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# Wellness at work: Profile of employees in Botswana

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*This study investigates awareness and understanding of wellness, health consciousness, personal well-being, gender differences, health improving activities and employer assistance desired by employees. Survey data was obtained from 523 randomly selected employees from 52 participating organisations in Botswana. Overall, the findings indicated that respondents have good awareness and knowledge of health promotion. Respondents indicated that training supervisors to address employees' concerns, more open communication, providing or supporting recreational or exercise programmes and other health benefits are effective ways to jump-start improving the health process. Potential benefits of the study, management implications of findings and limitations were also articulated.*

## Introduction and Background of Study

Workplace wellness is a potential tool for competitive advantage and sustainability in contemporary organisations. Wellness, this paper posit, is a highly valuable constituent of intellectual capital. This is especially timely as organisations increasingly strive to get the best out of their people by enhancing their morale and well being thereby reducing health related costs so that they remain competitive. Wellness is a positive, sustainable state that allows us to thrive and flourish (Hillier, Fewell and Shephard, 2005).

The genesis of employee wellness programmes can be traced to executive fitness programmes to keep top management teams fit which began in the 1970s (Collins, 2004), although the term 'wellness' was developed by an American doctor Halbert Dunn in 1959 (Mueller and Kaufmann, 2001). Workplace wellness has, recently, been used extensively by management in business and industry, health professionals, fitness experts and others (Wicken, 2000). In addition, Wicken (2000) noted that wellness is a dynamic concept that is also multidimensional. The literature on workplace wellness is still growing and unclear but is strongly linked to work-related stress where the literature, though massive, is relatively clear on the causes, symptoms and consequences. Similarly, the concept is linked with quality of life where the literature is also fairly extensive. In the UK, quality of life has been recognised as a key element in the sustainable development agenda (Office of Deputy Prime Minister [ODOM] 1999, 2004). Minimising work-related stress, enhancing quality of life and improving well-being is perhaps even more important in the developing world especially Africa where poverty levels are much higher than in the more developed countries.

The Chartered Institute of Personnel and Development (CIPD) in its 2005 survey of absence management in the UK reports that an average of 8.4 days per year are lost to sickness absence at a cost of £601.00 per employee (CIPD, 2005). Resulting from this and perhaps other reasons there appears (in the UK) to be an enhanced public interest and call for employers to take more than a passing interest but a responsibility for well-being and wellness (Hillier, Fewell and Shephard, 2005). While Hillier, Fewell and Shephard (2005) noted that organisations in the UK now ensure that environments in which people work foster health and well-being; Roslender, Stevenson and Kahn (2006) argued that employee wellness, or more correctly a lack of it, is a growing problem facing UK organisations, one which they do not appear to be managing successfully at this time. Evidence, however, suggests that the UK situation is typical of many of the advanced societies (Zwetsloot and Pot, 2004; Ahonen and Grojer, 2005).

The rising cost in health care delivery has been a major concern for many organisations around the world. It is a big issue in the USA, Canada, Australia and most of Europe. In addition to the cost reduction concern, employers also develop wellness programmes to encourage improved health and well being of employees and their families (DeMoranville, Schoenbachler and Przytulski 1998). Again the rising cost of medical care, accompanied by the mounting evidence that lifestyle is related to morbidity and mortality has been a major factor in the evolution of worksite wellness programmes (Eddy, Gold and Zimmeril, 1989; Kocakulah and Joseforsky, 2002; and Hillier, Fewell and Shephard, 2005). The high numbers of employees who work outside of the home makes it logical to offer worksite wellness programmes. In most developed countries this is arguable with an increasing number of employees now working part-time and from home. However, instead of being fixated with health care cost reduction only Hillier, Fewell and Shephard (2005) listed greater gains that may be experienced through: direct influence of positive employee health and well-being on individual or group productivity, improved quality of goods and services, greater creativity and innovation, enhanced resilience, and increased intellectual capacity. Possibly one of the strongest arguments yet in favour of workplace wellness in industry was advocated by Hillier et al (2005) when they argued that there is mounting evidence indicating that worksite wellness should be part of every strategic plan.

