Workplace Health Promotion:
Employee and employer perspectives

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Terry Buckingham
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Abstract

Purpose

This qualitative focus group study defines the experience of a Workplace Health Promotion (WHP) programme from employee and employer perspectives.

Method

Participants who completed a 10-week WHP programme were asked their opinions and perceptions of the programme. The following questions were used as a semi structured question guideline; What were the Strengths of the WHP programme; What were the Weaknesses of the WHP programme; What are the Opportunities for the WHP programme; What are the Threats to the WHP programme. This line of questioning is commonly referred to as the acronym SWOT (DeSilets, 2008). SWOT is a simple group work tool that is well recognised, easy to use and is used here as a data collection method.

Participants shared their opinions in two focus group discussions of employee participants (6) and a further purposive group who represented the employer participants (3) of the WHP programme. Focus groups were audio-recorded and transcribed. Transcripts were analysed using Thomas’ (2006) general inductive approach a method of thematic analysis where the researcher begins with an area of study and allows the theory to emerge from the data.

Results

Seven key themes emerged from the data. These were; barriers and enablers to participation; communication and information factors; tailoring and targeting issues; culture and leadership within WHP programmes; participation and competition influences; retention and attrition issues and finally health behaviour change and modification.

Implications of the research

This study provides insight into some important factors for those who participate, promote and deliver WHP programmes.
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Chapter One - Introduction

“The wealth of business depends on the health of workers.”

(Neira M, WHO 2009),

1.0 Introduction

Web-based or online approaches to workplace health promotion (WHP) are recognised for their ability to reach a large audience of participants and provide a cost effective means of delivery (Irvine et al., 2011). As WHP has evolved over recent years, health providers, employers and employees alike have adopted this new technology and web-based programmes are now widespread. Research that explores the use of these relatively new programmes is now required to provide valuable insights for those who deliver and those who participate in them (Cowdery, Suggs, & Parker, 2007).

1.1 Background

Many WHP programmes make the use of traditional health promotion methods such as the use of physical activity, healthy nutrition advice and smoking cessation interventions to encourage healthy lifestyle choices. Much of the research into WHP is quantitative and has proven that WHP programmes do have a persuasive effect on chronic diseases (Russell, 2009). Chronic disease or long term conditions are estimated to be responsible for half of all deaths in the world and is likely to emerge as accounting for two-thirds of all deaths globally over the next 25 years (PWC, 2008). Employers have a stake in the health of their employees and have embraced WHP as a new tool to maintain and improve their human resource.

Sixty eight percent or 2.3 million people of the working age population are currently employed in New Zealand workplaces (DoL, 2011). This represents a significant population setting for WHP initiatives that can be targeted towards prevention of long-term conditions. Long-term conditions are widely known to be a product of environmental and behavioural health.

Two in every three New Zealand adults have been diagnosed with at least one long-term condition (MoH, 2009). The predominance of modifiable risk factors such as physical
inactivity, obesity and smoking has continued to impact on the increase in long-term conditions in New Zealand. Most WHP programmes aim to have a positive effect on these risk factors and aim to influence health behaviours and choices of workers.

1.2 Springin2it – WHP Programme

One WHP programme that has shown promising results when evaluated is Otago Polytechnic’s, NZ proprietary Springin2it programme. Springin2it is a web – based WHP programme that runs over ten weeks and is designed as a flexible programme where interventions and activities are tailored to the worksite. For example, health education seminars and physical activity sessions such as walking groups are delivered over the ten-week programme. Participants enrol individually, become part of a team, and log their progress throughout the ten weeks by completing an online diary of their healthy eating and healthy action. More specifically participants enter how many portions of fruit and vegetables they have eaten daily; how many minutes of exercise they have completed; and how many litres of plain water they have consumed each day. As they log these amounts into the website, totals increase and count towards their overall total. Their individual total contributes to their teams total and is displayed on the front page of the website in real-time on a bar graph that represents their team. Other important aspects of the website include health screening results, motivational topics, news items and other health information to help participants interpret their health screen results. The website has de-identified username and participant chosen passwords to ensure privacy of their information along with 256 byte website encryption. Springin2it is wholly owned by Otago Polytechnic and delivered by staff and students. It is important to acknowledge here that Springin2it was conceived and developed by a multi-disciplinary team of exercise physiologists, nutritionists, nurses and information technology experts.

Springin2it has been run on an annual basis since 2009 for Otago Polytechnic staff. This study is based on the experience of a different group of participants and workplace who were the first to use the programme outside of Otago Polytechnic beginning in June 2011. The Springin2it programme was re-labelled to meet the workplace requirements. In order to protect the identity of the workplace where this research took place the Springin2it programme will be referred to as the “WHP programme” for this research report. There are some further characteristics listed below that provide a description of the workplace setting that can be reported without revealing the identity of the worksite and participants.
There is some merit in describing the workplace to provide context to the study and as a guide to the studies unique sample of participants.

The employer has described the unique characteristics of the worksite as:

- Publicly funded organisation with additional trust funding
- Hospitality and tourism sector
- Total of 50 fulltime, 9 part-time, 52 casual staff
- Middle income workers or commonly referred to as white-collar workers
- Average age of workers is 27 years
- All staff had good access to allocated or shared computers, the internet and a fast internet connection.

(Employer, personal communication with workplace employer, 7 June 2012)

1.2 Researchers Interest

In recent times there appears to have been a significant increase in the amount of WHP programmes that are on offer. Programmes of this nature have benefited from improvements in information technology and the advent of the internet as a tool to help nurses and others to deliver WHP information and programmes to wide audiences. In parallel with this proliferation of WHP programmes, a good many occupational health nurses have been involved in their planning, delivery and evaluation. The researcher’s interest has been influenced by practicing and delivering these WHP programmes and related initiatives over ten years practice in industries such as manufacturing, service and education sectors.

Much of the evidence available to nurses proves that WHP programmes do have their place as a method of improving workers personal and in some cases organisational health. Many short duration programmes such as the programme studied here aim to influence personal health over a defined period or simply long enough to be able to gain some measurement of benefit. This measurement of success in many cases is modest and some individuals depending on their engagement in the programme and underlying health condition do not experience significant change. Old health habits often return and any short-term gain in health biometrics such as cholesterol profile levels are lost. However much variability there
is in the effectiveness of WHP programmes the researcher noticed anecdotally that employees and employers alike appear to enjoy the experience and that there were more benefits than could be easily measured. The researcher witnessed over many years isolated cases of participants who have benefitted so much so that they appear to have made life-changing habits that last long beyond the typical ten-week programme. The experience of participants who take part in WHP does not appear to be well understood or studied. There appears to be few published examples of where nurses have sought the opinions and perceptions of participants. Many unanswered questions for the researcher stimulated a line of enquiry in a hope to better understand the experience of participants in WHP programmes. What was it about these programmes that led to rates of participation? What did the employers and employees get out of participating? Why is there such variation in participation at an individual and organisational level? These questions and many more led to the simple notion of asking participants what their perceptions and opinions were. The subject of this study is based on similar questions as to those above and attempts to answer some of the questions for the researcher. These answers may also be of use to other nurses and those who participate and provide WHP programmes.

1.3 Significance of the study

The significance of this study is that there are limited examples available of published or scholarly articles on WHP programmes in New Zealand. There are even fewer examples of research that uses qualitative methods of enquiry and seeks the opinions and perceptions of participants in WHP programmes. These issues combined with the rapidly changing technology that has enabled the use of web-based methods of delivery makes this study important to those who practice WHP in this new millennium. Many examples of best practice WHP programmes described to date are large overseas examples and may not relate well to New Zealand workplace settings. Ninety seven percent of New Zealand workplaces are small to medium sized enterprises (SME’s) with less than 19 employees (MED, 2011).

1.4 Research Aims

The primary aim of this study is to define the experience of a WHP from employee and employer perspectives by exploring their opinions and perceptions as recent participants in a 10-week WHP programme. By defining these experiences and identifying themes, valuable insights will be gained from participants. This information will be useful for those
delivering the programme and will assist in evaluation and continuous improvement for future delivery.

Secondary aims are to provide practice-based feedback from the research participants that is likely to be of interest to other planners, providers and professionals who are involved, or have an interest in WHP. Web-based otherwise known as online WHP, although becoming widespread, is a relatively new method for delivering health promotion in the workplace setting. Research that adds to this innovative way of promoting health is likely to add to the body of knowledge in WHP (Russell, 2009).

1.5 Research Question

The question of this research is; “What are the opinions and perceptions of employers and employees as recent participants in a 10-week web-based, WHP programme”.

1.6 Justification of the Research

To date internal evaluation of the WHP programme has centred mainly on evaluating the data that the programme measures. Primarily this is to ascertain whether there has been a positive effect on participants from when they entered the program as inputs, to when they finished the programme as outputs. In practice, biometric health measurements such as a participant’s weight, blood pressure and cholesterol level are measured and then compared from when they began to the end of the 10-week programme. This alone has provided valuable insights into the programme’s success. However, this evaluative information does not fully explain the experience of participants or allow a richer understanding of what factors are important to the program’s success or otherwise. Russell (2009) reports that there are few qualitative studies that provide information which may provide new insights into WHP and interventions that are well received by the participants and employers alike. This type of research can be described as plausibility building where interventions or new ways of delivering WHP are practiced then evaluated and reported on.

1.7 Workplace Health Promotion defined

Definitions of WHP programmes vary as much as the programmes that are promoted. Russell (2009) describes WHP succinctly as a means to achieve both individual and workplace wellness. The terms Wellness and WHP appear to be used interchangeably along with other common descriptors such as health and productivity programmes. Reardon’s (1998) brief definition is popularly referred to. “Wellness is a composite of physical,
emotional, spiritual, intellectual, occupational and social health: health promotion is the means to achieve wellness”.

A more comprehensive definition was proposed by the World Health Organisation in 2009 “A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace.” (WHO, 2010).

Nayer (2010) describes a component approach to defining wellness where many organisations offer differing components of WHP such as employee assistance programmes, on-site clinics. The study found that innovative companies offered broader programmes than others offer and included spiritual and security programmes.

1.8 The influence of legislation in Occupational Health and Safety in New Zealand

In the 1970’s most developed countries adopted health and safety laws which provided a regulatory framework for employers to follow. Occupational interventions were based on preventing disease and monitoring the effect of occupational exposures on worker health.

In New Zealand the Health and Safety Act (HSE Act) was first gazetted in 1992 and was seen as reformative legislation to replace and review a number of Acts and regulations such as the Factories Act 1891 and the Regulation of Mines Act 1874 which had provided specific protections for workers in typically high hazard industries. A number of other Acts followed until the reform of the 1990’s. This relatively new HSE Act intended to shift more responsibility on to employers and employees alike to ensure their own safety.

Deregulation was aimed at simplifying compliance and encouraged industry to assist in creating its own standards and best practice guides. These documents were gazetted by the Department of Labour (DoL) and can be described as statements of preferred work practices or officially as Codes of Practice (COP’s). These COP’s were then encouraged to be used as best practice or compliance guides to the HSE Act. Twenty years on from this reform, many argue that occupational health and safety outcomes have not improved significantly despite the focus and attention that has been placed on compliance and reform (Gunningham, 2011). An important research report estimated occupational disease rates in New Zealand in 2004 (Driscoll T, 2004). The report estimated that 700 – 1000 deaths per year in New Zealand were directly attributable to occupational disease. This equates to 2-4% of deaths of all people of over the age of 20 years. Additionally the same report estimated 17,000 – 20,000 new cases of work related disease each year.

Occupational diseases are those that are directly related to workplace exposures such as
cancers related to carcinogens. For example a form of leukaemia which is widely known to be a result of benzene solvent exposure.

Much of the practice of Occupational Health Nurses has been directed towards maintaining compliance with the HSE Act. Prevention of job related injuries and illness became the focus for occupational health nurse interventions in the form of health protection and has so far been the mainstay of occupational health nursing practice (Salazar, 2001).

1.8 Occupational Health Nursing in New Zealand

Vollweiler (2011) studied the history of occupational health nursing in New Zealand and described occupational health nursing as a form of public health nursing that focuses primarily on the workplace as a settings based approach to nursing. Occupational health nursing is concerned with the maintenance and promotion of health and safety and the prevention of illness by supporting safe and healthy work practices. As with other nursing professionals occupational health nurses are subject to registration under the Health Practitioners Competency Assurance Act 2003 (HPCA, 2003) and through the New Zealand Nursing Council are issued annual practising certificates that certify nurses who are competent to work within their scope of practice.

Occupational health nurses are ideally suited to the practice of WHP as they are often based within organisations and have access and influence on a population of people who regularly attend the workplace each day. As WHP programmes have prospered so too has occupational health nurses involvement to an extent where WHP has become a core function, and in some cases, the primary function of occupational health nurses.

