Talking to Women in Work

Kate Munro October 2002
Talking to Women in Work:
Report of a project using a Workplace Website to Facilitate the Participation of Women in Paid Employment in Consultation Activities

Kate Munro
October 2002
Project Supervisors
Norma Greenwood
Health Promotion Department, GGNHSB

Sue Laughlin
Department of Public Health, GGNHSB

Project Workers
Jackie Erdman
Health at Work, Health Promotion Department, GGNHSB

Lorna Dryburgh
Health at Work, Health Promotion Department, GGNHSB

Kate Munro
Department of Public Health, GGNHSB

Further information can be obtained from:

Kate Munro
Department of Public Health (Women's Health)
Greater Glasgow Health Board
Dalian House, 350 St. Vincent Street
Glasgow G3 8YU
Tel: 0141 201 4972
E-mail: kate.munro@ggbh.scot.nhs.uk
Table of Contents

Section 1: Executive Summary 4
  1.1 Findings 5
  1.2 Recommendations 7

Section 2: Introduction 9

Section 3: Consultation with Women 10

Section 4: Consultation via the World Wide Web 11

Section 5: Aims of the Project 13

Section 6: Methodology 14
  6.1 Design 14
  6.2 Process 15
  6.3 Survey Design 15
  6.4 Reporting 16

Section 7: Results 17
  7.1 Sample 17
  7.2 Women's Perceptions of Their Health 21
  7.3 Women's Use and Experience of Health Services 25
  7.4 Women's Health & Work 31
  7.5 Feedback on an On-line Survey and Workplace Web-site 35

Section 8: Discussion 37
  8.1 The Usefulness of a Workplace Web-site as a Mechanism for Consulting with Women in Paid Employment 37
  8.2 The Benefits and Limitations of a Workplace Web-site as a Means of Including Women in Paid Employment in Consultative Activity 38
  8.3 The Development of a HAW Gender-Specific Workplace Programme 39
  8.4 Information Relating to HAW Employers on Women's Health 41

Section 9: Recommendations 43
  9.1 Consultation via the World Wide Web 43
  9.2 Women's Perceptions of Their Health 43
  9.3 Development of a HAW Workplace Programme on Women's Health 43
  9.4 Development of a HAW Programme for Employers on Women's Health 44

Section 10. References 45

Annex A: 47
  HAW Survey Questionnaire
1. Executive Summary

This is the report of a project that explored the usefulness of the World Wide Web as a mechanism for facilitating women's participation in consultations on their health and health care. Consultation with patients and users has recently become the focus of much reflection and activity within the health service. The current policy context places patients and users at the centre of health service planning and delivery by making a commitment to strengthen patients and the public influence in the NHS. As a result a number of explicit policy statements and central government initiatives have encouraged the growth and development of public involvement in health services.

Effective public involvement is proposed as a catalyst for change. It is considered a method of engendering change that helps to build public trust and that has the potential to strengthen public confidence in the National Health Service. Furthermore, public involvement is seen as a method that reduces the risk of providing inappropriate services or services that do not meet the patients needs or wants. By providing a different perspective that could otherwise be overlooked there is the potential for different and innovative solutions. Thus services could be developed in ways that are responsive to patients.

However, despite the desire for dialogue and the expectation that this will facilitate the re-design of services from the patient’s perspective the creation of a process of representative consultation creates a number of challenges for the National Health Service. One such challenge arises from the need to develop consultation techniques that have the potential to recognise, understand and interpret the perspectives of different groups in the community.

This project formed one strand of a wider programme seeking to identify Glasgow women’s perceptions of their health and health care. It was concerned with testing out a method for engaging with women who are in paid employment. This group is often excluded from consultations on health and health care because of the demands arising from their multiple responsibilities and their lack of availability for more traditional forms of consultation activity. Nevertheless, this is a substantial group of women. Data from the Scottish Household Survey (Scottish Executive, 2002) shows that 62% of Scottish women were in paid employment in 1999/2000.

Furthermore, where women in employment have been included in consultations there is little to indicate that these have provided an opportunity for them to reflect on or explore how employment impacts on or is related to their health. This project then explored the feasibility of using a workplace web-site to engage with women at work. A web-based questionnaire was devised and explored as a means of facilitating the involvement of women in paid employment in a consultation on health and health care needs.

The project was jointly initiated and managed by the Greater Glasgow NHS Board Health at Work Team (HAW) and the Department of Public Health, Women's Health Team. Both shared a desire to engage with this group of women on the issue of health and to gather feedback on their issues, concerns and priorities. Further, both wished to examine the medium of an on-line survey as a means of interacting with women.
1.1 Findings

1.1.1 The Usefulness of Consultation via the World Wide Web

♦ The high level of positive feedback, the quality of the written comments and the satisfactory size of the sample suggested that the on-line survey was a useful and acceptable mechanism for consulting with women in paid employment, albeit limited to women in jobs that allow them access to the Internet.

♦ While a range of employers were represented the majority of participants (72%) were employed within the public sector. As public sector employees in Glasgow have had access to a wide range of other initiatives and awareness raising activity on women's health this may have created a 'readiness' in relation to the survey.

♦ The on-line survey was successful in facilitating the active participation of women in some forms of paid employment in a consultation about health and its interaction with employment. As such it proved to be useful in accessing a group of women who are often excluded from traditional forms of consultation activity on health. However, on other dimensions of exclusion the on-line survey was less effective.

♦ The sample was almost exclusively white, non-disabled women. Very few women from black and minority ethnic communities were among the sample and there appeared to be little representation of disabled women's perspectives.

♦ The sample did not reflect the numbers of women who have responsibilities for caring for children. A third of the sample were caring for children at home. This compares to the national rate where 60% of working women have dependent children at home.

♦ The sample did contain a more representative response from women with other caring responsibilities. 14% reported that they were the sole or main carer for an elderly relative or someone with a disability. This compares more favourably with the national picture where 12% of women are living with someone who requires regular help or care and 11% provide regular help or care for a sick, disabled or elderly person not living with them (Scottish Executive, 2002). No data was available on what proportion of these women are also in paid employment but this did appear superficially to be more representative.

♦ There appeared to be a number of opportunities to deliver information on issues of key importance to women in work e.g. stress via the medium of the World Wide Web. Most thought that this would be an easily accessed, convenient and user-friendly way of accessing information that was up to date but it was also noted that accessing health information would be dependent upon time being available and on the site being interesting.

1.1.2 Women's Perceptions of their Health

♦ Women's perceptions of the factors that affected their health demonstrated a sophisticated understanding of health and the social factors that influence it. While failure to respond appropriately on the part of the health service was discussed there was a clear recognition of the interaction between work and health as a key factor in maintaining health.
Stress was overwhelmingly identified as the biggest influence on women's health. Several sources of stress were reported such as difficulties in managing the demands of work and family life, a poor working environment and problems encountered accessing supportive, appropriate health services.

This need to 'juggle' the demands of work and family life was reflected in the difficulties women reported in the use of health services with the most frequently reported problems relating to the availability and scheduling of appointments.

Women reported that they knew what would make a positive impact on their health but that they often fell short of achieving this. For example, many felt that they should take more exercise or stop smoking but acknowledged that this was unlikely to happen given the many demands they were already trying to manage. It was recognised that emotional well-being influenced physical health and that stress or tiredness undermined the ability to stay well.

1.1.3 Women's Priorities for Health

Women identified preventative action on diseases such as heart disease and cancer as the most important priority in the Women's Health Policy for Glasgow.

Emotional and mental health was most highly rated as a personal priority but not as a priority for the city as a whole

Conversely, poverty was not highly rated by individuals but was identified as an important factor for the health of the city.

1.1.4 Improving Women's Health

The solutions to poor health proposed by women emphasised a holistic approach. Proposed improvements made repeated reference to the need to help women to better manage the competing demands on their time that led to stress or conflict.

There was high support for services that offered counselling or someone to talk to about health or other worries. Information on women's health services was also frequently identified but the most popular option was for greater access to complementary medicine.

1.1.5 Women's Health and Employment

The sample had a high awareness of some employment policies such as health & safety and equal opportunities but others such as bullying and harassment or balancing work & life policy were less well known.

There was similar variation in respondent's access to or awareness of a range of possible benefits that would derive from these policies. It was not clear from the survey why there was a lack of awareness of certain policies.

The sample appeared largely satisfied with their work place and working conditions. Small numbers identified a problem e.g. lack of child care, poor pay, unhelpful shift patterns, hazardous materials, sexual harassment and work related injury.
The issues of work-related stress and lack of opportunity for promotion emerged as presenting difficulties for a significant number of women.

Most women felt that they could report problems or difficulties at work but only half were confident these would be dealt with.

The impact upon staff when issues were not resolved or problems dealt with appeared profound. This lack of control over problems and inability to have them recognised and resolved appeared to be a considerable source of stress.

The importance of stress was again reflected in the suggestions made for workplace facilities and services that could improve health. The issue of stress and its relationship to working environment and working conditions was repeatedly identified as an area where employers could contribute to the improved health of their female employees.

Reductions in stress could be achieved, it was proposed, via a number of different routes. These included addressing the sources of stress e.g. inflexible hours, poor supervision and inflexible absence policies and better managing the impact of stress e.g. stress counselling, stress management sessions and better information.

1.2 Recommendations

This study examined the usefulness of the medium of an on-line survey as a mechanism for consulting with women in paid employment about their health. The following recommendations are made from the findings.

1.2.1 Consultation via the World Wide Web

There would appear to be some considerable benefit to continuing to develop on-line surveys as a means of including women in paid employment, albeit limited to women in jobs that allow them access to the Internet, in consultations about health.

Further consultation activities should be developed in order to include women from minority ethnic communities and disabled women. While there would appear to be advantages to electronic methods the suitability and acceptability of these should be explored further with these groups.

Where consultations with carers are desired that this group be considered as a part of the sample given the relative ease of access to a group of women with significant caring responsibilities.

1.2.2 Women's Perceptions of their Health

These findings on women's perceptions of their health and of the health services they use should be fed into the Women's Health Working Group.

These findings on women's priorities for their health and for women's health in Glasgow be considered alongside other consultations with women in the review of the Women's Health Policy for Glasgow.
1.2.3 Development of a HAW Workplace Programme on Women's Health

- It is recommended that HAW use the findings of the survey to help shape a programme of work with women in paid employment on their health issues. The content of this programme would include the following.
  - Managing stress
  - Managing the demands of work and family life
  - Emotional and mental health
  - Making effective use of supervision
  - Lifestyle advice e.g. exercise, healthy eating etc.

- An information component of the programme should address the following issues.
  - Information on accessing appropriate health services
  - City-wide access to health promoting services e.g. exercise classes, stress centres, counselling services etc
  - Health entitlements within employment policies

- It is further recommended that this programme be delivered, at least in part, via the medium of the World Wide Web.

