A PROCESS MODEL

FOR PLANNING WORKPLACE HEALTH PROMOTION

By

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A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree of

MASTER OF EDUCATION

Department of Curriculum, Mathematics and Natural Sciences

University of Manitoba

Winnipeg, Manitoba

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ABSTRACT

Health promotion as a discipline still lacks a unifying base to guide either scientific inquiry or appropriate research methods. Workplace health promotion has concentrated on individual lifestyle approaches to enhancing health in the physical domain, with little attention paid to a more ecological approach to health. The workplace itself is not an neutral environment and participation, longevity and success of planning are influenced by the dynamics of the workplace.

The objective of this study was to develop a process model for health promotion planning in the workplace that:

1) Is participatory in design

2) Is self sustaining beyond the study period.

3) Approaches health promotion as muti-dimensional.

The action-research mode is a collaborative one between the subjects and the researcher, where employees are actively involved in gathering information, analyzing it and acting on it. The researchers role is to help people develop their own tools for gathering data, assist in its interpretation and facilitate in problem solving. The present study was undertaken at a worksite, where an employee based planning committee worked in collaboration with the researcher to develop a health promotion plan for the worksite.

The process is described and a model is presented which can be used in other worksites.. This study concludes that action-research can be used to provide an integrative approach to health promotion planning.

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CHAPTER I

Introduction

The rationale for health promotion in the workplace is grounded in the concept that the determinants of health are multi-factorial and include the context of the work environment. This environment may exert a negative or positive influence on health outcomes. Health promotion in the workplace actively strives to provide opportunities for improving both personal and occupational health through organized and systematic efforts within the occupational setting.

In North America, there have been several landmarks in the evolution of the concept of health promotion. In 1974, the Lalonde report "A New Perspective on the Health of Canadians" introduced the concept of the "health field" which describes health as being determined by four factors: human biology, environment, lifestyle and health care organization. This report highlighted the multifactorial influences in both the genesis and prevention of disease. Consequently any effort to ameliorate the burden of disease and to promote health must concern itself with these factors.

In 1979 the U.S. Department of Health Education and Welfare published "Healthy People", which echoed the health field concept and was the basis for developing health goals based on health promotion and disease prevention.

In 1986 the Ottawa Charter described health promotion as the "process of enabling people to increase control over and to improve their health". This implies people actively participating in a process which seeks to influence and modify health outcomes. This process interfaces with the health field and is enabled through political and organizational

support. "Achieving Health for All: A Framework for Health Promotion" (Epp 1986) outlined three health promotion mechanisms; self-care, mutual aid and healthy environments and proposed strategies as a means of achieving health for all. These were; fostering public participation, strengthening community health services and coordinating healthy public policy.

Health promotion in the workplace is an application within the workplace of this broader vision of health. It has evolved from such corporate efforts as information based health education, employee assistance programs and health screening, coupled with the increasing requirements of occupational health and safety regulations. Since the 1970's there has been an emerging array of health promotion activities in the worksite ranging from smoking cessation to physical fitness programming. (Fuch and Richards 1985) Health is difficult to define and has been subject to numerous attempts of circumscription of which the World Health Organization's 1948 charter is widely quoted as "the complete state of physical, mental and social well-being and not merely the absence of illness". More recently the World Health Organization's Ottawa charter (1986) redefined health as "the ability to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment". It is clear from these definitions that health is multi-dimensional. This makes it hard to measure. It is entirely possible for instance, for one to have relatively poor physical health while at the same time enjoy excellent mental health. Despite the inherent limitations of using a linear model to quantify a multi-dimensional concept, it is useful to operationalize health on a continuum, where one pole represents extreme illness and premature death and the other pole represents a state of optimal health. (fig. 1)

HEALTH CONTINUUM

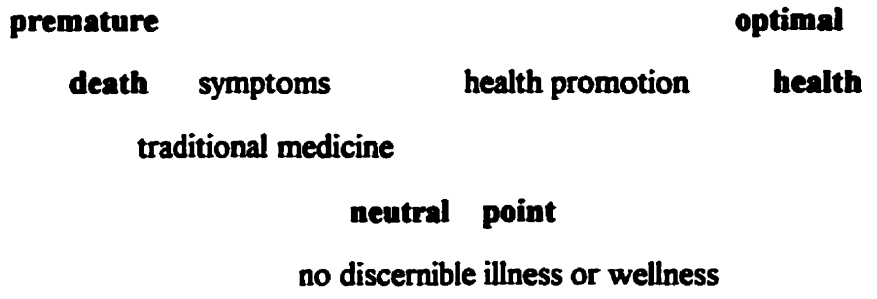


Fig. 1 (Adapted from Ardell and Travis 1975)

The midpoint is a neutral point of no discernible illness or well-being. It is at this point that health promotion begins to make its greatest impact. Working with people who are overtly healthy but at risk of becoming ill, health promotion helps people move towards optimal health. It does this by improving health related knowledge, attitudes and behaviours within an environment that is both health enhancing and supportive of lifestyle change. The further one moves towards the right of the continuum the greater is the capacity to act or respond appropriately to a wide variety of situations and to change or cope with the environment. The World Health Organization's Ottawa Charter (1986) states that "health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable".

Health promotion has been operationalized by Green (1981) as " the combination of health education and related organizational , economic and environmental supports provided at the workplace as a resource for optimizing employee health ". Optimal health is defined by O'Donnell (1986) as " a balance of physical, emotional, spiritual, intellectual and social health."

Health Promotion in the Workplace

There are a number of reasons why the workplace is a suitable environment for health promotion. It provides a relatively stable and consistent force in one's life with the potential to influence outcomes. It offers a structure where repeated intervention is possible on a stable target population. Employees can offer each other support for lifestyle changes which they are attempting to make or maintain. Employers can offer incentives that promote participation and increase the likelihood of success. It has the potential to meet corporate goals such as reducing absenteeism, decreasing employee turn over, and increasing employee morale and improving public image (Bertera 1990, Pencak 1991).

There is ample evidence that many worksites believe that health promotion is both appropriate and beneficial in the worksite. In early 1991 a survey of 260 Canadian companies reported on a sampling of 102 different companies who offered health promotion programs to their employees (Health and Welfare Canada 1991). A special study on labour force groups indicated a high level of support among workers for workplace health promotion (Minister of Supplies and Services Canada 1988).
In the United States, the development of worksite based programs has been driven by the need to reduce medical costs paid by employers through workplace medical insurance programs. The 1993 U.S. medical costs are estimated in excess of $900 billion, of which 51.7% is paid by employers. (Business Week 1993) Evaluation of health promotion in the workplace is becoming an important management tool for companies whose profits are being eroded by medical insurance costs. Pelletier (1993) reviewed 24 published studies between 1991-1993, which evaluated the health and in some cases the cost benefits of comprehensive health promotion and disease prevention programs in the worksite. All but

one study evidenced positive health outcomes. The rationale for health promotion in the workplace has withstood the test of time.

Background to Problem

However, many questions remain to be answered in the areas of planning, design, delivery and participation in such programs. Lovata and Green (1990) have reviewed the variation which occurs in program participation, between programs and worksites. Site variables such as environmental approaches, program design and pre-program diagnosis are seen as exerting influence on success and longevity of programs. Glasgow, McCaul and Fisher (1993) recommend improving the fit between company and program, as well as increasing employee ownership of programs. Formative evaluation procedures for tailoring programs to meet the need of specific worksite is strongly emphasized. The whole area of control and responsibility in worker's health adds to the complexity of planning and designing health promotion in the workplace, yet until recently (Green 1988) it has not been addressed.

This brings into question which are the most useful methodological approaches to health promotion planning, implementation and evaluation? The integration of qualitative and quantitative data for planning programs has recently been addressed. (Vries, Weijts, Dijkstra, 1992 and Steckler, McLeroy, Goodman, Bird, McCormick,1992)
Action-research provides a format which allows for the integration of both these methods while at the same time pursuing a participatory approach to research. Given that the Ottawa Charter definition of health promotion is " the process of enabling people to increase control over and improve their health", such an approach is both philosophically and theoretically attractive. The process of enabling implies that individuals are provided

with adequate authority, power, means or opportunity to do something. The collaborative approach implicit in action-research is respectful of this process.

Action-research involves a collaborative approach between the researchers and the study population in the process of selecting the problem, deciding on appropriate methodology, analyzing the results and utilizing the information. Collaborative research and social change have been reviewed by Stull and Schensul (1987). Collaborative research as described in this volume demystifies the research process, allowing those who will utilize the results the opportunity to understand and shape the data collection process. It builds a research capability in the community or organization that can extend beyond the period of formal research.

It is arguably a method of overcoming a number of barriers to successful health promotion planning. It can be used to identify and overcome barriers to participation and to facilitate sustainability of the project beyond the period of study.

Problem Definition

Health promotion still lacks a unifying theoretical base to guide either scientific enquiry or appropriate research methods. Workplace health promotion has concentrated on individual lifestyle approaches to enhancing health in the physical domain, with little attention paid to a more ecological approach to health promotion. Positivist methods, which require a standard environment, dominate in studying a process that by its definition is meant to enable individuals gain control over and change their environment. The workplace itself is not a neutral environment. Participation, longevity and success of planning are influenced by the dynamics of the workplace. Much has been published on planning health promotion in the workplace, but very little on the human dynamics of the process itself.

Objective of the study

The objective of this study is to develop a process model for health promotion planning in the workplace that :

1. Is participatory in design.
2. Is self-sustaining beyond the study period.
3. Approaches health promotion as multi-dimensional.

Action-research is the method of accomplishing the task. The action-research mode is a collaborative approach between the subjects and the researcher, where employees are actively involved in gathering information, analyzing it and acting on it. The researchers role is to help people develop their own tools for gathering data, assist in its interpretation and facilitate in problem solving. This invloves the formation of an action-research group from among the employees , who work with the action-researcher on a collaborative project. The present study was undertaken at a worksite, where an employee based planning committee worked in collaboration with the researcher to develop a health promotion plan for the worksite.

The worksite goals

1) Develop an organizational base for ongoing analysis, reflection and action in health promotion.
2) Complete a needs analysis pertinent to health promotion issues in the workplace.
3) Outline a planning strategy with decisions as to which health promotion activities the workplace would implement.
4) Carry out a preliminary exploration of policy and organizational changes which may need to be made to support the desired.

The Research Goals

1) Explore the usefulness of action-research as an integrative approach to health promotion planning.

2) Describe the process and develop a model which could be used by other worksites.

Limitations

Certain limitations are imposed on the study by virtue of the design and methodology. It is a case study, which is descriptive of one particular workplace, with its own unique dynamics and problems. Analysis and interpretation of data serves the direct needs of the worksite under study and is not generalizable to other work situations, though it may provide insight into influences on variables and generate future research questions. However, the process model is generalizable and of use to other worksites. Questions which were explored during the study included; triangulation between qualitative and quantitative data; development of ownership for the project; the nature of the relationship between the researcher and the research group; the potential for organizational change to support health promotion initiatives.

CHAPTER 2

LITERATURE REVIEW

Occupational Health Promotion:Planning Models

Health promotion planning in the workplace is a reflection of the ideology that motivates the intervention. The history of health promotion in the workplace illustrates how interventions have changed over the years. Fuchs (1988) traces the origins of health promotion in the workplace to turn of the century health education efforts, which focused largely on the industrial workers' health and safety. Planning these interventions consisted of developing prescriptive lectures and hygiene articles by company employed physicians. Employee assistance programs, first introduced in the 1940's and 1950's reflected a corporate concern for employee mental health, largely motivated by costs to industry for employee absenteeism, tardiness, alcoholism and poor relations with fellow workers. The U.S. Occupational Safety and Health Act of 1970 required companies to provide periodic surveillance examinations for workers exposed to a wide variety of chemical agents. The purpose of this law is disease prevention activity (LaDou 1978). Since the 1970's health promotion planning at the worksite has increasingly included, fitness and exercise programs as well as weight management and smoking cessation programming. Ardell (1985) in the "History and Future of Wellness" contends that the overriding reason for corporate enthusiasm for wellness activities is as a cost containment strategy. In 1993 U.S. medical costs were estimated in excess of $900 billion, of which 51% were paid by employers (Pelletier 1993).

One of the greatest frustrations in trying to compare and review planning strategies is, that while there is enormous literature describing single health habit interventions, there is scant review of attempts to examine the entire field of workplace health promotion.

Sloan (1987) suggests that though there is as yet no explicitly articulated paradigm for workplace health promotion, that reports of workplace health promotion programs suggest, that they are characterized by a paradigm which restricts interventions to those designed to foster changes in the health-related behaviour of individual employees.
An example of one such program plan is reported by Felix, Stunkard, Cohen and Cooley (1985). This report described the Pennsylvania County Health Improvement Program (CHIP) in 12 small industries that together employ 4,200 persons. This program was essentially a risk factor reduction program with improved heart health as the desired outcome. The 14 steps are:

1. Introduction of the Program to Management
2. Announcement of Program to the Employees
3. Recruitment and Organization of a "Heart Health Committee"
4. In-House Communication Planning
5. Employee Interest and Risk Factor Surveys
6. Formation of Risk Factor Subcommittees
7. Exploration of Community Risk Factor Reduction Programs.
8. Committee Review and Program Selection
9. Development of a Program Proposal
10. Discussion of the Proposal with Management
11. Promotion of Programs and Recruitment of Emloyees
12. Scheduling of Programs
13. Program Implementation
14. Evaluation and Feedback

The authors described the strengths of this process as its generalizability, the sense of ownership it gives to employees and the modesty of its costs. No major problems were encountered. The following were considered to be important but not serious; poor existing record keeping on the part of employers related to employee health, employee

layoffs which effected employee morale, inadequate management support which could compromise the effectiveness of worksite programs, and care to maintain confidentiality of employee records.

The PRECEDE:PROCEED model first described by Green in 1974, has been used extensively in planning and designing health promotion programs (Green and Lewis 1986). Green and Kreuter (1991) describe its application to occupational settings.

Phase 1: **Social Diagnosis,** assesses quality of life concerns and potential benefits from the perspective of workers and employers.
Phase 2: **Epidemiological Diagnosis,** this includes work related diseases and health problems which can be aggravated by work conditions.
Phase 3: **Behavioural and Environmental Diagnosis,** further specification of the behavioural and environmental and assessment of their relative changeability.
Phase 4: **Educational and Organizational Diagnosis,** assesses the relative importance and changeability of the factors predisposing, enabling and reinforcing the selected behavioral and environmental targets for the worksite program.
Phase 5: **Administrative and Policy Analysis,** assesses the the resources available to influence these determinants and the organization or regulatory policies that will facilitate or hinder the implementation of programs.
Phase 6-9: **Implementation and Evaluation,** adapts plans and policies to changing circumstances.

The authors advise close attention to the social and epidemiological steps to maintain neutrality with respect to the positions of management and workers. The former will promote greater collaboration between employers and employees and the latter will increase the likelihood that programs will include environmental reforms to improve

working conditions. Problems which can arise include, conflicting loyalties of health professionals, focusing attention exclusively on changing behaviour of victims of worksite hazards rather than on the hazards themselvs, labeling and coercion of individuals, and unintended consequences such as compromising of medical care benefits and discrimination in hiring practices.

Kizer (1987) developed a business plan for health promotion at the workplace, where health planning becomes a branch of strategic planning. This offers a company four specific things to do right away, with little commitment of money and not much personnel time. These involve the areas of smoking, alcohol, nutrition and exercise. Basic principles of business planning are applied to the development of workplace health promotion programs.

