that almost half (50.7%) of the occupational health and safety services are not accessible to the workers in the clinics in Mafikeng area This is due to the fact that the service of occupational health and safety is fragmented (i.e. it is placed in different departments and governed by many pieces of legislation), resulting in ineffective and inefficient management of the service.

Section F: Cross-tabulations

In this section, the data presented is the cross-tabulation of the different variables such as employees' gender, their age, their positions (levels) in the clinics and the period they have been in those positions (experience), with some of the statements and questions in the questionnaire. This is with special emphasis to achieve results that reflect the objectives set

out in Chapter One. Variables such as marital status of a person and a language spoken were left out as they were of no significance in achieving these results.

Table 11: Gender * Accessibility of the occupational health and safety services to the workers

		In your opinion would you say the occupational health and safety service of the Department of Health are accessible to the workers in the clinics in Mafikeng area?				
		Yes	No	Do not know	Undecided	Total
Male	Count	13	10	1	1	25
	% of Total	9.3%	4.7%	.7%	.7%	17.9%
Female	Count	58	41	11	5	115
	% of Total	41.4%	29.3%	7.9%	3.6%	82.1%
Total	Count	71	51	12	6	140
	% of Total	50.7%	36.4%	8.6%	4.3%	100.0%

Table 12: Position in the clinic * Accessibility of the occupational health and safety services to the workers

		In your opinion would you say the occupational health and safety service of the Department of Health are accessible to the workers in the clinics in Mafikeng area?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	9	11	2	1	23
	% of Total	6.4%	7.9%	1.4%	.7%	16.4%
Professional Nurse	Count	30	28	2	4	64
	% of Total	21.4%	20.0%	1.4%	2.9%	45.7%
Enrolled Nurse	Count	14	6	2	1	23
	% of Total	10.0%	4.3%	1.4%	.7%	16.3%
Enrolled Assistant Nurse	Count	18	6	6		30
	% of Total	12.9%	4.3%	4.3%		21.5%
Total	Count	71	51	12	6	140
	% of Total	50.7%	36.4%	8.6%	4.3%	100.0%

Table 11 above indicates that out of a sample of one hundred and forty (140) respondents, thirteen (13) males i.e. 9,3% and fifty eight (58) females i.e. 41,4% said Yes to the statement that the occupational health and safety services of the Department of Health are accessible to the workers in the clinics in Mafikeng area, whereas ten (10) males i.e. 4,7 % and forty one (41) females i.e. 29, 3 % said No to it. One male i.e. 0,7% said that he did not know and one

i.e. 0,7% was undecided. Those females who did not know were eleven (11) i.e. 7,9% and those who were undecided were five (5) i.e. 3,6% .In total 71 respondents (50,7%) said Yes to the statement, whereas 51 respondents (36,4%) said No to it. This indicates that the occupational health and safety services are only accessible o half of the population of workers in the clinics in Mafikeng area. This is not enough and it creates cause for concern.

Table 12 above indicates that out of a sample of 140 respondents, 23 (16,4%) are managers, 64 (45, %7) are professional nurses, 23, (16,4%) are enrolled nurses and 30(21,5%) are enrolled assistant nurses. A total of 71 (50,7%) respondents of all categories, said Yes to the statement that the occupational health and safety services are accessible to the workers in the clinics in Mafikeng area, 51 (36,4%) respondents said No to the statement that these services are not accessible to the workers, and 12 (8,6%) respondents did not know while 6 (4,3%) were undecided. This indicates that the health and safety services are accessible to the workers though not entirely. Only half of the population of employees can be said t have access to the services. Professional nurses are the largest respondents (21,4%) to agree to have access to the services, followed by enrolled assistant nurses (12,9%), then the enrolled nurses (10,0%) and lastly the managers (6,4%).

Table 13: Position in the clinic * The benefits derived from the occupational health and safety service

		In your opinion would you say the occupational health and safety in Mafikeng area are beneficial to the clinic staff members?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	12	7	3	1	23
	% of Total	8.6%	5.0%	2.1%	.7%	16.4%
Professional Nurse	Count	34	17	6	5	64
	% of Total	24.3%	12.1%	4.3%	3.6%	45.7%
Enrolled Nurse	Count	7	5	6	5	23
	% of Total	5.0%	3.6%	4.3%	3.6%	16.3%
Enrolled Assistant Nurse	Count	18	7	4	1	30
	% of Total	12.9%	5.0%	2.9%	.7%	21.5%
Total	Count	71	36	19	14	140
	% of Total	50.7%	25.7%	13.6%	10.0%	100.0%

Table13 above indicates that a significant percentage (24,3%) of respondents who are professional nurses said Yes to the statement that the occupational health and safety services benefit the workers in the clinics in Mafikeng area, 12,1% of these professional nurses said No the services do not benefit the workers, 4,3% of the professional nurses did not know and 5% of them were undecided. The enrolled assistant nurses followed the professional nurses by 12,9 % then the managers of the clinics (8,6%) and lastly the enrolled nurses (5,0%). This again indicates that the professional nurses agree that the occupational health and safety services benefit the workers in the clinics in Mafikeng area.