1.9 Structure of thesis

Chapter One: Introduction

This chapter offers background to the research describing WHP and the problem of long-term disease. The researchers’ interest in the topic of WHP provides insight into the line of enquiry that provided the basis for this study. The significance of the study is outlined to provide relevance to the study and its potential audience. The aims and research question are detailed. Wellness and WHP are defined. Legislation is described as it relates to its influence on the practice of occupational health nurses. Finally occupational health nursing is described as it relates to the practice of WHP.
Chapter Two: Literature Review

This chapter begins with description of the international literature describing global influences on WHP. The Ottawa Charter for health promotion is included as it has had a lasting impact on WHP worldwide. Web-based WHP research is outlined as it is specific to this study. A localised approach is then taken to explore the WHP research from NZ perspectives. Finally gaps in the research available are uncovered including methodology and design aspects.

Chapter Three: Methodology

This chapter describes the research design and focus group methodology used. It provides background to the research design, definitions, aims and ethics, then goes on to describe how data was collected and finally analysed.

Chapter Four: Results and Discussion

This chapter describes the results and discusses the study as it relates to the literature. Results are described in paired themes. A total of seven key themes were identified across all of the focus group interviews with both the employee and employer groups. Sub-themes are used as headings to describe the most important aspects of the paired themes and provide further structure and clarity. Quotations are taken directly from the transcripts and inserted into the results to provide excerpts of the original discussion and add meaning to the interpreted results.

Chapter Five: Conclusion and Recommendations

The final chapter summarises the study as it reflects on the literature review and research question and aims. The strengths of the study are summarised to provide overview of what the study adds to the research on WHP. Limitations of the study are discussed to provide context to the study and ensure credibility of the findings. Recommendations are made for further research as they relate to the literature and findings of the study. To close further recommendations are offered to support WHP practice in NZ.

1.10 Summary – Chapter One

Web-based or online approaches to WHP are an effective method of delivery. The evidence or case for WHP is now convincing as their effect on long term disease prevention is now proven. Springin2it the WHP programme, and subject of this study is in its third cycle of operation for Otago Polytechnic, a tertiary institution in New Zealand. This study is
based on the experiences of employees and employers that were the first to take part in
the WHP programme beyond Otago Polytechnic. The studies significance is based on the
fact that there are limited examples of WHP research in New Zealand and even fewer
examples of published accounts. These issues along with the rapidly changing technology
that has encouraged the adoption of web-based WHP makes this study important to those
who practice and participate in it. The influence of legislation on nurse’s practice is
explored along with a brief definition of occupational health nursing which has influenced
the researchers’ interest in the study.
Chapter Two - Literature Review

“Not examining the past dooms us to repetition. Misinterpreting the past condemns us to bungling the present”  
(Rowarth, 2006)

2.0 Introduction

Rowarth and Fraser (2006) describe the literature review as an important opportunity “to set the scene for the research which follows”. This literature review aims to provide an overview of the literature available as it relates to this study.

Initially the international literature detailing the global examples of WHP is described. These global examples of WHP research explore the wider importance of WHP and provide background to the study. The influence of the Ottawa Charter and World Health Organisation (WHO) are then described, as they are a key feature of evidenced based practice and have historically influenced the delivery of WHP. In an effort to set the context for this study, web-based or online approaches to WHP are detailed as this study specifically describes the experience of recent participants in a web-based programme. A more localised approach is then taken to exploring the literature to provide a picture WHP in New Zealand and what factors have influenced contemporary practice. Finally gaps in the research are explored along with aspects of methodology and design.

2.1 Literature Search Strategy

Journal sources for this literature review were based on database searches of CINAHL, Proquest and Sports Discus and Google Scholar using the following terms

- Wellness programmes/programs
- Workplace wellness or worksite wellness
- Workplace health promotion
- Web-based or Online or Internet
• Physical activity or health or diet or nutrition and
• Employee or employer or employment
• Occupational health promotion
• Effect or evaluation or assessment

The term Workplace Health Promotion (WHP) is used interchangeably with workplace wellness or wellbeing.

Other methods of literature search included hand and online searches of governmental websites, best practice guidelines, professional bodies, conference and workshop proceedings. The search was limited to 1990 to present as much of the research that set the foundations for WHP was carried out during this time. A rapid growth in WHP in the US led this global trend as employers realised the links between employee health and the workplace (Fertman, 2010). For historical background, some important earlier reports and studies have been included where necessary.

2.2 International Literature

The literature tells us there are a number of global examples of WHP’s (HAPIA 2007, Goetzel 2008, Chu 2000) that have been described and evaluated using mainly quantitative methods to determine their effectiveness and establish their benefits.

Evidence supporting WHP’s is described as clear and persuasive (PWC, 2008). It appears that there are sufficient programmes demonstrating evidence based interventions to justify the reasons for WHP programmes and their existence in the workplace (Jamner & Stokols, 2000).

A meta – analysis by Parks & Steelman (2008) indicates that participation in WHP is associated with low absenteeism and higher job satisfaction. Their search identified 98 published works and 17 of those met their inclusion criteria, which required data examining the effect of absenteeism and job satisfaction. Large review studies like this that have examined many different sources have proven the effectiveness of WHP programmes and add to the increasing body of knowledge that supports WHP as a valid and worthwhile method of improving health and productivity in the workplace.
Another frequently cited author in the literature describing the benefits of WHP is the work of Goetzel (2008). In this 2008 review further evidence of the effectiveness of WHP is offered providing many examples of WHP from the early 1990’s. Results of this review were able to provide employers and practitioners with concrete evidence that modern WHP programmes are effective. Goetzel cautions that WHP programmes need to be based on evidence and theories such as behaviour change models. Goetzel adds that interventions that are tailored to the individuals will also have a positive effect on the results of any WHP. Despite the many and varied types of WHP programmes those programmes that achieve modest outcomes may still be significant when considered in terms of the wider population and the impact on long-term illness. Several other studies by Goetzel from 1997 onwards appear to have further cemented the understanding that WHP is effective at influencing health in the workplace setting. It appears that the case or rationale for WHP, provided it is designed appropriately is now well established.

It is worth mentioning here that many of the published examples of WHP programs aimed at influencing health behaviours in the workplace setting or environment are based on behaviour change models. Behaviour change models or theories have been researched and validated in WHP and models such as the Prochaska’s Trans Theoretical Model otherwise known as the Stages of Change Model (Green, 2005) and form the basis of many WHP programmes where theory and practice are integrated. As contemporary WHP changes and more is known about practice and theory it is likely that models such as these will be adapted and new theories will emerge. Behaviour change is an important aspect of WHP as it is often what is measured in evaluation and arguably without behaviour change nothing will change. That is to say without individual action such as smoking cessation the individuals health is unlikely to improve. Allen (2008) is critical of WHP that focuses primarily of health behaviour change and describes this as the current approach of many of those who are offering WHP. Furthermore the author adds that this type of approach focuses on individual change and passes the responsibility on to the individual for improving their own state of health. Common interventions such as health expo’s and short-term team challenges are described. This approach of behaviour change arguably fails to address the wider determinants of health such as the social, physical, and economic factors, which influence health and may not be at the ability of the individual to change readily.
Pringle (2008) discussed the impact of the social and physical environment on health further in a qualitative study of the effect of receiving a green prescription (prescription for exercise and follow-up by phone, face to face or group work). In this study, 42 green prescription recipients were followed up through phone interviews and asked a range of questions related to the process of receiving a green prescription. The study found that participants responded differently to the advice given as part of the green prescription intervention depending on their “social structures, incomes and opportunities”. The results conclude that interventions that are focused solely on behaviour change will only have limited success if a person’s social and environmental situation is compromised. Pringle describes these influences as the social-ecological environment and urges government and those charged with health promotion to consider how they might integrate social-ecological models into policy and practice. Although this study is not directly related to WHP, Green Prescriptions are a commonly used tool for health professionals such as occupational health nurses who practice in the WHP setting.

Social-ecological frameworks for health promotion are becoming increasingly popular methods of delivery. Richards (2008) describe how there are multiple levels of influence on physical activity and weight management. To simply focus on the individual would miss the opportunity to look at other factors such as workplace factors that have an influence on health. They point to the fact that the working population spends the majority of their day in workplace settings and the influence of work and the workplace can have a strong impact on the health of workers.

WHP’s similar to the one described in this study have been researched and describe attributes that prove effective or interventions that improve their effectiveness. Initiatives such as tailoring to individuals or health risk assessments (HRA’s) designed to be specific to the individual are known to increase effectiveness of WHP programmes. Many of these programmes appear to be US examples where the health insurance industry has led to employees and employers embracing WHP initiatives as a way of improving employee health and reducing costs associated with burgeoning healthcare costs. Employers are estimated to be paying up to 30 percent of the national healthcare costs in the US (Reardon, 1998). In a 2010 report on the cost
effectiveness of WHP programmes Baicker (2010) reported that 60 percent of US health insurance schemes are sponsored by employers. Return on investment (ROI) was estimated at US$3.27 for every US$1 spent on WHP. Many of these studies are based on the direct costs of healthcare insurance premiums and the cost of absenteeism where the amount of sick leave is totalled in any one period. Limitations of many of these studies are that they do not explore other measures of cost such as loss of productivity and the cost to replace absent workers.

2.3 Ottawa Charter and the World Health Organisation

Whitehead (2003) points to the pioneering work of the World Health Organisation (WHO) in the 1980’s when the Ottawa Charter for Health promotion (Fig. 1) set the groundwork for a settings based approach to the practice of health promotion (WHO, 2010). Settings can be described as the physical and social aspects of people’s environments that have an important role in the health of the individual. The Ottawa Charter was one of the first well known models to recognise the importance of social and environmental determinants of health that are wider than previous efforts focusing on individual change (Talbot & Verrinder, 2005). From this settings approach the workplace among other settings or places such as schools, homes and communities were given legitimacy as important areas for health professionals to focus their attention.

Figure 1: Ottawa Charter for Health Promotion. Source (Talbot & Verrinder, 2005)
Since then WHO have continued to offer frameworks and guiding principles for WHP. In 2009 WHO developed another WHP model titled; Healthy Workplaces (WHO, 2010). This report followed a workshop of 56 experts from 22 different countries who were brought together to discuss the findings of a global literature review. As a key outcome of this workshop a healthy workplaces model was established. This simplified and focused model of four factors is specific to the workplace. It is designed as a globally relevant framework that can be applied in multiple countries and workplaces big and small. Within this model four areas of influence were developed.

1. **Physical Work Environment** factors focus on the hazards that workers are exposed to such as chemicals, noise and biological hazards.
2. **Psychosocial work environment** explains the important of organisational culture and values that affect the mental wellbeing of workers. These include hazards such as stressors, and lack of work life balance.
3. **Personal health resources** are those initiatives that are provided to employees to directly affect their personal health such as health information, insurance, clinics, smoking cessation programmes.
4. **Enterprise Community Involvement** refers to the benefits of partnerships and alliances with the wider community to support each other recognising that workplaces are an integral part of their wider communities.

2.4 Web- based WHP Programmes


Nearly all New Zealand workplaces are now using computers, the internet (web) and broadband connections. A national survey in 2010 indicated high rates of business use of the internet (96 percent) and the percentage of organisations relying upon older dial-up connections fell from 15 percent in 2008 to 8 percent in 2010 (MED, 2011). This combination of high use of the internet and proliferation of web-based WHP programmes provides a catalyst for studies that describe and report on web-based WHP.
Irvine (2011) describes a randomised control trial of 221 workers who used a self-reported, web-based WHP programme to improve their physical activity. Compared to the control, group participants made significant improvements across multiple variables such as minutes per day of activity, rates of depression and stress levels. The authors suggest that the use of the web sites to promote physical activity and other health measures showed promising results and are reportedly well received by participants. However, authors report that the results of many web-based WHP programmes have been mixed due to variance in the way that programmes are designed and delivered. Participation rates are often low and there is a lack of employer support.

Low participation rates and high attrition rates are a common feature of WHP programmes. In order to understand this practice issue, Hasson (2010) studied the factors associated with high participation rates in web-based stress management WHP programme in Sweden. A total of 317 participants were recruited from ten companies. All participants were offered a traditional static website that included a screening questionnaire that gave feedback on their current status and a suggested plan to improve their ratings. The intervention group were offered additional interactive web-based self-help exercises that were designed to lower stress levels. Results of this study suggest that baseline variables such as the individual’s gender (being female), higher level of education, good exercise habits and positive prior expectations of the programme led to higher participation rates. Those that received the interactive and more personalised website had higher rates of engagement and participation than those in the control group who had the use of the static web-site.