O'Donnell (1988) in his book "Design of Workplace Health Promotion Programs" has developed a model that combines three levels of programming; awareness, lifestyle change and supportive environment to develop a more comprehensive program. He outlines three steps in the design process:

Phase I: Research, includes feasibility study or needs assessment .
Phase II: Program Design, includes program contents, managment options, financing the program and eligibility for the program.
Phase III: Program Implementation, includes timetables, resources, progress monitoring.
O'Donnell maintains that individuals responsible for designing the program should have expertise in all the following areas:
Organization theory, group process, operations management, communications methods, motivation techniques, design process and clinical aspects of health promotion including,

health assessment, fitness, nutrition, stress management, smoking cessation, medical self-care and social health.

Report of an ongoing workplace health promotion initiative in British Columbia was published in October 1994 (Population Health Resource Branch, Ministry of Health and Ministry Responsible for Seniors). This initiative used participatory action-research. The report outlined the following stages in a healthy workplace process:

Commitment

Issue Identification

Healthy Workplace Profile and Plan

Action Plan

Review Progress

Coincidentally the present research followed a very similar pattern, though the research design and work were completed before the above report was published.

Barriers to Participation and Success of Programming

The question of who comes to work-site wellness programs and what influences participation and success of programming has been explored by a number of authors. Conrad (1987) surveyed the difference between participants and non-participants in a fitness program at a medical technology company with approximately 600 employees. Four major significant differences were found between the groups:

Participants were less likely to be smokers; less likely to have been hospitalized in the past five years; more likely to rate their health better; and more likely to agree that they are more interested in health than most people. The most important reasons cited by non-

participants for not participating were; the course schedule did not fit with their work schedule and and they did not have time for fitness classes. Conrad concluded that participants may be healthier than non-participants. Davies et al. (1987) looked at risk factors and psychosocial variables as a means of predicting participation in worksite health promotion programs in the four areas of weight, exercise, alcohol consumption and the handling of stress and tension. For exercise, participants tended to be persons whose job stress was high and whose anxiety was high. In the case of weight control, those who had high body mass index and high job stress were more likely to participate. Participants in stress management also had higher levels of job stress.

Sloan and Gruman (1988) looked at the contribution of health and organizational factors to participation. They found that though health variables such as perceived overall risk of disease, overall health satisfaction and intention to change made a small contribution to participation, that organizational climate, such as control of workload, relationship with and support from supervisor had a stronger effect on participation.

Orlandi (1986) analysed barriers to effective dissemination of worksite health promotion innovations and linked them to a few specific factors: (a) a general lack of concensus among researchers and providers of worksite health promotion innovations; (b) a lack of appreciation for the employer's perspective regarding the role of health promotion within the entire corporate agenda; and (c) a lack of objectivity among providers who have a vested interest in the specific innovations they offer. He suggests the use of change agents who operate as objective advisors and provide a linkage between the users and the providers.

Wilson (1990) suggests a marketing plan to increase participation in workplace health promotion, including competitions, incentives, networking, changes in corporate culture and public monitoring of participation and outcomes.

Green (1988) considered issues of responsibility and control of workers health and outlined the interrelationships between work, health and behaviour and questions the assumption that for all populations the greatest influence on an individual's health are personal behaviours. Before participants are urged to assume responsibility for their health, one should first consider what opportunities these individuals have for controlling their work-life. Employers should view health promotion which emphasizes intrapersonal change as supplementary to providing a work environment that is conducive to health both physically and psychosocially. She suggests that the best way to ensure the locus of responsibility and control resides with the workers is to give them an active, decision making role. This includes decision making in defining, planning, implementing and evaluating programs.

Personal empowerment and its implications for health promotion have been explored by Lord and McKillop Farlow (1990). Participation contributes to empowerment. In designing health promotion programs, the program participants must be the ones to identify the problems and plan the solutions. Health educators can play a role in this transfer of power by behaving as facilitators rather than teachers. Greater attention should be paid to the process .

The tension between worker interest and employer motives are highlighted by Gordon (1987). She contends that the workplace is not a neutral setting and that the interface between job site health promotion and occupational health and safety programs are replete with contradictions. Many of the companies who spend large amounts of money to fight proposed occupational safety and health standards are proponents of health promotion programs.

It is understandable therefore that employees are often supspicious of employer motives when health promotion programs aimed solely at intra-personal lifestyle variables are offered to them.

A 1993 document by Grossmann and Scala for the World Health Organization, describes the complex nature of organizations and their natural resistance to the high level of change connected with the implementation of health promotion. It outlines the need for organizational change and the need to address social systems within organizations to develop settings conducive to health promotion.

Health Promotion Research Methods

As the knowledge paradigm that informs health promotion shifts and reforms, so too does the inquiry paradigm that is used in researching it. The dominant model to date has been the scientific, or positivist paradigm with a strong emphasis on quantitative research methods.

The contending model is an interpretive sociological one, with a strong emphasis on qualitative research methods. This debate is not just fueled by intellectual discourse, but also by philosophical questions on the nature of reality, what can be known and how we can come to know it. (Lincoln 1992) The outcome of this debate, which is as yet by no means clear does have important ramifications on whose work is treated as respectable and worthy of publication and dissemination. Expanding the repertoire of health promotion research methods was the subject of a special supplement of the Canadian Journal of Public Health (1992). The submissions for this supplement ran the gamut from feminist methods in health promotion research, which puts women at the centre of the research process and begins with different epistemological assumptions, (Clarke) to the applied use of Freirian methods to encourage empowerment (Poland). A recurring

theme in the debate is the need to match research methods with theory. Lincoln (1992) observed that the move from a bio-medical model of health which is passive to a wellness model which is participatory, reflects the new understanding of moving from being a subject to being a a respondent and active participant in the research and evaluation process.

Steckler et al. (1992) discussed how qualitative and quantitative methods can be combined. Qualitative methods can be used to develop quantitative measures, as in using focus groups to develop a structured questionnaire; qualitative results may be used to interpret and explain quantitative findings or visa versa; the final approach is to use the two methodologies equally and parallel to cross-validate the study findings.

Action Research

The origins of action-research may be traced back to work by Kurt Lewin, who coined the term in his work "Action Research and Minority Problems" (1948). Though he in fact wrote very little specifically on action-research and provided very little methodological guidelines other than the three cyclical stages of planning, action, and reviewing the results of the action, he described it as research leading to social change. Peters and Robinson (1984) reveiwed the present status of action research and found its practise to vary widely; from its use as strictly a research methodology to its use as an epistemological basis for social research. Those who fall into the latter category (Argyris, 1980, Elliot, 1987; Kemmis, 1981) link the action research mode of inquiry to a particular interpretation of social science. They emphasis the importance of the participants values, beliefs and intentions. Theory and practice are seen as developing together in a series of evolutionary steps. The former approach is the most commonly used one and provides a problem solving methodology.

Both versions share the following requirements:

1. They involve change.
2. They have an ongoing cyclical approach, of planning , action, reflection, which is organic in process.
3. There is collaboration in the endeavor.

Cunningham (1976) developed a procedural model for action-research, which outlines a step by step how to approach. The importance of group development and group building is stressed as being necessary to make the research genuinely cooperative and effective. Action research has traditionally been applied to community development projects (Lees, Smith, Routledge 1975) and more recently has been used in educational research (Carson et al. 1975). There are few examples of action-research being applied to health promotion published in research journals. This may be more a reflection of present publishing and granting criteria than its popularity among health promotion activists. A notable exception is the work of Israel, Schurman and House (1989) and Hugentobler, Israel and Schurman (1992) who have been collaborating on a longitudinal study on occupational stress involving workers as researchers. The B.C. healthy workplace project has involved 35,000 employees in public and private sector organizations in an action research process.

Three dilemmas in action research were described by Rapoport (1970) . These relate to issues of ethics, goals and initiatives. There is the ethical issue of confidentiality and protection of the respondent. This can be very difficult depending on the organizational make up. Information may be used in employee management conflict. The major goal dilemma is one of balancing the research goal with the practical agenda of the organization which is often to find a rapid solution to a problem. The third dilemma is one of initiatives. The client/organization may present a problem to the researcher, which may

over the course of the project evolve as less important than an underlying problem which is subsequently uncovered.

CHAPTER THREE

METHODOLOGY

The worksite studied is a government department. Considerable downsizing has occurred within the department over the past five years, which has involved a significant amount of organizational change. The workforce is predominantly professional in its make up, with a small number of clerical staff providing support services. It is a human services organization.

The project was a case study in action research as a method in planning health promotion. The procedure used was informed by Cunningham's procedural model (1976) and "The Action Research Planner" (Kemmis and McTaggart 1982).

This involved the researcher and organization members in a joint process aimed at meeting both research and worksite objectives. The research objective was to observe and describe the planning process. The worksite objective was to develop a health promotion planning strategy for the workplace. An ongoing cyclic process of action planning, action taking, reflection on the outcome and adaptation as new issues or problems arose characterized the conduct of the study. (see fig.2) The project involved five steps for completion of the worksite objective.

1) Overview of goals of study and outline of steps in completing the study delivered in a seminar format to proposed worksite.

The researcher presenting an overview of the project to the executive board of the worksite. The executive agreed that they would like to proceed with the project if there was support from the staff.

ACTION RESEARCH SPIRAL (adapted from Kemmis & McTaggart 1982)

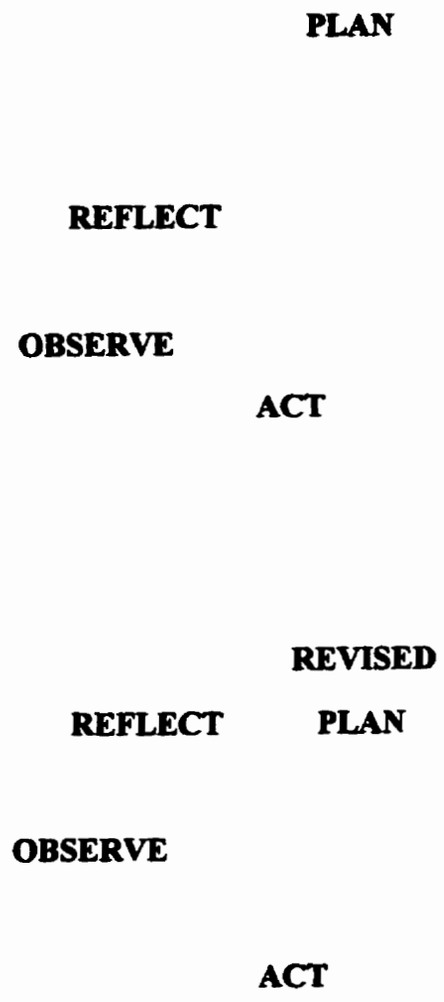


Fig. 2

2) Feasiblity Survey

A feasibility survey containing three questions was handed out to all staff. The questions asked employees if they felt the workplace was an appropriate place for health promotion activities, whether they were in favor of health promotion in their workplace and whether they would like to be actively involved in a health promotion project. Out of 70 surveys, 31 were returned. Of these, 87% were in favor of the project. Eight people indicated that they would be prepared to sit on a planning committee. The feasibility survey was an important prerequisite for the project as action-research was the proposed method for developing a health promotion planning strategy. The action-research mode is a collaborative approach between subjects and the researcher. Workers are actively involved in gathering information, analyzing it and acting on it. The researcher's role is to help people to develop their own tools for gathering data, assist in its interpretation and facilitate in problem solving.

Why Action-Research?

Research shows that initial and ongoing participation in health promotion programs in the workplace are subject to a number of variables. These include: heterogeneity of employees, perceptions of personal need, convenience, as well as issues of control and responsibility. Action-research provided a participatory model for decision making throughout the project, which shifted the locus of control regarding the direction of the project from the researcher to the employees. The feasibility survey served two functions:

a) To elicit a response regarding:

- Employee attitudes on health promotion in the workplace.
- Willingness to commit time and energy to the study.
- Perceived benefits of health promotion in the workplace.

b) Formation of an employee health promotion planning committee.

Six people agreed to serve on a planning committee. All branches of the worksite were represented on the committee. Members of the committee were volunteers who were supportive of the project and had been given time during work hours to attend meetings. The committee became the project partner in design, interpretation and analysis of the needs assessment.

3) Needs Assessment

The needs assessment provided information about people's attitudes, ideas, preferences and present health practices. This information was used to help define and solve problems, to set priorities, and to develop support and stimulate action. Both qualitative and quantitative information were gathered.

Qualitative

The first step in the needs assessment was to generate research questions for a health promotion survey. This was done by holding a number of focus groups to explore perceived needs and barriers to health promotion in the workplace. A total of six focus groups were held. Employees from each branch were invited by committee members to come to discussion groups. Group size varied from 5-8 participants.

Participants were provided, prior to the meeting, with a two page background document to the project as well as a definition of health promotion and questions which they were to consider before the meeting. (see appendix D) The discussion group was facilitated by either the researcher or a member of the planning committee.

Each participant was asked to briefly address each question. After all of the participants had an opportunity to address the questions, an interactive discussion followed.

The focus groups were audio-taped to allow the researcher to assume the role of participant observer. Each focus group took approximately one hour. Ideas from each focus group were collated by the researcher and presented to the planning committee to provided a context from which a relevant health promotion survey could be developed.

Quantitative

Quantitative information was gathered through the health promotion survey. This survey included questions on lifestyle indicators of health, attitudes and perceptions and program preferences. The purpose of the survey was to further explore ideas and issues raised in the focus groups. A variety of questioning techniques were used, including Likert scale, closed and open ended questions. While some of the questions used were the same as those developed and validated for previous health promotion surveys (Canada Health Promotion Survey 1990 and Hamiota District Health Centre Health Promotion Needs Assessment Project 1992), many were specifically developed to have direct relevance to the problems and issues raised at the focus groups and had face validity only. The survey was intended to serve as an exploratory mechanism for gauging attitudes, health beliefs and practices as well as defining potential risk situations.

The survey contained a total of 46 questions, divided into the following sections; social, emotional, physical, intellectual, spiritual and general. Development of the survey was achieved through a collaborative effort between the researcher and the planning committee. Data from the surveys was collated by the researcher and then reviewed by the health promotion planning committee.

Interpretation and Analysis of Data

Interpretation of the data was a collaborative effort between the researcher and the health promotion planning committee. A search for triangulation between the qualitative and the

quantitative data helped to prioritize needs and identify practical options. Solutions for health promotion issues were explored on three levels; awareness, lifestyle change and environmental support.

Report

A written report summarized the study and the analysis of data. It included tables of the survey answers as well as outlining a strategy for action based on the priorities and options for health promotion identified. (see appendices G,H,I)

Research Methodology

Observation and description of the process were achieved by using a variety of ethnographic techniques. These techniques have been outlined in "The Action Research Planner" (Kemmis and McTaggart 1982). They included audio-recordings of meetings, the making of field notes and diary entries.

Audio-recordings were taken with the permission of participants. This made it possible for the researcher to become a more active participant as the requirement for lengthy note taking during meetings was removed. Recordings also captured the tone of meetings as well as all data in an unfiltered state.

Field notes provided a written descriptive and longitudinal account of events as they occurred. They included context and any relevant events, preceeding or following the meetings.

Diary entries contained observations, feelings, reactions and interpretations on process.

Ethics

The ongoing and participatory nature of the study meant that data collection instruments were developed during the study. This necessitated a stepped approach to ethics approval for the study. Ethics approval was given in three steps; initial approval for entry to the workplace and formation of the health promotion planning committee, approval of group discussion format and approval of survey instrument. Informed consent of participants was received for each of these steps (see appendices A,B,C,F.). Participants agreed to audio-taping of discussion and planning sessions. Audio-tapes were reviewed by the primary researcher only and are to be destroyed at the completion of the thesis.

Confidentiality of survey participants was maintained, as their was no coding for branch and the researcher was the only one who read the individual surveys.

CHAPTER FOUR

DESCRIPTION OF THE PROCESS

GROUP DEVELOPMENT

The first three meetings are described in detail as they represented an important phase in group development.

First meeting: April 8/94 (5 of 6 members present, meeting length 2 hours 10 minutes)

The health promotion planning committee was a volunteer committee, with representation from all branches within the department. They had been recruited either through the feasibility survey or by invitation for volunteers at the branch level, which was conducted by a staff member who agreed to act as a liaison between the researcher and the workplace during the initial stages of the project.