While employees largely view wellness centres as a perk or benefit, the company often views it as a health care cost reduction measure. Specifically reduced sick leave and absenteeism, decreased turnover, lower health care claims, and increased productivity are typically cited as potential benefits (DeMoranville et al 1998). Wellness programmes practice preventive care and help employees better manage their health. Across the world wellness programmes are being implemented in both large and small companies and the results are believed to positively impact the bottom line. Wellness programmes are thus generally good news for most organisations. They help control health-care cost by encouraging employees and their families to adopt healthy lifestyles and detect, prevent and manage illnesses. Health promotion programmes could also be useful as a morale booster as employees who not only see it as a perk but indeed often feels good about it as a positive HR programme.

There has been an increase in the use of wellness programmes in many countries especially the USA and Canada, but also in the

UK. Collins (2004) indicated that more than 81 percent of US businesses with more than 50 or more employees have some form of health promotion programme, although their breath and formats vary widely. Surprisingly, the primary beneficiaries – the employees – have not embraced wellness programmes as might be expected. Employee participation in company sponsored health promotion programmes is relatively low overall (Busbin and Campbell 1990; Glasgow et al., 1995) and only the healthiest employees tend to participate (Conrad, 1987; Nice, Stephen and Susan, 1990; and Lewis, Huebner and Yarborough, 1996). There are yet other studies suggesting that employees who participate in worksite health promotion programmes achieve positive health outcomes (Heany and Goetzel, 1997; Goetzel et al., 1998). The value of the health promotion programme will depend to a large extent on participation of employees for whom the programme has been created in the first place. The level of employee participation is low according to Busbin and Campbell (1990) averaging just about 20 percent within sponsoring companies. A higher participation level is desirable and would be a pivotal factor in the success of the programmes. Consequently, and because it is voluntary, wellness programmes needs to be made more attractive to employees.

It is not surprising that individuals already leading a healthy, active lifestyle before wellness programme is initiated are more likely to participate in a formalised programme (DeMoranville et al., 1998). A useful question therefrom would be what programmes are most likely to encourage participation from those who typically avoid wellness centres? DeMoranville et al., (1998) found that respondents across all segments express more interest in health management programmes than in exercise programmes and that females are also more interested in nutritional counselling and weight loss classes than males across all segments.

Just like in many developed countries, in the recent past the cost of medical care in Botswana has also escalated. Both employees and employers have been complaining about these rising medical costs. The human tragedy of HIV/AIDS pandemic has also made health consciousness issues very important at this time given the statistics of high infection rate in Botswana. The most recent UNAIDS statistics for 2007 reveals a decrease in HIV infection levels in Botswana from 36% in 2001 to 32% in 2006 suggesting that the epidemic may have reached its peak and could be on the decline. Nevertheless, it is estimated that one in four (24%) adults (15–49 years) in Botswana were living with HIV in 2005 (UNAIDS, 2006). Botswana's epidemic therefore remains severe [see details at: http://data.unaids.org/pub/Report/2008/jc1526_epibriefs_ssafrica_en.pdf] (UNAIDS, 2008).

The present study arises out of the several needs and the potential benefits are many. A most critical reason is the increasing cost in medical aid in Botswana provided largely through medical insurance societies [mainly BOMAID, PULA & BPOMAS]. Wellness programmes are generally believed to reduce the cost of Medicare. Wellness programmes may be a viable solution to health care cost containment (Wicken, 2000; Hillier et al, 2005). There is also the growing impact of globalisation and technological changes in the workplace which does not leave out the country. Some potential benefits of a well received and widespread wellness programme in Botswana include: increasing employee productivity; improving employee welfare benefits and morale; and enhancement of the corporate image of organisations resulting from the implementation of wellness programmes. All these are desirable objectives of organisations. The awareness of health promotion appears low in Botswana. A study like this one may therefore increase this awareness and create the enabling environment for the mass education, propagation and possible implementation of wellness programmes in both the private and public sector. No previous study investigating existing wellness programmes or attempting to establish the need for increased awareness of these programmes in Botswana was found, as is perhaps the case in most other African countries. This exploratory pioneering effort would therefore add to knowledge specifically in this critical area of enhancing the quality of work lives and Human Resource Management generally.

