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Health Profile of Faculty and Staff at the Adventist University of the Philippines: A Basis for Workplace Health Promotion

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Abstract: *This study determined the health profile of faculty and staff at the Adventist University of the Philippines. Using the descriptive research design, a total of 83 respondents participated in the study. Results of the descriptive analysis revealed an overall good health status of the respondents. There were however, few occurrences of poor health profile in terms of high systolic blood pressure (41%), high diastolic blood pressure (31.3%), low back pain (18.1%), asthma (10.8%) and sinusitis (7.2%). Additionally, 38.2% of respondents experienced anxiety and 19.7% experienced sleep disturbance. There was a difference in gender based on waist-to-hip ratio (WHR) finding. Based on the WHR results, more than half (56%) of the female respondents were at high risk ($WHR \geq 0.86$) for cardiovascular diseases, while only 3% of the male counterparts had a moderate risk ($WHR 0.96-1.0$) for cardiovascular and other non-communicable diseases. In fact, none (0%) of the male respondents was at high risk for cardiovascular diseases. Amidst the few occurrences of poor health, the respondents experienced considerable life enjoyment and exhibited high priority for attaining their health goals. Respondents are therefore entreated to engage in healthy lifestyle practices (exercise, healthy eating and stress management), avail for regular check-ups and screenings and access medical services in order to prevent and/or control chronic lifestyle-related diseases.*

Keywords: *Physical life, emotional state, stress, life enjoyment, quality of life, health profile*

Introduction

The escalating rates of chronic lifestyle diseases among workers, coupled with the impact on work quality and productivity call for employers to establish workplace health promotion programs. Health promotion requires the collaboration of employers, employees and society to foster the health of employees in the workplace. The idea involves improving the work organization and working environment, increasing workers' participation in shaping the working environment and encouraging personal skills and professional development (WHO, 2017).

Workplace is an integral part of human environment. Because no occupation is hazard-free, workplace should provide an essential avenue for health protection, health promotion and disease prevention programs. The health and efficiency of workers in any organization is greatly influenced to a large extent by conditions in the working

environment. Thus, workplace health programs can influence social norms, establish health-promoting policies, increase healthy behaviors such as dietary habits, physical activity and stress management, improve the health knowledge and skills of employees, increase employees' access to needed health services and decrease employees' on-the-job exposure to hazardous substances (Centers for Disease Control and Prevention, 2016).

It has been established that having a healthier workforce reduces direct costs in terms of insurance premiums and worker's compensation and may lower indirect costs associated with absenteeism and worker productivity (Sorensen, Barbeau, Stoddard, Hunt, Kaphingst & Wallace, 2005). To this end, the US Bureau of Labor Statistics (2016) recommends that employers ensure a conducive workplace that fosters health of their workers.

The American Time Use Survey (2011) views the college environment as an ideal setting to promote

health and wellbeing. In a study by Linnan *et al.* (2010), they surveyed 59 community college campuses. Of the 48 that responded, 13 (27%) reported having some sort of structured wellness programs for their employees. Supportive environment, onsite physical activity resources, healthy food options and a committee or dedicated staff were shown to be essential elements of a successful workplace promotion program.

Hill-Mey, Kumpfer, Merrill, Reel, Hyatt-Neville and Richardson (2015) found college setting to be conducive for implementing health promotion programs, even though the large and diverse employee population may pose some challenges. Furthermore, the authors argued that there were not sufficient studies to indicate the strengths and weaknesses of health promotion programs in the college setting.

Studies have indicated the existing impact of bad health on labor force. The study of van, Robroek, Brouwer and Burdorf (2014), for instance, established that self-rated poor health is a risk factor for disability benefit [relative risk (RR) 3.61], unemployment (RR 1.44) and early retirement (RR 1.27). A study by Reeuwijk, van Klaveren, van Rijn, Burdorf and Robroek (2017) found European workers with poor health to be more prone to exiting the labor force than workers with good health. Notably, older workers with a poor self-rated health were at risk of leaving paid employment.