1.2.4 Development of a HAW Programme for Employers on Women's Health

- It is recommended that the findings from the survey are used to help shape the development of a programme on women's health that could be implemented with HAW employers. This programme would address the following issues.
  - Developing a raised awareness of women’s health and the workplace
  - The health promoting implications of employment policies such as health & safety, equal opportunities, bullying and harassment or balancing work & life
  - Workplace stress, its consequences and relationship to working environment and working conditions

- There would appear to be some scope for HAW to take the initiative in some areas by providing information for employers on models of good practice and the potential benefits of:
  - Work-place child care provision
  - Healthy environments at work e.g. provision of facilities such as rest areas, drinking water etc
  - The health benefits of employment policies
  - Work-place stress, it's costs and implications
  - Strategies for tackling stress at work
2. Introduction
The creation of dialogue between health authorities, service users and the public has recently become the focus of much innovation in public policy. In the pluralistic context of health and social care the views of users have increasingly been recognised. The current policy context set by national documents Designed to Care (1998), Our National Health (2000) places patients at the centre of health service delivery and planning by promoting greater public involvement in decisions over service provision. This is proposed as the basis of effective, accountable and responsive services and is conceived as having the potential to challenge traditional perceptions of health.

Effective public involvement is proposed as a catalyst for change. It is considered a method of engendering change that helps to build public trust and that has the potential to strengthen public confidence in the National Health Service. Furthermore, public involvement is seen as a method that reduces the risk of providing inappropriate services or services that do not meet the patients needs or wants. By providing a different perspective that could otherwise be overlooked there is the potential for different and innovative solutions. Thus services could be developed in ways that are responsive to patients.

However, despite the desire for dialogue and the expectation that this will facilitate the re-design of services from the patient’s perspective the creation of a process of representative consultation creates a number of challenges for the National Health Service. These arise from:

♦ the lack of a model process for engaging with users and patients

♦ the lack of tested consultation techniques that have the potential to recognise, understand and interpret the perspectives of different groups in the community

♦ the paucity of evidence on consumer perceptions that acknowledge the influence of social, cultural, political and economic factors on health and health care

♦ the need for further investigation on how to link the outcomes of consultation to service development and mechanisms giving increased control over the policy process

This project formed one strand of a wider programme seeking to identify Glasgow women’s perceptions of their health and health care. It sought to explore a mechanism for engaging with a particular group that is often under represented in consultations on health and health services. This group is women in paid employment. They are often excluded from consultations on health and health care because of the demands arising from their multiple responsibilities and their lack of availability for more traditional forms of consultation activity. Nevertheless, this is a substantial group of women. As data from the Scottish Household Survey (Scottish Executive, 2002) shows that 62% of Scottish women were in paid employment in 1999/2000.

Furthermore, this is a group that when it is involved in consultations these rarely explore the relationship between health and paid employment. No literature was identified that explored women’s perceptions of their health in the context of
employment or of their understanding of the how paid work impacted upon their access to and use of health services.

This project explored the feasibility of using a workplace web-site to engage with women at work. A web-based questionnaire was devised and explored as a means of facilitating the involvement of women in paid employment in a consultation on health and health care needs. A copy of the questionnaire is given in Annex A.

The project was jointly initiated and managed by Greater Glasgow NHS Board Health at Work Team (HAW) and the Department of Public Health, Women's Health Team. Both shared a desire to engage with this group of women on the issue of health and to gather feedback from them on their issues, concerns and priorities. Further, both wished to examine the medium of an on-line survey as a means of interacting with this group of women.

3. Consultation with Women

To date the majority of activity on women's health in Glasgow has been guided by the priorities identified within the Women's Health Policy (GGNHSB, 2002). These priorities were developed through consultation with women in the city on their perceptions of the key issues for health and health care. The policy was built on the principle of the sovereignty of women's views and the centrality of these to the identification of priorities for any subsequent programme of activity.

However, whilst the Women's Health Policy has a substantial history of community involvement recent years have seen a shift of emphasis, away from women in communities and towards professionals. This has resulted in a lack of the necessary evidence to underpin the development and refinement of a future programme of women's health activity and a paucity of feedback on the continuing relevance of the Policy's priorities. In response the Women's Health Team at Greater Glasgow NHS Board developed a programme of work in relation to identifying women's perceptions of health and health care. This programme sought to maximise the opportunities for women's views, ideas and concerns to be raised.

In addition to the methodological issues outlined earlier there are a number of other factors that have served to further marginalise women's voices in consultative and participative activity. The first of these is the paucity of research evidence generally available on women's perceptions of health and health care. This is as a result of research and consultation activity that has homogenised health users as a single group. Diversity with respect to sex has rarely been taken into account and as a result women's voices have been marginalised. The available evidence suggests that although they are major health care providers in professional as well as informal care and major health service users women remain under-represented in decision-making in health care.

Furthermore there are some groups of women who are often excluded from consultative activity because of additional barriers such as language, lack of childcare or low self-esteem. Where wide-ranging consultations have been held with women (Glasgow, Belfast, British Columbia) a key part of the process has been to identify such barriers and to seek to reflect diverse communities of women in the sample.
Specific arrangements have been made to include groups such as:

- Disabled women
- Ethnic minority women
- Lesbians
- Women in prison
- Older women
- Refugee women
- Women with experience of the mental health system

However, one group that remains difficult to engage and who as a result are often not represented in the outcomes of consultation are women in paid employment. Nevertheless, the Health Education Board for Scotland (1992) and the Scottish Executive (2000) have identified the workplace as an important site for health improvement and there is some reason to believe that women in paid employment may have an important contribution to make to our understanding of women's perceptions of their health and health care needs. Women consistently recognise that issues such as lack of childcare and multiple responsibilities impinge on their health. These are issues that are likely to impact on women in paid employment but the extent to which they recognise and feel these influence their health remains largely untested.

Where consultation with women has taken place the methods adopted have largely comprised:

- Community based consultation seminars and focus groups
- Discussions/focus groups within organisations and groups
- Surveys
- Written and telephone interviews

However, women in paid employment, particularly in sectors outwith health and social care, have often been excluded as a result of:

- their lack of availability at the times identified for meetings and focus groups
- recruitment strategies that focus largely on community based groups
- the nature of the multiple responsibilities many women in paid employment manage resulting in a lack of time for participation in consultation activities

This project sought to overcome these barriers by exploring the use of the World Wide Web as a mechanism for reaching women in paid employment and for facilitating their involvement in a consultation activity that explored health in the context of paid employment.

4. Consultation via the World Wide Web

The World Wide Web is a relatively new communications medium that facilitates fast, convenient and confidential access to a wide range of information, including health information. Recent surveys have shown that 40 - 50% of patients access medical information via the Internet and that this information affects their choice of treatment (Metz et al, 2001; Yakren et al, 2001; O'Connor and Johanson, 2000). The rapid spread of health information available on the World Wide Web has led to concerns
about the quality and accuracy of the information. However, some commentators suggest that these concerns are largely based on speculation rather than research and that they may be exaggerated (Terry, 2002).

In a recent study of breast cancer sites, one of the most popular search topics on the world wide web, Meric et al (2002) found that many sites do not conform to benchmarks devised by the Journal of the American Medical Association - authorship, references, currency and disclosure. Nevertheless they found evidence to suggest that compliance was increasing. The most popular sites were more likely to contain information about on-going clinical trials, the results of randomised clinical trials, results of other breast cancer research, information on legislation and advocacy, information on opportunities for psycho-social adjustment and to allow interaction through a message board service. Although they found a number of sites that contained inaccurate information (7%) this did not differ between popular and less popular sites.

Eysenbach and Köhler (2002) examined the ways in which consumers searched for and appraised health information on the World Wide Web. They reported that although their search technique was sub-optimal Internet users successfully and quickly found health information in answer to their questions (mean search time = 5 minutes, 42 seconds). Participants in the study reported that they assessed the credibility of a web-site in two dimensions. Trustworthiness was assessed by the source, professional design and scientific or official association while comprehensible language and ease of use defined accessibility. However, no participants actively searched for information on who was responsible for providing the site and none checked the disclaimers or disclosure statements. They concluded that more work was required to design and evaluate how users are guided to high quality health information on the web.

The web also allows researchers to contact patients in non-medical settings. As such on-line surveys conducted via the World Wide Web have become an increasingly popular method for the gathering information on health. A search of the health databases revealed 66 papers with the words 'on-line survey' in the title or abstract. Of these the majority (44) related to the use of on-line surveys to gather information from health professionals or health services on aspects of the structure and delivery of care. A further 14 explored the uses and methodology of on-line developments while 6 reported on studies that had surveyed patients or members of the public.

These illustrated the feasibility of conducting on-line surveys with patients (Taulois-Braga and Marcenes, 1995; Sell, 1997; Agbamu, 1997; Soetikno et al, 1997; Barlow, 1998; Schneider, 2000) but highlighted the potential limitations due to limited or differential access to the web. Soetikno et al., (1997) found that those patients recruited to a study via the web were younger, more ill and had lower health status than those identified in a surgical clinic. They concluded that it was feasible to conduct epidemiological research using the medium of the World Wide Web but that differences between clinic and web groups may limit the applicability of findings.

Other studies such as Saphore (2000) have pointed to the feasibility of the on-line survey by proving that the responses were the same to a paper and an on-line survey and that there were no differences in the psychometric qualities of the survey. There
is some debate, however, over the nature of responses to an anonymous medium such as an on-line survey. Some studies of computer-patient interviewing suggest that patients' are more open in computer mediated interviews than in personal interviews (Card and Lucas, 1981) but not all agree (Skinner et al, 1985).

One study of particular relevance to this project compared postal, e-mail and World Wide Web methods of conducting a health survey in the workplace (Jones and Pitt, 1999). Based on the assumption that staff connected to the Internet represent the workforce of the future they compared the different methods of survey in respect of response rates, speed of response, validity and costs. They found that the postal survey obtained the best response rate but it was also the most expensive at twice the cost per reply of the electronic methods. Electronic responses, however, were made more rapidly and required less work to analyse. They also found evidence, albeit weak, that the electronic methods were valid. They concluded that further work was required in order to more fully explore the use of electronic surveys given the growing use of the Internet and the increasing familiarity of users with it.

As with much research in health there is little to indicate that gender has been addressed in studies examining the medium of the World Wide Web and health. Nevertheless there is considerable evidence to suggest that there are gender differences in the use of the Internet (Bimber, 2000; Jackson et al, 2001; Boneva et al, 2001). Boneva et al (2001) found that the use e-mail replicated existing gender differences in communication with women more likely to use it to maintain distant social networks, to be more personal in their messages and to find e-mail gratifying. Bimber (2000) proposed that two significant gender gaps exist on the Internet: in access and use. The access gap can be explained in terms of socio-economic and other differences between men and women. For example, Schumacher and Morahan-Martin (2001) in a comparison of two surveys of US college students in 1989 and 1997 identified decreasing gender differences in Internet access as computer skills and experience increased.

However, the differential uses made of the Internet by the sexes cannot be explained solely in these terms. Jackson et al (2001) found that women used e-mail more than men did but that men used the World Wide Web more often. They characterised this as 'women communicating and men searching'. Mediators of gender differences in Internet use were identified as computer self-efficacy, loneliness and depression but gender was revealed to continue to have a direct effect on use after these factors were considered. Bimber (2000) proposed that the differences in use were the result of both socio-economic and underlying gender factors. He concluded that around one half of the 'digital divide' between men and women on the Internet is fundamentally gender related.

Such findings suggested that there would be some value in exploring the Internet as a consultation medium with women. Its acceptability as a communication tool (Boneva et al, 2001) and pre-existing use as a source of women's health information (Meric et al, 2002) supported the further exploration of this as a tool for consulting with women.