This paper presents an investigation of employee perspective and understanding of the importance of wellness generally, their personal well-being, and how organisations can improve wellness in Botswana. Specifically, the study seeks among others to do the following:

1. Determine the general health consciousness and awareness of employee wellness and identify the factors considered important by employees in wellness. Are there any significant gender differences?
2. Identify stress inducing activities of employees in Botswana.
3. Identify the health improving activities employees' desire; the hindering factors for positive behavioural change and determine the employer assistance desired by employees.

# Research Methodology

This study is exploratory using a descriptive design. Data was collected using observation (of the various workplaces), personal interview (with top management representative) and a survey using structured questionnaires (for randomly selected employees of participating organisations) in Botswana. This report presents results only for the descriptive data of the survey (employees) across Botswana.

## Procedure and sampling

Over 250 organisations were invited to participate in the study with about 52 consenting. Having a company wellness programme was not a condition for participation. The invite was extended to several organisations through a letter to the head of Human Resources department. Only organisations that have responded to cooperate and participate in the study were approached and used for questionnaire administration. The snowballing method also enabled increase in the number of participating organisations. HR managers of volunteering organisations persuaded participation from other organisations where they have work or professional relationship. Conscious effort was made to ensure that the organisations invited were broad based to include private and public sector organisations. The questionnaires were administered to randomly selected employees of the participating organisations. Sampling limitations and restriction have been imposed by the voluntary nature of this study since participation by the organisations was by self-selection. However, sampling within each participating organisation was random and scientific. About 1300 questionnaires were administered in 52 organisations with 523 questionnaires returned usable representing a 40.23 percent response rate.

## Findings, Discussion and Managerial Implications

The characteristics of the respondents are presented in Table 1. There are more females (53%) than male, about 30 percent were married, and majority were aged between 30-39 constituting about 43 percent and next are those aged between 20-29 comprising about 34 percent. Over 53 percent of the respondents have worked for up to 9 years. All respondents had some level of education with up to 23 percent possessing a university degree. Three in every four (over 75%) were responsible for own children and the percentage goes higher (83%) when other dependants are added.

**Table 1: Summary of Sample Characteristics (N = 523)**

| Personal Profile | Frequency | % | Personal Profile | Frequency | % |
|---|---|---|---|---|---|
| ***Gender*** | | | ***Education*** | | |
| Male | 242 | 47 | Junior Certificate | 61 | 12 |
| Female | 273 | 53 | Form 5 | 118 | 23.3 |
| ***Age*** | | | College Certificate | 66 | 13 |
| Below 20 | 7 | 1.3 | College Diploma | 132 | 26 |
| 20-29 | 179 | 34.3 | Did not finish university | 12 | 2.4 |
| 30-39 | 224 | 42.9 | University degree and higher | 118 | 23.3 |
| 40-49 | 96 | 18.4 | | | |
| 50-59 | 15 | 2.9 | ***Marital Status*** | | |
| Over 60 | 1 | 0.2 | Single | 315 | 60.6 |
| ***Experience*** | | | Married | 158 | 30.4 |
| Less than 1 year | 88 | 17 | Widowed | 11 | 2.1 |
| 1-4 | 165 | 31.9 | Separated | 5 | 1.0 |
| 5-9 | 114 | 22 | Divorced | 8 | 1.5 |
| 10-14 | 76 | 14.7 | Living with partner | 23 | 4.4 |
| 15 and above | 75 | 14.5 | | | |
| ***Job Position*** | | | ***Responsible for own Children*** | | |
| Manager and higher | 57 | 11.5 | Yes | 392 | 75.5 |
| Supervisor | 124 | 25.1 | No | 127 | 24.5 |
| Clerk | 64 | 12.9 | ***Responsible for other Dependants*** | | |
| Office Assistant | 59 | 11.9 | Yes | 427 | 83.1 |
| Others | 191 | 38.6 | No | 87 | 16.9 |

Note: Only valid percent are reported in the tales.

A number of cross-tabulation and Chi square tests for some of the questionnaire items with respondents' gender were undertaken. The results are presented in Table 2. Our findings indicate no statistically significant difference between men and women for some of the study variables including their perceived state of health, being physically or mentally tired at the end of work, seeking help or counselling for a non-medical personal or emotional problem, having trouble with sleeping, eating pre-packaged or fast foods, skipping meals and taking up to 6 glasses of water daily.