Over-loaded and under staffed workers including healthcare providers are susceptible to poor mental and physical health. The study by Mishra, Mehta, Sinha, Ahmed and Kawatra (2011) reported that poor work culture was the key stressor which led to job dissatisfaction. Poor departmental organization, lack of cohesiveness in departments, difficult superiors and juniors were found to be key work environmental stressors. Harassment, favoritism, discrimination and denial of self-expression ($P \leq 0.003$) led to dissatisfaction on the job.

In the US, chronic lifestyle diseases including heart disease, depression and musculoskeletal disorders are the leading physical and mental health conditions causing huge medical costs and reduced productivity to employers. In response to this crisis, effective workplace health programs and policies have been recommended to decrease health risks and improve the quality of life for 138 million workers in the United States (Centers for Disease

Control and Prevention, 2016). To determine the prevalence and incidence of low back pain (LBP), Goetzel, Thomas, D'Arco & Yarborough (2015) used claims and demographic data of 1 million workers from a group of 18 US benchmark companies and compared with the Lockheed Martin Corporation. The prevalence of LBP in the Market Scan normative group was 15.6% in the final study year (2012), while the incidence of new cases was 7.2% in 2011 and 7.3% in 2012. Compared with the normative group, the company's prevalence and incidence rates were lower. Furthermore, women and older workers were more likely to experience LBP compared with men and younger workers.

Another health condition that is a determinant of disease and fatality among workers is obesity. A research by Damorou *et al.* (2013) determined the prevalence of obesity and its risk factors among Togolese workers. Results revealed that 30.6% of the study's population were obese [Body Mass Index (BMI) $>30\text{kg/m}^2$] with 39.4% having abdominal obesity. Being a female ($p < 0.0001$), low education level (OR = 2.45 95% CI: 1.78-4.55, $p = 0.001$) and physical inactivity or sedentary lifestyle (OR = 3.57 95% CI = 2.34-9.67, $p = < 0.001$) were significantly related to obesity. The body mass index had a positive correlation with age ($r = 0.145$, $p = 0.0004$), and diastolic blood pressure ($r = 0.10$, $p = 0.013$) and waist circumference also had a positive correlation with age ($r = 0.381$, $p < 0.0001$).

In the Philippines, studies have focused on the health status of college students and not faculty and administrators. However, one study, Tan (2017) identified predictors of stress among Filipino professors in public universities. Findings of the study revealed that age, job satisfaction, work load and negative religious coping predicted stress among the respondents. Additionally, there were significant negative associations between job satisfaction and factors causing stress, relative to reward and recognition and impact of department or college.

Therefore, the alarming rates of chronic lifestyle diseases among workers, coupled with the impact on work quality and productivity called for employers to establish workplace health promotion programs. With less attention given by researchers to investigate the health status of faculty members at the universities in the Philippines, the researchers sought to determine the health status of employees of the Adventist University of the Philippines (AUP).

Findings of the assessment would inform the development of workplace health promotion programs for AUP employees.

Research Methodology

This section presents the study design, population and sampling technique, instrumentation, data gathering procedures, ethical considerations and statistical treatment of data.

Research Design

The study utilized a descriptive research design. This approach allowed the researchers to describe the health profile of selected faculty and staff members of the Adventist University of the Philippines. According to Gravetter and Forsano (2003), descriptive survey describes a single variable but when multiple variables are involved, it gives separate description for each variable.

Population and Sampling

The study recruited faculty and staff of the Adventist University of the Philippines during the academic year 2016-2017. A total of 83 (15% of the total Faculty and Staff population) was randomly selected to participate in the study.

Instrumentation

The instruments used in this study were survey questionnaire, weighing scale, tape measure and height device. Survey questionnaire consisted of six sections. The first section dealt with demographic profile of respondents; the second section involved the health assessment of the respondents, the third section comprised of the medical history of the respondents; the fourth section dealt with behavioral health problem checklist; the fifth section involved the health life and symptoms which comprised of physical, emotional, stress, life enjoyment and quality of life; and the sixth section dealt with health goals of the respondents.

Ethical Considerations

Ethical clearance was obtained from the Ethics and Review Board of AUP to conduct the research. The university provided permission for the researchers to publish results of this study. Informed consent (written) was secured from participants before partaking in the study. The study adhered to strict anonymity as well as confidentiality as respondents' identities were hidden.