5. Aims
The central aim of the project was to test the usefulness and rigour of a workplace web-site as a mechanism for consulting with women. It also aimed to explore the
nature of the responses to the workplace web-site and to assess their usefulness to the women's health work of Health at Work.

The objectives of the project were:

- to investigate the usefulness of a workplace website as a mechanism for consulting with women in paid employment
- to explore the benefits and limitations of this in addressing the exclusion of this group of women from consultative activity
- to examine the rigour of this medium for generating a representative sample of participants
- inform the development of materials for a workplace programme on women's health applicable to Health at Work (HAW)
- to investigate the awareness of women's health within the HAW network of employers

6. Methodology

6.1 Design
An online questionnaire was developed and delivered through the Health at Work (HAW) website. Access to the questionnaire was through the website but a number of other media such as the HAW newsletter and a mail shot to HAW supporters was used to raise awareness of the questionnaire and to direct women to it. E-mails to HAW supporters with electronic links to the questionnaire were used to facilitate access. It had originally been envisaged that the on-line questionnaire would be publicised in a Health at Work supplement in a national newsletter. This did not prove possible. However, whilst this could have led to an elevated response rate this would have been an exceptional level of promotion and as such not representative and probably not replicable.

An incentive in the form of a prize draw for completed entries was offered to encourage participation.

An on-line return system was developed to facilitate ease of response. This system included an analytical package allowing the responses to be quantitatively analysed as they were returned.

6.2 Process
The process followed is described below.

Design phase: Development of the questionnaire
Development of the IT response system and analytical parameters

Intervention: Launch of the on-line questionnaire for a period of 11 weeks
Analysis phase: Analysis of the results
Production of written report with recommendations for HAW (on the topic of women's health within the health at work agenda) and the Women's Health Team (on the usefulness of a workplace website in engaging with this group of women).

6.3 Survey Design
A questionnaire was designed to elicit responses to a range of questions on the subject of women's perceptions of their health and health care. Women were asked how they felt about their own health, the health services they used and how work affected their health.

The questionnaires comprised closed questions with response lists and open-ended questions. Where participants were asked to rate different options a five-point Likert response format was used. Negative wording was utilised in some of the questions to reduce response bias. The questionnaire (see Annex A) comprised three sections.

Section A was designed to provide information about their views of their own health. The questions asked them to report on the following:

♦ their current health
♦ their current health in comparison to most women of their age
♦ any long-standing health problems
♦ their mood most of the time
♦ any periods during the past year when they felt sad or depressed
♦ their personal priorities for the Women's Health Policy for Glasgow
♦ their view of the priorities of the Women's Health Policy for women in the city
♦ their view of what most affects their health

The second section gathered information on and their experience of the health services they had used during the past 6 months. Health problems identified by respondents were coded under the following categories: infection, chronic disease, mental health, reproductive health, and non-specific complaints.

The following areas were included:

♦ use of the GP for own health in the past 6 months
♦ other services used regarding health in the last 6 months
♦ any problems encountered when using these health services
♦ what would improve women's health services in Glasgow
♦ what local services/facilities could be provided that would improve health

The third section asked a series of questions that required reflection on how health was affected by work. These were:

♦ how do they get time off to attend appointments for GP, dentist, clinics etc?
♦ does the workplace have written policies addressing health issues?
♦ what difficulties do they experience with work?
♦ how are problems at work addressed?
what special leave or workplace facilities that are supportive of health do they have access to?
• are there any services/facilities that could be provided in the workplace that would improve health?

The third section gathered demographic information in order to describe the respondents. The areas covered were:

• age
• marital status
• postcode
• caring responsibilities, including both children and other dependants
• hours and times of work
• nature of work contract
• occupational category
• size of employer
• ethnic group
• disability

Finally, the questionnaire asked respondents to reflect on the medium of an on-line survey and to assess its usefulness. Two open questions were used to gather views on a workplace web-site.

• do you think that an on-line survey is a useful way of asking you about your health?
• would you read health information if it was posted on the web?

6.4 Reporting
The qualitative data collected was analysed using qualitative methodology and interpretative processes.
7. Results

7.1 Sample
Participation in the study was voluntary. 152 submissions were received from women over an 11-week period.

Figure 1: Ages of Respondents

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 - 25</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>26 - 35</td>
<td>54</td>
<td>35</td>
</tr>
<tr>
<td>36 - 45</td>
<td>44</td>
<td>29</td>
</tr>
<tr>
<td>46 - 55</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>56 - 65</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>65 +</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

The sample included women from the full range of working ages (16 - 65).

The most frequently represented were women aged 26 - 35 who made up 35% of the sample. Women aged 36 - 45 were the next most common at 29% of the sample. Young women (16 - 25) comprised 13%, as did women aged between 45 and 55.

Women aged 56 - 65 were the least well represented, comprising only 3% of the group. 10 responses (7%) were missing.

Figure 2: Marital Status of Respondents

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>56</td>
<td>37</td>
</tr>
<tr>
<td>Single</td>
<td>39</td>
<td>25</td>
</tr>
<tr>
<td>Living with partner</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Widowed</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

Women were asked to report on their marital status and as before this showed that the sample included a wide range of respondents. Most women were either married (37%) or living with a partner (16%). However, 25% were single while a further 11% were separated or divorced. 4 women were widowed (3%) while 12 responses were missing.

Very few women described themselves as disabled.
Figure 3: Disability

<table>
<thead>
<tr>
<th>Disability</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Sensory</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Learning Difficulty</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>None</td>
<td>138</td>
<td>91</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

Similarly, the ethnic origin of the group was overwhelmingly White/European with very few other groups represented.

Figure 4: Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Freq.</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Europe</td>
<td>132</td>
<td>87%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>African/Caribbean</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other*</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Missing</td>
<td>17</td>
<td>11.5</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

* Where 1 was American and 1 from New Zealand.

The type of neighbourhood that respondents lived in was classified from their postcode according to the Carstairs Deprivation categories.

Figure 5: Neighbourhood Type

<table>
<thead>
<tr>
<th>Neighbourhood Type</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or 2 most affluent</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>3, 4 or 5</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>6 or 7 least affluent</td>
<td>46</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Outwith Glasgow</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Missing</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

This showed that the sample contained women from all 7 categories from the most affluent to the most deprived. The largest group (30%) came from groups 6 and 7.
The next most frequent group came from the middle categories of 3, 4 and 5 (22%) while the smallest number came from Carstairs categories 1 and 2 (12%). This indicates that the sample was broadly representative of the population of Glasgow as a whole in terms of neighbourhood type.

19 women lived outside the city. Of these most lived in the Paisley area (13) while 5 were from Lanarkshire and 1 from Ayrshire.

The other data relates to new postcodes for which no Carstairs category was available. The high number of missing data in this section is accounted for by the high number of errors in the completion of this question. In most cases insufficient information was given for the neighbourhood type to be determined.

**Figure 6: Caring Responsibilities**

<table>
<thead>
<tr>
<th>Caring Responsibilities</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>48</td>
<td>31</td>
</tr>
<tr>
<td>No children at home</td>
<td>94</td>
<td>62</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Caring for Others</td>
<td>22</td>
<td>14</td>
</tr>
<tr>
<td>No caring responsibilities</td>
<td>117</td>
<td>77</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

48 respondents (31%) reported that they were bringing up children at home. In total they were responsible for 108 children. 28 of these were under 5 years, 69 were aged 5 - 15 years (school age) and 11 were 16 - 19 years. 10 responses were missing. This compares to the national rate where 60% of working women have dependent children at home.

A smaller number, 22 (14%) reported that they had caring responsibilities for an elderly relative or someone with an illness or disability. Most considered they were the sole or main carer but a smaller number were helping someone else to care. 13 responses were missing. The sample did contain a more representative response from women with other caring responsibilities. This compares more favourably with the national picture where 12% of women are living with someone who requires regular help or care and 11% provide regular help or care for a sick, disabled or elderly person not living with them (Scottish Executive, 2002). No data was available on what proportion of these women are also in paid employment but this aspect of the sample did appear superficially to be more representative.

The sample consisted overwhelmingly of women who worked full time (80%), were on permanent contracts (74%) and who worked between the hours of 9 and 5 (81%). Some women worked more variable hours or shifts or had less secure forms of contracts but these numbers were very small. 10 and 11 responses respectively were missing.
Figure 7: Pattern of Work

<table>
<thead>
<tr>
<th>Pattern of Work</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hours of Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>121</td>
<td>80</td>
</tr>
<tr>
<td>Part time regular</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Part time variable</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Type of Contract</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>113</td>
<td>74</td>
</tr>
<tr>
<td>Fixed term, rolling renewal</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Fixed term, temporary</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>No contract</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Outside contractor</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Time of Work</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early mornings</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>9 to 5</td>
<td>123</td>
<td>81</td>
</tr>
<tr>
<td>Back shift</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Evenings</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Night shift</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Variable shifts</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

A number of different businesses were represented. However, most responses were from the public sector - local authority (38%), education (22%) and health (12%).

Figure 8: Occupational Category

<table>
<thead>
<tr>
<th>Nature of Business</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Service</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Local Authority</td>
<td>57</td>
<td>38</td>
</tr>
<tr>
<td>Health</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Finance &amp; Insurance</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Education</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>Media</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Marketing</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Missing</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
The private sector was less well represented with only 10% working in the service industry, 2% of the sample working in insurance & finance, 4% working in media and 0.5% in both retail and marketing. 17 responses were missing.

Other sectors such as manufacture, information technology, electronics, engineering and agriculture were not represented at all.

Very few respondents were manual workers (1%). Most were either clerical/administration (39%) or professional (36%). The remainder was managerial (13%). These occupational categories were perhaps to be expected given that this method primarily targets those women in occupations that use or have significant access to a computer. This will exclude women in many manual jobs.

Figure 8 (ii): Occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Freq.</th>
<th>Percent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Clerical/Admin.</td>
<td>59</td>
<td>39</td>
</tr>
<tr>
<td>Managerial</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Professional</td>
<td>55</td>
<td>36</td>
</tr>
<tr>
<td>Missing</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As would be anticipated in a sample where the public sector was heavily represented the largest group of respondents (49%) worked in companies who employed more than 250 employees. 32% worked for medium sized firms employing between 51 and 250 but very few, 3% worked for small businesses. 13 responses were missing.

Figure 9: Size of Employer

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 10</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>11 to 50</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>51 to 250</td>
<td>49</td>
<td>32</td>
</tr>
<tr>
<td>251 +</td>
<td>75</td>
<td>49</td>
</tr>
<tr>
<td>Missing</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

7.2 Women’s Perceptions of their Health

Women were first asked how they would describe their health at the moment. Most (60%) described their health as good. 20% thought it fair, 16.5% rated it as excellent while 0.5% considered their health to be poor. 4 responses were missing.

This finding is comparable to the Scottish Health Survey (1998) where 77% of women rated their health as "very good" or "good".
Figure 10: Self-defined Health

<table>
<thead>
<tr>
<th>Health</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>25</td>
<td>16.5</td>
</tr>
<tr>
<td>Good</td>
<td>91</td>
<td>60</td>
</tr>
<tr>
<td>Fair</td>
<td>31</td>
<td>20</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

When asked how they thought their current health compared to most women of their age most (60%) felt it was about the same. However, 30% thought their health was better while 7% thought their health was worse. 5 answers were missing.