The first meeting with the committee was an introductory session to provide the members with a background to the project and to discuss the relationship between thesis and workplace objectives. Other topics covered at the first meeting were; review of feasibility survey, exploration of health issues pertinent to the workplace, definitions and key concepts related to health promotion and consultation on working protocol for the committee and the researcher. The committee had received a short list of definitions related to health and health promotion prior to the meeting.

Questions fielded and issues raised: The committee sought clarification regarding the product that the workplace would have developed by end of project. This was reviewed verbally by the researcher with an agreement to distribute to committee members, a copy of the project proposal which had been submitted to the executive prior to entry to

workplace. A discussion was held re definition of workplace for the purposes of the study. The following statement was approved: " That health in the occupational setting would be the focus for the health promotion planning committee. The occupational setting would include, physical, mental, and social environments within the workplace".

Confidentiality: It was agreed that to allow frank and full discussion on health topics and to respect the privacy of the individual, that information would be shared within the department and in the thesis in a manner that was general and avoided attribution to individuals. Regarding the use of audio-recordings to assist in accurate data collection, the committee agreed that their sessions could be taped, with the qualification that the audio tape would be turned off upon request. Each focus group would be asked permission to record their discussion. If this was unacceptable to any group, note taking would suffice. All audio-recordings were to be destroyed following the completion of the thesis.

Participation in any aspect of the project was to be voluntary in nature, with each individual having the right to opt out of either committee work or other aspects of the project such as focus groups, survey etc.

Keeping staff informed: It was decided that progress reports would help keep staff up to date with how the project was proceeding. Committee members agreed to share information with staff in their branches in the manner they felt would be most effective.

<u>Diary Entry</u>

As well as keeping field notes, the researcher made diary entries to record, observations, reflections and interpretations of the process. Entry from first meeting included the observation that all members participated in the discussion, some a little more assertively than others. A note was made of using a discussion format, particularly for focus group

sessions which would avoid uneven participation and would encourage all members of the value of their contribution. Use of a sharing circle format perhaps? Group displayed some unease regarding commitment from management to implement strategies.
Cohesion of Group: There was an atmosphere of co-operation and a willingness to avoid personal agendas dominating or interfering with the committee working as a unit.

Second Meeting: April 15/94 (5 of 6 members present, meeting length 3 hours)
The objective of this meeting was to consult on format and questions for focus group discussions and interviews. This preliminary step was intended to generate ideas and questions which could be further developed and explored in a workplace health promotion survey. To facilitate the discussion, an initial open ended question was posed to the group by the researcher: "What in your opinion are the major obstacles to optimum health in this workplace". A sharing circle approach was taken to fielding this question.
There was a good deal of concordance between members of the committee and a central obstacle that was identified was one of job related stress. Work stressors identified were both of a physical and mental nature. Physical stressors included poor temperature controls, ergonomically unsuitable work stations as well as the sedentary nature of most peoples jobs. Mental stressors included poor interpersonal relationships, ineffective communication and lack of a supportive community within the workplace. The rapid rate of change within the department contributed to a growing uncertainty about and dissatisfaction with the workplace environment. Lack of awareness of the ill effects of a poor workplace environment, combined with no existing vehicle for exploring health related issues also posed an obstacle to optimum health.

The recent relocation and centralization of the offices of the workplace was seen as an opportunity to develop a sense of community and interdependence within the department.

A long discussion was held on types of questions and format for focus group discussions. It was agreed that a minimum of four and a maximum of eight people would participate in each focus group. Each committee member agreed to invite people to attend a focus group in their branch. The researcher would try and attend all focus group meetings. Some individual interviews would be carried out to give people an opportunity to participate who had been unable to come to the focus group discussions, or who felt more comfortable in an interview setting. Each participant would receive an information package and letter prior to attending the focus group or interview. The focus groups and interviews would be led by either a committee member or the researcher.

Issues: Very little information sharing had occurred since the first meeting. Some members had not received the progress report in time. Others felt that the project needed to be introduced to the staff by the committee members as an initial step , before too much information sharing proceeded. There were questions as to how much information and in what order, using which strategies should be used? It was agreed that flexibility was important and that committee members should use their own judgment as to how to approach this. The importance of committee members being responsive to the needs of individual staff was stressed. They should provide as much information about the project as individuals requested. This would also be part of the marketing process of health promotion that is, developing awareness and a sense of the possibility of health promotion in the workplace. Final clarification of initial steps was, that :

1) A general introduction to the project would be given by committee members to staff in their respective branches.
2) Committee members would set up focus group discussions and/or interviews , to explore some specific health concerns and issues.

The following questions were generated by the committee as exploratory questions for focus groups and interviews:*

1. In your opinion which health issues can be effectively addressed in your workplace?
2. Which aspects of the work environment would you like more input into or influence over that would make your workplace healthier?
3. What in your opinion are the major obstacles to health in your workplace?
4. How can you contribute to health promotion in your workplace?

* To avoid repetition I have submitted the questions as they were worded after editing and approval by both the planning committee and the ethics committee at the university.

Diary Entry

Committee still a little unsure of their liaison role. A lot of clarification and discussion required on the issue of how much information to share and how. Indicates to me the importance of constant and clear communication between the researcher and committee. Sharing circle went very well with interactive discussion helping to instill a sense of mission and unity within the group. A greater sense of ownership achieved at the end of the meeting, with a committee member agreeing to chair the next meeting.

Third Meeting April 19/94 (5 of 6 members present, length of meeting 45 minutes)

The purpose of the meeting was to review and edit information packages and focus group plus interview formats which had been prepared by the researcher following the April 15th meeting. Minor adjustments were made to the wording of the questions and clarification was required for length of time for focus groups. While most committee members felt that an hour was sufficient for a focus group session, there was concern that it may not be sufficient for all groups. It was agreed that those leading the focus groups should be clear about the timing and that participants should receive information in advance so that they

are prepared to address each question briefly. However the format should be flexible to allow for a full interactive discussion within the time limitations considered reasonable by each focus group.

Issues: The committee was anxious to have the data collected from interviews plus focus groups as soon as possible so that the workplace health promotion survey could be designed and circulated by the end of June. The interview plus focus group formats had first to be submitted to and approved by both the researcher's thesis committee and the ethics committee of the Faculty of Education.

Diary Entry

Brief well run meeting, chaired by a committee member. Business like approach used to edit and clarify questions for focus group discussions.

This concluded the group development phase.

GENERATION OF RESEARCH QUESTIONS

The qualitative data collected at focus group sessions were used to develop the questions for the survey. This also corresponded to a reconnaissance phase prior to planning, an opportunity to see what issues appeared to be of concern at the workplace.

Focus Groups

Only one individual interview was held. A total of six focus group meetings were held. Five of these were at branch level and one was at executive level. One branch did not participate in a focus group session. The committee member from the branch in question, attributed this to upheaval in the branch during the time the focus groups were being run, with further cut backs in staffing and resulting difficulty in getting people together in the

allowed time frame. The first five focus groups were held over a one week period from May 11th to May 17th. The executive focus group occurred at a later date on June 7th after compilations of the preceding sessions had been made. This allowed the researcher the opportunity of sharing these with the executive, after they had given their personal input. The purpose of this was to allow them to have some input as an executive into the development of the survey. Also it provided for an update of the project to the executive.

Dominant Themes: There was a high degree of concordance between groups on the issues identified, but there was variation between groups on the relative importance which they assigned to issues.

Physical Environment was identified by all groups, except for one group who were at a different location as having problems. These included poor air circulation, temperature fluctuations, windows that do not open and poor water quality. Symptoms that people attributed to this included, headaches, tiredness and lack of energy. There was general concern over ergonomics of work stations, computer related strain such as back, neck and eye strain.

Physical Fitness was addressed by most groups, with the suggestion that it needs to be encouraged. The possibility of developing a fitness facility within the building was raised by some participants. (see appendix E for complete focus group compilations).

Mental Health was seen as being affected by the stress of re-organization which had affected psychological security. There were unanswered questions related to long term planning, work overload and lack of time. Lack of communication both horizontally and vertically were identified as stressors by a number of participants.

Poor social interaction and communication between branches was an important issue for three of the first five focus groups. There is not enough understanding of what everybody else is doing - no common objectives or sense of team work. Many people seen as working in relative isolation. One group was concerned about the isolation within the branch itself.

Group Dynamics

The group dynamics were quite variable between groups. Some groups were facilitated by committee members, some were facilitated by the researcher. Three of the first five did not have directors present. The researcher attended all focus group meetings. Diary entries provide some insight into observed differences.

Diary Entries

Focus group 1: The committee member monitored the phones so that clerical staff could attend the meeting. The researcher facilitated the discussion. The director was not present. A sharing circle approach was used. This group seemed quite dispirited and disempowered. There were more confirmations of sick building syndrome and poor communication. There was a feeling of vertical isolation between managers and non-professional staff. Constant change and flux. A great sense that input could not produce change.

Focus group 2: Committee member facilitated the discussion. The director was present. An open forum to fielding questions was used. When I asked the committee member after meeting why this method was chosen, the response was that most of their branch meetings and discussions were conducted this way and that people were comfortable with this format. It appeared to work well for the group except for one person, who was reluctant to participate until the very end when the tape had finished. I left the tape recorder off at

this stage. Overall there was a sense of a fairly egalitarian environment with many decisions being made collectively.

Focus group 3: The committee member facilitated the discussion. Sharing circle format used. The director was present. The facilitator tried to probe beneath the surface. Poor social interaction, especially between branches highlighted. Social events often too competitive between branches. Facilitator felt that this group had not been very open.

Focus group 4: The researcher facilitated the discussion. Sharing circle format used. The director was not present. Great feeling of isolation between branches, but also within branch. Need to improve communications horizontally first and then vertically. Very open group, who seemed pleased with the opportunity to discuss issues and a willingness to try to build community.

Question raised as to how much change can be brought about and whether it will be supported by management.

Focus group 5: The researcher facilitated the discussion. Sharing circle format used. Director came to start of session, but decided not to stay, to allow group more freedom of expression. Very cohesive group. Lots of support for each other. Seemed happy and satisfied overall, with some minor frustrations, usually emanating from outside of their branch. Different office location, with very obvious change in atmosphere and decor.

Focus Group 6 (Executive)

The executive focus group was facilitated by the researcher. Non of the planning committee were present. A sharing circle format was used. Areas which executive felt could be addressed in the workplace were: **Physical health** issues of safety, air quality and

ergonomics to some extent. Cost factors were seen as an overriding concern. Physical fitness was seen more as an individual responsibility with management providing flexibility in work routine to accommodate staff participating in fitness programs. **Mental Health** was seen as an area that could be addressed and it was acknowledged that some of the concerns would be management issues. Stress management was a specific area highlighted. **Social and Spiritual** issues raised were the recognition of the need to improve communications and to try to put a more positive light on things. It was noted that there may be some communication expectations from staff that would not be possible for management to meet. Most participants expressed the view that they had a reasonable degree of control and influence over their work environment, which helped to mediate their work stressors. On the question of what obstacles to health existed in the workplace, most felt that there were not many obstacles to health. The primary responsibility rested on the individual, and the view was expressed that the workplace was responsive and flexible enough to accommodate individuals in this pursuit. The sedentary nature of the work and the limitations in terms of time and resources were noted.

Diary Entry

Executive showed a willingness to be open and flexible. Many felt that they were already responsive to the needs of staff. There was a keen sense of their position as managers when answering questions, in particular question 4 on what they could do to promote health in the workplace. This made it more difficult for them to respond to the questions on a personal level. There was a tension between the need to get a job done with shrinking resources and the desire to be responsive to staff needs. One executive member who participated, but had not been present at original project proposal to executive, required clarification of steps in process and project outcome. This was of concern to me because it indicated less than optimal communication at branch level on the project. I

noted a need to ask the committee member to give this executive a copy of the project proposal.

Planning Committee Reflections on Focus Groups (all committee members present)

The general feeling was that focus groups had served their purpose for generating ideas for the survey. Questions were not always answered, but served as a catalyst for discussion. Feed back from focus group participants to committee members had been positive. Clerical staff glad of opportunity to have their voice heard. There were mixed feelings as to whether having a director present influenced the discussion. Some felt that it had no bearing on the discussion and that it was good to have the director present. One member felt that not all issues had been put on the table and that having the director present might have influenced this. There was some overlap in how questions were answered, but questions had served as a catalyst for discussion.

Development of the Survey

Development of the survey marked a new phase in the group process, which was similar to the "performing " phase of the group life cycle. It also represented the first planning phase of the action research cycle. The committee now had some tangible material to work with and there was a cluster of issues which needed further investigation in the survey. The committee noted that there were some dimensions of health which had only been minimally addressed during the focus group sessions, namely the areas of intellectual and spiritual health. It was agreed that they should include these areas in the survey to provide some further opportunity for feedback. The survey format was to include sections on physical, social, emotional, intellectual and spiritual health. The researcher facilitated the development of the survey by drafting the survey based on the compilation from focus groups and the additional inclusion of questions on intellectual and spiritual health. Once the initial draft of the survey was completed and presented to the committee, there

followed three intense meetings to edit, clarify and format the survey. Committee members added, deleted and reworded questions to reflect the workplace context more accurately. The final survey had then to be presented to both the thesis committee and the ethics committee of the Faculty of Education, before being circulated to staff. Diary entry for the final survey meeting reflect the degree of participation by committee members in this process. The survey questions and results are reproduced in full in appendices H and I.

Diary Entry June 21st - Final survey meeting.

Planning committee have now developed a strong sense of ownership of process. Group integrity allows for a high level of consultation, where there is frank and open sharing, without attachment to pursuing an individual agenda. The committee have made one executive decision regarding setting up a workshop in the fall on office ergonomics. One member has agreed to provide professional and support staff to properly format the survey and to sample test the survey for comprehension and readability. Two members of the planning committee will approach the Deputy Minister re writing a cover letter of support and recognition for the project.

Time Frame

The original plan was to distribute the survey before the end of June. However it had a delayed passage through ethics committee. This delay was based on their meeting schedule rather than any problems with the survey itself. The survey was finally distributed during the third week in July and collected on August 22nd. Time frames presented a problem throughout the project due to the difficulty of fitting in meetings around the very busy schedules of all committee members, coupled with the stepped approach to ethics approval of research instruments. Administering of the survey corresponded to the first action phase in the action- research cycle.

Needs Assessments Results

The researcher collected all completed surveys. A total of 46 surveys had been completed. The workplace at that time had 72 employees, giving a response rate of 64%. The researcher was the only person to read the surveys. The numerical responses were put into tables and the comments were collated for each question. Once this task was completed, the researcher distributed the results to all committee members. The project report gives an overview of results.

Interpretation and Analysis :The process

This corresponded to the observation phase of the action-research cycle. The project team began to look at the results of the survey, which had been an action taken to gather data for the planning strategy.

September 16th meeting

The planning committee met on September 16th to review results. The researcher posed the question to committee members "It's your workplace, is this what you expected?" Five of the six committee members were present. At this time the committee accepted with regret that one of the committee members would not be able to participate any further in the process, due to illness.

Most members felt that the survey results were much as they expected. Everyone was pleased with the response rate, especially as the survey had been circulated during peak holiday time. There was an acknowledgment that responses in comment questions seemed genuine and well thought out. There was quite a variation in responses and it was noted that there was a lot of very positive responses. The amount of data in the 5 point scale tables was somewhat confusing and difficult to interpret. This was partly due to the range

of responses for some questions and the difficulty in reading tables based on a five point scale.