Statistical Treatment of Data

The data were treated using the Statistical Package for Social Science (SPSS) software. Percentages

were used to describe the demographics, medical history and behavioral health problems of respondents; systolic values and diastolic values were used to assess the level of blood pressure; waist-to-hip ratio values were used to determine respondents' susceptibility to cardiovascular diseases (CVD); and means were used to describe the physical life symptoms, mental/emotional state, stress level, quality of life, level of life enjoyment and health goals of the respondents.

Results and Discussion

This section presents the results of the study based on the analysis of data and review of related literature.

Socio-demographic Profile of Respondents

As shown in table 1, this section gives the demographic profile of respondents in terms of age, sex, department/college, work status, position, length of service and residence. Of the 83 faculty and staff who enrolled in the study, the age range 36-45 accounted for about one-third (29, 34.9%), followed by the age range of 46-55 (24.1%), the age range of 26-35 (19.3%) and the age range of 56 years and above (16, 19.3%). There were two missing data, representing 2.4% because two of the participants did not indicate their age range. In terms of sex distribution, more than half 50 (60.2%) were females while 33 (39.8%) were males.

When the respondents were categorized in terms of department/college, majority 23 (27.7%) came from the College of Allied Health, followed by 14 (16.9%) and 10 (12%) that came from the College of Nursing and College of Business, respectively. The College of Dentistry (1.2%) and cafeteria section (2.4%) accounted for the least of the respondents surveyed.

As shown in table 1, majority 70 (84.3%) of the respondents were regular employees, followed by 11 (13.3%) who were full-time contractual employees and 2 (2.4%) who were part-time contractual employees. Relative to position, more than half 54 (65.1%) of the respondents were faculty members, followed by 13 (15.7%) who were non-teaching staff. Administrators constituted the least (1.2%) of the respondents surveyed.

Table 1 also shows the length of service of respondents prior to the assessment. Thirty-seven (44.6%) had served for 10 years and below, 30 (36.1%) had served from 11-20 years and 10 (12%)

had served for 21-30 years. Respondents serving 31 years and above accounted for the least (7.2%). In terms of residential status, majority (46, 55.4%) of

the respondents lived off-campus while 37 (44.6%) lived in-campus (within the University premises).

Table 1: Socio-demographic Profile of Respondents

Category	Number	Percent
AGE OF RESPONDENTS		
26-35	16	19.3
36-46	29	34.9
46-55	20	24.1
56 AND ABOVE	16	19.3
Missing	2	2.4
TOTAL	83	100
SEX		
Male	33	39.8
Female	50	60.2
TOTAL	83	100
DEPARTMENT/ COLLEGE		
College of Nursing	14	16.9
College of Health	8	9.6
College of Theology	4	4.8
College of Business	10	12.0
College of Arts and Humanities	23	27.7
College of Dentistry	1	1.2
College of Education	6	7.2
College of Science and Tech	5	6.0
Administration	3	3.6
Cafeteria	2	2.4
Housing	3	3.6
Community Extension Services	4	4.8
TOTAL	83	100
WORK STATUS		
Regular	70	84.3
Full Time Contractual	11	13.3
Part Time Contractual	2	2.4
TOTAL	83	100
POSITION		
Administration	1	1.2
Director	2	2.4
Dean	3	3.6
Department Chair	4	4.8
Teaching Faculty	54	6.5
Clinical Instructor	6	7.2
Non-Teaching Staff	13	15.7
TOTAL	83	100
LENGTH OF SERVICE		
10 years and below	37	44.6
11-20	30	36.1
21-30	10	12.0
31 years and above	6	7.2
TOTAL	83	100
RESIDENCE		
In campus	37	44.6
Off campus	46	55.4
TOTAL	83	100

Health Profile Status of Respondents

This section describes the health profile status of the study participants in terms of blood pressure, waist-hip-ratio, medical history, behavioral health problems, physical life/health symptoms, mental/emotional health, stress evaluation, life enjoyment, quality of life and health goals.