Figure 11: Health in Comparison with Peers

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better than most</td>
<td>44</td>
<td>30</td>
</tr>
<tr>
<td>About the same</td>
<td>92</td>
<td>60</td>
</tr>
<tr>
<td>Worse than most</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Missing</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100</td>
</tr>
</tbody>
</table>

A total of 56 women (37%) reported having one or more long-standing health problems. 89 reported they did not while 7 responses were missing. These health problems can be described as follows.

Figure 12: Long-standing Health Problems

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Mental Health</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Chronic Illness</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Non-specific Complaint</td>
<td>39</td>
<td>51</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

Most women described their long-standing health problems in terms of non-specific complaints (51%). These included back pain, allergies, migraine headaches, joint pain and irritable bowel syndrome. 21% experienced chronic conditions such as diabetes, asthma or arthritis. Reproductive health conditions such as endometriosis or problem periods accounted for 11% of the problems described while 8% were related to infections e.g. hepatitis c, recurring urinary tract infections or a propensity for chest infections. Mental health difficulties were described in 9% of cases. These included depression, anxiety, bereavement and low self-esteem.
The next two questions asked women to reflect on their emotional health and to assess their mood. The first asked how they would describe their mood most of the time.

**Figure 13: Women’s Assessment of their Mood**

<table>
<thead>
<tr>
<th>Description</th>
<th>Freq.</th>
<th>Percent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very happy</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Good</td>
<td>68</td>
<td>45</td>
</tr>
<tr>
<td>Fair</td>
<td>31</td>
<td>21</td>
</tr>
<tr>
<td>Sometimes low</td>
<td>35</td>
<td>23</td>
</tr>
<tr>
<td>Miserable</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Over half (52%) described their mood as good (45%) or very happy (7%). 21% thought that their mood was fair. The remainder, 25%, described their mood as being sometimes low (23%) or miserable (2%). However, when asked how often they had had periods during the past year when they had felt sad or depressed an overwhelming number admitted to having these at least sometimes.

54% said they sometimes felt sad or depressed while 21% said they felt like this a lot of the time. A smaller number, 2%, reported that they very often felt this way.

In contrast only 5% said they never felt sad or depressed while 16% said almost never.

**Figure 14: Frequency of Periods of Sadness or Depression**

<table>
<thead>
<tr>
<th>How often?</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very often</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>A lot of the time</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>Sometimes</td>
<td>82</td>
<td>54</td>
</tr>
<tr>
<td>Almost never</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Never</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Respondents were then asked to identify their own priorities for health. They were given a list of the priorities identified in the *Women’s Health Policy for Glasgow* and asked to identify which 3 were most important to them.

The highest levels of support were for addressing emotional & mental health and tackling diseases such as heart disease and cancer. The next most supported priorities were addressing violence and abuse and improving the physical and social environment.

The lowest priorities, although still well supported were reproductive health, reducing poverty and support for women as carers.
Figure 15: Women's Personal Health Priorities

<table>
<thead>
<tr>
<th>Rating</th>
<th>Priority</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emotional &amp; mental health</td>
<td>93</td>
</tr>
<tr>
<td>2</td>
<td><strong>Avoiding disease e.g. heart disease, cancer</strong></td>
<td>90</td>
</tr>
<tr>
<td>3</td>
<td>Health &amp; safety at home, work and in the community</td>
<td>67</td>
</tr>
<tr>
<td>4</td>
<td>Improving the physical and social environment</td>
<td>53</td>
</tr>
<tr>
<td>5</td>
<td>Reproductive health</td>
<td>50</td>
</tr>
<tr>
<td>6</td>
<td>Reducing poverty and its impact on health</td>
<td>46</td>
</tr>
<tr>
<td>7</td>
<td>Support for women as carers</td>
<td>40</td>
</tr>
</tbody>
</table>

When further asked to identify which of these priorities they thought was the most important women identified number 2, avoiding disease. This received 41 votes compared to 38 for emotional and mental health. 20 women thought that health & safety in the home, work and the community was the most important issue, 12 voted for reproductive health, 10 for improving the environment, 9 for support for carers and 8 for reducing poverty.

Women were then asked to consider the list of priorities and to rate them in terms of which they thought should be the Health Board's top 3. This produced a slightly different priority list. While some priorities remained static in terms of ratings and placings others such as emotional and mental health and reducing poverty were affected. Reducing poverty was much more highly rated than it had been in women's lists of personal priorities while emotional & mental health dropped down the list. This suggests that while reducing poverty may not be a high individual priority women recognised that it was important for the city as a whole.

Similarly, it may well be that emotional & mental health had personal resonance as an issue but that women felt this was personalised and not applicable to other women in Glasgow.

Figure 16: Women's Health Priorities for Glasgow

<table>
<thead>
<tr>
<th>Rating</th>
<th>Priority</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Avoiding disease e.g. heart disease, cancer</strong></td>
<td>98</td>
</tr>
<tr>
<td>2</td>
<td>Reducing poverty and its impact on health</td>
<td>76</td>
</tr>
<tr>
<td>3</td>
<td>Emotional &amp; mental health</td>
<td>74</td>
</tr>
<tr>
<td>4</td>
<td>Health &amp; safety at home, work and in the community</td>
<td>59</td>
</tr>
<tr>
<td>5</td>
<td>Improving the physical and social environment</td>
<td>48</td>
</tr>
<tr>
<td>6</td>
<td>Reproductive health</td>
<td>35</td>
</tr>
<tr>
<td>7</td>
<td>Support for women as carers</td>
<td>34</td>
</tr>
</tbody>
</table>

When asked to reflect on which of these should be the top priority avoiding disease was again rated the most important with 60 votes. Reducing poverty came second with 31 women considering it to be the most important priority. 18 women thought emotional & mental health the top priority while 15 considered that this should be health & safety. The remaining issues received very few votes. Reproductive health, 7, support for women as carers, 6 and improving the environment, 4.
In order to explore further women's perceptions of health they were asked what factors they thought most affected their own health. The responses demonstrated a sophisticated understanding of health and the social factors that influence it.

**Figure 17: Women's Perceptions of Factors affecting their Health**

<table>
<thead>
<tr>
<th>Rating</th>
<th>Factor</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stress</td>
<td>42</td>
</tr>
<tr>
<td>2</td>
<td>Lifestyle</td>
<td>24</td>
</tr>
<tr>
<td>3</td>
<td>Work/Family Life Balance</td>
<td>22</td>
</tr>
<tr>
<td>4</td>
<td>Working environment</td>
<td>18</td>
</tr>
<tr>
<td>5</td>
<td>Existing physical health problems</td>
<td>12</td>
</tr>
<tr>
<td>6</td>
<td>Poor interface with health service</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Long hours and lack of time for self</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Tiredness</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>Emotional &amp; mental state</td>
<td>6</td>
</tr>
<tr>
<td>10</td>
<td>Treats and looking after yourself</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>Relationships with others</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Economic factors</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Travelling</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Others attitudes to health problems</td>
<td>1</td>
</tr>
</tbody>
</table>

Stress was overwhelmingly identified as the biggest influence on women's health. Several sources of stress were also reported such as difficulties in managing the demands of work and family life, a poor working environment and problems encountered accessing supportive health services.

Although the question did not specifically ask what factors had a negative impact on health very few responses identified positive influences. Women also reported that they knew what would make a positive impact on their health but noted that they often fell short of achieving this. For example, many felt that they should take more exercise or stop smoking but acknowledged that this was unlikely to happen given the many demands they were already trying to juggle. It was recognised that emotional well-being influenced physical health and that stress or tiredness undermined their ability to stay well.

8 respondents raised the interaction between the health service and work as an issue. Women identified a lack of protected time for health appointments and a perceived pressure to return to work after a period of illness as factors affecting their health. Lack of services or poor access times could have an impact on health, particularly where women already felt pressurised in terms of time.

**7.3 Women's Use and Experience of Health Services**

The next section of the survey asked women about their recent use of health services and their experiences of these.

The first question asked if they had attended a GP about their own health in the past 6 months. No one reported that they were not registered with a GP. This is consistent with the findings of the Scottish Household Survey (Scottish Executive, 2002) that
showed almost universal registration with a GP (99%). Attendance was reported as 104 (68%) who had visited the GP during this period while 44 had not. 4 answers were missing. Comparative data was not available but the Scottish Household Survey (Scottish Executive, 2002) suggested that 84% of adult women registered with a doctor visited a GP about their own health at least once during the year 1999/2000.

The reasons for attendance at the GP are given in the table below.

### Figure 18: Reasons for Attending GP

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Mental Health</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Reproductive Health</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td>Chronic Illness</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Non-specific Complaint</td>
<td>42</td>
<td>37</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>112</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The most frequent reason given for attending the GP was non-specific complaint (37%) e.g. repeat prescription, injury, pain etc. The next most common reason was reproductive health (27%) e.g. consultations for contraception, routine smear tests, ante and post natal checks and painful periods. Appointments for infections were the next most frequent at 14% while those related to the routine monitoring and on-going treatment of chronic illnesses e.g. diabetes, hypertension etc. accounted for 12% of visits. Mental health was the reason for attending the GP in only 10% of cases.

Women were then asked to comment on the experience of visiting the GP and to describe any problems they encountered. 104 women reported that they had attended the GP in the past 6 months. Of these 40 (38%) reported not having experienced any problems. The remaining 64 (62%) identified the following difficulties from a list of options.

### Figure 19: Problems Encountered when Attending GP

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long waiting time for an appointment</td>
<td>27</td>
<td>42</td>
</tr>
<tr>
<td>Unhelpful attitudes of staff</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Unsuitable or difficult appointment time</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Long wait to be seen once at appointment</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Not enough information given on my health issue</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Lack of information about service</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Personal circumstances not taken into account</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Poor access e.g. lack of parking, not on a bus route</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
The most frequently reported problems related to difficulties in obtaining an appointment. 59% of those who encountered difficulties reported that these related to the availability and scheduling of appointments. Of these, 42% were unhappy at the length of time they had to wait before being given an appointment, 9% found their appointment time unsuitable or difficult while a further 8% felt that the waiting time to be seen once at the surgery was a problem.

The second most frequent difficulty encountered was reported as the unhelpful attitudes of staff. 14% of women who had encountered problems identified this issue. One described this as:

"GP unhelpful, they tend to give the impression that you are always faking it"

Other issues identified related to a lack of information. Women reported that they would have liked more information about their medical conditions or about the services they were trying to access.

Lack of consideration of personal circumstances also caused problems.

"lack of child care facility means I can only get an appointment when I can arrange child care or take my child with me"

One woman reported that she found access to the surgery to be poor.

8 women reported other problems with the GP service. These included:

"GP always running late. Feel rushed and never get to talk about problem fully"
"Allocated time for GP appointments is too short"
"Blood test results lost and I was not informed"

Women were then asked to report on the other services they had used regarding their health in the past 6 months. The group identified 207 contacts over a 6-month period. The largest number of these contacts was with hospital out-patient departments or clinics (44). Women's reproductive health accounted for 77 contacts via gynaecology (27), maternity (21), family planning (6) and well woman clinics (13).

Women made 20 visits to Accident & Emergency and on 11 occasions were surgical day or in-patients.

Relatively high numbers reported using homeopathy and complementary therapy (18) although this was often not provided on the NHS and had to be privately funded.

