Positive Health in Dutch Public Health Services

Possibilities for integration of the concept Positive Health in work-related activities of professionals

at the Dutch Public Health Services (GGD)

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Abstract

Introduction

At the moment the health system in the Netherlands is dominated by a biomedical, body and disease oriented approach. In order to meet the challenges in healthcare a transformation towards a broader-oriented system is necessary. In recent years a new, more holistic approach, has been introduced. This approach: Positive Health, is focussing on the ability to adapt to, and self-managing of social, physical and emotional challenges. Because this concept is embraced by several Public Health Services, a change for the employees towards Positive Health is necessary. This study focuses on the employees' willingness to change and possibilities and difficulties for integration of the concept Positive Health in the Public Health service' daily work-routine.

Methodology

This explorative research uses a mixed method design. To study the employees' willingness to change, the possibilities and difficulties regarding Positive Health in the work-related sphere both quantitative and qualitative methods are used. To measure the willingness to change and to what extent the employees themselves think how they are working towards the concept an online questionnaire was used. To explore how the concept is reflected in the activities and what possibilities and difficulties the employees encounter with the integration of the concept, focus-group interviews and semi-structured interviews were carried out. The guidance of the interviews is based on the concept Positive health. Every sub-department of the department Public Health, of the Public Health Service Twente was interviewed, including the head of the department and a secretary. For the data analysis the design of parallel triangulation strategy is used. The quantitative data is analysed with the program SPSS and the qualitative data with the program ATLAS.ti.

Results

The analysis was carried out on 36 respondents. In general the employees are willing to change to the concept of Positive Health, but the aspects of 1) effects on their work activities, 2) the provision of information and 3) the control the employees have towards the change were rated more negative. The sub-departments inspection & hygiene and public mental healthcare rated more aspects negative than the other sub-departments. The extent to which the employees think they are working towards the six dimensions was rated in average from 4.2 to 4.9, on a nine points Likert scale. The sub-departments inspection & hygiene and forensics rated the concept Positive Health lower on average in average the concept Positive Health lower. The sub-department tuberculosis rated the concept Positive Health higher on average. Related to the dimensions bodily function and mental functions & perception the most work activities were mentioned, the least for quality of life and daily functioning. The sub-department sexual health identified the most and most different work activities. Motivational Interviewing, broaden organizational-wide approach, looking beyond your main tasks and a greater collaboration were mentioned possibilities for a better integration of the concept in their work activities. Difficulties mentioned most by the employees are: not every aspect is a task for the

employees, some employees only have indirect influence to the client, the language-barrier in certain cases and definitions within and of the concept of what Positive Health is, is considered to be vague.

Discussion

This explorative mixed method research focuses on the views of employees of the Public Health Service Twente regarding the concept Positive Health in their work activities, and is the first study on Positive Health in the department of Public Health. Using this design much data is collected. When interpreting the quantitative results, selection bias has to be taken into account, because the number of respondents of some sub-departments was very low. Two interview types were used, that have been taken into account with the interpretation of the qualitative results.

Respondents mentioned in the quantitative research are willing to change towards the concept Positive Health, but rated some aspects negatively. Despite of the identification of work activities and possibilities by the sub-departments several difficulties were also mentioned. Meetings about the continuation between employees is necessary for further integration of the concepts, the term Positive Health with corresponding aspects has to be evaluated and Motivational Interviewing seems like the best feasible working method for Positive Health.

Samenvatting

Introductie

De gezondheidszorg in Nederland wordt gedomineerd door de biomedische, lichamelijke en ziekte georiënteerde benadering. Om de uitdagingen in de gezondheidszorg aan te gaan is een transformatie naar een meer gezondheid georiënteerd systeem nodig. Een nieuwe en holistische benadering is geïntroduceerd. Deze benadering, Positieve Gezondheid, focust zich op het kunnen aanpassen en de zelf management van sociaal, fysieke en emotionele uitdagingen. Verschillende Gemeentelijke Gezondheidsdiensten (GGD) hebben dit concept omarmd en daarbij is een verandering van de medewerkers noodzakelijk. Dit onderzoek richt zich op de bereidheid tot verandering, gebaseerd op het DINAMO-model, de mogelijkheden en moeilijkheden van de medewerkers voor integratie van het concept Positieve Gezondheid in werkzaamheden.