Table 14: Age * Accessible of the occupational health and safety services to the workers

		In your opinion would you say the occupational health and safety services of the Department of Health are accessible to the workers in the clinics in Mafikeng area?				Total
		Yes	No	Do not know	Undecided	
21- 25	Count		1	1		2
	% of Total		.7%	.7%		1.4%
26- 30	Count	34	4			8
	% of Total	24.3%	2.9%			5.7%
31-35	Count	7	6	1	4	8
	% of Total	5.0%	4.3%	.7%	2.9%	5.7%
36 – 40	Count	18	16	4		25
	% of Total	12.9%	11.4%	2.9%		17.9%
41-45	Count	71	11	2	1	37
	% of Total	50.7%	7.9 %	1.4%	.7 %	21.5%
46 – 50	Count	6	10	3		19
	% of Total	4.3%	7.1%	2.1%		13.6%
51 – 55	Count	6	1	1	1	9
	% of Total	4.3%	.7%	.7%	.7%	6.4%
56 – 60	Count	2	2			4
	% of Total	1.4%	1.4%			2.9%
Total	Count	71	51	12	6	140
	% of Total	50.7%	36.4%	8.6%	4. %	100.0%

Table 14 above indicates that a slightly larger percentage 22 (15,7%) of respondents from the age group 41- 45 years said Yes to the statement that the occupational health and safety

services are accessible to the workers in the clinics in Mafikeng area, followed by those within the age group 36 – 40 years (12,1%), then those within the age group 31 – 35 years (10,0%). In general it can be said that the larger percentage of respondents came from respondents within the age range 31 – 45 years, which is the middle age group.

Table 15: Position in the clinic * Treatment of cases of occupational diseases and injuries in Mafikeng area

		Do you treat cases of occupational diseases and injuries in your clinic?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	10	7		6	23
	% of Total	7.1%	5.0%		4.3%	16.4%
Professional Nurse	Count	33	28	3	8	64
	% of Total	23.6%	14.3%	2.1%	5.7%	45.7%
Enrolled Nurse	Count	6	5	9	3	23
	% of Total	4.3%	3.6%	6.4%	2.1%	16.3%
Enrolled Assistant Nurse	Count	15	8	7		30
	% of Total	10.7%	5.7%	5.0%		21.5%
Total	Count	71	36	19	14	140
	% of Total	50.7%	25.7%	13.6%	10.0%	100.0%

Table 16: Position in the clinic * Recording of cases of occupational diseases and injuries in the clinics in Mafikeng area

		Do you record cases of occupational diseases and injuries in your clinic?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	9	14			23
	% of Total	6.4%	10.0%			16.4%
Professional Nurse	Count	24	36	1	3	64
	% of Total	17.1%	25.7%	.7%	2.1%	45.7%
Enrolled Nurse	Count	7	7	8	3	23
	% of Total	5.0%	5.0%	5.7%	2.1%	16.3%
Enrolled Assistant Nurse	Count	13	12	5		30
	% of Total	9.3%	8.6%	3.6%		21.5%
Total	Count	53	69	14	4	140
	% of Total	37.9%	49.3%	10.0%	2.9%	100.0%

Table 15 above, indicates that a total number of 64 (45,7%) respondents of all categories agree that they do treat cases of occupational diseases and injuries in the clinics, whereas a total number of 40(28,6%) respondents said No to the question, followed by 19 (13,6%) of respondents who did not know and lastly 17 (12,1%) were undecided. This indicates that the occupational diseases and injuries are treated in the clinics in Mafikeng area, though to a lesser extent.

Table 16 above indicates that a total number of 69 (49,3%) respondents of all categories from a sample of 140 respondents, said No they do not record cases of occupational diseases and injuries in the clinics in Mafikeng area, whereas a total number of 53 (37,9%) of the respondents said Yes to the question. This is followed by 14 (10,0%) who did not know and lastly 4(2,9%) who were undecided. Professional nurses amounting to 36 (25,7%) said No to the question, whereas 24 (17,1%) of these professional nurses said Yes to the question. Then follows 1 (0,7%) of the professional nurses category who did not know and lastly 3 (2,1%) of the professional nurses were undecided. Fourteen (10,0%) of the managers said No to question, followed by enrolled assistant nurses (8,6%) and lastly the enrolled nurses (5,0%). This indicates that occupational diseases and injuries are poorly recorded in the clinics in Mafikeng area, resulting in the poor management of the service and the compilation of invalid and unreliable statistical reports.

Table 17: Position in the clinic* Reporting of cases of occupational disease and injuries

		Do you report cases of occupational diseases and injuries from your clinic to the employers?				Total
		Yes	No	Do not know	Undecided	
Manager	Count	11	12			23
	% of Total	7.9%	8.6%			16.4%
Professional Nurse	Count	21	42		1	64
	% of Total	15.0%	30.0%		.7%	45.7%
Enrolled Nurse	Count	6	8	8	1	23
	% of Total	4.3%	5.7%	5.7%	.7%	16.3%
Enrolled Assistant Nurse	Count	12	11	5	2	30
	% of Total	8.6%	7.9%	3.6%	1.4%	21.5%
Total	Count	50	73	13	4	140
	% of Total	35.7%	52.1%	9.3%	2.9%	100%

Table 17 above indicates that from a sample of 140 respondents, only 50 (35,7%) of the respondents of all categories said Yes to the statement that they do report cases of occupational diseases and injuries in their clinics. On the other hand 73 (52,1%) of the respondents said No to the question. Thirteen (9,3%) did not know and 4 (2,9%) were undecided. A large percentage of responses came from the category of professional nurses where 21 (15,0%) said Yes to the question and 42 (30,0%) of these professional nurses said No to it. It can therefore be concluded that since the largest percentage of the responses to this question are those that said No they do no report cases of occupational diseases and injuries in their clinics, the services are poorly managed and the statistical reports on these incidents are then unreliable and invalid.