Tailoring web-based interventions to individuals is thought to increase levels of participation in WHP. Traditionally rates of participation range from 5 percent to 30 percent of workers who take part on WHP programmes (Cowdery et al., 2007). More recently, a focus group study of tailored emails in the workplace to evaluate the use of accelerometers to increase physical activity highlighted a number of practice implications (Yap & James, 2010). Participants described eight themes that supported the use of tailored emails in WHP programmes:

1. Personal preferences for the type of interventions offered were variable and not all participants supported the interventions.
2. Content of the tailored emails needed to be personally relevant to be read and utilised.
3. Friendly workplace competition helped engagement.
4. The amount of time required to view the emails was a barrier to participating.
5. Suggestions were made of how to tailor the emails to personal and work circumstances to improve the relevance for participants.
6. Repetitive information and information that negatively portrayed their health results did not help.
7. Graphs that gave comparisons with the overall results of the others in the programme were enjoyed.
8. Rewards that were not overly expensive and designed to recognise achievement were wanted.

2.5 Workplace Health Promotion in New Zealand

A 2008 survey completed by Equal Employment Opportunities Trust (EEO) in New Zealand of mainly larger employers revealed that more than two-thirds of the respondents (69%) had WHP programmes, up from 55% in the same survey in 2006 (McPherson, 2008). This is consistent with Australian findings where 60% of organisations offered WHP initiatives in 2006, up to 71% in 2007.

WHP is typically provided by health professionals such as nurses, doctors, physiotherapists, nutritionists, occupational therapists and exercise physiologists. Anecdotally there are also a number of other allied health professionals such as naturopaths, chiropractors, counsellors and psychologists that provide components of WHP programmes that are contracted or brought into organisations to provide WHP services to employees. In 2011 a group of fifteen health professionals who provide WHP and wellness products and services formed an incorporated society called Health and Productivity Institute of New Zealand (HAPINZ, 2011a). HAPINZ objectives are to grow the industry by promoting workplace health and wellness to government and employers. To ensure best practice, and accreditation; and to have policy input at government level regarding WHP. HAPINZ model is based on a similar institute in Australia named the Health and Productivity Institute of Australia (HAPIA, 2011) who’s purpose is similar to that of HAPINZ and is to contribute to health reforms, improve health outcomes and reduce health costs through WHP. HAPIA held their inaugural congress in 2007 to highlight the latest trends and research in WHP in Australia. These
relatively new alliances are evidence that WHP in Australasia is an emerging sector and is currently defining its own professionalism and practice.

The Ministry of Health (MoH) commissioned an environmental scan report in 2011 to assist with a one-day workshop to develop the WHP industry in NZ (Passera, 2011). This qualitative enquiry consisted of a desktop review and telephone interviews with six key stakeholders in the public and private sector who are actively involved in providing WHP. The study revealed some interesting results that are discussed below as they relate to this study. There was criticism that web-based approaches to WHP may not reach some audiences if there are literacy issues and access to the technology required. That there is a general lack of research activity in NZ aside from a notable example the research unit at Auckland University of Technology (AUT) which specialises in Physical Activity and Nutrition in settings such as the workplace. It found that there were only a few providers of WHP programmes and that most of the innovation or new programmes were driven by the private sector. That public funding for health promotion is subject to political influences and is subject to reallocation away from WHP. That there does not appear to be any effectiveness studies such return on investment research available for NZ workplaces. That there is generally limited available research or published examples of best practice in the NZ setting.

HAPIA published its Best Practice Guidelines for Workplace Health in 2011 – released at their annual meeting in Sydney (HAPIA, 2011) which provides a framework for practice and examples of WHP programmes that have been evaluated and deemed successful approaches. HAPIA recommends in its framework that any WHP programme should be evaluated using both quantitative and qualitative methodologies. Suggesting that programme satisfaction, participation and program reach are all examples of what should be explored. In a similar New Zealand document produced by HAPINZ in 2011 titled the productivity of New Zealand’s workforce: Moving to a solution (HAPINZ, 2011b), authors suggest that New Zealand is facing threats its productivity as more hours are worked yet productivity is low compared to other comparable countries who are members of the Organisation for Economic Co-operation and Development (OECD).

There are a number of government agencies that set the direction for WHP including the MOH, DOL, Ministry of Sport and Recreation (SPARC) and District Health Boards
(DHB’s). Despite the range of providers there is no single public provider of WHP in NZ that sets the direction for public policy and funding (Passera, 2011). As mentioned in the previous chapter there are no over-arching policy directives or acts of parliament that mandates WHP in NZ. There are however a number of initiatives that are offered by government departments and non-government organisations (NGO’s) that span the private and public sectors as examples of partnerships and collaboration. Healthy-Eating, Healthy-Action (HEHA) is an example of one of these initiatives led by the MOH in partnership with SPARC. Resources are allocated to targeted settings such as the workplace. For example funding has been available for workplace initiatives such as breastfeeding friendly workplaces where facilities and employer policies actively encourage breastfeeding/breast-milk for infants either in the workplace or breaks to be able to breastfeed in and away from work (MoH, 2008).

A review of WHP targeting cardiovascular disease (CVD) in blue-collar workers in New Zealand again found no local examples of RCT research for a their literature review carried out at the end of 2005, early 2006 (Novak, 2007). A single published account of the effectiveness of a WHP for CVD in South Auckland describing a non-randomised controlled trial of male blue-collar workers was available. Results of this study suggesting that health behaviours such as healthy eating and physical activity were significantly improved at 12 months in the intervention group (Cook, 2001). Participation in this programme was higher than most international examples of voluntary WHP programmes with 77% participation in workshops, retention rate of 95% at six months and 89% at twelve months. This study called for more robust research that focuses on those most at risk of CVD, New Zealand’s leading modifiable cause of death. Another interesting finding of this review was that the majority of the limited New Zealand research that is published is that of white-collar or middle-income workers who they reported have less risk of cardiovascular disease than their blue-collar counterparts do.

An informative literature review was commissioned by MOH in 2009 supported the development of NZ Well@work, a government initiative to provide a WHP programme, which was initially available for state sector employers and resources were available online for the public (Russell, 2009). In the 100-page review the benefits of WHP are comprehensively detailed including benefits for the employer, employee and wider community. Best practice examples of WHP are explored such as
healthy eating and healthy action programmes. One of the major outcomes of this review was outlining a potential framework for WHP for New Zealand workplaces. The review endorses the World Economic Forums earlier work detailed in a 2008 report: Working Towards Wellness; accelerating the prevention of long term disease (WEF, 2007). Within this framework, there are eight key strategies which have been condensed into four areas.

1. Leadership
Leadership aims at promoting the active participation and leadership of employer management in WHP. It emphasises the importance of managers and business leaders taking part in WHP and its positive effect on those that they lead.

2. Culture
Goals for WHP should be developed in line with the business strategy and core to the function of any business planning, rather than an add-on or ad-hoc approach. WHP should be core to the business objectives.

3. People
Targeted approaches led to improved employee participation and more relevance to the working population. Offer incentives and communicate WHP clearly.

4. Process
Collaboration and partnerships are encouraged to make the best use of existing relationships that will benefit WHP. For example public–private partnerships for the delivery of WHP make the best use of resources and expertise. Ensuring that WHP is evaluated leads to improvements and is likely to improve the quality of programmes for the future.

There is little published evidence that the Well@work framework has led to any major changes in the uptake or delivery of WHP and there does not appear to be any follow-up reports or evaluations of Well@Work. It is unclear what the uptake or dissemination of this framework has been for workplaces and those who provide WHP. Well@work is a programme delivered through Catalyst Risk Management (CRM) a former subsidiary of the Accident Compensation Corporation (ACC). In September 2011 CRM was sold to an Australian company, Employers Mutual a compensation management business (NZWell@Work, 2012). Russell commented that the original work programme was disbanded and dispersed across other organisations. (Russell, N. personal communication, June 6, 2012)
CRM commented that the website remains as a tool for WHP and that are plans to further develop the resources and initiatives offered as part of the Well@work programme. (Moon, R. Personal communication, June 11, 2012)

2.6 Research Challenges

Russell’s (2009) review identifies gaps in knowledge and research challenges. International randomised controlled trials (RCT’s) have demonstrated the effectiveness of programmes however as Hoffer (2003) notes the expense and resources required to complete large definitive RCT’s are not always available to researchers in WHP where participant numbers are often low and randomization of individuals is challenging where contamination of intervention can be caused by participants and controls working closely together (Hoffer, 2003). There are no published examples of RCT’s in New Zealand about WHP (Novak, 2007). This literature search did not reveal any further evidence of large scale empirical studies such as RCT’s in New Zealand that relate directly to WHP.

We now know that WHP is effective however more research is required to establish what it is about specific programs that lead to successful outcomes. What are the experiences of participants and their employers of these programmes and how they work are questions that are not fully understood and represent a gap in research. Descriptive studies or case studies are needed that can inform practice and be adopted by others to build the body of knowledge and expertise in the relatively new area of WHP. Most qualitative type research appears to have been done in social science and public health fields. More commonly health promotion has been practiced and researched in community settings and less often in workplace settings. Russell(2009) suggests alternative approaches to WHP research including qualitative designs to establish richer data and practice based data useful for building plausibility.

The study described here could be described as an example of a small-scale evaluative study. Holland (2011) supports the publication of “small-scale evaluative” studies for several reasons. Most importantly to publish innovations that are taking place in real world settings. Small-scale studies can often be the catalyst that leads to much larger studies. New ideas and practices can be reported which add the body of knowledge and provide an opportunity for nurses to share their practice.
Qualitative studies are a method that enables the researcher to explore people’s attitudes, opinions and perceptions (Goodall, 2008). This literature review highlights that there is a general lack of WHP research in NZ and likely to be even less that has been published. Most of the available research has been found in literature reviews which are based on international examples with little or no input from NZ studies. Original studies from NZ were scarce and this review did not find any examples of qualitative design seeking to explore WHP in the NZ setting.

New approaches to WHP such as web-based applications are encouraged to broaden the current state of knowledge and progress from traditional approaches to those that can reach a range of workers and workplaces with limited resources. These promising new approaches such as the WHP programme described in this study may involve some risk that they may not be as effective as previous models or have little proven effect (Nayer et al., 2010). However if new approaches are taken which are then evaluated and shared the evidence base for WHP in NZ will grow and hopefully benefit those that participate in it. This study seeks to explore a relatively novel and innovative approach to WHP through qualitative enquiry. Specifically the opinions and perceptions of participants who have participated in and completed a 10-week web-based WHP programme.

2.7 Summary

The literature review aimed to provide an overview of the evidence available as it relates to the study. The search strategies were described initially to provide context for the study. International literature is explored as an overview of the global body of knowledge in WHP. The Ottawa Charter is briefly described as it has had a profound effect on the beginnings of settings based approaches to health promotion in the 1980’s onwards. Contemporary studies in WHP are detailed before more specific studies on web-based programmes are discussed. New Zealand based studies are scarce and much of the available literature comes from literature reviews and professional bodies such as HPINZ who are interested in furthering WHP. Other research challenges include the lack of small-scale studies that can provide practitioners with evidence and best practice examples. To finish, new approaches to WHP research are encouraged to broaden the state of knowledge in WHP and research
is called for that describes innovative, novel programmes such as the WHP programme at the focus of this study.
Chapter Three - Methodology

Great things are done by a series of small things brought together.
Vincent van Gogh (Artist, 30 March 1853 – 29 July 1890)

3.0 Introduction
This chapter describes the research design and focus group methodology used. It provides background to the research design, definitions, aims and ethics, then goes on to describe how data was collected and finally analysed.

3.1 Background to the Research Design
Study design and concept was initially developed through nursing experience of delivering WHP programmes and the questions that inevitably follow on from nursing practice, such as: what are the unique experiences of participants who engage in WHP programmes; what are their opinions on the strengths and weaknesses of the programme; and what opportunities can they identify that may provide insights into how these programmes operate? Exploring these questions further led to the question of what participants saw as the strengths and weaknesses of the WHP programme. As mentioned previously, practice and evaluation had previously provided insights into the WHP programme’s success but did not fully explain the experience of participants. Richer understanding of what it is that works for participants or in fact does not work was sought. It was clear that a structure was forming around a need to know from participants what the strengths and weaknesses of the WHP programme were. From this thinking it was decided to use an established tool, the SWOT tool, a widely used method for group work and evaluative tool and is an acronym for Strengths, Weaknesses, Opportunities and Threats.

3.2 SWOT Methodology
SWOT methods are widely used in disciplines such as business and marketing (Narayanasamy, 2008). In this study SWOT is used as a simple data collection tool to provide a framework for semi-structured questions in focus group interviews.

The exact epistemology of the SWOT technique is not clearly known as it is thought not to have been well documented in its early conception in the 1960’s and 1970’s (Freisner, 2011).
Panagiotou (2003) described SWOT as first developed by two Harvard Business School professors where it was used to investigate organisational strategy in relation to their environments. In 1963 it was described in a business conference and was purported to be a major advance in strategic planning for business.

DeSilets (2008) describes SWOT as a useful tool for nursing that can be used for programme review. The main advantage of using the SWOT method is its simplicity and the ability to be used in group situations where evaluation and critique are required.