There were fewer contacts reported with mental health services (8), counselling (8) and the Centre for Women's Health (2). Services relating to the social aspects of health had fewer contacts. Housing was used 3 times, social work and women's aid once.

Of the remaining medical services 6 contacts were reported with cancer services, 4 with physiotherapy, although this was sometimes privately funded, 2 with genito-urinary medicine, 1 woman had used the practice nurse at her GP surgery and 1 had a clinical referral for plastic surgery. The following services were identified.
### Figure 20: Other Services Used

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Out-Patients or Clinic</td>
<td>44</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>27</td>
</tr>
<tr>
<td>Maternity</td>
<td>21</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>20</td>
</tr>
<tr>
<td>Homeopathy/Complementary Therapy</td>
<td>18</td>
</tr>
<tr>
<td>Family Planning</td>
<td>16</td>
</tr>
<tr>
<td>Well Woman Clinic</td>
<td>13</td>
</tr>
<tr>
<td>Surgical Day or In-Patient</td>
<td>11</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>8</td>
</tr>
<tr>
<td>Counselling</td>
<td>8</td>
</tr>
<tr>
<td>Cancer Services</td>
<td>6</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>4</td>
</tr>
<tr>
<td>Housing Services</td>
<td>3</td>
</tr>
<tr>
<td>Centre for Women's Health</td>
<td>2</td>
</tr>
<tr>
<td>GUM</td>
<td>2</td>
</tr>
<tr>
<td>Women's Aid</td>
<td>1</td>
</tr>
<tr>
<td>Social Work</td>
<td>1</td>
</tr>
<tr>
<td>GP Practice Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>207</strong></td>
</tr>
</tbody>
</table>

In 111 cases women reported that they did not encounter any problems when using these services. However, the balance of the sample identified 141 problems.

### Figure 21: Problems Encountered when attending Other Health Services

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long waiting time for an appointment</td>
<td>56</td>
<td>40</td>
</tr>
<tr>
<td>Long wait to be seen once at appointment</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>Unhelpful attitudes of staff</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Poor access e.g. lack of parking, not on a bus route</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Not enough information given on my health issue</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Lack of information about service</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Unsuitable or difficult appointment time</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Personal circumstances not taken into account</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Poor communication with service e.g. not getting letters or phone messages</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>141</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
As with Primary Care the majority of problems encountered related to waiting times, either the length of time before being allocated an appointment (40%) or time spent waiting once at the service (19%). In addition 3% of problems related to unsuitable or difficult appointment times. Several women reported that waiting times were so long for services that they paid for private treatment instead. Another woman reported that her mother waited so long to see a cancer specialist that by the time she was diagnosed it was too late to treat her.

Unhelpful attitudes of staff accounted for 10% of problems encountered while lack of information either about medical conditions or services was an issue in 6% of cases. Poor access to services was reported as a problem (8%) more frequently than it was in primary care (2%). This may be due to the location of clinics etc. in hospital rather than community settings.

The remainder of difficulties related to personal circumstances not being taken into account (2%) and poor communication with the service (1%).

Respondents identified 7 other problems. These were:

- Lack of continuity of treatment and staff
- Discouraged from seeing specialist
- Hospital environment shabby and depressing
- Ineffective triage system used at A&E
- Lack of consistency across services, had to pay for test provided free in other settings
- Systems designed around service's needs not patients
- Felt maternity care was not as thorough as in Germany where had had first baby.

Although most of the services commented on provided medical services those that related to the wider aspects of health were also identified as having problems. Long waiting times for an appointment was also an issue for social work while 2 women reported difficulties with housing. These were the unhelpful staff and very high costs associated with rented accommodation and the difficulties in getting repairs done.

When asked to select from a list of factors that could help to improve women's health in Glasgow most women chose at least 3 items. Their ratings of these factors were as follows.

**Figure 22: What Would Improve Women's Health in Glasgow**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to a range of complementary medicines</td>
<td>93</td>
</tr>
<tr>
<td>Improved access to services e.g. different/longer opening times</td>
<td>89</td>
</tr>
<tr>
<td>Information about women's health services</td>
<td>77</td>
</tr>
<tr>
<td>Someone to talk to about health and other worries</td>
<td>64</td>
</tr>
<tr>
<td>Counselling services</td>
<td>59</td>
</tr>
<tr>
<td>Women-only sessions or services</td>
<td>41</td>
</tr>
<tr>
<td>Help for women who do not speak English as a first language</td>
<td>38</td>
</tr>
<tr>
<td>Crèche facilities at health and other community services</td>
<td>4</td>
</tr>
</tbody>
</table>
The factors identified by respondents reflected the problems previously noted. Access to a range of complementary medicines was the most popular choice (93). The types of complementary medicine noted by participants included aromatherapy, massage, homeopathy, acupuncture and yoga. Greater flexibility in and improved access to services was the next most popular choice (89). Developments in information was the next most highly rated factor (77) whilst formal and informal counselling services were next with 64 and 59 votes respectively.

41 women identified women only sessions or services as a development that would help improve women's health in the city while greater help for women whose first language is not English received 38 votes. Only 4 women felt that crèche facilities at health and other community services would help improve women's health.

Other factors suggested by women were:

- More holistic approach to dealing with medical problems
- Increased links between different services used by women including those not normally seen as 'health' services
- Workplace crèche facilities
- City centre based health services for easy access by women during working hours
- Increased sensitivity from staff towards women's problems
- More discussion of the long term implications of medication
- Increased recognition of fertility problems and consistency in referrals
- More honesty about waiting times
- Easier/cheaper access to sports facilities
- Increased nurse-led services to reduce pressure on doctors and increase access for patients

When asked if there were any services or facilities that could be provided in their local area that would improve their health 42 (28%) women identified improvements they would like to see.

**Figure 23: Local Services/Facilities that would Improve Women's Health**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More flexible access e.g. outside working hours, drop-in</td>
<td>7</td>
</tr>
<tr>
<td>Greater access to complementary therapy</td>
<td>7</td>
</tr>
<tr>
<td>Better/cheaper access to sport &amp; leisure facilities</td>
<td>7</td>
</tr>
<tr>
<td>Better information on women's health &amp; more publicity of services</td>
<td>6</td>
</tr>
<tr>
<td>Counselling services</td>
<td>4</td>
</tr>
<tr>
<td>Crèche facilities</td>
<td>3</td>
</tr>
<tr>
<td>More local family planning services</td>
<td>3</td>
</tr>
<tr>
<td>More help to give up smoking e.g. therapy sessions</td>
<td>1</td>
</tr>
<tr>
<td>Parenting classes</td>
<td>1</td>
</tr>
<tr>
<td>More physiotherapy services</td>
<td>1</td>
</tr>
<tr>
<td>Longer sessions with the GP</td>
<td>1</td>
</tr>
<tr>
<td>Local asthma clinics</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>
Many of the suggestions related to improving access to existing services and facilities or increased local provision of services. However, there were also ideas for new developments such as counselling, crèche, parenting classes or therapy session to help give up smoking.

Information was also identified as an issue with women suggesting that more information about health issues would be useful, as would greater publicity about what services and supports are available.

7.4  Women’s Health & Work
This section of the survey asked women about the interaction between their work and their health.

The first question in this section asked women how they got time off to attend health appointments for the GP, dentist, clinics etc. 43% (65) reported that their employer allowed them time off to attend such appointments. 27% (41) used flexitime while 24% (36) went in their own time and outwith working hours. 10 responses were missing.

The next question looked at the availability of written policies addressing key health issues in the workplace. Not all women were aware of whether or not their workplace had these policies and some appeared to be more widely available than others are.

**Figure 24: Written Policies on Health Related Issues**

<table>
<thead>
<tr>
<th>Policy</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Safety</td>
<td>133</td>
</tr>
<tr>
<td>Equal Opportunities</td>
<td>121</td>
</tr>
<tr>
<td>Bullying &amp; Harassment</td>
<td>97</td>
</tr>
<tr>
<td>Balancing Work &amp; Other Life Concerns</td>
<td>62</td>
</tr>
<tr>
<td>Don't know</td>
<td>10</td>
</tr>
</tbody>
</table>

Most women were aware of written policies on health & safety and equal opportunities. Fewer reported knowing about a bullying and harassment policy and fewer still knew of a balancing work & life policy. There was similar variation in respondent's access to or awareness of a range of possible benefits provided by their employer.

**Figure 25: Benefits Provided by Employer**

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to employee counselling</td>
<td>97</td>
</tr>
<tr>
<td>Flexible hours</td>
<td>82</td>
</tr>
<tr>
<td>Paternity leave</td>
<td>79</td>
</tr>
<tr>
<td>Enhanced maternity leave</td>
<td>62</td>
</tr>
<tr>
<td>Carer’s leave</td>
<td>28</td>
</tr>
<tr>
<td>Breastfeeding facility</td>
<td>24</td>
</tr>
<tr>
<td>Workplace crèche or nursery</td>
<td>14</td>
</tr>
<tr>
<td>Don't know</td>
<td>16</td>
</tr>
</tbody>
</table>
Respondents were then asked to consider a list of 12 problems women commonly associate with work and to rate these according to how far these applied to them. The results of these ratings are as follows.

1. **Lack of childcare:** 62% of respondents thought that this was not a problem but for 17% it was. Furthermore, 12% of respondents considered it a major difficulty for them.

2. **Few opportunities for promotion:** responses to this issue were more evenly spread with 33% of respondents choosing the neutral option. 30% thought it wasn't a problem and 30% thought it was a major problem. 7% were missing.

3. **Poor pay:** very few respondents identified this as a problem (17%). For most it was rated as neutral or as not a problem (70%).

4. **Long hours:** as with poor pay this was overwhelmingly regarded as neutral or not a problem (68%). For 17% of respondents, however, it represented a problem.

5. **Unhelpful shift patterns:** again this was not an issue for 75% of respondents but represented a problem for 3% and a major problem for 4%.

6. **Lack of pay parity with male employees:** only 9% thought this was a problem or a major problem while 60% thought it was not an issue.

7. **Work related stress:** 34% of respondents thought that this was a problem for them. 31% said it was not and the balance was neutral.

8. **Inflexible hours:** as with earlier questions on shift patterns and hours the majority of respondents felt that inflexible hours was not a problem for them (64%). 11% were neutral on the issue but for 13% this represented a problem or a major problem.

9. **Hazardous materials:** most felt that this was not a problem, 74%, but 6% of respondents identified it as a difficulty.

10. **Difficulty juggling work and family demands:** 61% of respondents did not think this was a problem for them. However, 20% thought it was with 10% identifying it as a major problem.

11. **Sexual harassment in the workplace:** 76% said that this was not a problem but for 5% of the sample it represented a major problem.

12. **Work related injury e.g. RSI:** again the majority felt this was not an issue, 66%, but a small number identified it as a major problem, 3%, and a further 7% thought it was a problem.

The survey then asked women if there was someone at work that they could report these or other problems to. 90% said that there was while 3% said no. 7% were
missing. They were then asked if the problems they reported were dealt with. 118 women reported on how they felt problems were dealt with.

**Figure 26: Are Problems Reported at Work Dealt With?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Frequency (f)</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>51</td>
<td>43</td>
</tr>
<tr>
<td>Most of the time</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Sometimes</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Not usually</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Don't know</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>118</td>
<td>100</td>
</tr>
</tbody>
</table>

Most felt that problems were dealt with (43%) although 16% reported that they were not. The speed of management response to problems varied. Some women felt that their concerns were dealt with straight away but others reported that issues were resolved very slowly and that they needed to be persistent in order to ensure the problems were tackled.