Table 18: Position in the clinic * Knowledge about legislation governing occupational health and safety

		Do you know the legislation governing occupational health and safety in your workplace?				Total
		Yes	No	Do not know	Undecided	
Manager	Count	14	82	1		23
	% of Total	10.0%	5.7%	.7%		16.4%
Professional Nurse	Count	42	17	3	2	64
	% of Total	30.0%	12.1%	2.1%	1.4%	45.7%
Enrolled Nurse	Count	12	7	4		23
	% of Total	8.6%	5.0%	2.9%		16.3%
Enrolled Assistant Nurse	Count	13	16		1	30
	% of Total	9.3%	11.4%		.7%	21.5%
Total	Count	81	48	8	3	140
	% of Total	57.9%	34.3%	5.7%	2.1%	100.0%

Table 18 above indicates that from a sample of 140 respondents, 81 (57,9%) of these respondents from all categories said Yes to the statement that they know about the legislation governing occupational health and safety in their workplaces. On the other hand 48 (34,3%) of these respondents from all the categories said No to the question. Eight (8) respondents did not know and 3 (2,1%) were undecided. Here again a large percentage of responses came from the professional nurses where 42 (30,0%) said Yes to the question and 17 (12,1%) said No to it.

The managers of the clinics were next, followed by enrolled assistant nurses and lastly were the enrolled nurses. This indicates that the workers in the clinics know about the legislation governing occupational health and safety but they do not comply with its requirements.

Table 19: Position in the clinic* Drafting of a common national policy by all departments dealing with occupational health and safety

		Would you say the Department of Health, Labour, Agriculture , Minerals and Energy Affairs should draft a common national policy applicable to all sectors dealing with occupational health and safety?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	21	1		1	23
	% of Total	15.0%	.7%		.7%	16.4%
Professional Nurse	Count	51	2	6	5	64
	% of Total	36.4%	1.4%	4.3%	3.6%	45.7%
Enrolled Nurse	Count	13	1	9		23
	% of Total	9.3%	.7%	6.4%		16.3%
Enrolled Assistant Nurse	Count	24	1	1	4	30
	% of Total	17.1%	.7%	.7%	1.4%	21.5%
Total	Count	109	5	46	10	140
	% of Total	77.9%	3.6%	11.4%	7.1%	100.0%

Table 19 above indicates that from a sample of 140 respondents, 109 (77,9%) respondents of all categories said Yes to the statement that there should be a common national policy drafted by all departments that would deal with occupational health and safety. On the other hand, only 5(3,6%) said No to the question. Sixteen (11,4%) of the respondents did not know and 10 (7.1%) were undecided. Here again a large percent of the responses came from the category of professional nurses where 51 (36,4%) of them said Yes to the question and 2 (1,4%) said No to it. The enrolled assistant nurses were next, followed by the managers of the clinics and lastly were the enrolled nurses. This indicates that the overwhelming majority of the respondents of all categories agreed to the drafting of a common national policy that would deal with occupational health and safety. This national policy would alleviate the problem of fragmentation in rendering this service.

Table 20: Position in the clinic* The national policy to curb fragmentation in service delivery

		Would you say this national policy will curb the Fragmented service delivery of occupational health and safety in Mafikeng?				
		Yes	No	Do not know	Undecided	Total
Manager	Count	19		3	1	23
	%of Total	13.6%		2.1%	.7%	16.4%
Professional Nurse	Count	45	1	13	5	64
	% of Total	32.1%	.7%	9.3%	3.6%	45.7%
Enrolled Nurse	Count	10		8	5	23
	% of Total	7.1%		5.7%	3.6%	16.3%
Enrolled Assistant Nurse	Count	21	1	4	4	30
	% of Total	15.0%	.7%	2.9%	2.9%	21.5%
Total	Count	95	2	28	15	140
	%of Total	67.9%	1.4%	20.0%	10.7%	100%

Table 21: Duration in position* Treatment of cases of occupational diseases and injuries

		Do you treat cases of occupational diseases and injuries in your clinic				
		Yes	No	Do not know	Undecided	Total
Less than 6yrs	Count	13	14	7	3	37
	%of Total	9.3%	10.0%	5.0%	2.1%	26.4%
6 – 10	Count	21	15	6	11	53
	% of Total	15.0%	10.7%	4.3%	7.9%	37.9%
11 – 15	Count	16	9	3	3	31
	% of Total	11.4	6.4%	2.1%	2.1%	22.1%
Over 15yrs	Count	14	2	3		19
	% of Total	10.0%	1.4%	2.1%		13.6%
Total	Count	64	40	19	17	140
	%of Total	45.7%	28.6%	13.6%	12.1	100%

Table 20 above indicates that from a sample of 140 respondents, 95 (67,9%) respondents of all categories said Yes this common national policy will curb the fragmented service delivery of occupational health and safety in the clinics in Mafikeng area. On the other hand, only 2 (1,4%) said No to the question. Twenty eight (20,0%) of the respondents did not know and 15 (10,7%) were undecided. A large percentage of respondents oncemore came

from the professional nurses where 45 (32,1%) said Yes to the question and only 1 (0,7%) said No to it. The enrolled assistant nurses were next, followed by the managers of the clinics and lastly were enrolled nurses. This supports the idea that the majority of the respondents of all categories are in favour of drafting a common national policy that would deal with all matters of occupational health and safety even in the clinics in Mafikeng area.

Table 21 above indicates that the 21 (15,0%) of the respondents who have been in their positions for 6-10 years said Yes they do treat cases of occupational diseases and injuries in their clinics and 115 (0,7%) said No. about 6 (4,3%) of these respondents did not know 11 (7,9%) were undecided. This brings to 53 (37,9%) those respondents whose duration in their positions is between 6-10 years, but out of a total of 140 respondents. Those whose duration in their positions is between 11-15 years were next to agree to the question, followed by those over 15 years and lastly were those who are less than 6 years in their positions. On the whole 64 (45,7%) of the respondents said Yes to the question, 40 (28,6%) said No to it, followed by 19 (13,6%) who did not know and lastly 17 (12,1%) who were undecided. This once more indicates that the occupational diseases and injuries are treated in the clinics in Mafikeng area, though to a lesser extent, and even if these cases are treated, they are not being recorded or reported for statistical purposes.