However, there were other issues in which significant differences were found between men and women. More men tend to be involved in vigorous physical exercises and spend more time doing it than women. It appears using medication for sleep is a rare phenomenon among respondents with over 86% non-use. Nevertheless, the number of women users of medication is significantly more than men. On attendance at work, more women have been off duty than men confirming the general expectations and widely held stereotype that women tend to call in sick more or absent themselves from work especially because of family related issues. The study also found that significantly more men than women smoke, which is consistent with widely held belief about smoking. In the traditional African setting, smoking is largely a masculine habit and the acceptability of women smoking especially publicly is relatively new and still not widespread. About 85% of all respondents do not smoke at all again consistent with widely observed behaviour in Botswana. Similar to smoking, findings on the intake of alcohol revealed that significantly more men drink than women. The men who drink are almost twice the number of women, although up to 63% of all respondents claimed they do not drink at all, which is surprising given the drinking behaviour (of *Batswana*) reported in popular media.

The sleeping behaviour was rather interesting, women appears to sleep slightly more than men on the overall. However, more men sleep between 6-7 hours while more women sleep 8 hours or more daily. Results with regards to eating habits come out clearly in favour of women as they seem to be more concerned about their eating habits than men. This is consistent with the finding of DeMoranville et al., (1998). Our results also indicate that significantly fewer women eat foods high in cholesterol or fat. Although not statistically significant, fewer women also eat pre-packed food, more women than men skip meals and they drink more water daily than men. Again this is consistent with widespread stereotype that women are a lot more concerned about fitness, weight and aging or looks. Finally, as would perhaps be predicted, significantly more women than men contact people they can count on when they are worried, upset and under stress.