Participants in this study were asked to think about their experience of WHP in broad terms and then discuss their opinions and perceptions of the programme based on the four headings used in a typical SWOT group workshop:

1. What were the strengths of the WHP programme?
2. What were the weaknesses of the WHP programme?
3. What were the opportunities for the WHP Programme?
4. What were the threats to the WHP Programme?

3.3 Research Aims

The primary aim of this study is to define the experience of a WHP from employee and employer perspectives by exploring their opinions and perceptions as recent participants in a 10-week WHP programme. By defining these experiences and identifying themes this practice-based data will provide valuable insights into the participant experiences of the programme. This information will be useful for those delivering the programme and will assist in evaluation and continuous improvement for future delivery.

Secondary aims are to provide practice-based information that is likely be of interest to other planners, providers and professionals who are involved, or have an interest in WHP. Web-based WHP, although becoming widespread, is a relatively new method for delivering health promotion in the workplace setting. Research that adds to this innovative way of promoting health is likely to add to the body of knowledge in WHP (Brug, Oenema, & Campbell, 2003).

3.4 Research Question

The question of this research is; “What are the opinions and perceptions of employers and employees as recent participants in a 10-week web-based WHP programme?"
3.5 Definition of Focus Groups

Krueger & Casey (2009) describes focus groups as a “carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment” (p.2). By providing a permissive environment it is thought that participants will be more likely to disclose what they really think and feel about the particular topic in question. It is generally understood that focus groups are a method to obtain qualitative data that can be analysed into categories and themes to reflect the overall conversation that was had.

3.6 Advantages of Focus Groups

Here focus groups are used to gain a wide range of views on the WHP programme. An open semi-structured questionnaire allows different topics to be explored with a prescriptive set of questioning. This encourages open discussion and thoughts and allows ideas to be expressed openly and without the constraints of a more structured question route.

3.7 Underlying assumptions of the Focus Groups

Focus groups provide qualitative results based on an understanding from the moderator and later analysis of the discussion or data (Krueger & Casey, 2009). Questions were designed to gain a range of views on the WHP programme. Participants were known to each other as co-workers and likely influenced each other’s responses in the group discussion. This feature of the groups having similar characteristics is known as; homogeneity and is commonplace in focus group studies (Krueger & Casey, 2009).

3.8 Pilot Focus group

(Morgan, 1993) states that when a professional moderator is not available it is just as important to choose someone who has experience working with groups as it is in leading groups. For the purpose of this study and in order to gain experience as a moderator, the author chose to moderate the focus groups. Although not an experienced moderator, skills gained through twenty years nursing experience of group work helps meet this recommendation. Moreover, experience working with project groups, delivering WHP and group training and facilitation has honed similar skills required for focus group moderation.

A pilot focus group was used as a method to give the moderator some prior experience of leading a research focus group and as an important tool to evaluate and further develop
the semi-structured questions that would be used in the subsequent study. An experienced focus group moderator and a note taker attended this initial pilot focus group to observe and evaluate the interview. This feedback provided valuable insights into the moderating techniques and semi-structured question guide that was later refined and improved for eventual use in the focus groups that followed. Important lessons were learned about avoiding the use of leading questions and feedback in particular. This included allowing all participants an opportunity to speak, encouraging quieter members to speak and strategies for ensuring that no one dominated the discussion time. Other practical aspects of the pilot focus group were to practice housekeeping type activities including how to layout the meeting room, time keeping, and the use of the recording device. All of these learning’s and changes to the methods were to ensure that the eventual study focus group methods and discussion would be well planned and organised.

3.9 Focus Group Size and Frequency

The larger of the two focus groups was the Employee group (6) as it was made up of participants from the WHP programme participants of which there were thirty employees. This study was primarily focused on the opinions of those all those who had participated in the WHP. The Employer group (3) were purchasers of the WHP programme and as such are employers or managers in senior roles. It is worth noting here that as employers they have an assumed power differential over those in the employee group. For this reason alone was good practice to separate the two groups in a multi-category method as recommended by (Morgan, 1998) and described as a “break characteristic” to ensure that all participants share their views openly in a focus group discussion.

3.10 Focus Group Meeting Process

Focus Group interviews were carried out between August and September 2011. All focus group interviews were audio-taped with the permission of the participants and later transcribed by a professional transcription service. This raw data was then later used for data analysis. The transcribers signed confidentiality statements (Appendix 1).

3.11 Focus Group One and Two - Employee Participant Group

The focus groups were held in the worksite in a private meeting room adjacent to the participants working environment. A suitable sized meeting room was chosen with a large boardroom style table and comfortable seating. In agreement with the employer, it was decided that early morning starts of 8am to 9am (one hour each) would allow participants
to use thirty minutes of their work (paid) time and thirty minutes of their own time for each meeting to participate and not unduly disadvantage participants.

As participants arrived they were greeted and offered to take a seat around the table. Water, tea and coffee were offered at both meetings as refreshment and a relaxed informal conversation was encouraged to start. All participants were well known to each other as work colleagues. One participant was absent due to sickness for the first focus group meeting and was able to join the second focus group meeting with agreement from all the members that this would be acceptable to them.

Once all participants were seated, participants were initially thanked for their attendance and participation in the study. The purpose of the recording devices was explained to participants so that they were aware that the conversation would be recorded for later transcription and use in this research study. Brief introductions were made by each participant to the group which served the dual purpose of identifying to the transcriber who was in the room and for voice recognition of each participant. Copies of the consent form (Appendix 2) were circulated, signed and returned by those who had not yet completed this part of the process which had been offered earlier to ensure all participants present had fully understood the consent process. Copies of the core ground rules (Appendix 3) were circulated to the group and discussed so that participants understood the commonly used process for focus group interviews. This ensured that they understood why there were rules to protect confidentiality and respect each other’s input into the group discussion. An opportunity was offered to the group for additional ground rules to be added if required. None of the participants offered any further additions to the ground rules. An introduction to the research aims and methods was given to the participants by the researcher to recap the key points of the earlier information that participants had been given when invited to take part in the research.

To start the discussion a brief overview was given of the SWOT methodology to orientate the participants to what was to be covered during the two focus group interviews and provide participants with framework of semi-structured questions that could be easily understood.

The focus groups then progressed with the question of strengths and participants shared their view of what they saw as the WHP strengths. In this way participants were asked to describe the programme’s positive features before moving on to weaknesses, which could be seen as the negative aspects of the WHP. Once these strengths and weaknesses were
identified amongst the group the opportunities or ideas that may have been generated out of the strengths and weaknesses discussion were explored. Finally, threats such as barriers, costs and external factors that may threaten the programme’s effectiveness or future were discussed. A2 sized flip chart paper sheets were used as a visual aid to record the main topics of discussion. Consistent with the data collection method the SWOT tool was used as headings and then the sheets were posted on the walls for the group to read and refer to as a visual aid while the group discussion took place.

Krueger and Casey (2009) advises that a note taker can assist with facilitation and provide valuable notes that can be used in case of recording equipment failure. The first focus group meeting was attended by a fellow researcher as a note taker, known to the researcher but not the participants and also fulfilled the role as a research assistant helping with room setup and catering for refreshments for the participants. The note taker signed a confidentiality statement prior (Appendix 4). The participants were introduced to the note taker with an explanation of their role and that they would not take an active role in the discussion but record in summary form the discussion. Unfortunately the note taker was not available at the second focus group interview due to unforeseen illness, however the audio recording equipment functioned effectively and the A2 size paper used for group notes was used as a form of note taking. Two audio recording devices were used in case of equipment failure and placed in the centre of the meeting table.

3.12 Focus Group Three – Employer Participant Group

In contrast to the employee focus group meetings, the employer group was smaller with three managers who were responsible for administering the WHP in partnership with the lead administrator /researcher. A single meeting with a longer duration of two hours was agreed as sufficient to cover the full set of semi-structured questions. The question guide followed the same SWOT format as the previous meetings to maintain consistency with the data collection methods.

Practical tasks such as introductions, explanation of the purpose of the meeting, ground rules, consent forms and offering tea and coffee were all consistent with the previous focus group meetings described above. Again this meeting was held in the same meeting room with the boardroom table and chairs. One member of this group alerted the other members that they would need to attend to some urgent work and step out of the meeting for a short period. This was agreed by the other members as acceptable and the discussion continued. On consideration, it was decided that a note taker was not required for this
meeting as it was a smaller group. The audio recording equipment and the A2 sized note sheets had proved reliable methods for note taking in the previous groups.

3.13 Ethical approval process

Ethics approval was initially sought from Otago Polytechnic ethics committee, however due to ethics panel staff shortages and a backlog of applications a further application was made to Eastern Institute of Technology (EIT) for ethics approval. Ethics approval was gained without any further changes to the application (Appendix 5).

3.14 Ethical Considerations

The criterion used for eligibility of participants were that of those at the workplace who took part and enrolled into the WHP programme from its beginning and were still enrolled at the time they were invited to participate in the research. All the workplace participants were adults, aged over 18 years. Invitations and information was sent electronically via email to prospective participants (Appendix 6) all of whom have access to and regularly used email. Participants were then asked to sign an informed consent form as mentioned above. Some signed consent forms were collected prior to the initial focus group meeting where there was a further opportunity to answer any queries or concerns.

Participants were asked if they have read and understood the information sheet for volunteers (Appendix 7) taking part in the study, that they had the opportunity to discuss the study and were satisfied with the answers given.

Participants were asked if they understood that taking part in this study is voluntary (their choice) and that they may withdraw from the testing at any time and this would in no way affect their future participation in the WHP programmes, employment or any wellness initiatives at the workplace.

Participants were asked if they understood that their participation in the study is confidential and that no material which could identify them will be used in any reports on this study.

Participants were asked if they have had time to consider whether to take part, and knew who to contact if I have any questions about the study.

Signed, written permission was sought and gained from the employer where the research is undertaken to ensure they were aware and approved of the research activity in their workplace (Appendix 8).
Participants were asked to sign agreement, if they agreed to take part in the study as mentioned previously with the use of a consent form (Appendix 2).

There was a potential for participants dignity, privacy and confidentiality to be breached. These issues were controlled by providing full information to participants, restricting access to audio-taped interviews and transcription records to the researchers. The interviewer gave reassurance to participants that their information will be treated with confidence and that others in the focus group will be asked to respect privacy of each other’s information. Focus group interviews were held in the worksite within a private meeting room. Light refreshment and non-alcoholic beverages were available at each focus group meeting to provide an open and inviting atmosphere which valued the contribution that participants were making to the study. A written summary of the results for the study was delivered to individuals as part of a participant check of the results where the focus groups were later re-convened and presented with the researchers’ interpretations and main themes of the study.

There was an opportunity for individuals to rescind their information within three months of data collection. All identifying information was removed to ensure that anonymity is protected in the written results. If participants withdraw there were reassurances on the signed consent form that participant will not be disadvantaged and they can continue or withdraw from the study without penalty or consequence.

All research information will be treated private and confidential as per New Zealand Health Information Privacy Code and The Privacy Act (HPCA, 2003).

No specific issues of vulnerability were identified. However as the researcher was also the programme administrator this combined role raised the issue of reflexivity described below in section 3.21.

3.15 Sampling and Recruitment

The setting for this study is a workplace in the city of Dunedin, Otago, New Zealand. Dunedin has a population of 123,000 with a large student population of 25,000 and considered one of the four main urban centres of New Zealand (Dunedin, 2012).

All participants who had completed the WHP programme were eligible for the study and received invitations to participate. The target group for this study was chosen from the larger group of thirty that were participants in the WHP programme described in chapter
one. As all participants had email accounts invitation letters were sent via email to all the
WHP programme participants (30) inviting them to take part in the study. An ideal size for
focus groups is six to eight (Krueger & Casey, 2009). A total of six responded to the invite
and were subsequently able to be present for the focus groups. A further purposive sample
of three that represented the employer group were invited, this group consisting of
managers who assisted with the administration of the WHP programme.

All participants were given twenty-dollar vouchers for the internal cafe as an incentive and
to thank participants for their time and effort required to attend.

3.16 Exclusion Criteria

Non- participants of the WHP programme were excluded and not sent email invites as they
did not meet the study target group criteria as recent participants of the WHP programme.

3.17 Data Analysis

Data analysis was carried out using Thomas’s General Inductive approach (Thomas, 2006). A
general inductive approach was chosen as it is described as a straightforward method of
analysing qualitative data. Thomas describes how the general inductive approach is similar
to the Strauss & Corbin’s (1998) definition where: “The researcher begins with an area of
study and allows the theory to emerge from the data”(pg12).

In keeping with Thomas’s methods, the findings were influenced by the research objectives
and the findings were drawn directly from the raw text, not from any prior expectations of
the researcher or models (Thomas, 2006). The initial research question and methodology
provided a topic and process for study but did not pre-suppose the findings to what was
expected to be found. In this way the general inductive approach is different from
deductive approaches where typically hypothesis are tested and deductions are made. The
actual experiences of the participants is explained in the results and does not simply
describe the WHP programme effects in a predetermined way.