Table 22: Duration in position* Recording of cases of occupational diseases and injuries

		Do you record cases of occupational diseases and injuries in your clinic?				
		Yes	No	Do not know	Undecided	Total
Less than 6yrs	Count	13	18	5	1	37
	% of Total	9.3%	12.9%	3.6%	.7%	26.4%
6 – 10	Count	17	29	5	2	53
	% of Total	12.1%	20.7%	3.6%	1.4%	37.9%
11 – 15	Count	14	14	3		31
	% of Total	10.0%	10.0%	2.1%		22.1%
Over 15yrs	Count	9	8	1	1	19
	% of Total	6.4%	5.7%	.7%	.7%	13.6%
Total	Count	53	61	14	4	140
	% of Total	37.9%	49.3%	10.0%	2.9%	100.0%

Table 22 above indicates that 29 (20,7%) of the respondents who have been in their positions for 6-10 years said No they do not record cases of occupational diseases and injuries in their clinics and 17 (12,1%) in very duration range said Yes to the question. About 5 (3,6%) of these respondents did not know and only 2 (1,4%) were undecided. This brings to a total of 53 (37,9%) those respondents whose duration in their positions is between 6-10 years, out of a total of 140 respondents in the sample. Those whose duration in their positions is less than 6 years were next to disagree with the question, followed by those within the duration range of 11-15 years and lastly were those over 15 years in their positions. On the whole 69 (49,3%) of the respondents in the sample said No to the question. Fifty three (37,9%) said Yes to the question, followed by 14 (10,0%) who did not know and lastly were 4 (2,9%) respondents who were undecided. This again indicates that occupational diseases and injuries are poorly recorded in the clinics in Mafikeng area, resulting in their poor management, poor coordination of the services and unreliable compilation of statistical reports.

Table 23: Duration in position* Reporting of cases of occupational diseases and injuries

		Do you report cases of occupational diseases and injuries from your clinic to the employers?				
		Yes	No	Do not know	Undecided	Total
Less than 6yrs	Count	14	19	3	1	37
	%of Total	10.0%	13.6%	2.1%	.7%	26.4%
6 – 10	Count	16	31	6		53
	% of Total	11.4%	22.1%	4.3%		37.9%
11 – 15	Count	14	12	3	2	31
	% of Total	10.0%	8.6%	2.1%	1.4%	22.1%
Over 15 yrs	Count	6	11	1	1	19
	% of Total	4.3%	7.9%	.7%	.7%	13.6%
Total	Count	50	73	13	4	140
	%of Total	35.7%	52.1%	9.3%	2.9%	100%

Table 23 above indicates that 31(22,1%) of the respondents who have been in their positions for 6-10 years said No they do not report cases of occupational diseases and injuries to their

employers and 16 (11,4%) of the respondents said Yes to the question. About 6 (4,3%) did not know and none were undecided. Out of 140 respondents in the sample 53 (37,9%) were within the duration range of 6-10 years. Those whose duration in their positions is less than 6 years were next to disagree with the question, followed by those within the period range of 11-15 years and lastly were those over 15 years in their positions. On the whole 73 (52,1%) of the respondents said No to the question. Fifty (35,7%) said Yes to the question, followed by 13 (9,3%) who did not know and lastly were 4 (2,9%) who were undecided. This again indicates that occupational diseases and injuries are poorly reported from the clinics in Mafikeng area, resulting in poor management of these services.

Table 24: Duration in position* Knowledge about the legislation governing occupational health and safety

		Do you know the legislation (Act and Policies) governing the occupational health and safety in your workplace				
		Yes	No	Do not know	Undecided	Total
Less than 6yrs	Count %of Total	22 15.7%	13 9.3%	1 .7%	1 .7%	37 26.4%
6 – 10	Count % of Total	34 24.3%	14 10.0%	4 2.9%	1 .7%	53 37.9%
11 – 15	Count % of Total	17 12.1%	11 7.9%	2 1.4%	1 .7%	31 22.1%
Over 15yrs	Count % of Total	8 5.7%	10 7.1%	1 .7%		19 13.6%
Total	Count %of Total	81 57.9%	48 34.3%	8 5.7%	3 2.1%	140 100%

Table 24 above indicates that 34 (24,3%) of the respondents who have been in their positions for 6-10 years said Yes they have knowledge about the legislation governing occupational health and safety and 14 (10,0%) of the respondents within this very period range said No to it. About 4 (2,9%) did not know and 1 (0,7%) was undecided. Out of 140 respondents in the sample 53 (37,9%) were within the period range of 6-10 years. Those whose duration in their positions is less than 6 years were next to agree to the question, followed by those within the period range of 11-15 years and lastly were those over 15 years

in their position. On the whole a total count of 81 (57,9%) of the respondents said Yes to the question. Fourty eight (34,3%) said No to it, followed by 8 (5,7%) who did know and lastly 3 (2,1%) were undecided. This again confirms the fact that more than half of the respondents in the sample know about the legislation governing occupational health and safety in their workplaces but they do not comply with its requirements.