Level of Blood Pressure

Table 2 shows the level of blood pressure of respondents where more than half 49 (59%) had a

normal systolic blood pressure of 120mmHg and below, while 34 (41%) recorded a high systolic blood pressure of above 120mmHg. Fifty-seven (68.7%) of the respondents recorded a normal diastolic blood pressure of 80mmHg and below, while 26 (31.3%) had a high diastolic pressure of above 80mmHg. Even though majority of the respondents had a normal blood pressure, it is very important to monitor and control the blood pressure in order to maintain adequate health status.

Table 2: Level of Blood Pressure of Respondents

Category	N	Percent	Verbal Interpretation
SISTOLIC BLOOD PRESSURE			
120 mmHg and below	49	59.0	Normal
Above 80 mmHg	34	41.0	High
TOTAL	83	100	
DIASTOLIC BLOOD PRESSURE			
120 mmHg and below	57	68.7	Normal
Above 80 mmHg	26	31.3	High
TOTAL	83	100	

Table 3: Extent of waist-to-hip ratio

WHR value	N (Male)	%	Health Risk	WHR Value	N (Female)	%	Health Risk
0.95 or Below	32	97	Low Risk	0.80 or Below	7	14	Low Risk
0.96-1.0	1	3	Moderate Risk	0.81-0.85	15	30	Moderate Risk
1.1 and Above	0	0	High Risk	0.86 and Above	28	56	High Risk
TOTAL	33	100		TOTAL	50	100	

The results differ from that of a study by Fikadu and Lemma (2016) in Ethiopia that showed high burden of hypertension among teachers and bankers. Bulk (70.3%) of the participants in this study were teachers. Among the factors presented, the socioeconomic factors were strongly associated with the odds of having hypertension (Adjusted Odd Ratio 2.17 with 95% Cumulative Incidence 1.58–2.98). This study resulted to the promotion of healthy behaviors and interventions that targeted higher income groups. Furthermore, in a study about the health profile of Australian employees, Magee (2014) found about 1 in 10 (10.0%) workers to have high blood pressure and nearly a quarter (23.8%) to have high cholesterol. Elsewhere, a Nigerian study recorded a relatively high prevalence (34.9%) of blood pressure among employees of Obafemi Awolowo University. The distribution of teaching to non-teaching was 20.1% and 14.8% respectively (Adedoyin *et al.*, 2016).

Extent of Waist-to-Hip Ratio (WHR)

The Waist-to-Hip Ratio (WHR) was one tool used to measure the respondent's risk for cardiovascular disease and other non-communicable diseases.

Table 3 shows the extent of WHR of respondents where majority (32, 97%) of the males were at *low risk* (WHR \leq 0.95) for cardiovascular disease (CVD), followed by 1 (3%) that was *moderate risk* (WHR 0.96-1.0) for CVD. None (0%) of the males was *high risk* for CVD.

In the female category, more than half (56%) were at *high risk* (WHR \geq 0.86) for cardiovascular disease, while 15 (30%) with WHR of 0.81 to 0.85 and 7 (14%) with WHR \leq 0.80 were at *moderate risk* and *low risk* for cardiovascular disease, respectively.

The current study's findings suggest that respondents, particularly females, should endeavor to attain and maintain normal body weight to prevent or reduce the risk of cardiovascular diseases. These results are consistent with Dankyau *et al.* (2016) who found 23.2% of workers obese, 31.4% overweight and 60% abdominally obese. Female workers had higher waist-to-hip ratio and higher mean waist circumference compared to their male counterpart (92.1 ± 11.8 cm vs. 83.0 ± 9.8 cm, $P = 0.016$, Odd Ratio 9.1, 95% CI 6.0-12.3). A Togolese study also found female worker to be

more obese than male worker. Waist circumference, one of the indicators for measuring waist-to-hip ratio was positively correlated to age ($r = 0.381$, $p < 0.0001$) (Damorou *et al.*, 2013). Additionally, a study by Adedoyin *et al.* (2016) recorded high body mass index and waist circumference in both the teaching and non-teaching staff in a Nigerian university.