The speed of response appeared to depend on the issue being raised. A number of respondents reported that their line managers would try to resolve issues straight away but if the matter was beyond the authority of an immediate line manager and needed to be passed on then it was unlikely that it would be dealt with quickly.

The immediate line manager, their relationship with staff and their willingness to tackle problems appeared to be key to problem resolution. Several respondents identified that their relationship with their line manager was an important factor in having their concerns listened to and acted upon. In the absence of a supportive line manager problems were not tackled. However, in some circumstances the line manager was a part of the problem. This could lead to a significant difficulty for staff in seeking a resolution.

A number of respondents also reported that the response was dependent on the nature of the issue being reported. Many felt that there were some issues that their managers would not tackle. Issues such as workplace stress and lack of flexibility in shift patterns were among these. Others felt that the response was dependent upon the employer's agenda. This was despite the presence of policies which some reported were only paid lip service to.

Finally, a concern was raised that issues raised by staff may not be treated in confidence with a resulting fear that their problems could become gossip in the office. This acted as a deterrent to raising issues.

When issues were not addressed respondents reported that this affected them. They reported feeling angry, frustrated, stressed and demoralised by this. The most significant effect appeared to be feelings of devaluation or dis-empowerment.

"*Made to feel like a junior*"
"I had to really find the strength in myself to come back to work the next day."

They reported that they felt marginalised and isolated when treated in this way and that they felt there was little point in trying to raise issues. A number felt unsupported. Some reported that there were other places where they could get support and that this lack of response was not wholly unexpected.

"(Its) typical!"

"Sometimes you just have to grin and bear it and do whatever you can. It does make me angry sometimes."

Finally in this section they were asked what services or facilities could be provided within the workplace that would improve health. 111 women responded to this question. Of these, 50 felt that there were no services/facilities that would improve their health that could be provided by their workplace. However, 61 thought there were improvements that could be made and suggested 80 ideas.

**Figure 27: Workplace Services/Facilities for Health**

<table>
<thead>
<tr>
<th>Service/Facility</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to gym or exercise classes at lunch time</td>
<td>17</td>
</tr>
<tr>
<td>Increased recognition of and opportunities for stress management</td>
<td>10</td>
</tr>
<tr>
<td>Crèche or workplace nursery</td>
<td>10</td>
</tr>
<tr>
<td>Improved canteen facilities and access to drinking water</td>
<td>9</td>
</tr>
<tr>
<td>Improved working environment</td>
<td>8</td>
</tr>
<tr>
<td>Changes in hours and workload e.g. flexible hours</td>
<td>6</td>
</tr>
<tr>
<td>Provision of a rest room or quiet area</td>
<td>5</td>
</tr>
<tr>
<td>Health and lifestyle screening, including RSI clinic</td>
<td>4</td>
</tr>
<tr>
<td>Improved policies on absences and leave</td>
<td>3</td>
</tr>
<tr>
<td>Smoking policy</td>
<td>2</td>
</tr>
<tr>
<td>Counselling service</td>
<td>2</td>
</tr>
<tr>
<td>Health information and events</td>
<td>1</td>
</tr>
<tr>
<td>Supervision</td>
<td>1</td>
</tr>
<tr>
<td>Permanent contract</td>
<td>1</td>
</tr>
<tr>
<td>Shower facilities</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

The most popular suggestion was for access to gym or fitness facilities (17). These ranged from provision of an on-site gym to running yoga or keep-fit classes at lunchtime. Such classes were seen as one way of promoting health and also as a means of managing stress. Increased recognition of stress in the workplace was the next most frequent suggestion (10). Stress clinics and stress counselling were proposed. Other ideas were also related to reducing stress. These were changes in hours and workload, improved policies on absence and leave and better access to counselling services.

The provision of a crèche or workplace nursery was also a popular suggestion (10) with some women recognising that this would greatly reduce stress for those women who were trying to balance work commitments with child care responsibilities.
It was proposed that changes to the physical environment at work could help improve health. 8 women suggested ways in which the physical environment could be improved or made safer. 9 women felt that the workplace could support healthy eating in more proactive ways and there were a number of votes for access to cold, drinking water. The need for a rest room or quiet area was suggested 5 times. This seemed to be particularly important where offices were open plan. One woman felt that showers should be provided at work. Those that wanted to see gym or exercise facilities also suggested this.

The next group of suggestions related to the impact of working conditions upon health. Several women identified action to improve working terms and conditions and proposed that this would impact on their health. These included the introduction of flexi-time, supervision, improved policies on absences and flexible leave and the provision of permanent contracts.

There were relatively few suggestions around traditional health promotion activity but there was some support for health and lifestyle screening and for increased health information and events. 2 women wanted to see more action to address smoking.

7.5 Feedback on an On-line Survey and Workplace Web-site.
The survey first asked women if they thought an on-line survey was a useful way of asking them about health. The response was overwhelmingly positive with 94% agreeing that it was. The reasons for this are as follows.

**Figure 28: Reasons for Using an On-line Survey**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ease of use</td>
<td>31</td>
</tr>
<tr>
<td>Quick to complete</td>
<td>30</td>
</tr>
<tr>
<td>Anonymity/Confidentiality</td>
<td>23</td>
</tr>
<tr>
<td>Accessible</td>
<td>10</td>
</tr>
<tr>
<td>More likely to respond to e-mail than a written survey</td>
<td>8</td>
</tr>
<tr>
<td>Simple to return</td>
<td>8</td>
</tr>
<tr>
<td>Convenience</td>
<td>7</td>
</tr>
<tr>
<td>Effective research method</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
</tbody>
</table>

Respondents were largely agreed that the benefits of an on-line survey were that it was easy to use, quick, convenient, accessible and simple to return.

"I really had intended to complain about the lack of availability, family planning, as usual I did not get around to it, this has given me the opportunity to communicate my opinions."

There was also a high level of recognition of the anonymity and privacy offered by this method. Women felt that this had allowed them to make comments that they may not have made in a written survey or to an interviewer.

Several women commented that they were more likely to respond to e-mail than to a written survey, one felt that on-line was the future and one thought the survey was fun.
Other comments related to the use of this as a research method. There were some reservations expressed over the representativeness of a sample achieved by this method but there were other more positive comments about the benefits of the speed of returns and the savings in data entry. One woman expressed the view that as e-mail was easily forwarded this was a good method for reaching a wide group. In addition to giving them the opportunity to participate in the survey several women commented that the survey had raised their awareness of health issues and encouraged them to think more about their health.

There were a further 10 comments on why an on-line survey might not be useful. These related to the sample being limited to those who have Internet access; being biased towards those who want to respond and the danger that responses may not be honest because of anonymity. Furthermore, while some women had clearly valued the anonymity offered for others the method was perceived as cold and impersonal. They felt that this restricted the type of information women were likely to share.

In other comments about the methodology two women felt that the closed lists given with some questions had not reflected some of their issues while other women were keen to stress the need for respondents and employers to receive feedback.

Finally, when asked if they would read health information if it was posted on the web respondents gave a mixed response. 26% said they definitely would, 43% said probably. A further 18% said maybe while 5% reported that they probably would not. 1 woman said definitely not while 13 responses were missing. The reasons why women would access the web for health information were as follows.

**Figure 29: Reasons Accessing Health Information on the Web**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency (f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy to access</td>
<td>27</td>
</tr>
<tr>
<td>Have an interest in health issues</td>
<td>15</td>
</tr>
<tr>
<td>Convenient</td>
<td>13</td>
</tr>
<tr>
<td>Information on web is user-friendly</td>
<td>6</td>
</tr>
<tr>
<td>Information on web is up to date</td>
<td>4</td>
</tr>
<tr>
<td>Can access privately and discreetly</td>
<td>2</td>
</tr>
<tr>
<td>Can obtain information without taking up time of GP</td>
<td>1</td>
</tr>
</tbody>
</table>

Most thought that this was an easily accessed, convenient and user-friendly way of accessing information that was up to date. A number of women commented that they had an interest in health issues and as such were likely to visit health web sites. However, it was also noted that accessing health information would be dependent upon time being available and on the site covering issues of interest. This was illustrated by the following quote.

"If I was looking for specific information I would use the web to try and find it but I am unlikely to browse a health site."

There were two other reasons given for why women would not use the web to access health information. These were lack of time and use of other, more traditional sites of health information e.g. chemist.
8. Discussion

This discussion reflects on four main areas of interest.

- The usefulness of a workplace website as a mechanism for consulting with women in paid employment
- The benefits and limitations of a workplace website as a means of including women in paid employment in consultative activity
- The development of materials for a HAW workplace programme on women's health
- Information relating to HAW employers on women's health

Each is considered below. Recommendations for action resulting from this discussion are given in the next section of the report.

8.1 The Usefulness of a Workplace Website as a Mechanism for Consulting with Women in Paid Employment

The sample achieved appeared to be representative in terms of age, marital status and neighbourhood type. However, it was not representative of women in employment who have dependent children at home and was overwhelmingly made up of women who were in full time, permanent work within the public sector. This emphasis on the public sector is unlikely to be as a result of the mailing strategy adopted as all HAW contacts were targeted equally. It is however, representative of the profile of women in employment in Scotland where 67% work in public administration, education and health (Central Research Unit, 2000).

Women from manual occupations were not well represented with most either clerical/administration or professional. This finding may also account for the low response from women working part-time, variable hours or in other less secure forms of contracts as generally, women in non-manual occupations are less likely to work part-time compared with women in manual occupations, half of whom work part-time (Central Research Unit, 2000).

The poor response rate from manual jobs was perhaps predictable, given their low access to the Internet but the low numbers working in industries such as insurance & finance, media and marketing was less so. Taken together, the pattern of response suggests that responses were highest from those areas of business within the city where prior extensive work on women's health issues had created an awareness of or 'readiness' in relation to the survey.

Feedback from women who did complete the survey indicated that this was easy to use, quick, convenient, accessible and simple to return. There was also a high level of recognition of the anonymity and privacy offered by this method. In common with earlier studies (Card and Lucas, 1981) women felt that this had allowed them to make comments that they may not have made in a written survey or to an interviewer.

The high level of positive feedback, the quality of the written comments and the satisfactory size of the sample suggest that the on-line survey is a useful mechanism for consulting with women in paid employment, albeit limited to women in jobs that allow them access to the Internet.
8.2 The Benefits and Limitations of a Workplace Website as a Means of Including Women in Paid Employment in Consultative Activity

The on-line survey was successful in facilitating the active participation of a group of women in paid employment in a consultation about their health in the context of work. However, on other dimensions of exclusion the on-line survey was less effective.

The sample was almost exclusively white, non-disabled women. Very few women from black and minority ethnic communities were among the sample and there appeared to be little representation of disabled women's perspectives. However, it was apparent that whilst women did not describe themselves as disabled 7 reported they had long-standing mental health problems and 16 indicated they had a chronic illness. It is likely that both in terms of a medical model of disability, i.e. their medical conditions, and a social model, i.e. the barriers to quality of life they experience as a result of their medical conditions, these women could be categorised as disabled. It is, however, recognised that the term 'disabled' is often associated with negative, stigmatising stereotypes and low expectations. Thus, while many women may have shared the same needs and concerns as disabled women they may have been reluctant to adopt this label.