The overall conclusion that can be drawn from the cross-tabulation of these variables is that the occupational health and safety services in the clinics in Mafikeng area are only accessible to half of the population in this area. These services benefit only half of this population too. Most of the responses in this regard came from the category of professional nurses, followed by the enrolled assistant nurses, then the enrolled nurses and lastly were the managers of the clinics. Because the professional nurses are the ones that are in the majority in the clinics and are always hands on at these workplaces, they were in a better position to respond objectively to the questionnaire. Again the responses (in great numbers) with regard to questions posed to the workers came from those within the age range of 31-45 years. Occupational diseases and injuries are treated in the clinics in Mafikeng area but these incidents do not get recorded or reported to the employers for proper compilation of statistical reports. Again what has been realised is that most of the responses with regard to all the questions related to the management of occupational health and safety services arose from those respondents whose duration in their positions is within the period range of 6-10 years. This can perhaps be attributed to the fact that these workers have now the adequate experience and exposure to the working conditions and are eager to see them improving for the better.

CHAPTER 4

DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

4.1. Introduction

The previous chapter dealt with the presentation, analysis and interpretation of data. This chapter basically gives the findings of the study presented in chapter three, which might be useful in addressing issues related to the effective management of the occupational health and safety services in the clinics in Mafikeng area.

4.2. Findings of the study

It was quite evident that the majority of the respondents to this study were females, about 82,1% of the females participated. This is not surprising as it is traditionally taken or believed that nursing is the profession for females. This is gradually changing as even males are starting to enroll for this profession.

With regard to accessibility of the occupational health and safety services to the workers in the clinics in Mafikeng area, the following are the findings:-

The occupational health and safety services are to a little extent accessible to the workers in the clinics in Mafikeng area. The female population are the ones who indicated a greater response to this question than their male counterparts (Table 11). Again, from a population that comprised of managers of the clinics, professional nurses, enrolled nurses and enrolled assistant nurses, a greater response came from professional nurses who agreed that the services are accessible to the workers in the clinics (Table 12). This issue of accessibility of the services to the workers is also confirmed by those respondents within the age range of 41-45 years, followed by those within the age range of 36-40 years (Table 13). However, despite all these positive responses, when taken on a whole, i.e. when all categories of respondents are considered, as well as their ages, it becomes evident that the services of occupational health and safety have not yet been accessible and visible enough to all the workers in the clinics in Mafikeng area.

A significant majority of the respondents as shown in Table 8 indicated that they valued and expected the occupational health and safety services to be offered to them. The right to life is inalienable and is therefore priceless. The importance of this service to the health care workers in the clinics is confirmed by the definitive study into the occupational health and safety in hospital settings that was conducted in 1972 by the National Institute of Occupational Safety and Health (NIOSH). The study revealed that out of 2600 hospitals across USA, 65% of the smaller hospitals lacked occupational health and safety programs and 30% of the larger hospitals lacked such programs. This indicates that poor occupational health and safety programs exist for health care workers. The same conditions apply to our health care workers in the clinics in Mafikeng area as reaffirmed as well by the responses in Statements C2, C3 and C4 in Table 8.

The findings also go on to indicate in Table 10, Statement E.2. that 50,7% of the respondents in the sample of the workers in the clinics said they benefit from services of occupational health and safety. Arising from this population under study, 24,3% of them were professional nurses who agreed that they did benefit from these services. This still points to the fact that the other half of the population of workers in this study does not benefit from the services of occupational health and safety (Table 14).

This is also confirmed by Lunn and Waldron (1991) who believed that the service rendered by the health care workers is dependent not only on the professional expertise of these professionals but also on the maintenance of their health and safety. If this is the case then it would follow that a lack of health management of the health care workers would result in ill-health to this group with a concomitant decrease in the quality of their service.

Coming to the requirements that there should be pre-placement medical examination of all employees in the clinics, periodic health assessment of all employees, infection control through immunisation programs, prompt diagnosis and treatment of occupational diseases and injuries to the clinic staff and lastly periodic environmental inspections conducted in the

clinics, the overwhelming majority of the respondents support these statements (refer to Table 9).

The study has further on revealed that there is poor management of the occupational diseases and injuries in the clinics in Mafikeng area. This situation is also prevalent in the whole of South Africa and its source is the fragmented and uncoordinated management of the occupational health and safety services in South Africa. This problem of fragmentation of services was illustrated by the Benjamin and Greef Commission of Inquiry into a National Occupational Health and Safety Council in South Africa in 1997. Further on, the problem was illustrated by the Erasmus Commission of Inquiry into occupational health which pointed out major deficiencies as far back as 1974. The problem continues unabated up to now even in Mafikeng area (refer to Tables 13,14 and 15). A further study to determine why the recommendations of the above two commissions of inquiry had not been implemented yet, needs to be undertaken.

The findings also reveal that 45,7% of the respondents in the sample agreed that they do treat cases of occupational diseases and injuries in their clinics (Table 10, statement E.3). Out of this sample, 23,6% are professional nurses who agreed with the question (Table 15), followed by enrolled assistant nurses. Managers of the clinics responded the least to this question. It can also be said that amongst all categories of workers who agreed with the question on treatment of cases of occupational diseases and injuries, 15,0% were those who have been in their positions for 6-10 years, followed by those who have been in those positions for 11-15 years (Table 21). A conclusion can be drawn that cases of occupational diseases and injuries are treated to a far less extent in the clinics in Mafikeng area.

There is also poor recording of cases of occupational diseases and injuries in the clinics in Mafikeng area. This is confirmed by a very low percentage of respondents, 37,9% (Table 16) who indicated that they do record these cases. Out of a total of 140 respondents, 17,1% were professional nurses who participated the most than other categories of workers (Table 16). Again the poor recording of cases of occupational diseases and injuries is confirmed in

Table 22 where the majority of the respondents i.e. 49,3% said No they do not record these cases. Out of these respondents, 20,7% have been in their positions for 6-10 years, so they are certain of what they are saying.