Methode

Dit onderzoek is een exploratief onderzoek waar een mixed method design is gebruikt. Om de bereidheid tot verandering en de mogelijkheden en moeilijkheden van het concept in relatie tot de werkzaamheden zijn een kwantitatief en kwalitatief onderzoek is uitgevoerd. Om de bereidheid tot verandering, gebaseerd op het DINAMO-model, en in welke mate medewerkers denken dat ze werken volgens het concept te meten is een online vragenlijst gebruikt. Om te ontdekken hoe het concept terug komt in de werkzaamheden en welke mogelijkheden en moeilijkheden de medewerkers zien voor integratie van het concept zijn focusgroep interviews en semigestructureerde interviews afgenomen. Waarbij het leidraad van de interviews is gebaseerd op het concept Positieve Gezondheid. Elke aparte afdeling van de algemene gezondheidszorg (AGZ), van GGD Twente, is geïnterviewd plus de leidinggevende van de AGZ en iemand van het secretariaat. Voor de data analyse is het design van een parallel triangulatie strategie gebruikt. Waarbij de kwantitatieve data is geanalyseerd met het programma SPSS en de kwalitatieve data met het programma ATLAS.ti.

Resultaten

De analyse is uitgevoerd met 36 respondenten. De meeste medewerkers zijn bereid om te veranderen naar het concept Positieve Gezondheid, maar waardeerde de verwachte toegevoegde waarde naar de werkzaamheden, de concreetheid van de verspreide informatie en de invloed die de medewerkers hebben op de verandering negatiever. De afdelingen inspectie en hygiëne en openbare geestelijke gezondheidszorg waardeerde sommige aspecten aanzienlijke lager als gemiddeld. De mate waarin de medewerkers denken dat ze volgens het concept werken voor de verschillende dimensies werd gemiddeld met een 4.2 tot 4.9 gescoord, op een negen punt Likert schaal. De afdelingen inspectie en hygiëne en forensische dienst scoorde dit aanzienlijk lager dan gemiddeld, in tegenstelling tot tuberculose die aanzienlijk hoger scoorde. Gerelateerd aan de dimensies lichaamsfuncties en mentaal welbevinden werden de meeste werkzaamheden genoemd. De minste voor kwaliteit van leven en dagelijks functioneren. Motiverende gespreksvoering, organisatie breed kijken, aandacht schenken aan aspecten buiten je hoofd werkzaamheden en een betere samenwerking werden genoemd als

mogelijkheden voor een betere integratie van het concept. Ook werden er overeenkomstige moeilijkheden genoemd door de medewerkers, namelijk: niet alle aspecten zijn taken van de medewerkers, sommige medewerkers hebben alleen indirect invloed op de cliënt, een barrière omtrent de taal en de termen die worden gebruik met Positieve Gezondheid werden vaag genoemd.

Discussie

Dit exploratieve mixed method onderzoek focust zich op de kijk van medewerkers, van de GGD Twente, naar het concept Positieve Gezondheid in de dagelijkse werkzaamheden, en was het eerste onderzoek naar Positieve Gezondheid op de afdeling AGZ. Met dit design is veel data verzameld. Met de interpretatie van de kwantitatieve resultaten moet er rekening gehouden worden met mogelijke selectie bias, doordat het mogelijk is dat werknemers die positiever zijn naar het concept toe vullen sneller de online vragenlijst in. Daarbij was voor sommige afdelingen het aantal respondenten erg laag. Verschillende interview types zijn gebruikt, waar rekening mee gehouden moet worden met het interpreteren van de kwalitatieve resultaten.

Respondenten gaven in het kwantitatieve onderzoek aan dat ze in het algemeen bereid zijn te veranderen en scoorde de mate waarin ze al werken volgens het concept rond de helft. Ondanks het identificeren van verschillende werkzaamheden en mogelijkheden door de afdelingen, werden ook verschillende moeilijkheden genoemd. Gesprekken over het vervolg van de integratie van het concept tussen de verschillende medewerkers zijn nodig, de term Positieve Gezondheid met samenhangende aspecten moet geëvalueerd worden en motiverende gespreksvoering lijkt een goede methode om volgens Positieve Gezondheid te werken.