Using Thomas’s method, firstly the data collected as described earlier is typed into
transcripts. This text was then read repeatedly to identify and summarise the meaning of
the initial text. Categories and themes were allocated to the text as a method of
summarising the focus group discussion and drawing out the meaning or concepts from the
data. Once identified the themes were then able to provide a broad understanding of the
otherwise complex and lengthy conversations from the focus groups. Results were written
with the de-identified quotes that illustrated the themes well. Quotes were assigned an
alphabetical reference letter to demonstrate that a variety of participants opinions and comments were included. The process of data analysis is summarised in table below (Table1).

**Table 1: Process of Data Analysis**

<table>
<thead>
<tr>
<th>Step 1</th>
<th>A2 sized paper was used in the focus group meetings and posted on the walls. These were kept as notes and referred back to during data analysis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Following each focus group discussion audio-recordings were transcribed by a professional transcription service.</td>
</tr>
<tr>
<td>Step 3</td>
<td>Transcripts and audio-recordings were re-read and listened to by the researcher.</td>
</tr>
<tr>
<td>Step 4</td>
<td>A line-by-line data analysis was carried out interpreting the discussion into sub-themes and themes.</td>
</tr>
<tr>
<td>Step 5</td>
<td>The data from the line-by-line analysis was photocopied, cut out and sorted into their theme categories.</td>
</tr>
<tr>
<td>Step 6</td>
<td>Supervisors were asked to carry out a check on the clarity of the themes and sub-themes and to give feedback.</td>
</tr>
<tr>
<td>Step 7</td>
<td>Participant checks were completed by presenting the sub-themes and themes back to the focus groups to check that the interpretation was accurate portrayal of the discussion.</td>
</tr>
<tr>
<td>Step 8</td>
<td>Themes and subthemes were reconfigured into a final list of themes and subthemes for writing up.</td>
</tr>
<tr>
<td>Step 9</td>
<td>Final list of the sub-themes and themes discussed with supervisors.</td>
</tr>
<tr>
<td>Step 10</td>
<td>Results were written and presented as themes.</td>
</tr>
</tbody>
</table>

It is important to mention at this point that the SWOT tool was used as data collection tool only and not used as a method for data analysis. The SWOT tool influenced the discussion and provided a framework for the discussion but was not used later in data analysis.

Saturation is described by Kruger & Casey (2009) as a point in the discussion where there is no further new information. Saturation of data was reached in the discussions over two group sessions with employees. This was in line with what was learnt about timing of questions in the pilot focus group meeting. As there are fewer participants in the employer
group a single but longer two hour session was adequate to cover the semi-structured questions and provided the saturation required.

3.19 Trustworthiness

Schneider, Elliott & Whitehead (2007) suggest that there is no one single method agreed in qualitative research to ensure trustworthiness or rigour in the results of qualitative research. Instead of attempting to establish a criteria for establishing generalisability or trustworthiness, Krueger and Casey (2009) suggest outlining the several steps that the researcher has taken to ensure that the results are an accurate portrayal of the participants thoughts and feelings expressed in the focus groups. Krueger &Casey go on to argue that it is more important to outline the procedures, methods and analysis strategies for those who read the results to come to their own conclusions about whether the results can be applied to their own application or situation. The steps of data analysis and trustworthiness and the concept of reflexivity have been detailed as they are applicable to this study. Polit &Beck (2010) agree that there is general acceptance that “thick description” of the detail of the study is required to ensure that the study is rigorous in its approach to trustworthiness and concede that it may not be clear about how “thick” the description should be. In this study the author/researcher has attempted to outline for the reader as comprehensively as possible the steps and measures that were taken in the research to ensure trustworthiness of the results and process followed.

3.20 Trustworthiness of data analysis

Thomas (2006) describes various methods for assessing the trustworthiness of the data analysis which include a method of consistency checks where another coder takes the category descriptions and finds the text that belongs to the categories. In this study the initial coding was completed and a second coder in this case the research supervisors, took the role of consistency checking. The second coders, were given the evaluation objectives, the categories identified by the researcher and the descriptions of each category to check against the transcripts.

3.21 Reflexivity

Munhall & Chenail (2008) describes reflexivity as the process whereby “researchers recognize that they are an integral part of the research and vice versa”. In this study a dual role exists where the moderator of the focus group meetings is also the lead administrator of the programme or lead agency. A prior relationship is assumed. Although this was
made explicit to participants during the focus group meeting, reflexivity is a known issue in this type of study where the participants are known to the researcher. McConnell-Henry et al. (2009) describe this phenomenon as an insider relationship where role clarification is required to ensure that it is clear to participant’s that the role of the researcher is not as it was previously, in this case the programme administrator or lead agency. The role of the researcher moves from programme administrator to collecting data for the study or moderator. In order to prevent participants from essentially telling the moderator what they want to hear, the moderator explained early in the interview that honest opinions and perceptions are requested and that the moderator would not be upset by conflicting views or alternative opinions and honest discussion was important. McConnell-Henry et al. (2009) recognise that some authors suggest that it is important that the researcher does not have a prior relationship with the participants to maintain distance and independence so as not to influence participants views or opinions. However McConnell-Henry et al. (2009) go on to say that a pre-existing relationship is preferable as rapport is already established and normal stages of facilitation that encourage participants to share their opinions are advanced.

3.22 Commitment to the principles of the Treaty of Waitangi

This research can be described as a mainstream approach as defined by the Health Research Council - Te Ara Tika guidelines for Maori Research (Hudson, Milne, Reynolds, Russell, & Smith, 2010). This is where the researcher aims to protect the rights and interests of Maori. Furthermore where the research may not have direct relevance to Maori, nonetheless seeks to protect the rights and interests of Maori.

On discussion of the research aims with Dr Khyla Russell as Kaitohutohu for Otago Polytechnic the following items were identified:

Participation
Participants were invited by email to participate. Demographic questions will allow the opportunity for participants to identify as Maori.

Protection
Maori tikanga, traditions and cultural values will be respected and protected. For example food offered as refreshment for participants before the focus group interviews and will not be consumed while the interviews take place and are offered before meeting to ensure it is
tika. All participants will have the option of face to face discussion prior to participation and during participation.

The researcher will have knowledge of the Otago Polytechnic Maori Strategic Framework as it relates to research and participants.

**Partnership**

The researcher had recently completed a Treaty of Waitangi Workshop to gain an understanding of Kāi Tahu as Mana Whenua and a brief discussion or korero of the aims and methods has been discussed with Dr Khyla Russell as Kaitohutohu at Otago Polytechnic prior to the ethics approval process.

*(Personal communication, Dr Khyla Russell, March 2011)*

### 3.23 Summary

This chapter described the methods that were used to carry out the study. It provides background to the study and the SWOT data collection tool commonly used in group work. The three focus groups are explained in detail to provide an understanding of the process that was followed to reach the results. Data analysis methods and trustworthiness of the results is then detailed to provide credibility and clarity to the study. Ethical considerations and an explanation of how the research relates to the interests of Maori as Tangata Whenua of Aotearoa, New Zealand is provided.
Chapter Four - Results and Discussion

“Data is a precious thing and will last longer than the systems themselves.”

Sir Tim Berners-Lee (Born 8th June 1955 - Inventor of the internet)

4.0 Introduction

This chapter describes the results and discusses the study as it relates to the literature. Results are described in paired themes. Paired themes were developed as more than one word was required to define and title each theme. Paired themes also emerged from the data analysis process as they complimented each other as topics, or as dichotomies which in some cases were opposite in meaning. For example the complimentary theme of retention and attrition describes the challenge of keeping participants involved in the programme and retaining them. As an example of a dichotomy barriers and enablers presents both the positive aspects of the WHP programme as enabling factors and barriers that are opposing or negative factors that prevented participants from fully participating.

A total of seven key themes were identified across all of the focus group interviews with both the employee and employer groups. Sub-themes are used as headings to describe the most important aspects of the paired themes and provide further structure and clarity. Quotations are taken directly from the transcripts and inserted into the results to provide excerpts of the original discussion and add meaning to the interpreted results. Participants are identified simply by a unique upper-case letter attached to each quote. This is in an effort to provide a guide to the different members of the discussions as well as to protect anonymity of the participants as outlined in the ethics section.

Results were found to be similar for both groups and are described together without separation. A likely explanation for this similarity is that the employer group were also participants of the WHP programme. That their (employer group) discussion mirrored that of the employee group is therefore predictable. In the design of the study the two groups were separated to ensure that participants were able to share their views openly, as well as to provide an environment that would encourage frank, open discussion (without risk of being influenced by each other). The employer group have an assumed power differential with the employee group and the separation of the two groups as has been recommended as good practice (Krueger & Casey, 2009).
4.1 Themes

The seven themes generated from the focus group discussions are; barriers and enablers, communication and information, tailoring and targeting, culture and leadership, participation and competition, retention and attrition and finally behaviour change and modification. Each of these themes and their sub-themes are described below.

4.2 Theme 1. Barriers and Enablers

Participants identified a number of barriers and enablers to participation in the WHP programme. As participants reflected on the strengths and weaknesses they were able to describe many variables that contributed to this theme. This theme was the largest theme to be identified contributing to the most frequently discussed topic of discussion in the groups.

Enablers are identified here as those aspects of the WHP programme that led to increased participation and literally enabled the participants to get the most out of the WHP programme and to take part.

Barriers are those issues that prevented participants from enrolling, participating and fully engaging in the WHP programme activities and events.

4.2.1 Barriers and Enablers - Financial

Issues such as the cost of the programme to the individuals were discussed as a potential barrier. Despite the fact that the majority of the cost for the WHP programme was funded by the employer the out-of-pocket $25 participant fee was seen by a few as a factor that could have prevented non-participants from entering the WHP programme. Whether this was because the fee was set too high for some or whether or not it was perceived as good value for potential participants is unknown.

*C: Because there were certainly people who paid it and still didn’t do the programme as well, so it can’t have been that big a barrier, you know it was a barrier for some but others paid it to get involved and then did nothing.*

*B: Or maybe if more was made of the fact that the [workplace] had subsidised to an extent that it did, that people realised oh it’s just not my $20, it actually cost [the workplace] another $100 per person or whatever*

Some conceded that although the $25 fee was a potential barrier it could also be an enabler. It was thought that they were more likely to take part if they have some of their
own money invested in the programme. Russell(2009) describes this as taking personal responsibility for sustained change and often leads to improved commitment to the WHP programme.

E: I think the fee was really low, just because it’s easy to fork out a $20 note constantly, and I’m really clingy with my money, so it’s not that much of a commitment for you to take.

D: I think if it had been too much higher, people would’ve been like, oh...

F: I’m not doing it.

D: Yeah and I think any higher might’ve put people off in terms of what else they could, to achieve the same sort of thing...

Along this same line of discussion one salient comment was made that if they had been made aware of the full cost of the programme they may well have felt that they had to do well.

E: If we knew the percentage of the full price that we had paid, you feel that you had to do well.

Considering it was the first time a WHP programme of this type, had been run in this business it was decided by the employer that casual staff would not be included in the programme. Participants described this exclusion as a barrier and surmised that it may have been both a financial issue and due to a perception that casuals were less likely to be committed to the programme and benefit from it.

C: Oh ok, yeah ’cause was the barrier like the money benefit from the management team as to why casuals couldn’t get involved or was it like maybe, the thought of maybe casuals wouldn’t be as committed?

E: I think it’s more [the] money.

G: I think it was potentially a little bit of, well it was a little bit of both from memory but I guess it’s showing now, it’s a hindsight thing but just because you happen to be here more doesn’t mean you’re going to be more committed.

The employer group discussed the notion that their staff would be more likely to be productive staff if they were happy and healthy. They understood that a healthier workforce would likely lead to a more productive staff and therefore improve the financial position of the organisation.

H: Yeah people are gonna be more productive at work and make us more money
A report from the World Economic Forum (2007) supports this understanding and highlighted the results of a 12-month study conducted at Unilever sites in the UK. Worker performance increased by 8.5% in the study group who took part in WHP compared to that of the control group.

In a ROI meta-analysis by Baicker et al. (2010) medical costs were reduced by US $3.27 for every US $1 spent. In the same study absenteeism costs were calculated at US $2.73 savings for every dollar spent on WHP programmes.

Another well-known barrier to WHP programmes was explored, the direct cost to the employer. WHP is often seen as a luxury as opposed to a strategic role in the organisation. There are conflicting priorities for businesses and WHP is not always seen as core to the success of the business (Russell, 2009). As a medium-sized business a WHP programme such as this may be judged as costly, for smaller businesses it could be unaffordable.