Also what came out clear is that there is poor reporting of cases of occupational diseases and injuries in the clinics in Mafikeng area. This is confirmed by the fact that 52,1% of the respondents said they do not report these cases. Out of a sample of 140 respondents, 30,0% were professional nurses, followed by the managers of the clinics. Again it has been found that a significant percentage (22,1%) of those who have said they do not report cases of occupational diseases and injuries, have been in their positions for 6-10 years, followed by those who have been in their positions for less than 6 years (Table 23).

Again what came out clear in this study is the fact that the majority of the respondents (55,7) as indicated by statement B.2 in Table 7 did not regard health clinics as safe places to work in. This is due to the fact that technology is improving and chemical substances e.g. latex substances and new equipments are introduced, yet the health care workers do not receive protection from their hazardous effects. This is also confirmed by Karen (2002) in the journal; Occupational Health: Southern Africa in which he states that: "Identifying the kinds of technology, substances, processes and work organisation that reduce the risks is becoming even more relevant, particularly as there is often a synchrony with product quality and process efficiency". Therefore it would always be best if the clinic staff could be constantly made aware of the occupational risks facing them at their workplaces, rather than thinking that they are safe from harm due to the knowledge they have about health. The issue of lack of knowledge on occupational health and safety is also confirmed by the positive response from the participants that there is lack of awareness by the health care workers on matters of occupational health and safety (Statement B.3. in Table 7).

These unsafe working conditions in the clinics date far back as 1945 where Geiger wrote of the health care workers as the neglected group providing health services within the health

care industry. Felton (1990) also reported about this threat to the health and safety of the health care workers, but little was implemented to remedy the situation.

On the issue of knowledge about legislation (Acts and Policies) governing occupational health and safety, more than half (57,9%) of the respondents of all categories indicated that they had knowledge about such legislation. Out of a sample of 140 respondents, 30,0% were professional nurses, followed by the managers of the clinics (10,0%) (Table 18). Again the study found that 24,3% of these respondents were those who have been in their positions for 6-10 years, followed by those who have been in their positions for less than 6 years (Table 24). Once again this indicates that the health care workers in the clinics know about the legislation governing occupational health and safety but they do not comply with its stipulations, such as regular recording and reporting of cases of occupational diseases and injuries in the workplaces.

Lastly the study has revealed that for the occupational health and safety services to be effective and efficient, there should be a common national policy on occupational health and safety which will be implemented by all departments engaged in this service such as Departments of Health, Labour, Minerals and Energy Affairs and Agriculture. The Benjamin and Greef Commission of Inquiry into a National Occupational Health and Safety Council in South Africa (1997), has long recommended this approach, but to no avail (refer to Tables 16,17 and 18).

This is also confirmed by the overwhelming responses by all categories of the health care workers in the clinics in Mafikeng area (Tables 19 and 20), especially from the professional nurses, followed by the managers of the clinics, then the enrolled assistant nurses and lastly the enrolled nurses. Labuschagne (2003) also proposed legislation change in fragmented administrative systems. He also proposed changes in the scope and conceptual approach to occupational health and safety law. He goes on to say that the current administrative division in service rendering acts as an impediment to a more unified tripartite system and will continue to do so unless mechanisms for coordination are developed.

4.3. Conclusion

The most important factor to bear in mind is that while the cost of occupational health accidents on the economy of the country can be computed with a degree of precision, what is incalculable is the socio-economic impact of occupational diseases, injuries and fatalities on the well-being of workers and their families as well as society as a whole. For this reason, it can be argued that the investment on occupational health services is also justifiable on moral grounds. Given the sacredness of human life and the fact that digits and limbs are severed as a result of workplace accidents, and lungs are contaminated by corrosive gasses, it can also be argued that the provision of a healthy and safe environment for workers can be seen as a human rights issue. The right to life is inalienable and therefore priceless. For this reason, it cannot be traded for profit or sacrificed at the alter of markets. In other words, a workplace should not approximate a war zone. Workers should not go to work to die. Employers need to understand that it is foolish to allow the demand for short-term profitability to undermine their capacity to focus on the long-term sustainability. However, in the current situation of high unemployment, unscrupulous employers play on the vulnerability of workers who have to choose between working in hazardous situations or remain unemployed.

4.4. Recommendations

The following recommendations are based on what the study has revealed about the service of occupational health and safety in the clinics in Mafikeng area.

- ❖ The occupational illnesses and injuries should be adequately monitored and promptly diagnosed as work-related, so that appropriate control measures could be implemented.
- ❖ The occupational health issues should not be partitioned between ministries of health, mines, labour and agriculture. The systems in these ministries are not adequately coordinated (legally and administratively) and this leaves the worker or employer moving between many administrative authorities just to solve a single problem.
- ❖ Managers of the occupational health and safety services should ensure that the services reach out to all the employees in the Mafikeng area.

- ❖ The occupational health services provided to the clinic staff should be comprehensive, that is there should be promotion, inspection and prevention, occupational hygiene, medical surveillance of the workers, accident prevention and investigation, compensation and rehabilitation of injury, major accident prevention and disaster control.
- ❖ Managers of the occupational health and safety services should ensure that each and every occupational disease and injury in the clinic is recorded and reported to the employer.
- ❖ Although the clinic staff members have indicated that they have knowledge about legislation (Acts and Policies) governing occupational health and safety, it should be emphasized that they strictly comply with its stipulations such as recording and reporting of occupational incidents.
- ❖ In order to minimize the fragmented service delivery of the occupational health and safety by different departments such as Labour, Health, Mineral and Energy Affairs and Agriculture, there should be a common national policy drafted, that will encompass the services rendered by all these departments to the broader society.
- ❖ More research should be done on this study, as there may be aspects which might not have been satisfactorily covered in this study.