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1. Introduction

1.1 Changing healthcare

Healthcare in the Netherlands is facing several challenges at the moment. Aging of the population is a challenge in almost the entire world (Martelli, Pender, & Larbi, 2015). A second challenge is the shift from acute to chronic diseases. In 2011 33,7% of the society of the Netherlands was suffering one chronic disease, and 12.9% had two or more chronic diseases (Oostrom, et al., 2011). The expectation is that the trend of an increase in the number of patients with chronic diseases continues in the upcoming decennia (Ursum, et al., 2011). The Dutch Department of Public Health expects that 40% of the society in the Netherlands will have a chronic disease in 2030 (RIVM, 2014). Out of these two trends two conclusions can be drawn: people get more healthy and become more ill at the same time (Lucht & Polder, 2010).

There is a shift occurring in the composition of healthcare and at the same time the demand for healthcare is rising. Firstly, because of the aging of the population. Secondly because of the people with chronic diseases are major users of healthcare (Ursum, et al., 2011). That results the healthcare costs are rising with the demand. The healthcare costs for society are a significant part of the public expenditure already, but these costs are still rising as well (Adamson, 2016). In the Netherlands the healthcare costs relative to the GDP rose from 10.9% in 2001 to 14.1% in 2015 (Centraal Bureau voor de Statistiek, 2016).

Due to these challenges, healthcare in the Netherlands is changing. There is need for a decrease in the demand for care. This can be achieved by slowing down the increase in the amount of chronic diseases and delaying the age of getting diagnosed with a chronic disease. More focus on prevention is essential, because many chronic diseases are (partly) a result of lifestyle factors (Ministerie van Volksgezondheid, Welzijn en Sport, 2008). For this reason prevention of diseases, and thus the promotion of health (healthy lifestyles), is seen as a solution for the challenges in healthcare (Walg, 2014). To realize this, the care has to be organized more patient-centred. To achieve this patient-centred care, a more intensive collaboration between healthcare providers is necessary. This has to result in a situation where patients are able to take more control of their own life (Vrijhoef, 2010).

As a result of these shifts, there is a change in the organisation of healthcare in the Netherlands: decentralizations of healthcare. In 2015 the government decided to transfer several responsibilities from the general government to the municipalities. The general assumption is that decentralization lowers healthcare costs, because the municipalities are able to make more effective policy because they stand closer to society (Nijendaal, 2014). For this change several basic goals are defined. First of all, the social network has to be involved to increase own responsibility and possibilities for the citizens. The assumption is that this will result in less medicalisation and less use of care. And at last, when care is needed, organise the right care for the right person. This way less

expensive specialized care will be used (Koornstra, 2013). Due to this decentralization the Public Health Services receive more possibilities to implement prevention in the policies (Koornstra, 2013). The Public Health Services are an important part of this decentralization; this will result in a change in the relationship between government and citizens. With these decentralizations in the organization the accent will be more on personal responsibility and the social environment than before (Nijendaal, 2014). This is in accordance with the recent upcoming trend of self-management in healthcare (Verhoef, 2013). Especially with the growing amount of chronic diseases, self-management is rising in this group of patients (Eikelenboom, et al., 2015). Research has proven self-management is effective for the self-efficacy and quality of life for these patients (Harris, et al., 2008).

Because the way to approach patients and problems in healthcare is influenced by underlying models it is important to consider what the current approach in the Netherlands is (Engel, 1981). Because of the problem of increasing healthcare costs the approach to deliver this care is important to line out. Currently the health system in the Netherlands is dominated by the biomedical approach (Walg, 2014). This approach is body-, and disease-oriented, which results in an orientation of healing the body-, and disease-oriented complaints (Engel, 1981). Besides, when there is a biomedical orientation the impact of the mind on the body is ignored (Rahman, 2015). Despite of the dominated model in the Netherlands being disease-oriented the used definition of the Dutch Healthcare is more health-oriented. This definition consists of the maintaining and improvement of the health status, empowerment and to reduce, compensate and prevent when there is a lack of health (Rijksinstituut voor Volksgezondheid en milieu, 2014). To meet the challenges in healthcare a transformation towards a more health-oriented system is needed (Walg, 2014). For a longer period of time, a reaction on the biomedical model, the more holistic view is emerging. In contrast to the biomedical view, the holistic view is focussing on the human as a person, and not as a body with different components (Bruninckx & Mortelmans, 1999).