The committee felt that it was important to bring the results back in a relatively "raw" form to the branches and executive before any interpretation was made. This would allow for a wide base of input into interpretation and recommendations. It was decided that a preliminary discussion document should be prepared and circulated at branch and executive level. This discussion paper should contain a brief summary of what is, with highlights from survey with some brief numerical analysis. It was felt that it would be appropriate to collapse the 5 point scale for this report to perhaps a 3 point scale, for ease of reading. An appendix would include complete results. Comments and suggestions could be grouped or ranked according to theme. The researcher would prepare a draft of the discussion document for the committee before the next meeting.

Diary Entry

Interpretation of results marked a new phase in the process. Some momentum has been lost over the summer and the large amount of data collected in the survey is presenting quite a challenge to the committee. There seems a need at this point for the researcher to act as a resource person to organize data and provide guidance in interpretation.

September 30th Meeting

This meeting reviewed the draft discussion paper prepared by the researcher. Suggestions for formatting and editing were made. It was decided that as a courtesy to management, they should be the first to receive the discussion paper and should have a chance to meet with the researcher before disseminating the paper at the branch level. Each committee member would then facilitate a discussion at the branch level and report back to the researcher.

Many members indicated that though their commitment to the project remained strong, that job demands were placing increasing time constraints on them. We agreed that much of the interaction at this point in the process could proceed by memo, telephone conversations and faxes.

Meeting with Executive

This marked the start of the reflection phase of the action-research cycle as employees at different levels in the workplace had an opportunity to respond to the survey results and provide feedback which could be used for planning the report.

The meeting was facilitated by the researcher. A sharing circle approach was used to elicit individual responses to the discussion paper and survey results. An interactive discussion followed. General comments included the shared feeling that overall the survey results reflected quite positively on the workplace. This was especially reflected in question 43 (see appendix I) which asked respondents to rate the workplace as a place to work. Seventy-four percent of respondents gave it a very good or fairly good rating. There was a tendency to divide issues into those that were primarily an individual's responsibility and those that were management related. Issues raised at this meeting were mainly those of interpretation and at what level of dissatisfaction did one intervene. Some members were looking for bench marks relative to other workplaces. How much stress was too much stress? Was there a need to mitigate reported back, or neck strain, when there had been no workers compensation claims? What was the pay back to the workplace if they invested time and energy in addressing the issues raised? At this point in time, the researcher gave some interpretive feedback to the executive on the process to date. This was that the 74% satisfaction rating was an indication that the workplace had the ingredients for success, that people cared about where they worked and that taking everything into consideration they gave it this rating. There were many issue areas where

results were far less conclusive and that this was an indication that people felt that there were areas that could be and that they would like improved. Health promotion takes place at a point in the health continuum where there is no pathology, that it is intended to increase people's health resources so that they interact more favorably with their environment. The workplace would have to make judgment calls as to what was an acceptable level of perceived discomfort or stress. The survey can act as a baseline from which interventions can be evaluated by repeating pertinent survey questions at a later date.

Diary Entry

The executive seemed reluctant to act. The 74% satisfaction rating seemed to provide justification for complacency. Some members ready to dismiss results if no standard interpretation available. I perhaps acted too much as an advocate for the process and project, rather than as a facilitator to field management views and concerns. This was a watershed point in process. Very important that committee provides impetus at branch level to move forward and sustain the process. I was tired at the end of the session, which I felt had been a struggle, requiring me to justify and authenticate the survey.

Branch Meetings

Following the executive meeting, the discussion paper was released at the branch level. Committee members then facilitated discussion at the branch level and reported back to the researcher on ideas for actions and possible recommendations for the final report. The researcher combined this input with a search for triangulation between the focus group data and the survey data, to draft a preliminary report of the project with recommendations.

Editing of Report

Editing and writing the report corresponds to a new planning phase in the action-research cycle. Editing and writing of the project report was greatly assisted by the committee members. It marked the completion of transfer of ownership for the project from the researcher/facilitator to the workplace. The project report was going to be submitted to the Deputy Minister by the committee members not the researcher. They started to take a pro-active step towards reworking elements of the report that did not reflect their work context accurately enough, or that could be reworded to illuminate the meaning. Areas that the researcher had not addressed were picked up on, written and submitted for inclusion in the report. Finally the committee met on their own to consult on the final report and how they would present it to the workplace.

Discussion

An inherent problem with the practice of health promotion has been, that though it has been offered as a great new social movement, which is empowering and community directed, it has for the most part been directed from within the state. While it shares the language of a social movement, it has had a restricted social base. It has tended to be "expert driven". The list of expertise which Mc Donnell (1988) prescribes for health promotion programming ran the gamut from organizational theory to clinical aspects of health assessment. Most projects rely heavily on some "outside" knowledge source. Indeed there is a very real dilemma between providing no conceptual framework from which to proceed, relying totally on intuitive and perceived needs, running the risk of generating generalized notions and vague goals, and assuming the role of expert consultant, guiding the workplace through a pre-designed, standardized program which allows some contextual flexibility, but runs the risk of diluting the directional and problem solving input from the participants.

In this study the researcher attempted to maximize the input of participants as "knowers" within their work environment, while at the same time provide a common language to frame the discussion. This was done through initial meetings with the planning committee where some background to health promotion, including definitions of health promotion and health dimensions which could be explored were presented to the committee as a starting point. This background was used to inform the decision as to which parameters of health would be explored. Once there was agreement on the use of these parameters all participants in either focus groups or the survey were presented with the same background from which to frame their responses. This approach gave the researcher, two project roles, that of health promotion resource person and process facilitator. There were also two research roles, that of being a participant and an observer.

It is important to note that this workplace was not one with known occupational hazards such as those found in many industrial work sites. It did not provide an interface between occupational health and safety and health promotion and was therefore not subject to some of the possible contradictions found between these groups as outlined by Gordon (1987). It in fact did not have an active workplace safety and health committee. It arguably provided an optimum opportunity to approach health promotion from the mid-point of the health continuum (Ardell and Travis 1975).

Dilemmas

Of the three dilemmas in action research described by Rapoport (1970), ethical, goals and initiatives, two were manifest in this study.

Ethical

The workplace has a small workforce, which meant that some branches have less than ten staff. This made the issue of confidentiality very difficult to maintain without putting some constraints on the interactive process. For instance focus group discussions were reported in a general compilation. Because of concerns raised on the issues of confidentiality, participants in the survey were not asked to identify which branch they came from. This made it difficult to detect possible "hot spots" on certain issues. As the researcher had been present at all focus group sessions she had access to information that could have shed light on some specific branch issues, but was ethically bound not to disclose the information, as personal attribution would have been hard to avoid. Recommendations in the final report did attempt to take this dilemma into account.

Goals

The major goal dilemma was one of balancing the research goal with the worksite goals and the practical agenda of the organization. From a research perspective the major

function of the project was to serve as a tool for observation of a process. The requirements of a stepped approach to ethical review of all project instruments slowed down the project considerably. This was frustrating for the workplace. In essence, there were two research projects being conducted simultaneously. The researcher had the duel demands of being a participant in the project as well as an observer of the process. Commitment to the project and the project partners required as large a time investment as the observation of the process.

Research Methods

Project Instruments: Qualitative data were collected at the focus group discussions. Quantitative data were collected through the survey. One of the objectives of the study was to explore the usefulness of action-research as an integrative method for health promotion planning. This method lends itself to the use of both qualitative and quantitative instruments. "The Action Research Planner" (Kemmis and McTaggart 1982), describes an initial exploratory phase of action-research, which involves getting a lie of the land. The focus group sessions provided that initial exploration which served to inform the development of the survey. A search for triangulation between the focus group data and the survey data, did help to validate issues raised at the focus group level. It also served to put them into context within the total work environment. The wider base of participation at the survey level diluted the severity of issues, when examined using a broader net. Survey questions explored issues raised at focus groups in greater depth and identified parameters associated with specific issues. For example, work stress which had been identified at focus group level was explored in terms of identifying specific work stressors and their relative impact on individuals. This helped in problem solving and developing recommendations for the report. This approach is similar to the one Steckler et al. (1992) described where qualitative methods are used to develop quantitative measures. However qualitative data had a greater influence than this would suggest.

Further discussion at the branch level as well as ongoing consultation with the planning committee all served to inform and influence the final report. This is where the reflective stage of action-research allows for change and modification in an evolving process.

Process Instruments: The main tools which the researcher used in observing the process, were those of recording focus group and planning sessions to allow the researcher freedom to facilitate. Additional notes were taken at each meeting, with field notes being developed from a combination of these and review of the recordings. Diary entries were made to record personal notes, especially those relating to group dynamics. Much of this is similar to techniques described in Kemmis' "The Action-Research Planner" (1982). Audio-taped material was especially useful to review as it captured the atmosphere and mood of the meeting as well as unfiltered data. However it does produce some dissonance between being a participant and an observer (as discussed below).

Development of Ownership

One of the objectives of the study was to develop a process model, that was not only participatory in design, but was also self sustaining beyond the study period. Ownership, not only of the final project report, but also of the process itself was an important requirement for the model to be self-sustaining. Ownership developed in a number of phases. Group development was a very important initial phase in this process. The importance of this has been described by Cunningham (1976). Within a health promotion context, it required not only the development of a comfort level with roles and responsibilities within the planning committee, but also the development of a common language for exploring health promotion issues. This I believe was established and contributed to group cohesiveness. During this phase, the researcher's role as resource person was more dominant than that of facilitator.

The second phase in the development of ownership occurred in conjunction with the development of the survey. At this stage the data from focus groups had provided sufficient background to define the field for further exploration. It was at this stage where subjective knowledge of the work environment put the committee in a strong position to help shape the survey questions. The researcher still had the responsibility to provide a format which might best serve their needs. This however shifted the weighting from role as resource person to facilitator.

The third phase occurred during the writing of the final project report. The report was an internal document for review and action within the workplace. It therefore represented the material outcome of the project to be submitted to the workplace by the planning committee. There was a genuine desire to produce a report that contained recommendations that were both realistic and attainable within the context of the organization. Only the planning committee had the knowledge and expertise to make many of these judgments. The researcher at this point became more of a "shadow writer" than the major author of the report. The report also contained recommendations which would institutionalize the role of a health promotion committee. This if implemented ensures an organizational base for ongoing planning and review.

Potential for Organizational Change

One of the major advantages of an action-research approach to workplace health promotion planning, is its potential to mediate change within the social setting. It provides resonance to the premise that health in the occupational setting is influenced by physical, mental and social environments within the workplace and that health promotion is a process of enabling people to increase control over and to improve their health. It does this by providing employees with a mechanism to explore the relationships between these

health components within the work environment, while at the same time allowing them to influence the nature and direction of the exploration.

In this study, the wide base of consultation provided for through, focus groups, survey and branch discussions as well as the ongoing efforts of a health promotion planning committee provided a momentum for organizational change. It is too early to determine the extent of this change. However, a number of the recommendations in the workplace report look at systems within the workplace and their influence on health. This is evident in the recommendations related to improving communications, developing a stress management strategy and encouraging appreciation and recognition of employees. If these recommendations were solely the work of an outside consultant, they would be far less compelling. The project proposal had also received approval from the executive before its commencement. Institutionalization of the health promotion planning committee is in itself an example of organizational change. Organizations are complex networks and it would be naive to assume that a written report had in itself the power to bring about change. However, the study did bring the process to a point where there was an organizational base for ongoing planning. Since the completion of the project, the planning committee has developed an action plan to assist in implementing the recommendations, with a plan to review the process in March of 1996.

Role of the Researcher as a Change Facilitator

Orlandi (1986) suggested the use of change agents who operate as objective advisors in health promotion innovations, who provide a linkage between the users and the providers. This was not the role of the researcher in this present study. It more closely resembled the role described for project coordinators by Grossman and Scala (1993) on health promotion and organizational development. In this document, the project co-ordinator is seen as a change facilitator, who must maintain a neutral position towards contradictory

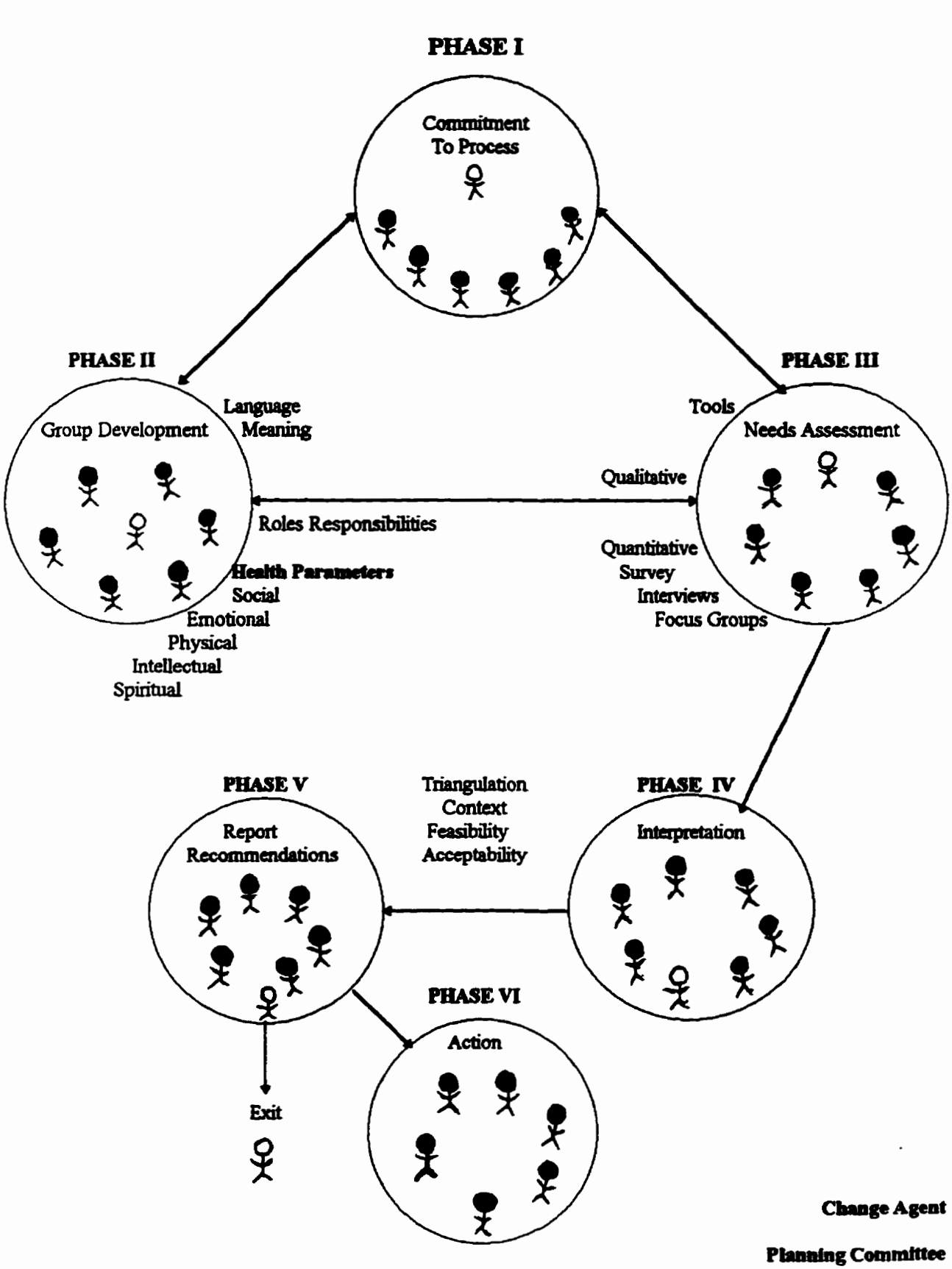
perspectives in the system. In this study the role of the researcher was more complex than either of these. Action-research brings about change in an inter-active and cyclical manner. As a project and process facilitator, I was committed to change as it unfolded. Communicating the process of change to different levels of the organization, such as occurred with meetings with the executive, necessitated some advocacy for the process among staff who were less closely involved in the project. This I believe requires a word of caution and would best be averted through closer association with management on an ongoing basis. Recommendations in the workplace report included inclusion of management on the health promotion planning committee. The dual responsibility of acting as resource person as well as facilitator also dictated that the researcher take a less neutral stance on some issues. An example of this was to encourage or at least provide a rationale for a pro-active response, to health issues that were of concern but did not appear to pose an immediate threat to health. The rationale for this is that health promotion has its greatest impact when intervention occurs at a point where there is no discernible illness, but serves to build up human health resources and increase the capacity to act or respond to a wide variety of situations.