**Table 2: Self-Report On Some Health Issues (N = 523)**

| S/N | Questionnaire items | Frequency | % | Male | Female | Pearson's Chi Square (F Value) | Sig. |
|---|---|---|---|---|---|---|---|
| 1 | State of health | | | | | N/S | .070 |
| | Excellent | 75 | 14.5 | 34 | 41 | | |
| | Very good | 148 | 28.7 | 76 | 69 | | |
| | Good | 209 | 40.5 | 103 | 102 | | |
| | Fair | 74 | 14.3 | 24 | 49 | | |
| | Poor | 10 | 1.9 | 4 | 6 | | |
| 2. | Time spent in vigorous physical activity (at least 20 minutes at a time) | | | | | F = 14.917, (d.f. 4) | **.005*** |
| | Never | 150 | 29.2 | 53 | 94 | | |
| | 1 or 2 times | 66 | 12.8 | 35 | 28 | | |
| | More than 5 times a week | 160 | 31.1 | 75 | 85 | | |
| | Less than once a week | 96 | 18.7 | 57 | 39 | | |
| | 3-5 times a week | 42 | 8.2 | 20 | 20 | | |
| 3 | Use of medication or prescription drugs for sleep | | | | | F = 11.618, (d.f. 4) | **.020*** |
| | None | 447 | 86.6 | 214 | 227 | | |
| | Only once | 42 | 8.1 | 21 | 19 | | |
| | 2-3 times | 14 | 2.7 | 2 | 12 | | |
| | Once or twice a week | 5 | 1.0 | 0 | 5 | | |
| | Daily or almost everyday | 8 | 1.6 | 3 | 5 | | |
| 4 | Days away from work (in the last 1 year) | | | | | F = 34.191 | **.025*** |
| | None | 221 | 45.6 | 119 | 99 | | |
| | 1-4 days | 155 | 31.9 | 75 | 79 | | |
| | 5-9 days | 64 | 13.2 | 24 | 38 | | |
| | 10-20 days | 29 | 5.9 | 10 | 18 | | |
| | More than 20 days | 16 | 3.2 | 2 | 13 | | |
| 5 | Being physically or mentally tired at the end of work | | | | | N/S | .178 |
| | Very often | 78 | 15.6 | 33 | 44 | | |
| | Often | 120 | 24.0 | 51 | 66 | | |
| | Not very often | 227 | 45.5 | 111 | 115 | | |
| | Never | 74 | 14.8 | 42 | 30 | | |
| 6 | Number of cigarettes (daily) | | | | | F = 25.940, (d.f. 3) | **.000*** |
| | None | 436 | 84.7 | 186 | 247 | | |
| | Fewer than 5 | 36 | 7.0 | 24 | 10 | | |
| | Fewer than 10 | 24 | 4.7 | 15 | 6 | | |
| | More than 10 | 19 | 3.7 | 16 | 3 | | |
| 7 | Frequency of alcohol intake (weekly) | | | | | F = 33.347, (d.f. 3) | **.000*** |
| | None | 328 | 63.8 | 123 | 201 | | |
| | Fewer than 5 times | 128 | 24.9 | 78 | 48 | | |
| | 5-10 times | 23 | 4.5 | 15 | 7 | | |
| | 10 or more | 35 | 6.8 | 24 | 10 | | |
| 8 | Sought help or counselling for a non-medical personal or emotional problem | | | | | N/S | .461 |
| | Yes, through a service provided by my employer | 24 | 4.8 | 11 | 12 | | |
| | Yes, but not through my employer | 62 | 12.3 | 23 | 38 | | |
| | No, but I thought about it | 80 | 15.8 | 38 | 41 | | |
| | No | 339 | 67.1 | 163 | 171 | | |
| 9 | Number of hours slept (daily) | | | | | F = 12.724, (d.f. 2) | **.002*** |
| | 5 hours or fewer | 31 | 6.0 | 16 | 15 | | |
| | 6-7 hours | 319 | 61.9 | 166 | 148 | | |
| | 8 hours or more | 165 | 32.0 | 58 | 104 | | |
| 10 | Trouble with sleeping | | | | | N/S | .061 |
| | More than once a week | 86 | 16.9 | 32 | 52 | | |
| | Once a week or less | 263 | 51.7 | 122 | 140 | | |
| | Never | 160 | 31.4 | 84 | 72 | | |
| 11 | Eat foods high in cholesterol or fat | | | | | F = 4.392, (d.f. 2) | **.036*** |
| | Yes | 229 | 45.5 | 117 | 106 | | |
| | No | 274 | 54.5 | 117 | 155 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 12 | Eat pre-packaged or fast foods daily | | | | | N/S | .290 |
| | Yes | 115 | 22.9 | 59 | 53 | | |
| | No | 388 | 77.1 | 108 | 203 | | |
| 13 | Skip meals | | | | | N/S | .948 |
| | Yes | 402 | 78.2 | 188 | 209 | | |
| | No | 112 | 21.8 | 52 | 57 | | |
| 14 | 6 glasses of water daily | | | | | N/S | .501 |
| | Yes | 259 | 50.3 | 125 | 130 | | |
| | No | 256 | 49.7 | 116 | 136 | | |
| 15 | Contact people when worried, upset or under stress | | | | | F = 11.639, (d.f. 1) | **.001*** |
| | Yes | 408 | 79.8 | 175 | 228 | | |
| | No | 103 | 20.2 | 63 | 38 | | |

Note: N/S mean non significant; * $p < 0.05$ or above

Another major interest of this study was to identify the major stress causing activities for respondents. A list of about 50 items that could possibly cause stress was developed from the several sources based on the author's experience within the environment as well as what the popular literature suggest. In Table 3, only the top 20 (most identified) is presented. Employees not being treated fairly, the death of a family member or friend, the illness or injury of a family member or friend, not having enough money, and arguments with a family member ranked as the top 5 most critical causes of stress for respondents. It is interesting that the fear of AIDS comes next at sixth. Taken together there is likely to be significant overlap between this stressor (fear of AIDS) and at least two of the earlier listed stressors (the death of a family member or friend and the illness or injury of a family member or friend). The prevalence of illness among citizens is perhaps not unconnected to HIV/AIDS related illnesses and the strains associated with caring responsibility that majority of the people have to endure.

At the bottom of the ladder are other issues which may have received more mention in countries like the USA and the UK. These include: divorce or separation (ranked 42), sexual harassment (43), fear of job loss (40), and birth of a new child (47). Table 3 could be broadly classified into two: issues that are personal and relate to the home and others that had to do with work.