Medical History

Table 4 presents the most critical medical history of respondents where 24 (28.9%) had high blood pressure, 15 (18.1%) had low back pain and 9 (10.8%) had asthma. Respondents with sinusitis and tonsillitis accounted for 7.2% of the employees surveyed. Diabetes *mellitis* accounted for the least

(1.2%) prevailing medical conditions amongst respondents.

Compared to our results, a study by Darwish and Al-Zuhair (2013) reported a higher prevalence of musculoskeletal pain disorders (79.17%) among secondary school teachers in Saudi Arabia (KSA). Major sites of pain were lower back (63.8%) followed by shoulder (45.4%), neck (42.1%), leg (40.0%), wrist (16.2%) and elbow joint (10.0%). Type of school (value 0.038), age (value 0.002), weight (value 0.007), number of children (value 0.006), shoe type (value 0.000), teaching years (value 0.003) and working daily hours (value 0.027) were factors responsible for musculoskeletal pain disorders among Saudi teachers.

Table 4: Medical History of Respondents

Medical Condition	N	Percent
Blood Pressure	24	28.9
Low Back Pain	15	18.1
Asthma	9	10.8
Sinusitis	6	7.2
Tonsillitis	6	7.2
Gouty Arthritis	4	4.8
Kidney Stone	3	3.6
Urinary Tract Infection	3	3.6
Hearing Loss	3	3.6
Heart Disease	3	3.6
Pneumonia	2	2.4
Myopia	2	2.4
Tuberculosis	2	2.4
Diabetes Mellitus	1	1.2
TOTAL	83	100

Table 5: Behavioral health problem of respondents

Medical Condition	N	Percent
Anxiety	29	38.2
Sleep Disturbance	15	19.7
Loss of Family Members	11	14.5
Mood Swing	7	9.2
Anger Aggression	6	7.9
Eating Disorder	3	3.9
Psychological Stress	3	3.9
Addiction to Social Media	2	2.6
TOTAL	76	100

Behavioral Health Problems

One of the indicators used to assess the health profile of respondents was the behavioral health problems. Twenty-nine (38.2%) of the respondents had experienced anxiety, followed by 15 (19.7%) who had experienced sleep disturbance and 11 (14.5%) who had experienced loss of family member. Respondents who were addicted to social media accounted for the least (2.6%).

The findings agree with a study by Mustafa and Saadi (2018) who determined the level of anxiety and motivation among kindergarten and grade one teachers in Saudi Arabia. The level of anxiety was higher in female teachers, while the level of motivation was higher in male Gender and workplace affected the levels of teachers' motivation and anxiety. Ashrafi-rizi *et al.* (2014)

conducted a study on anxiety level among the faculty members of Isfahan University of Medical Sciences (IUMS). Accordingly, the average research-related anxiety among IUMS faculty was about 3.27 ± 0.536 . The highest scores in descending order were associated with lack of timely payment of fees (3.97 ± 0.961), the long approval process of proposals and research project reporting (3.86 ± 0.99) and lack of research efficiency on the part of faculty (3.70 ± 1.00). The lowest scores were related to having insufficient funds to conduct research (2.67 ± 1.08), another's understanding of inability for researching (2.84 ± 1.192) and unfriendly behavior from journals and research center staff (2.89 ± 0.802). On the other hand, Swanson *et al.* (2010) noted chronic sleep deprivation among

American workers. One-thousand Americans who work 30 hours per week or more were asked questions about employment, work performance and sleep. Results show that long work hours were associated with shorter sleep times, and shorter sleep times were associated with more work impairments. Thirty-seven percent of respondents were classified as at-risk for any sleep disorder.

Physical Life/Health Symptoms

Table 6 shows the physical life/health symptoms of the respondents. The overall mean for the physical life/health symptoms of the respondents was 1.9036, indicating that the respondents *rarely* experienced physical/health symptoms. However, regarding physical life, respondents *often* worked out or engaged in activity (mean = 3.8675).