The low representation of women from minority ethnic communities and disabled women cannot be explained by their lack of presence in the workplace. The Labour Force Survey (Office for National Statistics, 2000) showed that in the working age population 73% of women from minority ethnic communities and just over half the population of disabled people were economically active. Although these figures are lower than the economic activity rate for the whole working age population (78%) they do represent a sizeable group that could have been expected to feature in the sample.

A further dimension of exclusion that was not met was in terms of women's responsibilities for caring for others. A third of the sample were caring for children at home. That is about half the number that would have been expected as nationally 60% of working women have dependent children at home (Scottish Executive, 2002).

The sample did contain a more representative response from women with other caring responsibilities. 14% reported that they were the sole or main carer for an elderly relative or someone with a disability. This compares more favourably with the national picture where 12% of women are living with someone who requires regular help or care and 11% provide regular help or care for a sick, disabled or elderly person not living with them (Scottish Executive, 2002). No data was available on what proportion of these women are also in paid employment but this did appear superficially to be more representative.

This is a group of women that any consultation on health would seek to include as a barrier to good health can be the "double shift" whereby women's role as carers, whether to children or to elderly relatives, in addition to paid employment also places huge demands on their energy. Furthermore, research in the home shows that women are still expected to carry out the majority of all domestic chores, regardless of how many hours they work.

Women often carry heavy burdens that can lead to exhaustion and frustration, often allowing them little time to look after themselves. For many carers, the majority of
them women, the burden is too great. Many have had to give up work and as a result may live in poverty. The health consequences of the double shift can include stress, tiredness and depression. In these circumstances it seems unlikely that women would be able to play an active part in consultation activities thus pointing to the usefulness of a method that could be completed easy and quickly within the work setting.

8.3 The Development of a HAW Gender-Specific Workplace Programme

There are 80 employers currently registered and active within HAW. These range from small businesses to multi-national offices. Reponses to the survey were received from all sizes of businesses but most participants worked in large or medium sized firms. The range of occupational categories was less well represented with few manual workers participating. As noted earlier the type of businesses was less representative of HAW's contacts as the majority were public sector with very few responses from the private sector. However, given the nature of the on-line survey it did appear to have engaged a useful sample of workers who had access to the Internet. Its usefulness was limited to this but nevertheless, this is a group who may have few other opportunities to contribute to health service consultations.

8.3.1 Women's Perceptions of Their Health

Overall this sample of women reported that their health was on a par with or better than most women of their age. Very few felt that their health was worse than their peers and most described their health as fair, good or excellent. These findings are comparable to the national picture as reported in the Scottish Health Survey, 1998.

A significant number, however, described one or more long-standing health problems including 9% who identified mental health difficulties. A larger group felt that their mood had been sometimes low or miserable (25%) over the past year. An overwhelming number (77%) admitted to at least sometimes having periods in the past 12 months when they felt sad or depressed. This suggests that while women may not identify with disease classifications or labels such as mental health there are nevertheless issues that cause difficulties on which they could be offered support and information.

Women's perceptions of the factors that affected their health demonstrated a sophisticated understanding of health and the social factors that influence it. While failure to respond appropriately on the part of the health service was discussed there was also a clear recognition of the interaction between work & health as a key factor in maintaining health.

Stress was overwhelmingly identified as the biggest influence on women's health. Several sources of stress were also reported such as difficulties in managing the demands of work and family life, a poor working environment and problems encountered accessing supportive, appropriate health services. Women identified a lack of protected time for health appointments and a perceived pressure to return to work after a period of illness as factors affecting their health. Lack of services or poor access times could have an impact on health, particularly where women already felt pressurised in terms of time.

This need to 'juggle' the demands of work and family life was also reflected in the difficulties women reported in the use of health services. The most frequently reported
problems in relation to attending Primary Care or other health services related to the availability and scheduling of appointments. In both primary, secondary and complementary care women reported problems related to difficulties in obtaining an appointment. The majority of these were unhappy at the length of time they were required to wait for an appointment but a number also identified a difficulty with unsuitable or difficult appointment times. Others felt that their personal circumstances were not taken into account in other ways such as a lack of childcare restricting access.

This finding is consistent with that of the Greater Glasgow Health Board Health Promotion Department's Youth and Men's Health Teams who in 2001 examined young people and men's access to primary care (Scottish Health Feedback, 2001). Their findings agreed with other authors (Wright, 1999; Woods et al, 2001 cited in Scottish Health Feedback, 2001) who identified a difficulty for men in inflexible opening times of GP surgeries. As they commented:

"Men had problems making appointments at times that suited their lifestyle and working or family arrangements, and were frustrated when having booked an appointment or taken time off work to attend, they were left waiting for half an hour or longer because the doctor was running late".

The flexibility and availability of health service appointments did appear to be a particular issue for this group of women as half of the sample (51%) attended health appointments in their own time. Of these 27% used flexitime and 24% went out with working hours. The other half of the group reported that their employer allowed them time off to attend such appointments. In their assessment of what would help to improve their health 59% thought that different or longer opening times that improved access to services would be beneficial.

Women also reported that they knew what would make a positive impact on their health but noted that they often fell short of achieving this. For example, many felt that they should take more exercise or stop smoking but acknowledged that this was unlikely to happen given the many demands they were already trying to juggle. It was recognised that emotional well being influenced physical health and that stress or tiredness undermined their ability to stay well.

8.3.2 Women's Priorities for Health

In order to assess women's agreement with the priorities identified for women's health within the Women's Health Policy for Glasgow they were asked to identify both their own personal priorities and those they felt were important for the city as a whole. In both cases the top priority was preventative action on diseases such as heart disease and cancer.

However, when the personal priorities are compared with those for the city several differences can be discerned. While some priorities remained static in terms of rating others such as emotional and mental health and reducing poverty were affected. Reducing poverty was much more highly rated as a priority for the city than it had been in women's lists of personal priorities while emotional & mental health dropped down the list. This suggests that while reducing poverty may not be a high individual priority women recognised that it was important for the city as a whole. Similarly, it
may well be that emotional & mental health had personal resonance as an issue but that
cwomen felt this was personalised and not applicable to other women in Glasgow.

8.3.3 Improving Women’s Health

Women’s awareness and understanding of the social influences on their health was
further demonstrated by their assessment of what would improve their health. When
asked to select from a closed list there was high support for services that offered
counselling or someone to talk to about health or other worries. Information on
women’s health services was also frequently identified but the most popular option was
for greater access to a range of complementary medicines. Complementary medicine
was a popular option with respondents with relatively high numbers reporting contact
with homeopathy and complementary therapy (18/152) even though this was not
provided on the NHS and had to be paid for privately.

The solutions to poor health proposed by women emphasised a holistic approach to
health. When asked to propose improvements in both their local area and their
workplace that would help to improve health there was repeated reference to the need
to help women to better manage the competing demands on their time that led to stress
or conflict. Lifestyle issues were also important with increased access to exercise a
popular suggestion. Other lifestyle issues were also mentioned but much less
frequently. These included healthy eating and smoking.

8.4 Information Relating to HAW Employers on Women’s Health

While the survey did not ask for information from HAW employers it did identify a
range of issues that will be of interest to them.

The sample was asked about their awareness of written policies addressing key health
issues in the workplace. For some policies such as health & safety and equal
opportunities there was a high level of awareness but others such as bullying and
harassment or balancing work & life policy were less well known. There was similar
variation in respondent’s access to or awareness of a range of possible benefits that
would derive from these policies. It was not clear from the survey why there was a
lack of awareness of certain policies. These may not have been in place in some HAW
employers or may not have been as widely promoted as Health & Safety for example,
for which there is a legal framework of implementation.

When asked to rate a list of problems women commonly associate with work
according to how far these applied to them the sample appeared largely satisfied with
their work place and working conditions. For most issues only small numbers
identified a problem e.g. lack of child care, poor pay, unhelpful shift patterns,
hazardous materials, sexual harassment and work related injury. However, despite the
small numbers it should be noted that these represented significant difficulties for the
individuals concerned. This is further confirmed by the findings of the Labour Force
Survey (Office of National Statistics, 2000) who found that 3% of women leave
employment for reasons relating to family or personal difficulties

Two issues emerged as presenting a difficulty to a significant number of women. For
both work-related stress and lack of opportunities for promotion a third of the sample
identified a problem. These findings were consistent with women’s identification of
stress as a major factor in their health.
Where problems had been identified most women (90%) felt that there was someone they could report these to. However, only half were confident that problems would be dealt with. Several factors were key to problem resolution. These were:

♦ The nature of the problem and, specifically, whether it fell within the immediate line managers responsibility

♦ The presence of a supportive relationship with a line manager

♦ The inclusion of the problem within an employer’s current agenda

There was a guarded recognition that some issues would be difficult or complex and that resolution would not be easy. However, the impact upon staff when issues were not resolved or problems dealt with appeared profound. They reported feeling angry, frustrated, stressed and devalued when treated in this way and that they felt there was little point in trying to raise issues. The lack of control over problems and inability to have them recognised and resolved appeared to be a considerable source of stress.

The importance of stress was again reflected in the suggestions made for workplace facilities and services that could improve health. While a third of the sample felt that there were no workplace services/facilities that would improve their health about a third suggested a range of ideas. These can be summarised as follows:

♦ managing stress e.g. stress clinics and stress counselling, changes in hours and workload, improved policies on absence and leave and better access to counselling services.

♦ access to a healthy lifestyle e.g. gym or fitness facilities, proactive support for healthy eating, health and lifestyle screening and increased health information and events

There was a clear recognition that addressing the following two factors would contribute to reducing stress.

♦ changes to the physical environment at work e.g. a rest room or quiet area, provision of cold water, crèche or workplace nursery

♦ changes to working conditions e.g. introduction of flexi-time, supervision, improved policies on absences and flexible leave and the provision of permanent contracts

While there were a range of issues identified around health promoting activities the issue of stress and its relationship to working environment and working conditions was overwhelmingly identified as an area where employers could contribute to the improved health of their female employees. Reductions in stress could be achieved, it was proposed, via a number of different routes. These included addressing the sources of stress e.g. inflexible hours, poor or absent supervision and inflexible absence policies and better managing the impact of stress e.g. stress counselling, stress management sessions and improved information.
Information was an issue that was repeatedly raised by respondents. A lack of information was felt by some to contribute to problems they experienced when attending health settings improved access to health information was a popular choice for how to improve women's health. With regard to the provision of information on the World Wide Web, there was a mixed response to this.

Most thought that this was an easily accessed, convenient and user-friendly way of accessing information that was up to date but it was also noted that accessing health information would be dependent upon time being available and on the site covering issues that were of interest to them. This point is illustrated by the following quote.

"If I was looking for specific information I would use the web to try and find it but I am unlikely to browse a health site."

Nevertheless, there would appear to be a number of opportunities to deliver information on issues of key importance to women in work e.g. stress via the medium of the World Wide Web.

9. Recommendations

This study examined the usefulness of the medium of an on-line survey as a mechanism for consulting with women in paid employment about their health. The following recommendations are made from the findings.

9.1 Consultation via the World Wide Web

♦ There would appear to be some considerable benefit to continuing to develop on-line surveys as a means of including women in paid employment, albeit limited to women in jobs that allow them access to the Internet, in consultations about health.