**Table 3: Stress Causing Activities (N = 523)**

| Rank | Activities or events that may have caused excessive worry, or stress in the last six months | Frequency | % | Male | Female |
|---|---|---|---|---|---|
| 1 | I'm not treated fairly | 176 | 33.7 | 77 | 96 |
| 2 | A family member or friend has died | 174 | 33.3 | 68 | 103 |
| 3 | A family member or friend has been ill or injured | 146 | 27.9 | 68 | 76 |
| 4 | I don't have enough money | 145 | 27.7 | 76 | 65 |
| 5 | Arguments with my partner/spouse and children | 123 | 23.5 | 56 | 66 |
| 6 | Fear of AIDS or other sexually transmitted diseases | 111 | 21.2 | 47 | 61 |
| 7 | Supervisors have unrealistic expectations of me | 103 | 19.7 | 46 | 57 |
| 8 | Finding a place to stay or moving to a new home | 99 | 18.9 | 46 | 53 |
| 9 | Arguments with other family members | 88 | 16.8 | 33 | 52 |
| 10 | Took on a big expense | 86 | 16.4 | 37 | 48 |
| 11 | I have trouble balancing home and work responsibilities | 83 | 15.9 | 34 | 48 |
| 12 | My work is boring | 75 | 14.3 | 31 | 43 |
| 13 | I am depressed | 72 | 13.8 | 38 | 34 |
| 14 | I feel isolated from my co-workers | 71 | 13.6 | 28 | 41 |
| 15 | Management tries to control my work too much | 69 | 13.2 | 24 | 44 |
| 16 | Conflict with other people | 69 | 13.2 | 38 | 31 |
| 17 | Took on a big loan | 69 | 13.2 | 35 | 34 |
| 18 | I have trouble getting to and from work | 67 | 12.8 | 29 | 37 |
| 19 | My duties are not clear | 64 | 12.2 | 23 | 41 |
| 20 | Child care problems | 62 | 11.9 | 21 | 39 |

This study was also interested in finding out how employees intend to personally get involved in improving their health. Specifically, what they would do in the next year to improve or maintain their health. The finding related to this indicated an interesting order in the ranking of most critical activities that could enhance or at least maintain the health of respondents. Of the 26 possible options provided in the instrument, the 15 most frequently ranked are presented in Table 4.

The picture painted is that of employees who understand what are most critical to sustained good health. All the 15 items shown in the table are personal issues requiring positive behavioural change. The need to exercise more, eat better, learning to cope better with stress, and learn how to relax are the most

preponderant. While most of the activities cited in Table 4 are behavioural, getting information on financial management strategies (ranked fifth) perhaps underscores the level of financial capacity of respondents. Of less importance in Botswana were other issues which again may have been higher up the ranking in Western countries including: quit smoking or smoke less (ranked 18), get help with cancer related illness, and cut down on painkillers (both of which did not make the top 20).

**Table 4: Health Improving Activities That Employees Desire**

| Rank | Things to do to improve or maintain health in the next year | Frequency | % | Male | Female |
|---|---|---|---|---|---|
| 1 | Exercise more | 359 | 68.9 | 162 | 192 |
| 2 | Eat better | 259 | 49.5 | 103 | 152 |
| 3 | Learn to cope better with stress | 217 | 41.5 | 84 | 132 |
| 4 | Learn how to relax | 203 | 38.8 | 79 | 121 |
| 5 | Get information on financial management strategies | 197 | 37.7 | 85 | 109 |
| 6 | Learn to cope better with anger | 154 | 29.4 | 54 | 99 |
| 7 | Remove a major source of worry | 152 | 29.1 | 69 | 82 |
| 8 | Lose weight | 147 | 28.1 | 39 | 105 |
| 9 | Develop hobbies | 136 | 26.0 | 61 | 74 |
| 10 | Change job situation | 111 | 21.2 | 48 | 62 |
| 11 | Get information on parenting and other care giving strategies | 111 | 21.2 | 45 | 65 |
| 12 | Get counselling or other support | 105 | 20.1 | 42 | 62 |
| 13 | Drink less alcohol | 94 | 18.0 | 61 | 31 |
| 14 | Change my home situation | 85 | 16.3 | 28 | 55 |
| 15 | Control my cholesterol | 80 | 15.3 | 39 | 41 |
| 16 | Get help with depression | 66 | 12.6 | 28 | 38 |
| 17 | Control my blood pressure | 65 | 12.4 | 21 | 43 |
| 18 | Quit smoking or smoke less | 60 | 11.5 | 42 | 15 |
| 19 | Cut down on headache medication | 37 | 7.1 | 12 | 24 |
| 20 | Get help with digestive illness | 32 | 6.1 | 15 | 17 |

Following from respondents' awareness of positive health improvement strategies, this study was also interested in finding out the hindering factors that have not made this change manifest. Table 5 presents the top 10 factors ranked as most critical hindrance of positive behaviour change. Up to 20 factors were listed in all. Not enough time and money ranked as the top two, and nearly the next eight relates to the absence of the will to get started. The import of this is perhaps that organisations that provides the opportunity and makes time available to its employees for wellness programmes might benefit from a more significant positive behavioural change than those that merely provide additional financial incentive believing that employees will seek positive behaviour changes with such funds.