Table 6: Physical life/health symptoms of the respondents

SYMPTOM	MEAN	VERB INTERPRETATION
Ability to work out or engage in activity	3.8675	Often
Feeling tension, stiffness, lack of flexibility	2.2530	Rarely
Incidence of allergies, eczema or skin rash	1.9759	Rarely
Incidence of cold or flu	2.2651	Rarely
Incidence of dizziness, nausea	1.8916	Rarely
Incidence of fatigue or low energy	2.1084	Rarely
Incidence of diarrhea or constipation	1.9518	Rarely
Presence of body pain like neck/back pain etc	2.3373	Rarely
Chest pain, palpitations	1.8072	Rarely
Coughing out blood	1.1566	Never
Swollen joints	1.2169	Never
Overall mean	1.9036	Rarely

Legend: 1.0-1.49 =Never, 1.50-2.49 =Rarely, 2.50-3.49 =Sometimes, 3.50-4.49 =Often, 4.50-5.00=Always

Table 7: Mental/emotional state of the respondents

Mental/Emotional State	Mean	Verbal Interpretation
Being overly worried about small things	1.9759	Rarely
Difficulty falling or staying asleep	2.1205	Rarely
Difficulty thinking or concentrating	1.9277	Rarely
Feeling of depression or anxiety	1.7470	Rarely
Moodiness, temper, or angry outbursts	1.9518	Rarely
Presence of negative feelings or negative energy	1.9639	Rarely
Overall Mean	1.9478	Rarely

Legend: 1.0-1.49 =Never, 1.50-2.49 =Rarely, 2.50-3.49 =Sometimes, 3.50-4.49 =Often, 4.50-5.00=Always

Darwish and Al-Zuhair (2013) do not support the findings of this study. They conducted a cross-sectional study to estimate the prevalence of musculoskeletal pain disorders among secondary school teachers (public and private schools) in Saudi Arabia (KSA). Results revealed the high (79.1%) prevalence of musculoskeletal pain disorders among the study participants. Main sites of pain were lower back (63.8%) followed by shoulder (45.4%), neck (42.1%), leg (40.0%), wrist (16.2%), and elbow joint (10.0%). Factors that showed significant relationship

were type of school (value 0.038), age (value 0.002), weight (value 0.007), number of children (value 0.006), shoe type (value 0.000), teaching years (value 0.003), and working daily hours (value 0.027).

Mental/Emotional State

As part of the process of describing the health profile of respondents, the mental/emotional state was considered. Table 7 shows the mental/emotional state of the respondents, with an

overall mean of 1.9478. This indicates that the respondents *rarely* experienced mental/emotional feelings. Respondents *rarely* faced difficulty in falling or staying asleep with a mean of 2.1205.

Even though the results reveal that respondents *rarely* experienced mental/emotional feelings, they suggest that respondents should continue to handle the condition of relative insomnia (difficulty in falling asleep) due to stress. These findings somewhat agree with a study by Sabherwal *et al.* (2015) that investigated occupational stress among faculty members in higher educational institutions in Pune, India. The researchers found that factors causing maximum stress were lack of regular breaks (85%) and long working hours (83%). Seventy three percent (73%) of the respondents felt lack of communication with staff; only 18% of the respondents felt neutrally stressed out due to work not valued, whereas 37% of respondents felt occasionally stressed out due to new styles of institutional management. Furthermore, Keller and colleagues found emotional exhaustion (EE), a core component of teacher burnout, to negatively impact teachers' professional lives. Accordingly, in 39% of all lessons, teachers experienced anger, whereas they experienced anxiety less frequently. Teachers

reported suppressing or faking their emotions during roughly a third of all lessons (Keller *et al.*, 2014). Ferguson and colleagues investigated the predictors of anxiety, depression, and job satisfaction in teachers in northern Ontario. Using data from self-report questionnaires, the study found workload and student behavior and employment conditions as determinants of depression and anxiety in teachers (Ferguson *et al.*, 2012). Elsewhere, a study by Panari and Simbula (2016) noted the mediating role played by presenteeism on the relationships with work tasks, work-to-family conflict and emotional exhaustion among Italian schoolteachers. Utilizing a self-report questionnaire, the study surveyed 264 secondary school teachers.