_H: “Financially they [WHP programmes] are expensive...we had to rob a bit of Peter to pay Paul”_

Until recently WHP programmes are a relatively new concept for employers in New Zealand and there has been a lack of evidence based, well-delivered programmes readily available to employers (Passera, 2011). Most evidence detailing the return on investment for employers is generated out of the US. Wellness programmes are commonly used by large US employers not only as a tool for improving workplace health but also an effort to off-set the direct cost of employee health insurance. The premise behind this is that employees with a lower health risk profile are likely to cost less to insure than their unhealthy counterparts. In New Zealand as in the US employer funded health insurance schemes are typically the domain of larger employers. In an economy dominated by small to medium-sized businesses employer funded health insurance is rare and likely has less of an influence on whether or not the organisations are likely to engage in WHP.

4.2.2 Barriers and Enablers - Accessibility

Accessibility describes barriers and enablers in terms of how accessible the events, activities and overall how the programme was perceived. For example, Moy, Sallam, & Wong (2006) described interventions that are held off site usually take more time to attend and are likely to be a barrier to participation.

This WHP programme was delivered over the winter season and for some, created a barrier to fully engaging in outdoor leisure activities or exercise that would contribute to their
recorded minutes of exercise. The winter in Dunedin, New Zealand, is described as a temperate winter climate with daily mean temperatures of between 6 and 7 degrees centigrade with approximately 9 hours a day of daylight hours (Dunedin, 2012).

E: yeah I mean the winter season was just, you know versus daylight hours to have available to exercise... and people in that kind of winter hibernation mode maybe are not that keen, or like you said, thinking about summer and I should get fit.

Sickness absence during the winter months is a known issue for organisations and was identified by participants as a barrier preventing some of them from accessing some aspects of the programme.

I: there was a bout of illness that went through the [workplace] during the programme.

H: I was away for 2 weeks and got the flu for two weeks, it was four weeks out of the 10 weeks gone, although I tried to keep up as best as I could.

Participants spoke about the WHP website in terms of its ability to be accessible at home and work. The website enabled them to log in from any internet connected computer and interact with the programme logging their daily exercise, nutrition and water intake.

F: Yeah I think just the fact that the website was really good ’cause you could, like I’d basically fill it out while I was at home, things like that so just having it accessible through the internet I guess was really useful.

Interestingly some were able to continue their WHP programme while on their holiday and while away on a conference.

C: I went to a conference right at the very start and I found it really good to be thinking about water and exercise while I was off doing something outside of work so it was quite a shift for me ’cause I wouldn’t normally be drinking that much water while I’m on holiday or in another city, I just don’t think about it.

Accessibility of the website further enabled them to continue. Web-based programmes provide this portability into the home and away from the worksite. Traditional worksite programmes where the programme is primarily based in the worksite are often inaccessible away from the workplace.

C: But you were still conscious of it when you were off work, like to me though, the whole point of the programme was that it fitted into your whole life so whether that was just when you were working or when you’re on holiday.
4.2.3 Barriers and Enablers - Supporting factors
Support is defined here as those supporting factors that were required for the WHP programme to be successful. Support from the programme administrators or owners. Support from the managerial staff or employers.

Initially the organisation looked for WHP programmes that would meet their needs. Options were considered and evaluated in terms of what they offered and affordability. It was important for the organisation to partner with a successful provider who could be available at a moment’s notice.

J: ... even though you’re on email, you kind of felt like you’re sitting in the desk next door....I didn’t feel like I was ever gonna get that from someone else.

Partnerships in health promotion are effective ways to develop mutually beneficial relationships (Fertman, 2010). This programme was an example of other unrelated but successful business-to-business projects that Otago Polytechnic had completed in collaborative partnerships.

Managers were keen to support the programme and to ensure that it was valued by the staff.

J: I’d like to think that the majority of people felt quite good about being involved and appreciated what we did.

4.3 Theme 2. Communication and Health Information
This theme emerged through comments around the importance of clear communication and easily understood health information. There were a number of mediums of communicating to participants throughout the WHP programme such as the website, emails, flyers, seminars and face to face consultations with the programme administrators and health professionals.

Participants commented that the health information offered at times difficult to understand and required some interpretation. This theme appeared to be related to the website information, health literacy or the ability to understand health information and the need for clear communication.

4.3.1 Communication and Health Information - Health Literacy
Biometric health information such as blood serum lipid profiles were included in the programme and participants were given laboratory results such high density lipoprotein
results. Results such as this required explanation and a good level of health literacy for the participants to understand and make use of this information.

Some comments suggested that although they were not easily able to interpret their own health results such as blood lipid profiles the health information that was listed on the website was emphasised by some as strength of the WHP programme.

\[ F: \text{The good thing about the website though if you have it on there is that people can come back and they've got a bit of time and they have a look around, you know they've lost their pamphlet or whatever they got at the beginning of the week.} \]

There appeared to be an increase in the awareness of wellness as a holistic concept that it wasn’t simply about healthy eating, healthy action and improving water intake. Comments suggested that there was some improvement in health literacy of participants who began to understand the wider definitions of wellness and finished with a broader knowledge and awareness of health information.

\[ I: \text{It kind of also made people aware that wellness just isn't sport exercise. There is a completely a whole lot more aspects to the complete wellness and I think something along the expectations that this programme helped them understand what to do you know, improve on all aspects rather than just sport, fitness and eating, you know.} \]

4.3.2 Communication and Health Information - Website Interactivity

As the discussion progressed more and more comments about the website arose as opportunities for improvement.

\[ J: \text{The website could be a bit more intuitive I think people struggled with that a wee bit.} \]

\[ H: \text{I did but then...thats down to me 'cause I'm techno pathetic.} \]

Some were confused by the information that was on the website and felt it was misleading. Graphs depicting overall team rankings were displayed on the front page of the website. As participants logged their results into the website the graphs would change and initially the graphs changed substantially with only minor input.

\[ F: \text{When he first did his ranking they were quite misleading, I think the bar graph with the ranking because yeah, like no matter if you were second by, you know a few seconds or something, you were still like a large gap below the next team so it made it look like you were a lot worse than perhaps you were.} \]

Several comments were made about the information that was available on the website and how they were able to refer back to it if needed.
F: The good thing about the website though if you have it on there is that people can come back and they’ve got a bit of time and they have a look around, you know they’ve lost their pamphlet or whatever they got at the beginning of the week...

More recommendations for improving the type and content of information on the website were offered.

G: And I thought that, the website, sorry, or the website could have, if it had like recipe ideas and stuff there, this containing however much iron, however much protein, blah blah blah and it’s how much of your recommended daily intake, that kind of thing.

These comments compliment the study by Hasson et al.,(2010) that described a number of factors that lead to high use of web-based programmes. The degree of website interactivity is an important feature and discussed how designers of websites can improve interactivity. In addition to this being female, educated and having prior healthy exercise habits were all found to be predictors of high participation in WHP programmes.

4.3.3 Communication and Health Information - Clear Communication

Many of the participants described how they were unsure of the WHP programmes expectations at the start.

E: I came into it with a little bit of background knowledge already because we’d talked about it in health and safety meetings but I still had a feeling of absolute horror at the idea of having to do an exercise programme, I thought it was gonna be like someone whipping us and make sure no-one had no clothes and like, I thought I was gonna be really bad but I was still excited to try it and it turned out to be a lot better than I thought, anyway, that’s all you can hope for I guess.

It was the first time this workplace had been involved in a WHP programme. Some may never have experienced health promotion in the workplace or participated in an event such as this. An information session and launch was delivered to all staff as an introduction to the programme and information had been circulated to all staff detailing the outline of the programme however it was assumed that staff would not be fully aware of all aspects of the programme until they had experienced it. Comments such as the one above suggested that there was some trepidation in starting the programme. This comment is in keeping with a commonly used theory for health promotion; Prochaska’s – stages of change model (Green, 2005). Nutbeam & Harris (1999) describes this model whereby potential participants experience contemplation phases which describe their readiness for change. Participants are those that were considering making a change in their health behaviour before they seriously commit to the change in behaviour. Those that have not considered
enrolling are those in the “pre-contemplation stage” or may even be consciously choosing not to participate.

Other mediums of communication such as emails to the participants were used as a method of keeping in touch and on track. Motivation emails reminded them of the number of weeks completed with regular tips and suggestions.

D: So every Monday morning, he would send us, like everybody through like a, this is week 3 of 10 weeks and he would say something like you might be kind of starting to veer off the track and to try and get back on, you could try and do these three things or, just to keep you motivated...

4.4 Theme 3. Tailoring and Targeting

Tailoring and targeting are used to describe the process of adapting the WHP programme to suit the needs of the target organisation or group and then tailoring it to the individual’s needs.

4.4.1 Tailoring and Targeting - Individual Tailoring

Multiple studies have shown that tailoring information for individuals leads to improved uptake of health promotion information and tailored information is more likely to be read and remembered (Cowdery et al., 2007). Health risk assessments are examples of tailored information and typically include metric health results such as blood pressure readings. These results are then displayed with comments on how the individual can improve their health results such as diet and exercise prescriptions.

D: Yeah I reckon also I personally think it’s quite good if we start to have to kind of set a specific goal or kind of make you think about what you actually want to get out of it, like we got the blood tests results and stuff and that was kind of like an eye opener but at that point it might’ve been nicer to like, ok here’s your results, here’s where you’re at, what do you want to achieve in the next 10 weeks

There was general agreement that the initial health assessment and interventions could have been tailored more to the individual. In this study the WHP programme gave general advice and did not offer any tailoring to the individual. An individualised approach was called for so that participants could set their own goals based on the assessment. Participants felt this personalised approach could have led to improved feedback and possibly lead to improvements in motivation.
4.4.2 Tailoring and Targeting - Worksite Targeting

The programme was targeted at the specific worksite and the website had been branded to suit their needs to include their company logo. Further targeting was requested amongst the groups so that it would be focused more on the individual on the front page of the website which may have led to improved individual ownership.

4.5 Theme 4. Leadership and Culture

The report by Price Waterhouse Coopers for the World Economic Forum (2007) lists leadership as the first priority in a set of four gold standards for preventing chronic disease. In a similar USA document, The National Institute for Occupational Safety and Health (NIOSH, 2008) lists leadership in its 20 essential elements of effective workplace programmes and policies for improving worker health and wellbeing. Leaders are able to influence organisations and individuals by modelling good health behaviours and aligning WHP with business strategy. Both of these papers suggest that wellness should be incorporated into business plans so that leaders are held accountable for promoting healthy workplaces.

4.5.1 Leadership and Culture - Manager buy-in

Participants expressed their opinion that their managers and senior staff in the organisation needed to take an active part in the WHP programme to demonstrate their leadership. It was felt that if they as participants were to buy in to the programme their needed to be significant buy in from management.

D: I guess there’s that whole leadership thing, you know...

F: You’ve gotta walk the talk.

D: Yeah that’s right.

C: Yeah, how could they encourage us to do it when they’re not even doing it themselves ___ if it was the mentality.
4.5.2 Leadership and Culture - Positive peer pressure

Focus groups described in their own words the positive workplace culture that evolved during the programme. Again this is a component of many workplace wellness frameworks such as the framework described by Russell (2009) “Supportive environments are created were wellness becomes a norm within the organisation and a positive culture is built where there is active staff participation built on trust, not fear”.

B: It did generate, well I thought a kind of positive peer pressure, the fact of eating well, you know in the staff room and people being wow look at all those veges you’re having for lunch and stuff like that and if you turned up with fish ‘n chips, you’d get a bit of grief you know.

One of the participants reported a “sense of community” in line with this theme of culture whereby a positive culture is demonstrated that encourages healthy choices and behaviour.

F: Yeah, there’s a sense of community or, I dunno know what it was but it was good

F: It’s an odd sort of social thing that people who have preferences of exercise and activity and sometimes the people who you would, you know maybe go running with would be quite different from the people you might socialise with normally, because people do have a sort of, exercise is traditionally quite personal I guess so people’s preferences as to what exercise they like can be quite different so you might end up, yeah meeting people who you wouldn’t normally I guess, like ___ going and doing the same activity

4.6 Theme 5. Participation and Competition

4.6.1 Competitiveness – Participation and Competition

The competitive nature of the WHP programme was identified by a few who were unsure as to whether or not it was a positive influence on their participation. Generally they described the day to day culture of the workplace as a healthy competitive environment and that this may have influenced many of the participant’s behaviour throughout the programme. There was an understanding that the WHP programme was primarily based on participatory type healthy eating, healthy action and not intended as a programme that creates winners and losers. Comments suggest that it may have become a little too competitive at times and this may be a reflection of the workplace culture and less about the WHP programme.
F: I think competitive was fun but I also at the same time, I think it got a little too competitive at times because the whole point really was to get lots and lots of people involved in, well this is what I felt anyway, lots of people involved in you know, being part of the programme, participating, having fun and all that kind of stuff ...