REFERENCES

- Antonsson, A. (1991). *Decision-making in the Work Environment: a focus on chemical health hazards in relation to progressive legislation*. Stockholm: Sweden.
- Ashton, I., Gill, F.S., (1992). *Monitoring for Health Hazards at Work*. 2nd ed. Blackwell Science Ltd: Australia.
- Bailey, K.D., (1982). *Methods of Social Research* 2nd ed. "The Free Press": New York.
- Bless & Higson-Smith, (1995). *Fundamentals of Social Research Methods: an african perspective*. Juta & Co. Ltd.
- Chapman, S., Lipton, D. (1994). *The Fight for Public Health: principles and practice of media advocacy*. BMJ Publishing Group: London.
- Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.30 of 1993)*
- Department of Health (1996). *Report of the Committee on Occupational-Health*. Pretoria: South Africa.
- Erasmus Commission (1974). *Occupational Health Services in South Africa*. Pretoria: South Africa.
- Farnsworth, B. Cox, T. Cox, S. Fergurson, E. (1994). *Managing Health and Safety in Hospitals*. *British Journal of Nursing*, 3 (16): 831-3 & 835-6, March-April.
- Felton, J.S. (1990). *Occupational Medical Management*. Boston: Little, Brown and Company.
- Franco, G. (1999). *Ramazzini and Workers' Health*. *Lancet* 354: 858-61.
- Harrington, J.M., Gill, F.S., (1983) *Occupational Health: 3rd ed*. Blackwell Science Ltd: Australia.
- Harrington, J.M. (1990). *The Health of Health Care Workers*. *Journal of the Royal College of Physicians of London*, 24(3): 189-95, February/March.
- Industrial Health Research Group, (1995)*. Cape Town: South Africa.
- International Labour Organisation: Convention 161, Recommendation 171*.
- Karen, M. (2002). *Health Care Workers: occupational health journal*, 8 (2): 4, March/April.
- Labuschagne, W.P. (2003). *The Strategic Importance of Occupational Health*. *Occupational Health Journal*, 9(2): 7-9, March/April

- Leon Commission (1994). *Safety in the Mining Industry*. South Africa.
- Litchfield, P. (1995). *Health Risks to the Health Care Professional*. royal college of physicians of London in association with faculty of occupational medicine. Salisbury: Cathedral Print Services.
- Loewenson, R. (1996). *African Newsletter Journal*, 2(1): 1-7, September.
- Loewenson, R. (1997). *Occupational Health Developments in Southern Africa*. *African Newsletter Journal*, 4(7): 17-45, February.
- Lunn, J.A., Waldron, H.A. (1991). *Concerning the Cares: guidelines for protecting the safety and health of health care workers*. Oxford: Butterworth-Heinmann.
- Mabope, R. (1995). *Occupational Health Services: an RDP perspective: occupational Health Journal*.1 (5): 24-25, September/October.
- Mine Health and Safety Act, 1996 (Act No.85 of 1993)*.
- Murphy, J. (2001). *Careers for Doctors in Occupational Health: occupational health journal*, 7(2): 16-19, September/October.
- National Institute of Occupational Safety and Health (1998a). Guidelines for Protecting the Safety and Health of Health Care Workers, New York: America.*
- National Institute of Occupational Safety and Health (1998b). Guidelines for Protecting the Safety and Health of Health Care Workers, New York: America.*
- Occupational Health and Safety Act, 1993 (Act No.85 of 1993), South Africa.*
- Pantry, S. (1995): *Occupational Health (1st edition)*. United Kingdom: Chapman & Hall.
- Ramantsi, M. (2002). *A Comprehensive Approach to Address the Challenge of Occupational Diseases in South Africa*. *occupational health journal*, 8(3): 18-19, May/June.
- Ramashia, R. (2000). *Workplaces not War Zones. an article presented at an international labour conference, Sweden.*
- Regulations for Hazardous Chemical Substances (1993). framed under the Occupational Health and Safety Act, Act No. 85 of 199, South Africa.*
- Rogers, B (1997). *Health Hazards in Nursing and Health Care. an overview*. *American journal of infection control*, 25(3): 248-61, July/August.
- Smook, I. (2002). *Occupational Health Services in South Africa. a basic model for reform: occupational health journal*, 8 (1): 12-15, January/February.

- Stanton, D.W., Swakamisa, K. (1996). *Occupational Health and Safety: occupational health journal*, 2 (60): 8-9, November/December.
- Ross, M.H., Stanton, D.W. (2003). *Silicosis Control in South African Mines. occupational health journal*, 9(4): 20-22, July/August.
- Salvage, J. Rogers, R. Cowell, R. (1998). *Nurses At Risk. Nursing Times*, 94 (33): 34-5, May.
- Sekudu, D.P. (2002). *Compensation Legislation Systems for Occupational Diseases in South Africa. Occupational Health Journal*, 8(4): 22 – 23, July/August.
- Waldron, H.A.(1991). *Lecture Notes in Occupational Medicine (4th edition)*. London: Blackwell Scientific Publications.
- Wilkinson, W.E. Salazar, M.K. Uhl, J.E. Koepsell, T.D. DeRoos, R.L. Long, R.L. (1992). *Occupational Injuries. A Study of HCW at a Northwestern Health Service Centre and Teaching Hospital. AA OHN Journal*, 40 (6): 287-93, January/February.
- World Health Organisation. (October 2000). *Occupational Health in Small-scale Enterprises in the Informal Sector*, Geneva: Switzerland.

COVERING LETTER

P.O. Box 4368

Mmabatho

2735

Enquiries: J.G. Ntebele

Tel No. (018) 384 0185

Cell: 083 4546 751

Dear Respondent

I am conducting research on occupational health and safety in the Mafikeng area. In order to assist me in this, all I ask is a few minutes of your time to complete the attached questionnaire.