Stress Evaluation

Table 8 shows the stress evaluation of the respondents, where the overall mean is 2.6695. This indicates that the respondents *sometimes* experienced stress conditions. Among the factors responsible for the stress experienced by respondents, work (mean = 2.9277) and finances (mean = 2.9157) accounted for the highest.

Table 8: Stress evaluation of the respondents

Mental/ Emotional State	Mean	Verbal Interpretation
Coping with daily problems	2.6627	Sometimes
Personal issues	2.5783	Sometimes
Family	2.4819	Rarely
Finances	2.9157	Sometimes
Health	2.6506	Sometimes
Relationships	2.4699	Rarely
Work	2.9277	Sometimes
Overall mean	2.6695	Sometimes

Legend: 1.0-1.49 =Never, 1.50-2.49 =Rarely, 2.50-3.49 =Sometimes, 3.50-4.49 =Often, 4.50-5.00=Always

These results parallel a study by Sabherwal *et al.* (2015) that determined occupational stress level among faculty members in higher educational institutions in Pune, India. The researchers found the lack of regular breaks (85%) and long working hours (83%) to cause maximum stress among faculty. Seventy three percent (73%) of the respondents felt lack of communication with staff, 18% felt stressed out due to underrated work performed and 37% felt occasionally stressed out due to new styles of institutional management. An English study by Kinman and Wray (2013) reported that nearly three-quarters of the study population strongly agreed that faculty and staff jobs and

responsibilities are stressful. More than half indicated that their general level of stress was high or very high, and more than one third always experienced levels of stress they found unacceptable. Colnerud (2015) said moral stress in teaching practice usually occurs when teachers act contrary to their consciences. Accordingly, institutional constraints compel teachers to act in ways that contravene their own morals.

Life Enjoyment

Table 9 shows the level of life enjoyment of the respondents, with an overall mean of 4.1205. This indicates that the respondents experienced *considerable* life enjoyment. Having interest in

maintaining a healthy lifestyle (mean = 4.2651), having compassion and accepting others (mean = 4.2048) and the ability to handle adversity (mean =

4.1566) were major contributors to the respondents experiencing considerable life enjoyment.

Table 9: Level of life enjoyment of respondents

Life Enjoyment	Mean	Verbal Interpretation
Confidence in ability to handle adversity	4.1566	Considerable
Compassion and acceptance of others	4.2048	Considerable
Experiences of relaxation, ease or wellbeing	4.0602	Considerable
Interest in maintaining a healthy lifestyle	4.2651	Considerable
Time devoted to things you enjoy	4.0964	Considerable
Level of recreation in your life	3.9398	Considerable
Overall Mean	4.1205	Considerable

Legend: 1.0-1.49 =None, 1.50-2.49 =Slight, 2.50-3.49 =Moderate, 3.50-4.49 =Considerable, 4.50-5.00=Extensive

Table 10: Quality of life of Respondents

Quality of Life	Mean	Verbal Interpretation
Handling problems in your life	4.0361	Satisfied
Adjusting to changes in your life	4.0000	Satisfied
The work you do	4.0964	Satisfied
Your personal life	4.0602	Satisfied
Your physical appearance	4.0723	Satisfied
Suitable spouse	4.1807	Satisfied
Making decisions	4.0482	Satisfied
Dealing with conflict	4.0120	Satisfied
Asserting yourself	3.9639	Satisfied
Getting along with people	4.1446	Satisfied
Living situation/condition	4.0120	Satisfied
Overall mean	4.0570	Satisfied

Legend: 1.0-1.49 =Very dissatisfied, 1.50-2.49 =dissatisfied, 2.50-3.49 =moderately satisfied, 3.50-4.49=Satisfied, 4.50-5.00 =Very satisfied

The findings are supported by Wesarat *et al.* (2015) that found culture to moderate the relationship between employment status, income, friendship, work responsibilities and happiness at the workplace. The researchers found happiness to be crucial to improving productivity in any organization. A study by Mukhtar (2012) utilized the existing database from the Iowa State University 2009-2010 to explore faculty work life balance and job satisfaction among academic disciplines. Results revealed considerable job enjoyment among faculty and was tied to good work life. Age and climate, culture and collegiality were determinants of job satisfaction or enjoyment. Also, the level of job enjoyment (satisfaction) was lower for hard pure disciplines as compared to soft pure disciplines in Iowa State University.