1.2 Towards a more person-centred approach

Following from the realization that healthcare costs have to be reduced, the health council in the Netherlands advises for elderly care to be more focussed on prevention and the empowerment of society (Health council of the Netherlands, 2009). With these advises the perception of healthcare is changing and the approach of what is the right way to access healthcare is changing. At the same time the perception of the definition of health is changing. In 1946 the World Health Organisation (WHO) defined health as; “health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (World Health Organization, 2016). 70 years ago this was a real breakthrough due to the addition of the social and mental well-being in the definition (Jadad & O'Grady, 2008). However there was also criticism, which intensified over the last decade (Huber, et al., 2011). This definition is not realistic according to the standards of current healthcare. Most criticism is on the word “complete”. In this disease-oriented definition “would leave most of us

unhealthy most of the time", as the British medical doctor and editor described (Smith, 2016). By using the word complete it seems like there is a shift backwards where health is the absence of disease: this will medicalise the healthcare (Huber M. , 2014). Thereby it is never possible, according to the definition, to be healthy and have a chronic disease at the same time (Huber, et al., 2011). Populations are changing in the world, the amount of people is, just like the life expectancy, increasing. Where this combination is the new standard, these people are not healthy according to the WHO definition. With the prevailing definition it minimises the empowerment of the people themselves (Huber, et al., 2011). Also the operationalization of the health definition is unachievable because of the word complete. Because a state of complete health is very hard to measure (Huber, et al., 2011). Other criticism is on the word "state", other scientists define health more as a dynamic element than a static element (Huber M. , 2014).

For decennia research has focused on concepts for a different definition of the WHO on health (Huber, et al., 2011; Huber M. , 2014). One of these new concepts on the view of health was from Antonovsky in 1979, the so-called salutogenesis. In this concept, health depended on three components of that he called the "Sense of Coherence". Defined as a generalized orientation towards the world which perceives it, as a continuum, as comprehensible, manageable and meaningful. Respectively this is how people understand their own lives, the experienced influence someone has on a situation and the experiences of the meaningfulness of life (Antonovsky, 1996). Another leading scientist towards a view on health is Seligman, he approximates health out of using the theory of positive psychology (Seligman, Positive Health, 2008). In this theory (mental) health is, besides the absence of (psychical) diseases, the presence of positive aspects like patient empowerment, positive emotions and strengths (Seligman & Csikszentmihalyi, 2014). Seligman focuses besides of the absence of diseases on more (positive) factors of health. For that reason the name "Positive Health" was introduced (Seligman, 2008).

To meet the criticism regarding the WHO definition of health, the changing healthcare and corresponding needs of the patients as discussed in previous paragraphs, a shift in the medical thinking has to be made to connect with the current situation in healthcare. With the other (not fully adopted) theories in mind, a new way of thinking in healthcare was introduced in 2009 (Huber, Vliet, & Boers, 2016). In 2011 together with this new way of thinking a concept definition for health was introduced: "Health as the ability to adapt and to self-manage, in the face of social, physical and emotional challenges" (Huber, et al., 2011). This allows society to have a broader and more dynamic view on health, and is not defined by the WHO as a state. In contrast with the biomedical approach, where the focus is on the physical and functioning of humans, the focus of Positive Health is on the subjective perceptions of the human. This is in line with the patient-centred approach that the researcher wants to pursue (Huber M. , 2014). This formulation is more in line with the changes in healthcare, and as well with the trend of the upcoming patient-centred care (Stewart, 2001). It is not just a new definition; it is

a new way of thinking about health. Because this broad way of thinking regarding the concept, they give it a broad name, (translated from Dutch) Positive Health (Huber, Vliet, & Boers, 2016).

1.3 Positive Health

An explorative research has operationalised Positive Health into six indicators. Six overarching dimensions are identified: 1) bodily functions, 2) mental function and perception, 3) spiritual/existential dimension, 4) quality of life, 5) social & societal participation and 6) daily functioning (Huber & Jung, 2015). The six dimensions are illustrated in figure 1. To clarify the major difference; in the old traditional way there was just one bio-medical perspective to health, the new way shows six perspectives of health. This reflects the shift from the bio-medical model to the more holistic view as well (Bruninckx & Mortelmans, 1999).