THE MODEL

This study embarked on a journey of completing a case study in action-research as a means of developing a process model for planning health promotion in the workplace. The description of this process as reported in this thesis is the template from which the following model was derived. This model requires an outside change agent to assume the dual function of health promotion resource person and process facilitator. The relative weighting of these roles changes as ownership for health promotion planning is transferred from the change agent to the workplace.

The model (fig.3) has five phases. Each phase has roles and functions for both the workplace and the change agent as well as tools outlined to assist the process. The meaning of the word "tools" in this context includes actions and strategies to assist the process. The schematic diagram of the process includes the five phases as well as a positional representation of the change agent in relation to the planning committee at each phase. This represents the changing relationship between the change agent and the planning committee at each phase of the process.

WORKPLACE HEALTH PROMOTION PLANNING MODEL



Phase 1 : Commitment to Process

Roles and Functions of Workplace:

Workplace makes a philosophical commitment to workplace health promotion.

- Employee survey to gauge interest and attitude towards workplace health promotion.
- Executive decision to support health promotion planning.
- Recruitment of health promotion planning committee can start at this time. The committee should be voluntary and represent a broad base within the organization.

Roles and Functions of Change Agent:

- Provide a background to workplace health promotion.
- Provide the workplace with a proposal for a planning project.
- Assist the workplace in determining interest in the project.
- Clarify roles and responsibilities for completion of project.

Tools: Presentation to executive, written proposal, written background information to workplace health promotion.

Phase 11 : Group Development

Roles and Functions of Health Promotion Planning Committee

- Commitment to serving on planning committee.
- Development of comfort with roles and responsibilities of committee.
- Development of a common language for health promotion.
- Development of group cohesiveness.
- Initial exploration of possible issues within group setting.
- Development of project goals.

Roles and Functions of Change Agent.

- Facilitate group development.
- Clarify roles and responsibilities of change agent and field all questions related to process.

- Provide background information to workplace health promotion.
- Take a leadership role for co-ordination of project during this phase.

Tools: Project updates, development of communication strategies, group consultation.

Phase 111: Needs Assessment

Roles and Functions of Health Promotion Planning Committee

- Collaborate with change agent in the development of assessment tools.
- Keep workplace informed of progress of project.
- Take on some responsibilities for administering assessment tools (e.g. organizing branch discussions, facilitating issues identification, distribution of questionnaires)
- Agree on health parameters which will be assessed.
- Take a more active role in forward momentum of project.

Roles and Responsibilities of Change Agent

- Provide assessment tool models for committee to review.
- Review the use of qualitative and quantitative methods for generating data.
- Facilitate reflection on process as it evolves.
- Allow committee make final editorial decisions on all instruments plus workplace memoranda.
- Facilitate collection of qualitative and quantitative data.

Tools: Encourage leadership roles within the committee, use committee member workplace knowledge as a resource for refining assessment tools.

Phase 1V: Interpretation of Needs Assessment

Roles and Functions of Health Promotion Planning Committee

- Provide a context for interpretation of data.
- Facilitate further discussion of results at branch level.

- Develop a group consensus on priorities for intervention.

Roles and Functions of Change Agent

- Collate data and present results in a form that is easy to follow.
- Facilitate in triangulation of qualitative and quantitative data.
- Provide some guidelines for interpretation of results.

Tools: Arranging of results into tables, collapsing scales, development of discussion paper to aid further consultation.

Phase V : Workplace Report and Recommendations

Roles and Functions of Health Promotion Planning Committee

- Develop recommendations based on degree of concern over issues and possibility for implementing change within the workplace.
- Delegate some recommendations to appropriate areas for implementation.
- Describe specific strategies which will help implement recommendations wherever possible.
- Take ownership for the report and take steps to institutionalize the process.

Roles and Functions of Change Agent

- Facilitate in the development of recommendations.
- Provide guidance in the area of health promotion resources which the workplace could access.
- Write report under the direction of the planning committee.
- Consult as widely as possible before finalizing the report.
- Facilitator starts to disengage from the process.

Tools: Committee members start to work independently in editing and reviewing draft report, consultation with individual committee members for a richer understanding of implications of recommendations, memos, faxes, telephone conversations to maintain a flow of communication.

Phase VI : Action

Roles and Functions of Health Promotion Planning Committee

- Present report to executive.
- Advocate for adoption of recommendations.
- Take initial leadership in implementation of recommendations where applicable.

Tools: Facilitation of discussion of report at branch level, informal consulation with co-workers, exploration of ways and means of implementing recommendations.

CHAPTER FIVE

IMPLICATIONS

Applications

This study generated a process model for workplace health promotion planning. The model is based on a single case study at a work site. Nevertheless it should have applications at other work sites. The collaborative nature of the model provides for close co-operation between an outside change agent and a worksite planning committee. This ensures that all elements of the model are influenced and directed by the worksite. Therefore the same process will generate very different plans depending on the characteristics of the worksite.

Change Agents

The model requires the use of an outside change agent, who has the dual role of resource person and facilitator of the process. The question arises as to where these change agents are going to come from is a challenging one. Independent health promotion consultants are one possible source. It is important however that they do not have vested interests in the use of any specific programs, as this may influence the direction of the planning. Another possible source are consultants working for government departments. This suggestion might appear naive given the new wave of government reduction and trimming especially in the area of social programs. However one could argue that the diversion of some resources from the area of health promotion programming to the development of health promotion capacity within organizations is a more effective and sustainable use of resources. The province of British Columbia has taken a lead in this respect, in that it has trained facilitators working with the B.C. Healthy Workplace Project.

Action Research

The study looked at the usefulness of action research as an integrative approach to health promotion planning. The experience suggests that it has the potential to develop a research capacity in a worksite beyond the life of the study period. It is too early yet to say if this project will survive, however the capacity and transfer of ownership was clearly demonstrated by the workplace planning committee. It readily lent itself to the integration of qualitative and quantitative data collection.

Health as Multi Dimensional

A stated objective of the model was that it would approach health promotion as muti-dimensional. This was of particular concern because of the strong focus in the literature on projects that were one dimensional with lifestyle change being the focus of intervention. This study provided a broad field of exploration circumscribed by a common language on definitions and dimensions to be explored. Such an approach explored within an occupational setting has the potential to challenge existing social settings within an organization, as participants examine health dimensions within their work environment. Consequently organizations who embark on such a project must be open to the possibility of organizational change.

Limitations

The author believes that the model described has application to a variety of work settings. There are a number of limitations however.

Commitment

Sustained commitment in terms of organizational attitude, resources and time is required for the successful application of the model. It is not a "quick fix" approach. It takes time to develop group cohesion, to encourage a broad level of employee participation in the

process, to disseminate data and to inform and update all employees on an ongoing basis. This is particularly difficult if no existing vehicle, such as a newsletter already exists.

Challenge

It is very likely to challenge the "status quo" and must be fair and include all levels of staff at varying stages of the process. This can be very difficult to achieve as time and work constraints vary among staff at different times. Resistance to change is an obstacle that is likely to be encountered. The development of a sense of community or common unity in response to health promotion planning may help over come some of these challenges.

Workplace Setting

This study focused on a worksite where there were no obvious or well documented hazards at the worksite. It would be very important that an industrial site did not abdicate its responsibility towards providing a safe work environment in favor of jumping on the health promotion band wagon. In reality the participatory nature as well as the muti-dimensional approach to health promotion in this model should ensure that this did not occur. However this study did not have the opportunity of working with an occupational health branch within the worksite and hence the word of caution. This worksite was a white collar worksite with a great deal of experience and expertise in the area of human resource management. Familiarity with group discussions, team problem solving was significant. Group development may take longer in a different work setting.

Further Research

This study was limited in its depth. Health promotion is a wide field of study and the net was cast wide to provide an unfettered approach to the workplace in its response to the project. Consequently many aspects of the study would have benefited from a greater depth of analysis. This was not possible given the limitations of time and resources

available to this study. Closer examination of barriers to change in organizational settings and the diffusion of health promotion innovations might well be studied further with the application of this model at future work sites.

Epilogue

When Kurt Lewin coined the term "action research" in 1948, he referred to it as research leading to social change and remarked that research that produces nothing but books will not suffice. This author concurs with these sentiments and believes that health promotion research methods and projects should be guided by the defining concept of health promotion as a process of enabling people to increase control over and to improve their health.

> ***"The learned of the day must direct people to acquire those branches of knowledge which are of use, that both the learned themselves and the generality of mankind may derive benefits therefrom. Such academic pursuits as begin and end in words alone have never been and will never be of any worth".***
>
> **Tablets of Baha u 'llah**

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APPENDIX A

Geraldine Guilfoyle,
Graduate Student,
Dept. of Curriculum:
Mathematics and Natural Sciences
University of Manitoba.

Dear Mr. :

I am a graduate student at the University of Manitoba in the Department of Curriculum, Mathematics and Natural Sciences. This letter is to inform you of the nature and purpose of a proposed study to be carried out at the worksite of the x. The proposed study is to collaborate with a worksite to develop a model for health promotion planning in the workplace. The proposed study would use action-research as a method of inquiry. This would involve a collaborative approach between staff and the researcher, where employees are actively involved in gathering information, analyzing it and acting on it. The researchers role is to help people develop their own tools for gathering data, assist in its interpretation and facilitate problem solving. By completion of the study the following components should be in place:

1) An organizational base for ongoing analysis, reflection and action in health promotion.

2) A needs analysis pertinent to health promotion issues in the workplace will have been completed.

3) A planning strategy with decisions as to which health promotion activities the worksite would like to implement.

4) Some preliminary exploration of the policy and organizational changes that may need to be made to support the desired change.

Participation in the study is voluntary and ongoing. Your consent to proceed with the study in no way binds either you , the x or any of the employees to participate in the project. It indicates approval of the proposal in principle and invites access to the workplace with the clear understanding that you have the right to withdraw your approval at any time without penalty.

The project will require the assistance of a health promotion planning committee formed by interested employees, who will help in the design of and give approval for all

instruments used for gathering data. Methods used to gather data for the study will include small group discussion, individual interviews and a written survey.

The purpose of group discussions and interviews is to explore perceived needs and barriers to health promotion in the workplace. It will provide a context from which a relevant health promotion survey can be developed. All data gathered of a personal nature will be reported in a manner which assures the confidentiality of the informant.

A report of the summary of the findings of the study will be made available to the worksite.

This proposal has been approved by my thesis committee and will be subject to the approval of the ethics review committee. Further information on the proposed study can be got by contacting me at my home address:

Box 143,
RR # 2,
Dugald,
MB. ROE OKO
Tel. 444-3890

My supervisor is Dr. Dexter Harvey, Dept. of Curriculum, Mathematics and Natural Sciences. He may be contacted at 474-9223.

Your written consent is necessary before I can proceed any further with this project.

Yours Sincerely,

Geraldine Guilfoyle

APPENDIX B

Cover Letter Health Promotion Planning Committee

Dear

I am a graduate student at the University of Manitoba in the Department of Curriculum, Mathematics and Natural Sciences. In a survey carried out at your workplace in December, regarding a proposal to introduce health promotion planning at your worksite, you indicated that you would be willing to sit on a health promotion planning committee. My name is Geraldine Guilfoyle and I am the graduate student who will be working collaboratively with the planning committee on this project.

The project will develop a health promotion planning strategy for the workplace. This will be achieved using action-research as the method of inquiry. This approach requires the planning committee and the researcher to act as a team in gathering information, analyzing it and acting on it. Members of the planning committee become part of the research team and are an integral part of the study. By completion of the study the following components should be in place:

1) An organizational base for ongoing analysis, reflection and action in health promotion.

2) A needs analysis pertinent to health promotion issues in the workplace will have been completed.

3) A planning strategy with decisions as to which health promotion activities the worksite would like to implement.

4) Some preliminary exploration of the policy and organizational changes that may need to be made to support the change.

Participation on the committee is voluntary. Members of the planning committee become research subjects as well as research partners. If at anytime a member of the planning committee wishes to withdraw from involvement in the project, they are free to do so without restraint. Should a member withdraw they have the right to request that their input into the project up to the point of withdrawal be purged from the research report.

Committee responsibilities will include collaboration with the researcher in the following areas: identifying health issues to be explored, developing a needs assessment survey questionnaire and assisting in its interpretation. All survey instruments will be approved by both the planning committee and the ethics review committee at University of Manitoba. The committee will in collaboration with the researcher co-author a report on the findings and recommendations of the project.

Action-research develops a broad base for decision making as well as a framework for ongoing evaluation and action within the workplace. The researcher's role will be to facilitate this process and provide background information, written updates of project , technical assistance throughout the project. Time commitment for committee members during completion of the project will be approximately two hours per week over a period of six to eight weeks. This will include time spent on producing the project report.

The confidentiality of individuals will be maintained at all times , with data being reported in a general manner that maintains anonymity. As the primary investigator I will be keeping field notes and personal notes during the study. These notes will be destroyed at the completion of the thesis. A description of the project and its findings will become part of the body of a thesis written by the graduate student. The thesis and research findings will be made available to all interested participants.

This proposal has been approved by my thesis committee and will be subject to the approval of the ethics review committee. Further information on the proposed study can be got by contacting me at 444-3890. My supervisor is Dr. Dexter Harvey, Dept. of Curriculum, Mathematics and Natural Sciences. He may be contacted at 474-9223.
I look forward to working with you on this project,

Yours Sincerely,

Geraldine Guilfoyle

APPENDIX C

Dept. of Curriculum,
Mathematics and Natural Sciences,
Faculty of Education,
University of Manitoba.

Dear Participant:

I am a graduate student at the University of Manitoba in the Department of Curriculum, Mathematics and Natural Sciences. My name is Geraldine Guilfoyle and I will be facilitating the project to develop health promotion planning at your worksite. this project will serve two functions. The one of primary interest to the workplace will be the completion of a health promotion planning strategy for the workplace. The second function will be a research one which involves the collection of data to describe the process that takes place during the development of this strategy. The research objective is to develop a process model for health promotion planning in the workplace. A description of the process will become part of the body of a masters degree thesis. This means that all participants in focus group discussions are research subjects.

The purpose of the focus group is to generate ideas and research questions for a workplace health promotion survey. The discussion will focus on health promotion issues of concern to the workplace. The discussion should take no longer than one hour. Participation in the focus group is voluntary and participants are free to withdraw at any time without constraint. Should a participant withdraw they have the right to request that their contribution to the discussion up to that point of withdrawal be purged from the research report.

The confidentiality of individuals will be maintained at all times, with data being reported in a manner that maintains anonymity. I will keeping field notes and personal notes during the study. These notes and any audio-tapes made will be destroyed on completion of the thesis. The thesis and research findings will be made available to all interested participants.

This proposal has been approved by my thesis committee and the Ethics Committee of the Faculty of Education at the University of Manitoba. Foe further information on the proposed study contact me at 444-3890. My supervisor is Dr. Dexter Harvey, Dept. of Curriculum, Mathematics and Natural Sciences. He may be contacted at 474-9223.

Yours Sincerely,

Geraldine Guilfoyle

APPENDIX D

FOCUS GROUP PARTICIPANT INFORMATION

A feasibility survey carried out at the workplace in December of 1993 indicated, that there is support among staff for a project to develop health promotion planning in the workplace. A number of respondents to this survey agreed to serve on a health promotion planning committee. A graduate student in health education from the University of Manitoba, Geraldine Guilfoyle, will be facilitating this process and writing a descriptive account of the process for her masters degree thesis.