H: ‘Cause it comes out in the competition, you can’t help that, especially with us, for most part we’re a competitive bunch, the only downside of competition can have a negative depending upon how the team’s done and that if you’re in a low activity team, either a big change has gotta happen or nothing is going to happen, so it’s like a strength and a weakness at the same time and that’s something that I would have learnt next time.

4.6.2 Participatory factors – Participation and Competition

The Ottawa Charter for health promotion set the groundwork for “creating supportive environments” as one of its key strategies (Fertman, 2010). Participatory type programmes aim to provide supportive environments that encourage practitioners and workplaces to resist creating competitive type programmes that potentially act as a barrier to participation. A well-known nationwide community health promotion programme called “Push Play” operates with participation in mind and recognises the importance of 30 minutes of exercise a day. Physical activity has well known benefits for all people, and programmes such as this attempt to address barriers and provide encouragement to improve overall participation rates in healthy activity (Leavy, Bull, Rosenberg, & Bauman, 2011).

In the design of the WHP programme described here, deliberate attempts were made to ensure that the programme maximised participation rates. Activities and events were tailored to ensure that they appealed to all levels of physical ability. Aqua-jogging, spin–cycling and motivational seminars are examples of some of the events that were on offer.

A: I’m pleased it was about participation, about inclusiveness, about that type of thing?

B: Yeah and there’s no, like at the start I thought oh I wonder if I can do it and there’s absolutely no reason why I couldn’t have done it.

Team graphs that tracked the cumulative totals of activity, portions of fruit and vegetables and water consumption were a main feature of the front page on the programme website. These graphs were intended as a simple visual tool for participants to see at a glance how their team was performing against other teams. Comments across the focus groups suggested that the team graphs could have acted as a de-motivator. That any positive
influence the graphs had may have also had negative consequences for those teams who were not rating high on the graphs.

F: I mean not that it really actually matters or anything but like you kind of felt a little bit sort of gypped that you’d been doing this work to kind of make it a more regular thing throughout the day and all the rest of it and then you kind of just get blown out of the water by a group who goes up and down the stairs all day, you know like, I did kind of go, oh and it put me off a little bit with that challenge and I know, yeah a couple of people thought the same time because yeah, it just didn’t seem in the spirit of what the challenge was about.

G: like to me it was about actually being able to fit in into your work place, ‘cause that was part of the challenge, to be able to do that so that it becomes you know, a habit and they do kind of, like if one team’s doing really really well and is miles and miles ahead and you’re in a team that was not doing so well, you kind of lost some motivation.

4.7 Theme 6. Retention and Attrition

The term Retention refers to the number of participants who started and then completed the programme. Attrition describes the issue of participants effectively dropping out of the WHP programme by not fully engaging or not taking part in the programme. Some participants described how they were technically enrolled but became non-participants, despite having enrolled at the beginning. The challenge of retention and attrition for WHP administrators is keeping participants engaged or actively involved in the programme.

4.7.1 Recruitment –Retention and Attrition

Recruitment of participants for the WHP programme is worth noting here. At around 50% of the eligible staff who took part in the programme, this uptake was high. According to Cowdery et al., (2007) low participation rates are a common issue for WHP programmes and there are limited examples of this being measured in studies. They reported estimates of between 5% and 30% uptake in WHP programmes.

I: But then is it better to have people who are joining that are 100% committed, a small amount of people that are 100% committed rather than a large amount of people where only half the people are committed.

In comparison with the same WHP programme run earlier in a different, (larger) workplace there was a participation rate of 20% of the total eligible staff (Polytechnic, 2010). In the same year a research poster presentation Gibbons et al.,(2011) reported a retention rate of 82% of those who started the programme. This equated to 84 completing the 10-week
WHP programme out of 102 workers that first enrolled. As mentioned in the literature review, Cook (2001) reported 77% participation in workshops and a retention rate of 95% at six months and 89% at twelve months. This variation in participation rates justifies the need for further research within the NZ settings.

Although only one participant of the WHP programme described here formally withdrew, they identified the fact that some failed to remain actively engaged or were perceived to have given up sometime throughout the 10-week WHP programme. Others thought that some members of the teams were more actively involved than each other.

G: I had a couple of comments from people that were in a team - I haven’t really done anything because my group hasn’t...Yeah I know a lot of people [that were] quite into it but like, I spoke to other people during the programme and they just seem to have kind of given up, they’re just like oh my team’s not really into it, I haven’t really done anything.

A comment that optional parts of the programme were not well attended is an example of attrition where interventions are offered and then not well attended. One event had to be cancelled altogether due to low attendance.

B: I think it was a shame that there wasn’t as much uptake with the, like events, with the optional kind of stuff and I don’t know what the solution would be, like I know that I personally couldn’t go to some things because I had other things on at that time.

The employer group expressed their concern about retention and attrition issues and reflected that there was some risk of the programme could fail if large numbers were not actively involved. They highlighted that the programme was championed by the team leaders and this likely led to the success of the programme.

J: The ones that didn’t take it up or the ones who took it up but then didn’t sort of, fell by the wayside and then if too many fall by the wayside, the whole programme was over, yeah one or two is not a big issue out of I think, 30 about 30ish, yeah that happened very quickly, but if too many people fell by the wayside, so in other words if or you’re [not] driving it the way we did, that would be a risk, so a champion is essential and it needs to be reinforced as much as is possible because that would be a big risk, ‘cause if it wasn’t championed and no events were done or anything like, it would just fizzle no matter what.

Goetzel (2008) discusses the important role the champions within the worksite demonstrating that small organisations often have managers that are good examples and
visibly lead WHP within their teams. Clearly, the employer focus group as managers of the programme described in this study fit this description of WHP champions.

4.8 Theme 7. Behaviour Change and Modification

This final theme of Behaviour Change and Modification refers to several well-known health promotion theories that describe the process of people changing their health habits or behaviours to improve their health. As described earlier Prochaska’s Trans-theoretical Model (Green, 2005) is one of the more common theories of health behaviour change and assumes that people go through a series of steps before they achieve lasting health habits that will be sustainable to the step that is known as maintenance (Martin, Haskard-Zolnierek, & DiMatteo, 2010).

The employer group spoke about health behaviour changes that they had noticed within their staff. Indirectly they had noticed participants in the WHP programme appeared to be more conscious of their health habits such as bringing in their own healthy lunches, walking the stairs more often and a running club that had continued beyond the 10-week programme.

\[ J: \text{I noticed a few more people bringing their own lunch and you know that was [also] to save money} \]

The employee group also commented that they themselves had made changes in their habits that lasted beyond the 10-week programme.

\[ D: \text{...since that challenge, I’ve probably only been in the lift once or twice, like it actually has since made me change my habits...} \]

\[ G: \text{Yeah and they’re things that can carry on then past the 10 weeks which, you know a running club for example, that could continue.} \]

However small these changes might be does not detract from the fact that conscious behaviour changes occurred because of the WHP programme and that with good intentions these changes may be lasting. It is beyond the scope of this study to comment on whether these health changes were sustained over time but is worth mentioning that there does appear to have been some change observed by the participants within their own workplace. On a final note one participant remarked that it would be a good for the programme to continue beyond the 10 weeks in some way.

\[ B: \text{I think it would be quite good to have a where to from here kind of thing at the end, so that it’s not just like a, alright you’ve done your 10 weeks now, you can go back to your old habits or whatever, but it’s} \]
actually like a, you know you’ve started a great thing, this is how you can work on sustaining it and developing.

4.9 Summary

This chapter described the results and integrated them as they related to the literature. Results are displayed in paired themes. A total of seven key themes were identified across all of the focus group interviews with both the employee and employer groups. Sub-themes were used as headings to describe the most important aspects of the paired themes and provide further structure and clarity. Quotations were taken directly from the transcripts and inserted into the results to provide excerpts of the original discussion and add meaning to the interpreted results.
Chapter 5 - Summary and Conclusions

“Alone we can do so little; together we can do so much”.
Helen Keller (June 27, 1880 – June 1, 1968)

5.0 Introduction
This chapter summarises the study as it reflects on the literature review and research question and aims. The strengths of the study are summarised to provide overview of what the study adds to the research on WHP. Limitations of the study are discussed to provide context to the study and ensure credibility of the findings. Recommendations are made for further research as they relate to the literature and findings of the study. To close further recommendations are offered to support WHP practice in NZ.

5.1 Reflection on the literature
The literature related specifically to the experience of participants in WHP was sparse. Most of the available literature appears to be related to the effectiveness of WHP and models and methods for its delivery in practice. Much of the research emanates from the US where many large employers pay for the health insurance of their workforce and where there are proven benefits from ROI studies. Nonetheless it appears that there is now a significant body of knowledge that supports the practice and delivery of WHP. The evidence is clear and persuasive (PWC, 2008).

WHO has played a significant part in the history of WHP with the introduction of the Ottawa Charter for Health Promotion in the 1980’s. Behavioural change theories such as Prochaska’s trans- theoretical model have provided programmes with theoretical foundations and furthermore programmes that have been designed on best practice principles show the best results. As more is known about the social and environmental determinants of health, new models are emerging that place less emphasis on the individual to make changes in their health habits and more on the wider social and physical environments of people’s lives.

Web-based methods are becoming increasingly popular method of delivering WHP. Ninety six percent of NZ workplaces are using the internet providing an ideal environment for the proliferation of innovative web-based WHP. However, there is variation in the way
programmes are designed, delivered and their outcomes. Low participation rates, high attrition and lack of employer support or buy-in are all factors cited in the research. Methods such as tailoring and targeting of WHP have proven effective (Cowdery et al., 2007) and improve engagement (Yap & James, 2010).

Legislation in NZ has played a pivotal role in shaping the practice of occupational health nursing to the extent that much of the effort has been focused on health protection and compliance with legislation to prevent injury and illness. There is no single government body in NZ that provides WHP but rather a group of government agencies that provide a number of initiatives. Funding for WHP is vulnerable to re-prioritising and political influences. Frameworks for WHP have been proposed for NZ based WHP but it is not clear if these have been well adopted. There are a limited number of WHP providers and it could be described as a developing health sector in NZ. NZ WHP is defining its own professionalism and practice through alliances such as the Health and Productivity Institute of NZ.

5.2 Reflection on the research question, aims and results

The research question is “What are the opinions and perceptions of employers and employees as recent participants in a 10-week web-based WHP programme.”

Participants readily shared their opinions and perceptions in a series of focus groups. Several topics clearly emerged from their discussions that were themed into seven distinct subjects for discussion. Each theme was discussed as it relates to what is currently known about WHP and similarities were identified and comparisons were made. On reflection all of the themes have been identified previously in some way or rather in the literature. However, the unique perspectives of the participants in the NZ workplace setting provided additional relevance to the study.

In summary the themes were:

1. Barriers and Enablers

Enablers were identified as those aspects of the WHP programme that lead to increased participation and literally enabled the participants to get the most out of the WHP programme and to take part. Barriers were those issues that prevented participants from enrolling, participating and fully engaging in the WHP programme activities and events. This theme was the largest theme to be identified contributing to
the most frequently and extensively discussed topic. Participants identified barriers such as the cost of the programme and accessibility of the events. Enabling factors included support from the administrators of the WHP programme.

2. Communication and Information

This theme emerged through comments around the importance of clear communication and easily understood health information. There were a number of mediums of communicating to participants throughout the WHP programme such as the website, emails, flyers, seminars and face-to-face consultations with the programme administrators and health professionals. Most comments appeared to be related to the website information, health literacy or the ability to understand health information and the need for clear communication.

3. Tailoring and targeting

Tailoring and targeting describes the process of adapting the WHP programme to suit the needs of the target organisation or group and then tailoring it to the individual’s needs. Participants called for more of this tailoring and targeting in their WHP programme.

4. Leadership and Culture

Participants expressed their opinion that their managers and senior staff in the organisation needed to take an active part in the WHP programme to demonstrate their leadership. It was felt that if they as participants were to buy in to the programme their needed to be significant buy in from management to create a culture of inclusiveness and participation.

5. Competition and Participation

The competitive nature of the WHP programme was identified by a few who were unsure as to whether or not it was a positive influence on their participation. Generally, they described the day-to-day culture of the workplace as a healthy competitive environment. There was an understanding that the WHP programme was primarily based on participatory type healthy eating, healthy action. Comments suggest that it may have become a little too competitive at times and this may be a reflection of the workplace culture and less about the WHP programme.
6. Retention and Attrition

Retention refers to the amount of participants who started and then completed the programme. Attrition describes the issue of participants effectively dropping out of the WHP programme by not fully engaging or not taking part in the programme. Some participants described how they were technically enrolled but became non-participants, despite having enrolled at the beginning.

7. Behaviour Change and Modification

This final theme of behaviour change and modification refers to the process of people changing their health habits or behaviours to improve their health. Both the employee and the employers noticed health behaviour changes within themselves and others.