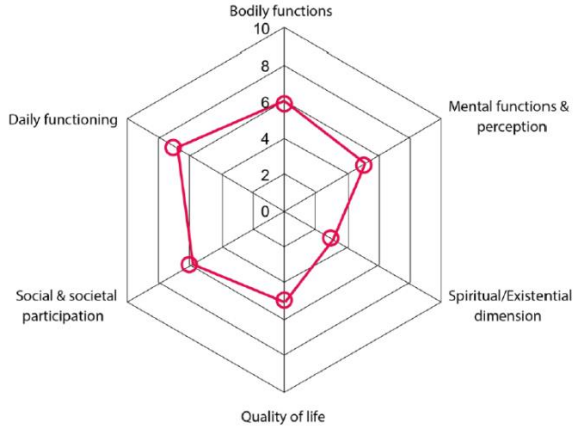

Figure 1: The six dimensions on a subjective scale, visualised for practical use, indicating a fictional estimation of a person's state of 'Positive Health' (Huber M. , et al., 2016)

The corresponding aspects related to the dimensions were identified by an explorative study including the main stakeholders in healthcare. The stakeholders were categorised as: healthcare providers, patients with a chronic disease(s), policymakers, insurers, public health professionals, citizens and researchers. With a mixed method study approach, 32 indicators were identified relating to Positive Health (Huber M. , et al., 2016). The indicators can be classified into the six overarching dimensions, presented in figure 2.

Bodily functions	*Mental functions and perception*	*Spiritual/existential dimension*	*Quality of life*	*Social and societal participation*	*Daily functioning*
▸ Medical facts	▸ Cognitive functioning	▸ Meaning/meaningfulness	▸ Quality of life/well-being	▸ Social and communicative skills	▸ Basic ADL
▸ Medical observations	▸ Emotional state	▸ Striving for aims/ideals	▸ Experiencing happiness	▸ Meaningful relationships	▸ Instrumental ADL
▸ Physical functioning	▸ Esteem/self-respect	▸ Future prospects	▸ Enjoyment	▸ Social contacts	▸ Ability to work
▸ Complaints and pain	▸ Experiencing to be in charge/ manageability	▸ Acceptance	▸ Perceived health	▸ Experiencing to be accepted	▸ Health literacy
▸ Energy	▸ Self-management		▸ Flourishing	▸ Community involvement	
	▸ Resilience, SOC (sense of coherence)		▸ Zest for life	▸ Meaningful work	
			▸ Balance		

ADL, activities of daily living.

Figure 2: Six dimensions of health indicators, covering 32 aspects of health (Huber M. , et al., 2016)

In the quantitative part of the mixed method research of Huber et al. (2016), 32 aspects were proposed to the stakeholders, and asked if the stakeholders found the aspects important for health. The results showed differences in the support for the concept Positive Health. Policy makers and care

providers evaluated the six dimensions significantly different than patients (Huber, Vliet, & Boers, 2016). Where the patients evaluated the six dimensions of health equally important, the researchers, providers and policy makers had a smaller view of health. They show a more bio-medical approach on health.

1.4 Positive Health in practice

With the operationalisation of Positive Health several organizations already want to embrace the concept. Despite of the identification of the 32 aspects the concept is still vague for what it means to the activities of care professionals. This is because it is still a new concept and therefore further operationalisation is needed. For two sectors, the curative and preventive sector, there were some expectations about what Positive Health probably could mean for these sectors. In the curative healthcare the central mind-set is focussed on illness most of the time. Next to the focus on illness of the patient it is expected with Positive Health it is possible to promote the recovery process of patients. But which activities should bring the change should be elaborated for individual organisations (Huber, Vliet, & Boers, 2016). For the preventive sector in public healthcare Positive Health could possibly be applied in the general model of "three P's of prevention" (Huber, Vliet, & Boers, 2016). The P's are as follows: 1) protection, 2) prevention, 3) promotion. Where the third P stands for the promotion of the (disease oriented) health. This can be supplemented with the promotion of the aspects of Positive Health. With this concept it is important to create an environment for health promotion. Also for this sector: global points have been made for possible ways of implementation of the concept but for each healthcare organisation it is still very broad (Huber, Vliet, & Boers, 2016).