♦ Further consultation activities should be developed in order to include women from minority ethnic communities and disabled women. While there would appear to be advantages to electronic methods the suitability and acceptability of these should be explored further with these groups.

♦ Where consultations with carers are desired that this group be considered as a part of the sample given the relative ease of access to a group of women with significant caring responsibilities.

9.2 Women's Perceptions of their Health

♦ These findings on women's perceptions of their health and of the health services they use should be fed into the Women's Health Working Group.

♦ These findings on women's priorities for their health and for women's health in Glasgow should be considered alongside other consultations with women in the review of the Women's Health Policy for Glasgow.

9.3 Development of a HAW Workplace Programme on Women's Health

♦ It is recommended that HAW use the findings of the survey to help shape a programme of work with women in paid employment on their health issues.
The content of this programme would include the following.

- Managing stress
- Managing the demands of work and family life
- Emotional and mental health
- Making effective use of supervision
- Lifestyle advice e.g. exercise, healthy eating etc.

- An information component of the programme should address the following issues.

  - Information on accessing appropriate health services
  - City-wide access to health promoting services e.g. exercise classes, stress centres, counselling services etc
  - Health entitlements within employment policies

- It is further recommended that this programme be delivered, at least in part, via the medium of the World Wide Web.

9.4 Development of a HAW Programme for Employers on Women's Health

- It is recommended that the findings from the survey be used to help shape the development of a programme on women's health that could be implemented with HAW employers. This programme should address the following issues.

  - Developing a raised awareness of women's health and the workplace
  - The health promoting implications of employment policies such as on health & safety and equal opportunities, bullying and harassment or balancing work & life
  - Workplace stress, its consequences and relationship to working environment and working conditions

- Although identified by small numbers of staff there may be scope for a review by employers of their policies in relation to poor pay, shift patterns, hazardous materials, sexual harassment and work related injury.

- There would also appear to be some scope for HAW to take the initiative in some areas by providing information for employers on models of good practice and the potential benefits of:

  - Work-place child care provision
  - Healthy environments at work e.g. provision of facilities such as rest areas, drinking water etc
  - The health benefits of employment policies
  - Work-place stress, it's costs and implications
  - Strategies for tackling stress at work
10. References

Agbamu, DA (1997) Staining for Helicobacter pylori: an e-mail survey. Human Pathology 28; 635-636
Belfast Healthy Cities Project (1998) Listening to women: summary report on the consultation process on a women's health policy for Belfast. Belfast Healthy Cities Project
Scottish Executive (1998) Designed to Care – Reviewing the National Health Service in Scotland. HMSO
Scottish Executive (1998) Scottish Health Survey. HMSO
Scottish Executive (2002) Scottish Household Survey. HMSO
Scottish Health Feedback (2001) Supporting Primary Care to develop more accessible services for young people and men, Greater Glasgow Health Board Health Promotion Department's Youth and Men's Health Team
Glasgow Women's Health Survey
Health at Work and Department of Public Health, Greater Glasgow NHS Board

Thank you for taking the time to complete this survey. We are interested in how you feel about your own health, the health services you use and how work affects your health. It should only take you 5 - 10 minutes to complete but if you want to add more information we'd be very interested in your comments.

All the information that you give us in this survey will be confidential. We won't be able to identify you or your employer from the information you give. However, you could win a prize of £25 worth of JJB Sports vouchers by returning this survey. If you would like to be entered in the prize draw then please make sure you complete the entry form at the end. This will be kept separately from your response to the survey.

Both the Board and Health at Work will use the results of the survey to plan new services and resources for women’s health. A summary of the finished report will be posted on the website or you can get a copy by contacting Health at Work.

Part 1. Your Health
In this part of the survey we're interested in your views of your own health.

1. How would you describe your health at the moment?
   - Excellent
   - Good
   - Fair
   - Poor

2. Compared with most women your age, do you think your current health is
   - Worse than most
   - About the same
   - Better than most

3. Do you have any long-standing health problems?
   - Yes
   - No
   If yes, what are they?_____________________________________

4. Over the past year how would you describe your mood most of the time?
   - Very happy
   - Good
   - Fair
   - Sometimes low
   - Miserable

5. During the past year, how often have you had periods when you felt sad or depressed?
   - Very often
   - A lot of the time
   - Sometimes
   - Almost never
   - Never
6. The Women's Health Policy for Glasgow highlights several areas of concern to women. Please tick the 3 that are most important to you.

- Emotional and mental health
- Reproductive health e.g. childbirth, family planning
- Support for women as carers (children, elderly relatives etc.)
- Improving the physical and social environment
- Avoiding disease e.g. heart disease, cancer
- Reducing poverty and its impact on women's health
- Health & safety at home, work and in the community e.g. domestic violence, workplace injuries, sexual harassment, fear of going out at night

Of these, which is the most important: ________________________________

6b. Now, thinking more generally about Glasgow, which do you think the Health Board should have as its top 3 priorities?

- Emotional and mental health
- Reproductive health e.g. childbirth, family planning
- Support for women as carers (children, elderly relatives etc.)
- Improving the physical and social environment
- Avoiding disease e.g. heart disease, cancer
- Reducing poverty and its impact on women's health
- Health & safety at home, work and in the community e.g. domestic violence, workplace injuries, sexual harassment, fear of going out at night

Of these, which is the most important: ________________________________

7. What would you say most affects your own health? __________________________

Part 2. Health Care
This part of the survey is interested in your views of the health services you use.

8. Have you been to your GP about your own health in the past 6 months?

- Yes
- No
- Not registered with a GP

If yes, why? __________________________________________

Did you encounter any problems when visiting the GP? If no, please go to question 9, if yes, please highlight any problems. To choose more than one problem hold down the control key and click on the problem.

- Not used
- No problems
- Long waiting time for an appointment
- Unhelpful attitudes of staff
- Poor access e.g. lack of parking, not on a bus route
- Lack of information about service
- Long waiting time to be seen at appointment
• Poor communication with service e.g. not getting letters or phone messages
• Unsuitable or difficult appointment time
• Personal circumstances not taken into account

If other, please state: ____________________________________________________________

9. If you've used any of the following services in the last 6 months then please indicate if you encountered any problems. To choose more than one problem hold down the control key and click on the problem.

Maternity
Mental health services
Surgical day or in-patient
Complementary therapy
Women's Aid
Gynaecology
GUM
Social Work
Cancer Services
Counselling
Hospital out-patients/ clinic
Housing Services
Family Planning
Accident & Emergency
Centre for Women's Health
Well Woman Clinic

10. If you've used another service in the last 6 months please indicate what it was and if you encountered any problems. To choose more than one problem hold down the control key and click on the problem.

Other service, please state. ____________________________________________________________

11. Which of the following would you like to see to improve women's health in Glasgow? Tick all that apply.
• Information about women's health services
• Counselling services
• Help for women who do not speak English as a first language
• Someone to talk to about health and other worries
• Improved access to services e.g. different/longer opening times
• Access to a range of complementary therapies
• Women-only sessions or service
• Creche facilities at health and other community services
• Other, please state ____________________________________________________________

12. Are there any services/facilities that could be provided in your local area that would improve your health?
• Yes
• No
If yes, what are they. ____________________________________________________________
Part 3. Health and Work
This section asks you some questions about how your health is affected by work.

13. How do you get time off to attend appointments for GP, dentist, clinics etc?
    • time off allowed by employer
    • use flexitime
    • in my own time, outwith working hours

14. Does your workplace have written policies addressing the following issues?
    Tick all that apply.
    • Equal Opportunities
    • Bullying & Harassment
    • Balancing work and other life concerns e.g. flexible working, job share etc.
    • Health & Safety Policy
    • Don't know

15. Below is a list of some of the difficulties women associate with work. Please rate these on how they apply to you where 1 = a major problem for you and 5 = not a problem for you.
    • Lack of childcare
    • Few opportunities for promotion
    • Poor pay
    • Long hours
    • Unhelpful shift patterns
    • Lack of pay parity with male employees
    • Work related stress
    • Inflexible hours
    • Hazardous materials
    • Difficulty juggling work and family demands
    • Sexual harassment in the workplace
    • Work related injury e.g. RSI, lifting & handling injuries

16. When you have a problem at work is there someone you can report this to?
    • Yes
    • No

If yes, do you feel problems get dealt with? ________________________________
If not addressed how does this make you feel? ________________________________

17. Does your employer provide any of the following? Please tick all that apply.
    • Carer's leave
    • Enhanced maternity leave e.g. additional unpaid leave up to 1 year
    • Paternity leave
    • Breastfeeding facility
    • Workplace crèche/nursery
    • Access to employee counselling
    • Flexible hours
    • Don't know
18. Are there any services/facilities that could be provided in your workplace that would improve your health?
   • Yes
   • No
   If yes, what are they? 

Part 3. About you.
Finally, we would like some information about you. Please note that you cannot be identified from the information you give us.

19. How old are you?
   • 16 - 25
   • 26 - 35
   • 36 - 45
   • 46 - 55
   • 56 - 65
   • 65+

20. Are you?
   • Married
   • Single
   • Living with a partner
   • Separated or divorced
   • Widowed

21. What is your postcode e.g. G14 5XX 

22. Are you bringing up children at home?
   • Yes
   • No
   If yes, how many are
   • Under 5 years
   • 5 - 15 years
   • 16 - 19 years

23. Do you have other caring responsibilities for an elderly person or anybody with an illness or a disability at the moment?
   • Yes
   • No
   Would you describe yourself as:
   • The sole carer
   • The main carer
   • Helping someone else to care

24. Do you work:
   • Full time (30 hours or more per week)
   • Part time regular (less than 30 hours per week)
   • Part time variable or sessional
Is your contract?
- Permanent
- Fixed term, renewed on a rolling basis
- Fixed term, temporary
- Don't have a contract
- Outside contractor

25. When do you work?
- early mornings
- 9 - 5
- back shift
- evenings
- night shift
- variable shifts

26. What is the nature of the business you work in?
- Manufacture
- Retail
- Service
- Local authority
- Health
- Finance & Insurance
- Education
- Information Technology
- Media
- Electronics
- Engineering
- Marketing
- Agriculture

27. What is the nature of your job?
- Manual
- Clerical/Administration
- Managerial
- Professional

28. How many are employed by your employer?
- 0 - 10
- 10 - 50
- 50 - 250
- 250 +

29. Which of the following groups best describes you?
- British/Irish
- Pakistani/Indian
- Chinese
- African/Caribbean
- Other, please specify
30. Do you have a disability?
   • Yes
   • No

If yes, do you have?
   • A physical impairment
   • A sensory impairment
   • A learning difficulty
   • A long term mental health problem

31. Do you think that an on-line survey is a useful way of asking you about your health?
   • Yes
   • No

If yes, why? __________________________
If no, why not? _______________________

32. Would you read health information if it was posted on the web?
   • Definitely
   • Probably
   • Maybe
   • Probably not
   • Definitely not

If yes, why? __________________________
If no, why not? _______________________

Thank you - Please return by the 15th of May 2002

If you would like to enter the prize draw then please complete the attached entry form below. Remember - this information is stored separately and can't be used to identify your responses to the survey

Name:

Contact Address or e-mail:

Winners will be notified by the 1st of June 2002.