The purpose of this questionnaire is an attempt to assess the management of occupational health and safety services in the Mafikeng area. Please give me your candid and honest opinion of the service.

Please attempt to answer all the questions to the best of your ability and rest assured that the contents of your answered questionnaire will be handled and treated with the strictest confidentiality. In order to protect your identity, you are not required to provide your name and surname on the questionnaire.

Thank you for your valuable time in completing the questionnaire.

Yours sincerely

J.G. Ntebele.

QUESTIONNAIRE

SECTION A: Biographical Data (tick where appropriate)

A.1. What is your gender?

MALE	<input type="checkbox"/>
FEMALE	<input type="checkbox"/>

A.2. What is your age?

Less than 20 years	<input type="checkbox"/>
21-25	<input type="checkbox"/>
26-30	<input type="checkbox"/>
31-35	<input type="checkbox"/>
36-40	<input type="checkbox"/>
41-45	<input type="checkbox"/>
46-50	<input type="checkbox"/>
51-55	<input type="checkbox"/>
56-60	<input type="checkbox"/>
61 and above	<input type="checkbox"/>

A.3. What is your marital status?

MARRIED	<input type="checkbox"/>
SINGLE	<input type="checkbox"/>
DIVORCED	<input type="checkbox"/>
WIDOWED	<input type="checkbox"/>
SEPARATED	<input type="checkbox"/>
OTHER (specify)	<input type="checkbox"/>

A.4. What is your position in the clinic?

MANAGER	<input type="checkbox"/>
PROFESSIONAL NURSE	<input type="checkbox"/>
ENROLLED NURSE	<input type="checkbox"/>
ENROLLED ASSISTANT NURSE	<input type="checkbox"/>
OTHER (specify)	<input type="checkbox"/>

A.5. How long have you occupied your position?

A.6. What language do you speak?

SETSWANA	
ENGLISH	
AFRIKAANS	
OTHER (specify)	
.....	

SECTION B: Occupational conditions for health care workers

Please rate the following statements according to the scale below. Place an "X" in the appropriate box.

- SA (1) = Strongly Agree
 A (2) = Agree
 U (3) = Undecided
 D (4) = Disagree
 SD (5) = Strongly Disagree

STATEMENT	SA	A	U	D	SD
B.1. Health care workers in the clinics in Mafikeng are safe from harm due to the knowledge they have regarding occupational health and safety.	1	2	3	4	5
B.2. Health clinics are safe places to work in.	1	2	3	4	5
B.3. There is lack of awareness of occupational health and safety services amongst the workers in the clinics in Mafikeng area.	1	2	3	4	5
B.4. The health district management has focused attention on providing a safe environment for the patients and not for the workers.	1	2	3	4	5

SECTION C: Evaluating the services of occupational health and safety

STATEMENT	SA	A	U	D	SD
C.1. Clinics in Mafikeng are traditionally orientated towards curative services and not preventive services.	1	2	3	4	5
C.2. Clinic staff in Mafikeng are professionals, therefore they are capable of looking after their own health without assistance.	1	2	3	4	5
C.3. The high turnover (resignations and transfers) of staff in the clinics, makes it difficult to develop occupational health and safety programs for them.	1	2	3	4	5
C.4. Implementing occupational health and safety programs for staff is expensive.	1	2	3	4	5

SECTION D: Safeguarding the health and safety of the workers

Please indicate how important the following statements are in occupational health and safety in terms of the scale below. Place an “X” in the appropriate box.

- VI (1) = Very Important
- I (2) = Important
- U (3) = Undecided
- Un (4) = Unimportant
- V/Un (5) = Very Unimportant

STATEMENT	VI	I	U	Un	V/Un
D.1. There should be pre-placement medical examination of all employees in the clinics in Mafikeng by a professional knowledgeable about the hazards to which the workers may be exposed.	1	2	3	4	5
D.2. There should also be periodic health assessment of all employees in Mafikeng specific to the hazards to which the worker could be exposed.	1	2	3	4	5
D.3. There should be infection control through immunisation programs for biological hazards such as diphtheria, hepatitis B, rubella and influenza.	1	2	3	4	5
D.4. There should be prompt diagnosis and treatment of occupational diseases and injuries to the clinic staff to reduce disability and lost time associated with these conditions.	1	2	3	4	5
D.5. There should also be periodic environmental inspections conducted in the clinics in order to provide an on-going evaluation of the health and safety hazards.	1	2	3	4	5

SECTION E: Expression of opinions regarding the delivery of the services

Please answer the following by placing an “X” in the appropriate box.

E.1. In your opinion would you say the occupational health and safety services of the Department of Health are accessible to the workers in the clinics in Mafikeng area?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.2. In your opinion would you say the services of occupational health and safety in Mafikeng are beneficial to the clinic staff members?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.3. Do you treat cases of occupational diseases and injuries in your clinic?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.4. Do you record cases of occupational diseases and injuries in your clinic?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.5. Do you report cases of occupational diseases and injuries from your clinic to the employers?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.6. Do you know the legislation (Acts and Policies) governing the occupational health and safety in your workplace?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.7. Would you say the Department of Health, Labour, Agriculture, Minerals and Energy Affairs should draft a common national policy applicable to all sectors dealing with occupational health and safety?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

E.8. Would you say this national policy will curb the fragmented service delivery of occupational health and safety in Mafikeng?

YES	
NO	
DO NOT KNOW	
UNDECIDED	

THANK YOU FOR YOUR VALUABLE TIME IN COMPLETING THE QUESTIONNAIRE.