For healthcare professionals at least one working method is in line with Positive Health, namely Motivational Interviewing (Huber, Vliet, & Boers, 2016). This method emerged that motivation is the start of changing a patients' behaviour (Dekker & Kanter, 2010). This method is already broadly applied in the treatment of addictions, but in more and more healthcare sectors the method is used (Schippers & Jonge, 2002). Motivational Interviewing is: "an intervention that incorporates a provider's understanding of their patient's current stages of changes to provide tailored counselling to support the patient's ability to progress towards the desired behavioural change" (Viau, et al., 2016). As written in the definition, the tool is only applicable for healthcare providers which have personal contact with their patients. The mind-set of Motivational Interviewing is not imposing but provoking the change of behaviour (Bartelink, 2013). The mind-set is based on five principles: expressing empathy, developing discrepancy, avoiding discussion, dealing with resistance and support self-efficacy (Miller & Rollnick, 2013). This theory is in accordance with the concept Positive Health.

After several studies, and with the concept slowly becoming more specific, there is a growing interest of organizations and the implementation of the concept Positive Health in the Netherlands (Steekelenburg, Kersten, & Huber, 2016). These interests came from several organisations like e.g.: health centres, general practitioners and care groups, community teams, institutions for long-term care, home care, schools, insurance companies and Public Health Services. Beyond the interest by these

organisations there are many which are embracing the concept. But with the embracement of this concept more questions arise for the practical implementation. This study focuses on one of the above mentioned organisations, namely the Public Health Services.

The Public Health Services in the Netherlands has a general task to protect, promote and monitor the health of the society, which is adopted in the law of public health (Klink, 2008). The Public Health Services have three key issues in general, namely the social domain, youth and safety. The Youth healthcare contains the issue youth. The public healthcare contains the social domain and the safety issue. This is care that is not asked directly by citizens but is necessary for a healthy society. Thereby there is special attention for vulnerable citizens. The last issue is about the prevention and identification of risks for the public health, this can vary from infectious diseases to major disasters. (GGD GHOR Nederland, 2016)

1.5 Willingness to change to Positive Health

A national working group is set up to make Public Health more known with the concept of Positive Health. Six Public Health Services are joining this working group (Rijksinsitituut voor Volksgezondheid en Milieu, 2016a). Because there is an intention to change, from the traditional approach towards the more holistic approach, it is important to look what organizational change entails. According to Metselaar (1997) change in an organization environment depends on the willingness to change by the involved employees. In the willingness to change there are three determinants identified, namely 1) do the employees want to change, 2) do the employees have to change and 3) are the employees able to change towards the concept. The third determinant, besides influencing the willingness to change, is also directly influencing the behaviour of the employee. This theory is operationalised in the DINAMO-model (Metselaar, Cozijnsen, & Delft, 2011). In chapter two the theory is lined out in a theoretical background.

1.6 Purpose of the research

Several Public Health Services have embraced the concept Positive Health, however, translating the concept to the professionals is a challenge. The fact that all of the organizations which have embraced the concept are searching for hands on starting points is important to take into account (Steekelenburg, Kersten, & Huber, 2016). One of these organizations is the Public Health Service Twente. This study is carried out, as a case, in this organization, more specially in the department Public health. Because previous research in this organization was carried out in the Youth healthcare it is important what the meaning of the concept and the future integration is in the public health department of the Public Health Service Twente.

Before the process of implementing can start there is a need to specify what the change is, what are the activities related to this change. Thereby the barriers and possibilities the professionals see have to be taken into account. Besides this concretizing, identifying the willingness to change

towards the concept is important as well. It is important to identify the current support of the employees towards the concept of Positive Health. From this point of view it's possible to research what activities must be added or changed in relation of the concept of Positive Health. This can help the Public Health Services make progress in the process of adapting the concept. As written in the paragraph Positive Health, there are differences between stakeholders towards the concept Positive Health, this has to be taken into account into the research as well.

At the moment there is little scientific research available about the perspective of care professionals towards the concept of Positive Health (Backhaus, Lamers, & Cornelissen, 2015; ZonMw, 2016). Thereby the concretizing part of this research can complement studies which explore the possible effects of the concept to an organization (Boers & Huber, 2015). This study helps to generate scientific knowledge to concretize the concept for employees. The purpose of this study is to provide insights of making the concept more specific and of the willingness to change of the employees of the Public Health Services towards the concept Positive Health. With the results the Public Health Services gets starting points for the implementation of the concept Positive Health.