The objective of the project is to develop a health promotion planning strategy for the workplace. This will involve a collaborative approach between the researcher and the health promotion planning committee in the process of selecting health issues relevant to the workplace, deciding on appropriate methodology, analyzing the results and utilizing the information. To assess the health promotion needs in the workplace a number of focus group sessions will be held to discuss health concerns and generate questions for a workplace health promotion survey. Some individual interviews will also be conducted. By completion of the project the following components should be in place:

1) An organizational base for ongoing analysis, reflection and action in health promotion.

2) A needs assessment pertinent to health promotion issues in the workplace.

3) A planning strategy with decisions as to which health promotion activities the workplace would like to implement.

4) Some preliminary exploration of the policy and organizational changes that may need to be made to support the desired change.

For the purpose of this study the following definitions will serve as reference points for the participants:

Health: The complete state of physical, mental and social well-being and not merely the absence of illness.

Health Promotion: The process of enabling people to increase control over and to improve their health.

Health in the occupational setting will be the focus for the health promotion planning committee. The **occupational setting** includes, the physical, mental and social environments within the workplace.

the goal of health promotion is to help people to move toward a state of optimal health. Optimal health has been defined as a balance of physical, emotional, spiritual, intellectual and social health.

Physical: Fitness, nutrition, medical self-care, control of substance abuse.

Emotional: Care of emotional crises, stress management.

Social: Communities, families, friends.

Intellectual: educational, achievement, career development.

Spiritual: Love, hope, purpose.

The focus group session you will be attending will address the following:

1) In your opinion which health issues can be effectively addressed in your workplace?

2) Which aspects of your work environment would you like more input into or influence over that would make your workplace healthier?

3) What in your opinion are the major obstacles to health in your workplace?

4) How can you contribute to health promotion in your workplace?

Each participant will have an opportunity to address all of these questions as well participating in an interactive discussion on issues and strategies for promoting health in the workplace. Participants are asked to give some consideration to these questions before the focus group session and to come prepared to address each question briefly.

APPENDIX E

FOCUS GROUP COMPILATIONS

A total of five focus groups have been held to date and one interview has been completed. The dominant themes at these discussions have been collated between groups under different headings. There is a high degree of concordance between groups on the issues identified but there is variation between groups on the relative importance which they assign to these issues.

Physical Environment

All groups working at (x) identified the building in which they worked as presenting obstacles to health. Problems included poor air circulation, temperature fluctuations, windows that don't open, lighting and poor water quality. Symptoms that people attributed to this included headaches, tiredness and lack of energy. In contrast those who work at the building (y) found the physical environment conducive to health. The building manager has been responsive to requests and they have been able to make adjustments to meet individual needs within their office.
Other aspects of the physical environment not specific to the building included concern over ergonomics of work stations, computer related strain such as back, neck and eye strain.

Suggestions: Need a specific person to contact re building problems, who is both responsive and has the authority to bring about needed change. Need more individual control over environment.
Shields for computers, proper height adjustments of computer terminals and other equipment.
Introduction of plants, fish and other personal touches in the office.

Physical Fitness

The need to encourage physical fitness was addressed by most groups. A fitness facility within the building was explored. There is a room in the basement that has showers, but now being used for storage? Also there are rooms available on the 11th and 12th floors?

Suggestions: Tai Chi at lunch time, aerobic classes for all levels, cheaper membership at the Y made available through work, massage therapy, group walks at noon time, after work activities.

Mental Health

Stress of change - stress of re-organization has affected psychological security. Amount and type of work, restructuring of job demands, unanswered questions related to long term planning - work overload - lack of time. There are new areas of expertise which employees have to master without enough training, this also causes stress. Lack of communication both horizontally and vertically a stressor. The workplace is insensitive to

people who get laid off. Many individuals are sensitive, but not there at the organizational level. The same holds true for lines of communication.

Suggestions: Jobs need to be made more understandable with improved communication both horizontally and vertically within the workplace. Stress management used to be offered by (Z), could be resurrected. People need more input into what the workplace is going to look like, need to know that their work is valued and have a say in the direction and a contribution in the organizational planning.
Flexibility in working hours and place of work would help. Ability to take mental health days. For clerical staff, lunch time can either be very uncertain or rigid and inflexible. These staff are more likely to be isolated during lunch hour and coffee breaks. There should be an EAP in place for personnel at EAP branch.

Social
Lack of communication and poor social interaction between branches was an important issue for three of the focus groups. Not enough understanding of what everybody else is doing - no common objectives or sense of team. The workplace is not initially a friendly environment in which to work because of the relative isolation in which many people work. Branches work in isolation of each other. At social functions people stay in their cliques because they have never had a chance to get to know each other at work. Relationships seen as a threat to authority and control. Social functions tend to die. Golf - too competitive between branches, no interaction at Christmas party. One group was very concerned about isolation within the branch itself.

Answers to question 4 "How can you contribute to health promotion in your workplace"

Being aware of personal needs and trying to meet those needs.
Lighten up - humor - joke of the day- freedom to laugh- being able to have fun.
Debrief with colleagues before going home.
Regular time every week to get together for coffee and social interaction with colleagues.
Being honest with people in terms of feedback.
Help create positive conditions.
Talking with colleagues and being more sensitive to the needs of others.
Being more active.
Go out at lunch time.
Look after oneself - accept what you can't change.
Stay at home when sick.
writing letters to building management.
Need to search out supports which are available and use them.
Getting shields for computers.
Plants for office.
Work station at home.
Regular staff meetings for information sharing - assess planning and follow up.

Things that people find are working and promote health *

Building concerns are quickly addressed (branch y only).
People encouraged to work out.
Individual input into decor of offices - plants etc.
Group consultation for planning holidays.
Team meetings once a week.
Gone to re-usable cups.
A lot of permission to talk about things.
Informal debriefing + consultation as well as formal.
Intellectual areas of health being dealt with - job advancement - open door policy.
Egalitarian environment - collective decision making.
Flexibility in work routine.
Branch already does a lot around stress management.
Sharing information - sensitive to each others needs.
Regular coffee breaks with colleagues.

* These ideas are being tried to a greater or lesser extent by different people in different branches. Where they are being used, they are perceived to be a positive influence on health.

APPENDIX F

Dept. of Curriculum,
Mathematics and Natural Sciences,
Faculty of Education,
University of Manitoba.

Dear Participant:

I am a graduate student at the University of Manitoba in the Department of Curriculum, Mathematics and Natural Sciences. My name is Geraldine Guilfoyle and I am presently facilitating a project to develop health promotion planning at your workplace. A description of the project and the planning process will become part of the body of a masters degree thesis.

Many of you have already participated in focus groups which helped to generate the research questions for this workplace health promotion survey. The objective of the survey is to gather data relevant to the needs of your workplace that can be used to develop a planning strategy to promote health at the workplace. Survey data will be reported in the thesis. Completion of the survey should take about 30 minutes. Participation in completing the survey is voluntary and participants are free to fill out as much or as little of the survey as they wish.

The confidentiality of individuals will be strictly maintained. All surveys will be collected at a central location and will be read by me alone. Results will then be tabulated and reported in a manner that maintains anonymity. A report of the project will be made available for all staff as well as a copy of the thesis and research findings.

This survey has been approved by my thesis committee and the Ethics Committee of the Faculty of Education at the University of Manitoba. For further information on the study contact me at 444-3890. My supervisor is Dr. Dexter Harvey, Dept. of Curriculum, Mathematics and Natural sciences. He may be contacted at 474-9223.

Yours Sincerely,

Geraldine Guilfoyle

APPENDIX G

HEALTH PROMOTION NEEDS ASSESSMENT
FINAL REPORT

INTRODUCTION

Health is a dynamic state on a continuum, where one pole represents extreme illness and premature death and the other pole represents a state of optimal health. (Fig.1) The midpoint is a neutral point of no discernible illness or well-being. It is at this point that health promotion begins to make its greatest impact. Working with people who are overtly healthy but often at risk of becoming ill, health promotion helps people move towards optimal health. It does this by improving health related knowledge, attitudes and behaviours within an environment that is both health enhancing and supportive of lifestyle change. The further one moves toward the right hand side of the continuum the greater is the capacity to act or respond appropriately to a wide variety of situations and to change or cope with the environment. Many employers are now recognizing the potential benefits of having a healthy workforce with increased capacity to respond to a variety of situations.

HEALTH CONTINUUM

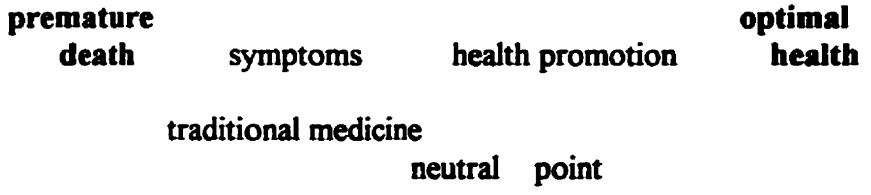

Fig. 1

BACKGROUND

A feasibility survey carried out at the workplace in December of 1993 indicated, that there was support among staff for a project to develop health promotion planning in the workplace. The executive agreed to a proposal by Geraldine Guilfoyle, graduate student in health education at University of Manitoba to facilitate a project, which would develop health promotion planning at the workplace. The graduate student would work collaboratively with a health promotion planning committee to accomplish the following:

1) An organizational base for ongoing analysis, reflection and action in health promotion.

2) A needs analysis pertinent to health promotion issues in the workplace.

3) A planning strategy to implement health promotion activities at the worksite.

4) Preliminary exploration of the policy and organizational changes necessary to support the desired change.

In April of 1994 the health promotion planning committee met for the first time. For the purposes of the study the following definitions served as reference points:

Health : The complete state of physical, mental and social well-being and not merely the absence of illness.

Health Promotion: The process of enabling people to increase control over and to improve their health.

The goal of health promotion is to help people to move towards a state of optimal health, defined as a balance of physical, emotional, spiritual, intellectual and social health.

Methodology: A total of five focus group discussions were held at different branches of the workplace during May and June. The purpose of the focus group discussions was to discuss health concerns and to generate questions for a workplace health promotion survey.
The survey questions were designed to explore further, issues and responses generated at focus group discussions. The survey was organized into five sections to reflect the physical, emotional, spiritual, intellectual and social components of health. Health promotion in the occupational setting is the focus of this project. A total of 46 people completed the survey.
Appendix H contains summary tables. Appendix I contains aggregate of comments.

GENERAL

This section addressed attitudes towards the workplace as a place to work. It looked at respondents willingness as well as interest in attending lunch time presentations on health topics and it asked for respondents opinions on how best they could contribute to health promotion in the workplace.

The workplace was rated as either a very good or fairly good place to work by 74% of the respondents. It was rated as neither good nor bad by 11% of respondents and 15% of respondents rated it as either not very good or not good at all.
The two most frequent responses to what people liked most about their workplace were, colleagues and the nature and challenge of the work. Responses to the question on what people liked least about their workplace were far more varied. The four most frequently cited were management style and communication issues, inconsistencies and/or dissatisfaction re layoffs, promotion and training development and work overload/pressure.

Interest in attending lunch time presentations on health topics was high, with 69% of respondents indicated either a definite or probable interest in attending sessions. The top four topics of interest were:

Stress management = 49%

Personal financial management = 31%

Communications in relationships = 29%

Caring for family as they age = 29%

When asked how best they could contribute to health promotion in the workplace the majority of respondents indicated a personal commitment to health coupled with supporting and encouraging others in their efforts.

Discussion:

The positive attitude towards the working at X is a strong base from which to bring about change and make improvements where warranted. It is not an indication that change is not desired, as other sections contain far more varying results in relation to degree of satisfaction/concern over specific issues. The human resources available at the workplace and the nature of the work provide an excellent resource base for addressing many of the concerns raised in the survey.

SECTION 1
PHYSICAL HEALTH (physical health includes absence of illness, adequate nutrition, control of substance abuse, fitness and general physical well being)

Air Quality

Too little air movement, uncomfortable temperature and stuffy air was experienced at a rate greater than 1/week by 43%, 41% and 49% of respondents respectively. In contrast less than 8% of respondents were exposed to unpleasant odor at a rate greater than 1/week.

Ergonomics

Respondents rated their degree of satisfaction with their work station on a scale from 1-5, where 1 is very satisfied and 5 is very dissatisfied.

Enough surface to lay out work.
1-2 = 45%
3 = 17%
4-5 =36%

Comfortable chair.
1-2 = 54%
3 = 11%
4-5 = 34%

Convenient furniture arrangement.
1-2 = 50%
3 = 11%
4-5 = 38%

Comfortable desk height.
1-2 = 56%
3 = 13%
4-5 = 30%

Appropriate lighting.
1-2 = 48% s
3 = 22%
4-5 = 29%

Symptoms

The symptoms that respondents reported most frequently at a rate greater than 1/week were:
Lack of energy and tiredness = 45%
Painful or stiff neck and shoulders = 37%
Eye strain = 37%
Back pain = 34%

Discussion:

Though the perception of air quality as being poor was quite high, there was no corresponding high frequency of reported symptoms such as cough, headaches, nose or throat irritations. Tiredness was commonly reported. Tiredness has many causes and poor air quality may be one contributing factor. It may also be influenced by stress. However it is important to keep in mind that symptoms occur when the body's buffering system has been overwhelmed. Symptoms are manifested when the battle has been lost. Poor air quality is at the least a source of irritation and physical stress to over 40% of respondents.
Symptoms related to poor ergonomics such as back, neck and eye strain suggest that the area of office ergonomics would benefit from review.

Physical Activity

80% of respondents reported being physically active for 30 minutes or more at least 3 days per week. A wide variety of activities were reported with walking, cycling and aerobics being the most popular.

The most frequently cited factors which prevent people from being physically active were; lack of time, lack of easily available facilities and lack of incentive. 62 % of respondents indicated that they would either probably or definitely make use of an exercise area/program if it were available at the workplace.

Interest in the following programs was indicated:
Fitness facility with equipment = 45%
Massage therapy = 45%
Cheaper membership at commercial fitness facility available through work = 39%
Aerobic classes = 34%
Group walks = 34%
Tai Chi = 32%
Additional suggestions were yoga and karate.

Discussion:

The level of physical activity reported was very high and lack of facilities at the workplace does not seem to have been a deterrent to maintaining an active lifestyle. There appears to be a commitment to self-care and individual initiative in this regard. A supportive environment within the workplace could serve to enhance individual effort and encourage even wider participation.

Work Related Eating Patterns

Lack of time, extended meetings, work deadlines and lack of facilities resulting in skipped meals or less healthful meal choices were the most frequently cited factors which affected eating pattern during the work week.

Discussion:

A common area set aside for meals and breaks and equipped with some basic fittings, such as a sink, fridge, kettle and microwave would serve two functions:

a) An opportunity to make simple, fast and nutritious lunches.
b) A common place to promote social interaction.

It is understood that some of this equipment is already in place at the workplace but it is not all in a single location that is conducive to social interaction.

Smoking

20% (9) of respondents currently smoke tobacco. Of these 77% (8) want to quit, 33% (3) would attend a workplace smoking cessation program and 66% (6) are not sure if they would attend.

Discussion

The smoking rate at the workplace is below the national average of 31%. Because of the low numbers, it is unlikely that there would be enough support for a workplace cessation program. However individual employees may well benefit from programs and materials designed to assist individuals to quit smoking.