The primary aims were define the experience of a WHP from employee and employer perspectives to gain valuable insights from participants for the future delivery of WHP and programme improvement. This aim was achieved through the value of the shared opinions and perceptions of the participants. The study results will be useful to the programme administrators to continuously improve the WHP programme which has continued beyond this study time period.

Secondary aims were to provide practice-based feedback from the research participants that is likely be of interest to other planners, providers and professionals who are involved, or have an interest in WHP. Research that adds to web-based WHP as an innovative way of promoting health is likely to add to the body of knowledge in WHP. The themes that were identified in the focus groups provide useful feedback that can be used elsewhere provided that they are considered in the context of the limitations of this small-scale evaluative study in a NZ workplace.

5.2 Strengths of the study

There are limited accounts of participant’s experience of WHP and only a few examples of published articles specifically on WHP in New Zealand. This qualitative enquiry into WHP sought to define the experience of WHP from employee and employer perspectives and provide practice based data that may be useful for the future delivery of WHP and at the same time adding to the evidence base for NZ research. Studies such as this may be the catalyst for further research into WHP of which is scarce and published examples are few. Investigation into innovative new ways of delivering WHP such as this has been called for in
the literature. Although there may be some risk that new methods such as web-based programme are not any better than traditional methods there is value in exploring new ways of promoting health provided that risks are minimised to an acceptable level.

5.3 Limitations of the study

Limitations of this study are similar to those of many qualitative studies in that the results cannot be generalised necessarily to other environments. The opinions and perceptions of those who participated in this study represent two groups only; that of a group of employees and their employers. However, the value of their experience is important and adds to the practice-based knowledge available about WHP in a New Zealand setting.

Not all those who took part in the WHP programme were involved in the focus groups and therefore the findings will not necessarily represent the views of all the participants or the total workforce in the organisation. Casual staff (50) were excluded from taking part in the WHP programme mainly due to cost restrictions for the employer where just under half of the total staff count are casual staff. However, there was a broad enough cross section of study participants as both employees and employers were involved. The number of participants in this study (9) represented more than 30% of the total number (30) of those that participated in the WHP programme. Efforts were made to ensure trustworthiness of the results such as participant checks of the findings and results.

5.4 Recommendations for further research

1. Ongoing evaluative study on the WHP programme that was the subject of this study. This includes longitudinal type studies that track the progress of the WHP programme over successive years.

2. More practice-based and small-scale evaluative research into WHP will add to the body of knowledge and provide examples of best practice.

3. ROI studies in WHP for the NZ setting

4. Further and larger studies may provide new insights into WHP in New Zealand settings.

5. Further research to establish how and where WHP efforts should be prioritised in NZ. For example high health risk areas.
5.5 Recommendations for the practice of WHP

1. Further development and improvement of the WHP programme detailed in this study. Taking into consideration the themes, feedback and perspectives shared by participants in this study.

2. Further innovation and adoption of web-based applications for WHP

3. An agreed framework/model for WHP could be developed by the public and private sectors that is unique to the NZ environment and health challenges.

4. Consideration to be given to a single government body with majority of the responsibility and leadership for WHP in NZ with prioritised funding.

5. Any legislation changes should support WHP as an important feature of NZ’s health and productivity.

6. Further collaboration within the WHP sector is encouraged to share resources and skills to improve the WHP landscape in NZ.

5.6 Summary

This final chapter summarised the study as it reflects on the literature and research question and aims. The strengths of the study were summarised to provide overview of what the study adds to the research on WHP. Limitations of the study were discussed to provide context to the study and ensure credibility of the findings. Recommendations are made for further research as they relate to the literature and findings of the study. To close further recommendations are offered to support WHP practice in NZ.
References


MED. (2011). SMEs in New Zealand: Structure and Dynamics 2011, from


Appendix 1. Confidentiality Agreement for Transcribing Audio Files

Confidentiality Agreement for Transcribing Audio Files

I ________________________________ agree to maintain confidentiality of participants audio-taped interviews in the research conducted by Terry Buckingham.

I agree to:

• Maintain security of the audio files and computer discs during the period which I am transcribing the tapes. This includes having a password protected computer and keeping computer discs locked away.
• Not discuss the details of the focus group meetings with anyone other than the researcher
• Return all material to the researcher on completion of transcribing the audio files
• Return all material to the researcher on completion of transcribing the audio files
• To delete from my computer all transcribed material from my computer when the researcher confirms that this should occur

Signed:

______________________________________________________(Transcriber)

Signed:

______________________________________________________(Researcher)

This research project has been reviewed and approved by the EIT Research Ethics Committee and notified to the Otago Polytechnic Research Ethics Committee Reference No. 19/11, 29/07/11.
Appendix 2. Consent Form

CONSENT FORM

Project Title: “Employee and Employer perceptions of a 10 week workplace health promotion programme”

Researcher(s): Terry Buckingham – Researcher, Alex Lubransky - Assistant

I have read and I understand the Information for Research Participants sheet dated 15/08/11 for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand I am able to withdraw all of my information until 1st October 2011.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the testing at any time and this will in no way affect my future participation in the employment or any wellness initiatives at Otago Museum.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

I agree to take part in this research

Yes ☐ No ☐

I consent to my focus group interview being audio taped

☐ ☐
I wish to receive a summary of the results

Please send to address:

Signed: _______________________________________________

Name: ________________________________________________

Signature of Research Participant’s Support Person (if applicable)

________________________________________________

Date:  _____________________

Witness:  _______________________________________________

I/We as researcher(s) undertake to maintain the confidentiality of information gather during the course of this research.

Signed_________________________________________________

Dated______________________

This study has been approved by the EIT ethics committee 29/07/11 Reference # 19/11
Appendix 3. Core written ground rules for focus group meetings

Core written ground rules for the focus group meetings

Re: Employee and Employer perceptions of a 10 - week workplace health promotion programme.

It is necessary for all participants to agree to these ground rules before participation in focus group meetings.

These are the core ground rules.

Additional ground rules can be added if all participants agree:

- All participants will attend the meeting/s
- All participants contribution is valid
- The purpose of the focus group meeting is to gain as many opinions as possible therefore there are no right or wrong answers
- All participants are encouraged to contribute to the discussion
- Only one person will speak at a time
- All participants are encouraged to not mention client names or identifying characteristics.
- Confidentiality and anonymity of focus group members and dialogue not to be discussed with any third party, all discussion to remain in the room
- Meeting to start and finish on time
Appendix 4. Confidentiality Statement

Confidentiality Statement

I understand that as a research assistant (circle one) for a study being conducted by Terry Buckingham of the EIT Master of Nursing programme under the supervision of Bob Marshall, I am privy to confidential information. I agree to keep all information heard or seen during this study confidential and will not reveal it to anyone outside the research team.

Name: __________________________________________________Signature: __________________________

Date: ___________________________________________________Researcher

Signature: __________

________________________________________________________________________________________

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I have received payment for my services $___ per hour for ___ hours. $___

Name: __________________________________________________Signature: __________________________

Date: ___________________________________________________Researchers

Signature: __________
Appendix 5. Letter confirming Ethics Approval for Research Ref no. 19/11

Reference Number 19/11

15 August 2011

Terry Buckingham
C/- Otago Polytechnic
Dunedin

Dear Terry,

I am pleased to inform you that your research project "Employee and Employer perceptions of a 10 week workplace health promotion programme" has been approved for a period of 2 years, by the Reviewers of the Research Ethics & Approvals Committee on 29 July 2011.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number of all correspondence to the Committee.

Please provide the Committee with a progress report after one year of the project and a brief summary at the conclusion.

The Committee wish you well for the project.

Yours sincerely,

Kay-Morris Matthews
Acting Chair – Research Ethics & Approvals Committee
PARTICIPANTS NEEDED FOR RESEARCH

I am looking for participant volunteers to take part in a research study:

“Employee and Employer perceptions of a 10 week workplace health promotion programme”

As a participant in this study, you would be asked to take part in focus group discussion interviews. Your participation would involve you attending two (2) sessions, each of which is approximately one (1) hour duration at your workplace.

The first focus group interview is scheduled for Tues 13th. Sept 2011 at 8am and the second a week later on 20th Sept. 2011 at 8am in a meeting room at [Otago Museum]

For more information about this study, or to volunteer for this study please contact:

Terry Buckingham
Masterate Research Student of
Eastern Institute of Technology
P: + 64 3 474 8468
E: terryb@op.ac.nz

This study has been reviewed by, and received ethics approval by the EIT Ethics Committee and accepted by Otago Polytechnic Ethics Committee by Notification. Approval has also been gained from your employer for you to take part.
Thank you for showing an interest in this research project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

**What is the Aim of the Research?**

This research is being undertaken as part of the requirements for a Masters Degree in Nursing through Eastern Institute of Technology (EIT).

The purpose of the study is to determine and define the effectiveness of the OMG Challenge from employee and employer perspectives.

The primary aim will be to gather opinions and perceptions of whether or not the OMG Challenge is meeting the needs of both employees and employers.

Secondary aims of this research will be to identify the strengths and weaknesses of the OMG Challenge and identify areas where changes can be made to improve the programme.

**What Type of Participants are being sought?**

Participants of the OMG Challenge run at Otago Museum by the Otago Polytechnic.

**What will participants be Asked to Do?**
Should you agree to take part in this project, you will be asked to take part in a series of two (2) focus group interviews of one hour duration each. This will involve sharing your perceptions, opinions and attitudes towards the OMG that you have participated in.

The first focus group interview is scheduled for Tues 13th. Sept 2011 at 8am and the second a week later on 20th Sept. 2011 at 8am in a meeting room at Otago Museum.

These will require approximately 60 minutes each focus group interview to complete and will be completed in a private interview room on site at Otago Museum at the beginning or end of the normal working day.

Please note that the researcher – Terry Buckingham is the same person as the administrator for the OMG that you will have met already when you completed your health tests.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

**Can Participants Change their Mind and Withdraw?**

You may withdraw from the project at any time and without any disadvantage to yourself of any kind. However after the 1st of October 2011 the information you gave at the focus group interviews will be analysed and unable to be withdrawn after this point to enable the results to be included.

**What Data or Information will be Collected and What Use will be Made of it?**

Information will be collected using focus group interviews and audio taped transcripts, and observations made during the interviews. The information will be used to determine the research aims.

The results of the study may be published at a later date and presented at conferences in the future and pseudonyms will be used for all participants to guarantee anonymity. You are most welcome to request a copy of the results of the project if you wish to participate using the consent form option.
Please be assured that your responses will remain strictly confidential, and all data collected will be securely stored in such a way that only a transcriber and the researchers mentioned below will have access to it. At the end of the project any personal information will be destroyed immediately except raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.

**What if Participants have any questions?**

If you have any questions about our research project, either now or in the future, please feel free to contact either: -

**Terry Buckingham**
Masterate Student
P: +64 3 474 8468
E: terryb@op.ac.nz

**Bob Marshall**
Principal Supervisor
P: +64 6 974 8000 x5422
E: bmarshall@eit.ac.nz

**Megan Gibbons**
Associate Supervisor
P: +64 3 474 7282
E: megang@op.ac.nz

This research project has been reviewed and approved by the EIT Research Ethics Committee and notified to the Otago Polytechnic Research Ethics Committee Reference No. 19/11, 29/07/11.

Appendix 8. Permission to undertake research letter – To Employer
Dear Chris

Seeking permission to undertake research in the workplace

I am currently working towards a Master of Nursing degree through Eastern Institute of Technology, which requires me to undertake a formal research project.

I have chosen to study “Employee and Employer perceptions of a 10 week workplace health promotion programme” that Otago Museum is currently participating in otherwise known as the 

My intention is to collect audio taped data through focus group interviews of both an employee group (5-8 participants) and an employer group (2-5 participants) recruited by inviting participants of the 

I envisage that each focus group interview will be at the start of a working day. Each participant would need to commit to a total of 2 focus group interviews (2 hours in total)

The first employee focus group interview is scheduled for Wed. 7th Sept 2011 at 8am and the second a week later on Wed. 14th Sept. 2011 at 8am in a meeting room at 

Participation will be entirely voluntary and each participant will have the option of withdrawing at any time.

I have enclosed the Invitation to Participate, Participants Information Form and the Consent form for Participants for further information.

I would very much appreciate your permission to recruit voluntary participants via email invites from your staff who are currently participating in the in partnership with Otago Polytechnic.

If you agree to allow this request as described above please sign the permission approval overleaf and return a copy to me in the enclosed envelope.

Please do not hesitate to contact me with any further queries or requests for information.

Thank you for your consideration.

Terry Buckingham – Masterate Research Student
Otago Polytechnic

I, [Name], [Position], hereby give permission for Terry Buckingham, Masterate Research student at Eastern Institute of Technology, to formally invite staff of [Organization] to participate in a research study, “Employee and Employer perceptions of a 10 week workplace health promotion programme”.

Signed: [Signature] for and on behalf of [Organization]

Date: [Date]