**Table 5: Behavioural Change (Health) Hindrance Factors**

| Rank | What is stopping you from making this change? | Frequency | % | Male | Female |
|---|---|---|---|---|---|
| 1 | Not enough time | 186 | 35.6 | 85 | 99 |
| 2 | Not enough money | 185 | 35.4 | 85 | 97 |
| 3 | Don't know how to get started | 93 | 17.8 | 41 | 49 |
| 4 | I don't know what is stopping me | 83 | 15.9 | 35 | 48 |
| 5 | Problem isn't serious | 73 | 14.0 | 37 | 35 |
| 6 | No encouragement or help from employer | 71 | 13.6 | 38 | 32 |
| 7 | Too much stress right now | 59 | 11.3 | 23 | 36 |
| 8 | Not enough energy | 58 | 11.1 | 21 | 36 |
| 9 | Lack of self-confidence | 51 | 9.8 | 19 | 29 |
| 10 | It's too hard | 50 | 9.6 | 19 | 31 |

Finally, the study was interested in finding out what the employee thinks the employer could do to assist in the health improvement drive. Table 6 provides a list of the top 10 most critical employers assistance desired by employees. Training supervisors to address employees concerns, more open communication with employees, providing more workplace health and safety training, providing or supporting recreational or exercise programmes and providing health benefits are the top five ways respondents feel employers could use to jump-start the process of improving their health.

**Table 6: Employers' Assistance Desired By Employees**

| Rank | How employer could help improve health | Frequency | % | Male | Female |
|---|---|---|---|---|---|
| 1 | Train supervisors to address employees concerns | 192 | 36.7 | 90 | 101 |

| | | | | | |
|---|---|---|---|---|---|
| 2 | Communicate more openly with employees | 190 | 36.3 | 82 | 107 |
| 3 | Provide more workplace health and safety training | 179 | 34.2 | 80 | 96 |
| 4 | Provide or support recreational or exercise programmes | 173 | 33.1 | 90 | 81 |
| 5 | Provide training on communication and conflict skills | 171 | 32.7 | 84 | 85 |
| 6 | Provide health benefits | 164 | 31.4 | 84 | 78 |
| 7 | Introduce job sharing, job rotation or flexible hours | 144 | 27.5 | 72 | 71 |
| 8 | Provide employee assistance programmes to help people get counselling | 125 | 23.9 | 58 | 66 |
| 9 | Provide or support stress control programmes | 110 | 21.0 | 49 | 61 |
| 10 | Get more employee advice on how work is organised | 98 | 18.7 | 44 | 53 |

The general respondents' profile (see Table 1) indicates a relatively low level of education, childcare responsibility for own children or other dependants, many employed in relatively junior positions and hence may not have incomes that allow them medical aid. In this context, it is essential for organisations to effectively respond to the need to implement effective and appropriate health and wellness programmes in the workplace especially with the challenges of reducing Medicare related cost, improving general employee wellness, and addressing the scourge of HIV/AIDS. Offering the right incentives for employees to participate in wellness programmes (e.g. benefits, cash, or recognition) by organisations may be useful.

On the overall, it is clear that the respondents have good knowledge of health awareness and promotion as is manifested in Tables 2, 4, 5 and 6. For example, over 70% are involved physical exercises weekly, 54% keep away from foods high in cholesterol or fat, and more than 77% keep away from pre-packed or fast food. It seems, however, that incentives may be needed to recruit more employees to get involved. Today's organisation need to consider having a wellness programme that is meant to address the health, social and family needs of its employees. From this result, many employees feel stressed because they are not treated fairly, are going through some personal loss or caring responsibility or do not having enough money (see Table 3) and hence activities to engage them in a positive way outside of work schedule may form part of the overall wellness programme contributing positively to the total health of employees. The need to maximise the well-being and productivity of employees is the issue highlighted here.