SECTION II

EMOTIONAL WELL BEING (emotional well being includes stress management, care of emotional crises, mental health)

Stress

Respondents were asked to select the major source of stress in their lives at this time. The results were as follows:

Financial security	= 37%	Other	= 4%
Work/job dissatisfaction	= 21%	No major stress	= 4%
Home life/family	= 21%		
Job security	=17%		

Respondents were asked to rate job stressors on a scale of 1-5 where 1 = rarely and 5 = very often. The most frequently cited work stressors which were rated at 3 or greater level of frequency were:

Hearing about possible layoffs = 72%

Work overload = 67%

Having to satisfy too many people = 45%

Not having enough information to do my job = 35%

Lack of focus and direction = 34%

Respondents were asked to rate their level of satisfaction with a number of working conditions on a scale of 1- 5 where 1 is very satisfied and 5 is very dissatisfied.
The top two ranked conditions were:

	(rating 1-2)
Flexibility in working hours	**= 71%**
Ability of organization to adapt to change	**= 52%**

Bottom of the list were:

	(rating 1-2)
Communication between branches	**= 24%**
Acknowledgment that work is valued	**= 39%**

Respondents were asked to review a list of life events, normally considered stressful. 73% of respondents indicated a stressful life event as having occured in the preceding 12 months.

58% of respondents rated the workplace as either very supportive or supportive in accommodating peoples needs during times of crisis.
26% of respondents felt that the workplace was either very consistent or consistent in its treatment of all employees.

Discussion:

It is not surprising given the recent changes and down sizing at the Commission that hearing about layoffs was the most commonly identified work stressor. Work overload and having to satisfy too many people are understandable consequences of the former. The question arises as to what level of stress constitutes a concern that needs to be addressed. This in essence is a judgment call which must be based on philosophical considerations as well as physical data. If we adopt the vision statement "to provide a cohesive, supportive work environment that allows each employee to realize their full professional and personal potential" (see pg. 88 recommendations), we need to examine whether it is appropriate to mitigate some of the concerns raised. Increasing the human resources available to the workplace by reducing work stressors could in fact improve efficiency within the organization.

SECTION III

SOCIAL SUPPORT (social support provided by family, friends and social networks which is health enhancing)

This section explored respondents perception on how much support they received from family/friends, peers and management as well as social interaction within and between branches. Responses were rated from 1-5 where 1 was very supportive and 5 was very unsupportive.

Family/close friends = 88% (rated 1-2)

Peers = 66% (rated 1-2 for supporting them professionally)

Management = 54%

Peers = 62% (rated 1-2 for supporting them personally)

Management = 47%

Feelings, on social interaction within and between branches, were very mixed. Those who felt social interaction was good indicated team spirit, openness, good communication and getting together outside of work for social events. Those who felt social interaction was poor, indicated cliques, compartmentalization, stratification by job or profession. (Please refer to appendix I for further detail on this issue)

The top three ranked suggestions for improving social interaction were :

Greater effort to integrate new employees and help them to get to know people.

Team building events within the workplace.

Regular staff meetings within branches.

Many other suggestions are included in appendix I.

Discussion:

Social interaction should reflect individual preferences and needs. However the organizational climate can serve to enable or to pose barriers to social interaction. While the former creates a climate in which individuals can choose to strengthen social bonds within the workplace, the latter effectively limits that choice. The workplace by virtue of the compartmentalization of its work has some natural barriers to socialization between and in some cases, within branches.

SECTION IV

INTELLECTUAL HEALTH (intellectual health is sustained by adequate training, education, career development and achievement)

Respondents were asked to rate their responses to a number of statements related to training, education and career development, where 1 = strongly agree and 5 = strongly disagree.
On the question of whether the workplace provides:

(rated 1-2)

Good opportunity for job advancement = 25%

Adequate continuing education = 30%

Adequate training for the job = 62%

General job satisfaction = 64%

94% of respondents felt that it is a joint responsibility between employer and employee that they are adequately trained for their job.
56% of respondents felt it was the employees responsibility that their career aspirations were met.
43% felt that it was a joint responsibility between employer and employee that their career aspirations were met.

Discussion:

The poor response related to opportunity for job advancement may well be a reflection of the down sizing and reorganization that has taken place in the workplace over the past five years. Because employees no longer have traditional routes within the workplace to fully utilize and enhance their knowledge, skills and abilities (ie. job advancement), other ways that are congruent with their professional roles could be explored. This could include some latitude in work schedules to allow for volunteerism and working within the community on projects that improve their skills and subsequent contribution to the organization.

SECTION V

SPIRITUALITY (Spirituality in this context means anything we experience that leads to a greater sense of balance in ourselves and/or in relationship to others e.g. purpose, love, hope, inner peace, harmony and a sense of belonging)

82% of respondents rated spirituality as either important or very important to them.
In response to the question of whether there is a role for spirituality within the workplace based on a scale from 1-5 where 1 is not at all and 5 is yes definitely:

42% rated it a 1-2
23% rated it a 3
33% rated it a 4-5

Areas that respondents would like to see attention given to at the workplace:

Developing a sense of community in the Civil Service Commission = 41%
Ethical issues = 36%
Quiet space in workplace for reflection/meditation/ prayer = 11%
Opportunity to celebrate or give recognition to important holy days of all faiths = 9%
Issues of intolerance 7%

Discussion:

It was recognized that spirituality is viewed, by many, as an intensely private matter and that some people might be uncomfortable with its inclusion in the survey. However, it is part of our nature and colors the lens through which we view the world. If work practices or relationships at the workplace are incongruent with one's spiritual view of the world, there can be a great deal of resulting stress. A health promoting organizational climate will provide some opportunity to discuss concerns of this nature as they arise. Ethical issues and developing a sense of community in the workplace are two areas that have been highlighted in this survey.

RECOMMENDATIONS

The survey was intended to serve as an exploratory mechanism for gauging attitudes, health beliefs and practices as well as identifying potential risk situations. It does not define the health of the organization, but rather surveys the scene to provide information which can be used as a first step in a cyclical and ongoing planning process for health promotion.

To provide complete anonymity we decided not to ask respondents to indicate which branch they came from. This makes it impossible to detect "hot spots" in various branches. Therefore results reflect an average for the workplace which may not reflect the particular situation for a given branch. Each branch is asked to focus on the recommendations that would be most helpful for them. This will require an honest appraisal of their own strengths and weaknesses. Some of the recommendations will be pertinent across all branches. It is also worth keeping in mind that, if the workplace is viewed as a community, the outcome for one group affects the outcome for all.

Vision Statement: "To provide a cohesive, supportive work environment that allows each employee to realize their full professional and personal potential."

Goals of Health Promotion in the Workplace :

1. To maintain a healthy physical environment in which to work.

2. To promote active living among employees.

3. To promote improved communication horizontally and vertically within the organization.

4. To develop a stress management strategy for the workplace.

5. To encourage appreciation and recognition of all employees.

6. To develop health information resources within the organization.

Health promotion in the workplace requires an organizational framework for ongoing planning and implementation. A Healthy Workplace Committee should be established as a permanent committee in the organizational structure. The policies and procedures may be based on those developed for Workplace Health and Safety Committees, but should be adapted to reflect the vision statement and to meet the goals outlined in this report. The committee should have representation from all branches and should include representation from clerical, professional and management staff. Membership should be rotating and voluntary.
Executive recognition and support for health promotion in the workplace is a necessary ingredient for success and sustainability of the process.

Maintaining a healthy physical environment

The two areas addressed in the survey relating to physical environment were air quality and ergonomics.

Air Quality

There should be some mechanism by which employees can consult and have input into the regulation of air movement and temperature.
Leasing agreements should address this issue and include clear lines of communicating problems as they arise.

Ergonomics

Training should be provided for all staff in the maintenance of an ergonomically correct work station. Information on exercises and other techniques to reduce strain common to their work demands should also be provided. Ergonomic criteria should be considered when purchasing equipment and office furniture.

Promoting Active Living

Active living can be supported through flexible working hours to allow employees participate in activities of their choice.
Employees wishing to develop workplace programs should be encouraged in their efforts.
Corporate rates at fitness facilities should be pursued.
At least some of the social events at the workplace could incorporate an active living theme in their planning.

Improving communications:

Establish team meetings to discuss service issues across divisions.
Provide for a wider and ongoing participation in the strategic and operational planning process.
Re-establish yearly meeting where strategic plan is presented to all workplace staff.
Develop more inter-branch project teams.
E-mail distribute to all staff the minutes of executive and managers meetings.
Schedule more branch meetings.
Produce a quarterly newsletter to foster a sense of community within the workplace.

Developing a stress management strategy:

A stress management strategy could include the following components:

Communication: The communication related to layoffs within the Commission could be carefully reviewed and adapted to reduce the stress associated with this action. This may involve changes in how people are informed and supported during layoffs.
The recent Employment Equity Review may well address concerns related to sick leave for mental health and family illness and will be a valuable resource for policy decisions which may impact on stress in the workplace.
Procedure: Employee input into reasonable work goals, expectations and evaluation could be re-assessed. Team problem solving for specific work stressors, such as work overload, deadlines, prioritization could be used.
Program: Stress Management seminars and Time Management seminars could be run. A corporate membership to Peak Performance could also be considered.
Intervention: Employee Assistance Program is already available but because it is a function of the workplace, not all employees at the workplace feel comfortable accessing it. EAP should also be available through outside contracting of services for staff working at the EAP branch.

Encouraging appreciation and recognition of all employees:

Staff social functions could also serve as a forum for recognizing and appreciating employees.
Branches could issue their own employee bouquets.
Newsletter could also serve as a vehicle for appreciating employees.

Developing Health Information Resources:

A Healthy Workplace bulletin board should be displayed in a prominent area.
A journal rack containing bulletins and journals from Workplace Safety and Health, Health Canada and other sources could be displayed close by.
This rack could contain information on a variety of health related topics.
Lunch time presentations on the topics highlighted from the survey could be investigated.
Quarterly newsletter could contain a section on health promotion.

Conclusion:

The workplace has a wealth of human resources with which it meets the needs of thousands of government employees. The demands of meeting the needs of others should not become a barrier to using the same principles to promote health within the workplace. The increasing demands of fiscal restraint do not make health promotion unaffordable but rather an indispensable resource for increasing the capacity of an ever pressed workforce.

APPENDIX I

Appendix I contains the tables of results from questions requiring a numerical response. The number of responses to each question is in brackets at the beginning of each table.

SECTION I

PHYSICAL HEALTH (physical health includes absence of illness, adequate nutrition, control of substance abuse, fitness and general physical well being)

Air Quality

Q. 1 During the past two months how often have you been exposed to the following conditions at work?

Please circle the correct response.

Response Scale 1 = never 2 = 1-2 times/month 3 = 3-4 times/month 4 = >1/week 5 = almost daily

	n	1	2	3	4	5
Too little air movement	(44)	20%	25%	11%	11%	32%
Uncomfortable temperature	(46)	11%	32%	15%	24%	17%
Stuffy air	(45)	18%	26%	6%	18%	31%
Unpleasant odor	(38)	65%	21%	5%	5%	3%

Ergonomics

Q. 2 To what degree of satisfaction do you have the following at your work station? Please rate your response from 1-5, where 1 is very satisfied and 5 is very dissatisfied.

	n	1	2	3	4	5
Enough surface to lay out your work	(46)	28%	17%	17%	10%	26%
Convenient furniture arrangement	(46)	28%	22%	11%	8%	30%
Comfortable chair	(46)	41%	13%	11%	6%	28%
Comfortable desk height	(46)	43%	13%	13%	13%	17%
Appropriate lighting	(44)	32%	16%	22%	13%	16%
Other						

Q. 3 Does your job require you to work in uncomfortable positions or use awkward motions? Please rate your response from 1-5, where 1 = rarely and 5 = very often

(45) 1(68%) 2(18%) 3(4%) 4(4%) 5(4%)

Symptoms

Q. 4 During the past 6 months how often did you experience the following symptoms?

Response Scale 1 = never 2 = 1-2 times/month 3 = 3-4 times/month 4 = >1/week 5 = almost daily

	n	1	2	3	4	5
Nose or throat irritation	(45)	30%	28%	19%	13%	6%
Colds or sore throats	(45)	38%	40%	9%	9%	4%
Persistent cough	(46)	56%	28%	4%	4%	6%
Headache	(45)	20%	35%	18%	15%	11%
Lack of energy, tiredness	(46)	13%	19%	22%	28%	17%
Itchy eyes	(46)	52%	19%	8%	15%	4%
Nausea	(45)	82%	13%	4%	0%	0%

Musculoskeletal

Q. 5 During the past 6 months how often have you experienced the following symptoms?

Response Scale 1 = never 2 = 1-2 times/month 3 = 3-4 times/month 4 = > 1/week 5 = almost daily

	n	1	2	3	4	5
Cramps in hands, fingers or wrists	(45)	49%	33%	11%	2%	4%
Painful or stiff arms or wrists	(45)	44%	42%	2%	6%	4%
Painful or stiff neck and shoulders	(45)	24%	26%	11%	20%	17%
Back pain	(44)	38%	18%	9%	20%	14%
Eye strain	(43)	23%	21%	18%	25%	12%
Other _____						

Physical Activity

Physical activity includes activities such as jogging, team sports, dance classes, aerobics, brisk walking as well as daily activities such as walking to work, gardening, etc.

Q. 6 Are you physically active for 30 minutes or more at least 3 days a week?

(46) Yes 80% No 19%

Q. 7 Which activities do you participate in that you consider physically active? (Actual numbers, not percentages)

Dancing (2)
Yardwork/gardening (11)
Stationary bike (4)
Aerobics (14)
Slow pitch/soft ball (3)
Housework (3)
Hiking (1)
Running (1)
Fitness equipment (1)
Skiing (4)
Court sports (5)
Step machine (1)
Walking(32)
Roller blading (1)
Aquacise (1)
Karate (1)
Hockey (1)
Golf (5)
Cycling (15)
Weight training (4)
Jogging (4)
Ski machine (1)
Swimming (3)
Playing with kids (1)
Curling (1)

Q. 8 The following factors sometimes prevent people from being physically active. Please rate the following in terms of the impact they have on preventing you from being physically active, where 1 = very little impact and 5 = a lot of impact.

	n	1	2	3	4	5
Lack of time	(42)	9%	21%	24%	16%	28%
Lack of transport	(42)	86%	7%	5%	0%	2%
Lack of money	(42)	45%	19%	21%	9%	5%
Lack of easily available facilities	(40)	32%	25%	20%	20%	2%
Lack of interest or relevant activities	(41)	51%	19%	17%	10%	2%
Illness or disability	(42)	69%	14%	7%	2%	7%
Lack of incentive	(39)	33%	23%	15%	20%	7%
No one to exercise with	(38)	60%	15%	8%	8%	8%

Q. 9 If an exercise area/program were available at your workplace would you make use of it?

(45) Yes definitely 29% Probably 33% Not likely 35%
Definitely not 2%

Q. 11 Which of the following activities would you be interested in participating in, if they were available at work.

Activity

(37)
Tai Chi _40%
Aerobic Classes _ 43%
Group walks at noon _40%
Cheaper membership at commercial
Fitness facility available through work _48%
Massage therapy _56%
Fitness facility with equipment _56%
Your own personal suggestions __Yoga(2%) Karate (2%)

Q. 12 Are you comfortable with your present weight ?
Please rate your response from 1-5 where 1 = very comfortable and 5 = very uncomfortable.

(46) 1(19%) 2(24%) 3(37%) 4(11%) 5(8%)

Smoking:

Q. 13 At the present time do you smoke tobacco?
(If you answer No to Q 13 please go to Q 17)

(46) Yes 20% No 80%

Q. 14 How many cigarettes do you usually smoke in a day?

Less than 10 = 33%
10-20 = 33%
More than 20 = 33%

Q. 15 Do you want to quit smoking?

Yes 77% No ___ Sometimes (11%)

Q. 16 If a smoking cessation program was offered at your workplace would you participate in it?

Yes 33% (3) No _ __ Not Sure 66%(6)

SECTION II

EMOTIONAL WELL BEING (emotional well being includes stress management, care of emotional crises, mental health)

Stress

Q. 17 What is the major source of stress in your life at this time? (Select just one answer) (46)

Home life / family 17%
Work/ job dissatisfaction 21%
Job security 17%
Financial security 37%
Other (Please specify) 4% Health (1), Keeping up with work demands (1)
No major stress (4%)

Q. 18 Do the following situations cause you stress at work? Please rate your response from 1-5 where 1 = rarely and 5 very often.
response.