Quality of Life

Table 10 shows the quality of life of the respondents, where the overall mean is 4.0570 shows that the respondents were *satisfied* with their overall quality of life. Getting along with others (mean = 4.1446), having suitable spouse (mean =

4.1807), having a suitable job (mean = 4.0964) and being satisfied with one's physical appearance (mean = 4.0723) contributed to the satisfactory quality of life of the respondents.

The study's findings agree with Srivastava and Kanpur (2014) who described quality of life of faculty and staff wellbeing in Axis College, India. The researchers found high degree of quality of life to lead to job satisfaction and ultimately effective and efficient performance. Another study, Wesarat *et al.* (2015), found employees' happiness to differ in different cultural contexts. The authors concluded that happy people are productive people while those people who are unhappy may not pay full attention to any task. Narehan *et al.* (2014) examined the relationship between quality of work life programs and quality of life among Malaysian employees. The findings reveal work environment and job facets as key factors influencing the quality of life of the study participants. Researchers concluded that quality of work life (QWL) programs may influence quality of life (QOL) of employees in organization.

Health Goals

Table 11 shows the health goals of the respondents, where the overall mean is 4.3157. This shows that the respondents had *high priority* in terms of attaining their health goals. Spending quality time with family (mean = 4.5301), taking time daily for

spiritual revival (mean = 4.5060) maintaining a cheerful, hopeful outlook on life (mean= 4.4337) and eating more plant-based foods (mean = 4.3012) contributed to respondents having *high priority* for attaining their health goals.

Table 11: Health goals of respondents

Quality of Life	Mean	Verbal Interpretation
Get adequate rest daily	4.2048	High
Get regular physical activity	4.1566	High
Eat more plant-based foods	4.3012	High
Eat more whole-grain breads & cereals	4.2771	High
Achieve/maintain a healthy weight	4.0723	High
Choose healthy fats	4.1205	High
Be free of dependence on tobacco, illicit drugs or alcohol	4.0482	High
Maintain a cheerful, hopeful outlook on life	4.4337	High
Spend quality time with family	4.5301	High
Take time daily for spiritual revival	4.5060	High
Overall mean	4.3157	High

Legend: 1.0-1.49 =Least priority, 1.50-2.49 =Less priority, 2.50-3.49 =Moderate priority, 3.50-4.49=High priority, 4.50-5.00 =Highest priority

Respondents of the current study have *high priority* for attaining their health goals; meaning, they are very concerned about their health and wellbeing. This is consistent with Miller and Suff (2016) who proffered that optimal health is the main priority of employees and employers. Employee's well-being should be the hallmark of every good leader in order to ensure conducive working environment. The researchers maintained that well employees are physically and mentally able, willing to contribute in the workplace and likely to be more engaged at work. In a previous study, Dieleman and Harnmeijer (2006) enumerated factors such as living conditions, financial considerations, working conditions, management capacity and style and work safety to affect employees' quality of life. The study revealed that staff retention can be achieved if their health goals and priorities such as personal and lifestyle-related factors are taken into consideration.

Conclusion and Recommendations

The respondents in this study generally had a good health status. However, there were few occurrences of poor health status like high blood pressure, low back pain, asthma, sinusitis, tonsillitis, anxiety and sleep disturbances. Remarkably, there was a difference in gender based on the waist-to-hip ratio results as more than half (56%) of the female respondents were *high risk* (WHR ≥ 0.86) for cardiovascular diseases, while only 3% of the male counterparts had a *moderate risk* (WHR 0.96-1.0)

for cardiovascular and other non-communicable diseases. It is therefore advisable for respondents to engage in healthy lifestyle practices (exercise, healthy eating and stress management), avail for regular check-ups and screenings and access medical services in order to prevent and/or control chronic lifestyle-related diseases. AUP can play a pivotal role in this endeavor by establishing workplace health programs that focus on weight management, healthy nutrition, exercise and stress management. This will promote quality, long lives for employees and ultimately better out-turn to the institution and stakeholders.

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