HR managers should also show more respect and pay more attention to the fact that male and female employee lifestyles differ to some extent. Consequently being able to develop acceptable wellness programmes and policies that target the particular needs of both is pertinent otherwise it is difficult to reap the full potential of higher productivity from both groups. It is also plausible to argue that men tend to live more risky lifestyles compared to their female counterparts by indulging in habits like excessive smoking, drinking, etc. and hence they need to be more involved in health awareness programmes that focus on the importance of healthy living. Nevertheless, it is important for organisations choosing to invest in and successfully implement wellness programmes to offer variety of topics and engagement strategies to catch and sustain interest and to involve, as much as possible, all employees. Employees also indicated some of the areas (see Table 6) they think employers can be most helpful include training for higher placed managers and more open communication among others. Roslender, Stevenson and Kahn (2006) effectively encompass the importance of employee wellness when they argued that employees are the source of the stocks of intellectual capital that organisations require to deliver value to their customers. As a result, they argued, employee wellness is a highly valuable asset, which senior management must take steps to promote in order to secure the greatest benefits from their workforces. In sum, there is need for appropriate organisational policies and programmes to be developed to support wellness among employees in Botswana.

The potential benefits of this study are many. It provides a tentative background data for understanding and valuing employee and employer's awareness of wellness in Botswana. An interrelated potential benefit from this is that health promotion campaigns in Botswana organisations may be enhanced. Moreover, for organisations in the process of, or considering the implementation of wellness programmes findings such as this give stronger impetus for commencement because of its value and benefits. It may also strengthen their planning for the programme and thus accelerate its implementation. Alternatively, organisations may delay implementation for a more thorough preparation. Finally, government agencies and departments involved in the promotion and monitoring of such programmes may also benefit in terms of invigorating their efforts in this direction.

## Limitations of Study

Like all research, this study is not without some limitations. First, the study made use of volunteering organisations as such a fair and representative spread of organisation cannot be guaranteed. Moreover, the success of the study will depend on the willingness of the participating organisation to cooperate and provide accurate and useful information. It is, however, believed that since participation is voluntary, volunteering organisation must have been convinced about the possible benefits and implicit in this is that they provide valid and useful information. Secondly, the exploratory nature of the study does not make it easily amenable to hypothesis testing. Therefore the study did not test any hypotheses but it is hoped that the findings will provide answers to the research questions and open up the forum for detailed future studies that will be able to test productive hypothesis to advance knowledge in this area. Related to this is that the study uses nominal data putting a ceiling to the extent to which data could be analysed and tested for relationships. Thirdly, data collected relied on self-report data with attendant weakness of subjectivity. It, however, adds to the information on health promotion strategies and awareness in an African context which is rare. Finally, the interrelated issue of acquiescence and social desirability of response needs mentioning. To what extent could respondents give socially desirable answers independent of truthfulness? Podsakoff *et al.* (2003) suggest, however, that the influence of acquiescence can be limited by assuring anonymity of respondents which was done in this study.

## Conclusion

Employee wellness is important for any workforce because a healthy employee is a productive employee. A fit and healthy workforce is a very valuable organisational asset. Neither a high level of health promotion awareness nor merely promoting a wellness programme is sufficient to sustain a competitive advantage for an organisation if not coupled with high levels of management's commitment. Clearly, employee wellness reduces the number of medical claims, yet many other potential benefits are difficult to measure, because the cost savings attributable to the programmes are difficult to determine (Kocakulah and Joseforsky, 2002). The illustrative example of Kocakulah and Joseforsky (2002) perhaps best captures this dilemma: *"… if extremely high blood pressure is detected in an employee's wellness screening and the employee sent to the doctor, a possible cardiac arrest could be prevented from ever happening. The medical savings, however, would be difficult to measure, because one cannot know with certainty what would have happened had the employee not received early treatment. What the company does know is that, according to research, the savings potential is astronomical p. 30".*

Organisational interventions in the form of right policies and practices could contribute significantly to the development and delivery of a healthy workforce for the country. The present study, being possibly the first in this area in Botswana, will form a basis upon which future studies will build thus creating a foundation for building a database for this area of Human Resource Management in a non-Western setting.

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