Stressor	Rating					
	n	1	2	3	4	5
Hearing about possible layoffs	(46)	11%	17%	24%	24%	24%
Not having enough information to do my job	(46)	30%	43%	15%	8%	2%
Having to satisfy too many people	(46)	24%	30%	13%	24%	8%
Feeling inadequately trained	(46)	28%	43%	19%	6%	2%
Work overload	(46)	6%	26%	19%	24%	24%
Poor relations with supervisor/management	(46)	54%	21%	8%	6%	8%
Poor relations with other employees	(45)	60%	26%	6%	0%	6%
Lack of focus and direction	(46)	39%	26%	24%	6%	4%

Q. 19 How satisfied are you with the following conditions at work ? Please rate your response from 1-5 where 1 is very satisfied and 5 is very dissatisfied.

	n	1	2	3	4	5
Communication within my branch	(45)	22%	26%	24%	18%	9%
Communication between branches	(45)	9%	15%	29%	22%	24%
Amount of input you have into direction and planning	(44)	20%	25%	25%	20%	9%
Acknowledgment that your work is valued	(46)	13%	26%	30%	17%	13%
Flexibility in working hours	(45)	49%	22%	15%	6%	6%
Ability of organization to adapt to change	(46)	28%	24%	30%	11%	6%

Q. 20 Please read the following list of life events and check yes if one or more happened in your life during the past 12 months.

Serious financial difficulties.
Illness, injury or surgery of yourself, children or spouse.
Problems related to your marriage.
Problems related to your children.
Problems in dealing with caring for your parents.
Divorce or marital separation.
Death of a parent, sister or brother.
Death of a spouse or children.
Other personal event that caused you great concern.

(45) Yes 73% No 27%

Q. 21 In your opinion is the workplace supportive as an organization in accommodating peoples needs during times of personal difficulties?
Please rate your response from 1-5 where 1 = very supportive and 5 = very unsupportive

(44) 1(29%) 2(29%) 3(23%) 4(11%) 5(7%)

Q. 22 Generally speaking , in your opinion are all employees treated in a consistent manner at the workplace?
Please rate your response from 1-5 where 1 = very consistent and 5 = very inconsistent.

(46) 1(15%) 2(11%) 3(28%) 4(13%) 5(32%)

SECTION 111

SOCIAL SUPPORT (social support provided by family, friends and social networks which is health enhancing)

Q. 24 How supportive are your family and/or close friends? Please rate your response from 1-5 where 1 = very supportive and 5 = very unsupportive.

(45) 1(53%) 2(35%) 3(6%) 4(4%) 5(0%)

Q. 25 Do you feel that your peers at work support you professionally? Please rate your answer from 1-5 where 1 = very supportive and 5 is very unsupportive.

(45) 1(35%) 2(31%) 3(29%) 4(2%) 5(2%)

Q. 26 Do you feel that management supports you professionally? Please rate your answer from 1-5 where 1 = very supportive and 5 = very unsupportive.

(46) 1(32%) 2(22%) 3(32%) 4(8%) 5(4%)

Q. 27 Do you feel that your peers at work support you personally? Please rate your answer from 1-5 where 1 = very supportive and 5 = very unsupportive

(46) 1(45%) 2(17%) 3(19%) 4(15%) 5(2%)

Q. 28 Do you feel that management supports you personally? Please rate your answer from 1-5 where 1 = very supportive and 5 = very unsupportive.

(45) 1(29%) 2(18%) 3(29%) 4(18%) 5(6%)

Q. 29 How would you rate the social interaction between branches at the workplace? Please rate your answer from 1-5 where 1= very good and 5 = very poor

(46) 1(28%) 2(15%) 3(28%) 4(15%) 5(13%)

Q. 30 How would you describe the social interaction within your own branch Please rate your answer from 1-5 where 1 = very good and 5 = very poor

(44) 1(13%) 2(13%) 3(34%) 4(25%) 5(13%)

Q. 31 The following suggestions have been made for improving social interaction in the workplace: Please rate each suggestion from 1-5 where 1 = not likely to have much impact and 5 = would have a lot of impact

	n	1	2	3	4	5
A common room where people can meet during breaks	(45)	20%	24%	24%	17%	13%
Non-competitive social events	(43)	4%	28%	32%	23%	11%
Social events which will facilitate mixing between branches	(43)	11%	23%	28%	25%	11%
Family oriented social events	(46)	28%	15%	28%	15%	13%
Regular staff meetings within branch	(44)	13%	13%	34%	25%	13%
Regular meetings between branches for all staff	(42)	16%	16%	16%	33%	14%
Team building events within the workplace	(45)	15%	15%	26%	26%	15%
Regular time every week to get together for coffee and social interaction with colleagues	(39)	41%	18%	23%	18%	13%
Greater effort to integrate new employees and help them get to know people	(41)	7%	5%	34%	36%	19%

SECTION IV

INTELLECTUAL HEALTH (intellectual health is sustained by adequate training, education, career development and achievement)

Please respond to the following statements:
Rate your responses from 1-5 where 1= strongly agree and 5 = strongly disagree

Q. 32 The workplace provides good opportunity for job advancement.

(46) 1(8%) 2(17%) 3(30%) 4(24%) 5(19%)

Q. 33 There is adequate continuing education provided to employees at the workplace.

(45) 1(17%) 2(13%) 3(37%) 4(22%) 5(9%)

Q. 34 I feel adequately trained for the job I am expected to do.

(46) 1(30%) 2(32%) 3(17%) 4(19%) 5(2%)

Q. 35 In general I am satisfied with my job.

(45) 1(33%) 2(31%) 3(15%) 4(11%) 5(9%)

Q. 36 In your opinion whose responsibility is it to ensure that you are adequately trained for your job.

(46) My responsibility 6% My employer's responsibility 0%
It is a joint responsibility 94%

Q. 37 In your opinion whose responsibility is it that your career aspirations are met.

(46) My responsibility 56% My employers responsibility 0%
It is a joint responsibility 43%

SECTION V

SPIRITUALITY (spirituality in this context means anything we experience that leads to a greater sense of balance in ourselves and/or in relationship to others. eg. purpose, love, hope, inner peace, harmony and a sense of belonging)

Q. 38 Is spirituality important to you ?
Please rate your response from 1-5 where 1 is not very important and 5 is very important.
(44) 1(7%) 2(9%) 3(2%) 4(41%) 5(41%)

Q. 39 In your opinion is there a role for a sense of the spiritual within the workplace?
Please rate your response from 1-5 where 1 is not at all and 5 is definitely

(44) 1(13%) 2(29%) 3(23%) 4(20%) 5(13%)

Q. 40 Please check the following areas that you would like to see attention given to at your workplace.

(44) Ethical issues 36%

Quiet space in workplace for reflection/meditation/prayer 11%

Developing a sense of community in the workplace 41%

Opportunity to celebrate or give recognition to important holy days of all faiths 9%

Issues of intolerance based on .....(please list all those you feel need attention) 7%

GENERAL

Q. 41 Which of the following health topics do you feel you need more information about?

(45) 4% Acquired Immuno Deficiency Syndrome (AIDS)
11% Cancer
29% Caring for Family as they Age
9% Child Care
29% Communication in Relationships
20% Ergonomics in the Workplace
13% Exercise
11% Healthy Weight
11% Heart Disease
9% Mental Health
24% Motivational Material
24% Nutrition and Diet
31% Personal Financial Management
22% Preparing for Retirement
6% Smoking
49% Stress Management

Q. 42 Would you be interested in attending lunch time presentations on health issues of concern to you?

(45) Yes definitely 29% Probably 40% Not likely 29%
Definitely not 2%

Q. 43 Generally speaking would you say that as a place to work the X is:

(46) 39% Very good
35% Fairly good
11% Neither good nor bad
13% Not very good
2% Not good at all

APPENDIX H

Appendix H contains the collated comments from the survey. They have been edited in places so that they can be grouped thematically or to improve clarity.

Q18. Do the following situations cause you stress at work?
Other: There were 7 additional comments to this question.

Computer malfunctions.
There is an interrelationship between stress over job security and the job itself.
Continuous overload.
Withholding of information.
Lack of development opportunities outside own branch.
Stress more an issue of self management than the organization's responsibility.
Isolation, having no involvement with branch/division level co-workers resulting in uncertainty as to what's going on and status of projects.

Q19. How satisfied are you with the following conditions at work?
Your suggestions for reducing stress in the workplace.

There were 12 respondents who made additional suggestions.
Better communication was the theme of five of these responses. Suggestions for improving communication:
Increased flow of information from the top down; deputy minister to have a meeting with staff once a year; increased teamwork and socialization between management; clerical and professional staff; creating greater understanding of branch roles and values through quarterly branch meetings; more planning, better sense of direction and information sharing.

Other singular responses to this question were:
Everyone assuming responsibility for stressors of the department.
Treated with respect by management and given adequate time to learn.
New management style.
More flexible hours
Need adequate support staff.
Need to bring a sense of professionalism to the job, the pursuit of excellence or even competence will do more than anything else to reduce stress.
Too many projects taken on as a collective unit, will result in disappointment of clients.

Q23. How can the workplace become more responsive to employees during times of personal difficulties?

There were 22 responses to this question.
Four responses related to being more empathetic towards problems, recognizing them early and problem solving.
Six responses related to policy. This included; supporting the MGEU demand to have a "family needs" leave charged to sick leave credits; letting employees take time off as sick leave when stress becomes very difficult; external guidelines for managers and communication as to how the workplace will respond to personal difficulties; not laying off people because they become ill; and time with pay for compassionate leave.
Three responses indicated that treatment needs to be more equitable among staff.
Three respondents felt that the workplace was already very responsive and did not need to be more responsive.
The remaining responses were singular responses.
Preference to keep personal problems out of the workplace.
Gossip less.
Play more of a management leadership role.
I don't know.

Q29. How would you describe the social interaction within your branch? Please explain.
There were 19 explanations to this question.
Those who gave social interaction a high rating added the following explanations:
Fairly good group.
Among the group there is a sense of camaraderie, but very exclusionary to outside organization.
An open team that gets together outside of work to share some fun.
A lot of laughter at staff meetings.
Overall it is excellent, with weekly opportunity for social interaction outside of workplace and humor in the workplace is a daily event.
Attention paid to arrange for social events, coffee breaks and retreats.
Good attendance and support for events such as Xmas party and Xmas brunch.
We are a working family.
Communication is good, everyone is very approachable and easy to talk to.

There was a group of mixed responses which indicated that interaction was inconsistent or perhaps not that important:
Good with team but very poor with branch.
There are pockets of good social interaction that do not seem to extend out to other groups.
Too busy to be social.

Social interaction is I believe as it should be, as peers and colleagues - not as personal friends.
Do not look to branch for social interaction.

There was a group of responses that gave social interaction a definite low rating.
No interaction and too many camps of one group vs another.
Different groups within the branch and none of them intermix.
No mixing between clerical and professional staff.
Isolation in a clerical position, with no social interaction.

Q 29. How would you rate the social interaction between branches at the workplace? Please Explain.
There were 17 explanations to this question.

There were three responses which indicated that social interaction was either very good or adequate to get work done and meet social needs.

There were three responses which indicated that interaction was inconsistent, with some branches interacting well and others not.

The remaining eleven responses all indicated that social interaction between branches was poor for the following reasons:
Too many cliques with rigid boundaries (2); competitive/closed compartmentalized (4); need for information flow, staff meetings, memos (1); time constraints (2); low turn out at social functions, need more events (1); value of "working better" not appreciated by government. (1)

Q31. Additional suggestions for improving social interaction in the workplace.
There were eight additional comments/suggestions.

Greater communication from the top, verbal communication to staff by executive.
Have 1-2 total workplace meetings yearly, at times such as fiscal year end or at reorganization.
Making correspondence available between branches would help us know what others are working on.
Celebrate all holidays and have a food harvest collection or something of that sort on months that don't have holidays.
Social events themselves go well, but dividing walls are back up the next day at work.
Maybe increased social events would help to bring the barriers down.
Events that are casual with low time pressure.
Spouse has been reluctant to attend social events.
Don't believe that social interaction should be forced. If any branch wanted or needed more they would initiate it.

Attend social functions which fit me, less likely to attend more expensive events such as Xmas parties which are not a lot of fun for my partner.

Q 40. (Spirituality) Please check the following are that you would like to see more attention given at your workplace.

Other areas of concern:
There were 9 additional comments.

We need to concentrate on hope, harmony and a sense of belonging, especially in this unstable job environment. Need to reinforce that people are valued.
Lots of competent people at the workplace, but there is a reputation for gossiping and back stabbing, perhaps a monthly employee appreciation day.
Better communication regarding person/branch role within the workplace as well as overall goal and purpose of the workplace.
Action to increase outside respect for the workplace. Stop branch bashing and undervaluing work of other branches.
Greater acceptance of job share arrangements, greater willingness to accommodate people who are temporarily ill. Maternity should not be viewed as a career limiting move.
Openness to varied lifestyles.
On issues of intolerance, one response indicated that the workplace has been tolerant to a fault of poor/marginal performers.
Some employees expect the workplace to do all and be all, without taking any responsibility for seeking out their own solutions to concerns.

Q 44 a. What I like most about my work is----

There were thirty three responses to this question.
Colleagues/people one meets or works with(17)
Nature/challenge of the job and type of work(11)
Flexibility and/or freedom to act independently (8)
Team and/or manager. (6)
Office/physical environment (2)
Dealing with the public (1)
The sense of family (1)
Ability to work part-time at a professional level position (1)
Working down town (1)

Q 44 b. What I like least about my workplace is ----
There were thirty responses to this question.
Management style and/or communication issues (6)
Limited opportunities for advancement (3)
Inconsistencies in staff treatment (2)
Work overload/pressure(3)

Complaining /back stabbing/resistance to change (3)
Politics (2)
Physical environment/poor air quality (2)
Competitive nature of labour relations division(1)
Very little satisfaction or recognition from job(1)
The relatively few individuals who want the system to take care of all their needs(1)
Feel my job is not important (1)
Would like a change in physical environment (1)
Poor building management (1)
My lack of security (1)
Kept in the dark (1)
Should be counselling available for personnel who work in EAP(1)
Physical location (1)
More predictability + stability in government environment would reduce stress (1)
The occasional display of poor teamwork exhibited by some colleagues (1)
Nothing (1)
It is not a fun place to be (1)

Q 46. Any general comments which you would like to make about health promotion in the workplace.

There were sixteen responses to this question.

While the workplace can be supportive, a positive state of health is very much dependent on taking personal responsibility.
Needs to be greater emphasis on individual responsibility.
We need to take some responsibility for our own health and well being.
It is everyone's responsibility - not just the employee - everyone gains.
We need to put some resources into it to demonstrate a commitment.
Inconsistent practices re hiring/promotion of staff; inconsistent and lack of communication has frustrated a lot of people, causing a lot of stress.
The workplace does not follow its own guidelines in terms of selection of staff and developmental opportunities.
Air quality a critical concern.
I'd like to see more interest in events like corporate challenge, that would allow different teams to be formed to represent our department.
More willingness for people to speak up, vehicles for that to happen.
As the workplace staff ages, more attention needs to be paid to health promotion.
Secondments to other departments for at least six months would help people see that change can happen smoothly.
If the department paid the health facility perhaps more people would join. Initial cost up front but benefit of healthy employee and less sick time.
Health promotion not a significant issue.
Looking forward to the results - glad we looked into it.

One respondent felt that the survey lacked balance and was too focused on complaints about the organization and reflected a paternalistic view of the organization. The respondent felt that the survey should have had more emphasis on individual responsibility and self assessment /appraisal.