1.7 Research question

To elaborate the purpose of this study there are four research questions formulated:

1. *To what extent are the employees of the Public Health Services willing to change towards the concept Positive Health?*

2. *How is the concept Positive Health reflected in the daily work activities of the employees of the Public Health Services?*

3. *What possibilities and difficulties do the employees of the Public Health Services see for further integration of the concept Positive Health in their daily work activities?*

4. *What are the differences and similarities towards the willingness to change, daily work activities, possibilities and difficulties related to the concept Positive Health between the sub-departments in the Public Health Services?*

Different questions are used because of the great variation of focus in this study, namely: the willingness to change, the daily work activities and the differences and similarities in the Public Health Services. Employees are in this case the employees of the department Public health of the Public Health Service Twente.

2. Theoretical background

As written before, several organizations have adapted the concept Positive Health, and want to incorporate the concept in their organizations. This consequently implies the employees have to change from a more biomedical view to a more holistic view. The main problem of changing is people appreciate the current state of their life, and due to this fact people naturally resist change (Moran & Brightman, 1998). To identify what influences this resisting behaviour towards change in an organizational environment the DINAMO model of Metselaar (1997) is used. This model is based on one of the most frequently cited and influential models of the prediction of social behaviour, namely the theory of planned behaviour of Ajzen (2011). In the next paragraph the theory of planned behaviour is lined out shortly, following with a paragraph where the DINAMO model is set out.

2.1 Theory of planned behaviour

In the theory of planned behaviour different determinants that have an effect on the behaviour of an human are identified. The intention to show behaviour is a central determinant in this model (Ajzen, 1991). This intention is an important indicator for the performance of behaviour. “The stronger the intention is, the more likely should be its performance”. This intention is depending on three determinants, 1) attitude, 2) subjective norm and 3) perceived behavioural control. The relation of these determinants, the intention and behaviour are illustrated in figure 3. (Ajzen, 1991)

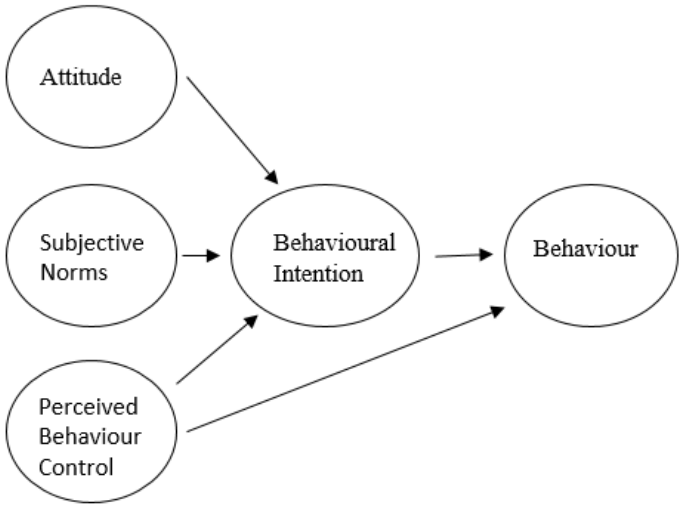

Figure 3:Theory of planned behaviour model (Ajzen & Timko, 1986)

2.2 DINAMO model

In this study the focus is more on a change of employees in an organizational setting instead of the change of health behaviour as presented in the model of Ajzen. For this reason there can be spoken about the willingness to change (Metselaar E. E., 1997). Based on the model of planned behaviour willingness to change is defined by Metselaar as: “A positive behavioural intention towards the implementation of modifications in an organization’s structure, or work and administrative processes,

resulting in efforts from the organization member's side to support or enhance to change process" (Metselaar E. E., 1997). For this model the theory of planned behaviour is used as a model to declare the willingness to change in an organizational environment (Metselaar E. E., 1997). The three identified determinants for the intention of behaviour are translated for the organizational change. Attitude as the expectation of an employee related to the process of change, subjective norm as the attitude of the colleagues towards the process of change and the perceived behavioural control is the extent of experiencing control to the process of change. This organizational change is elaborated in the DINAMO-model. (Metselaar, Cozijnsen, & Delft, 2011)

Further translation is necessary to make the model more practicable. For this reason, Metselaar uses different terms as determinants, namely want (attitude), have to (subjective norm) and be able (perceived behavioural control), relating to the process of change. Where the change of behaviour is the final step in the theory of planned behaviour, change of behaviour in the DINAMO-model is all about what the behaviour brings, for that reason result is added to the model. In figure 4 is this model illustrated.

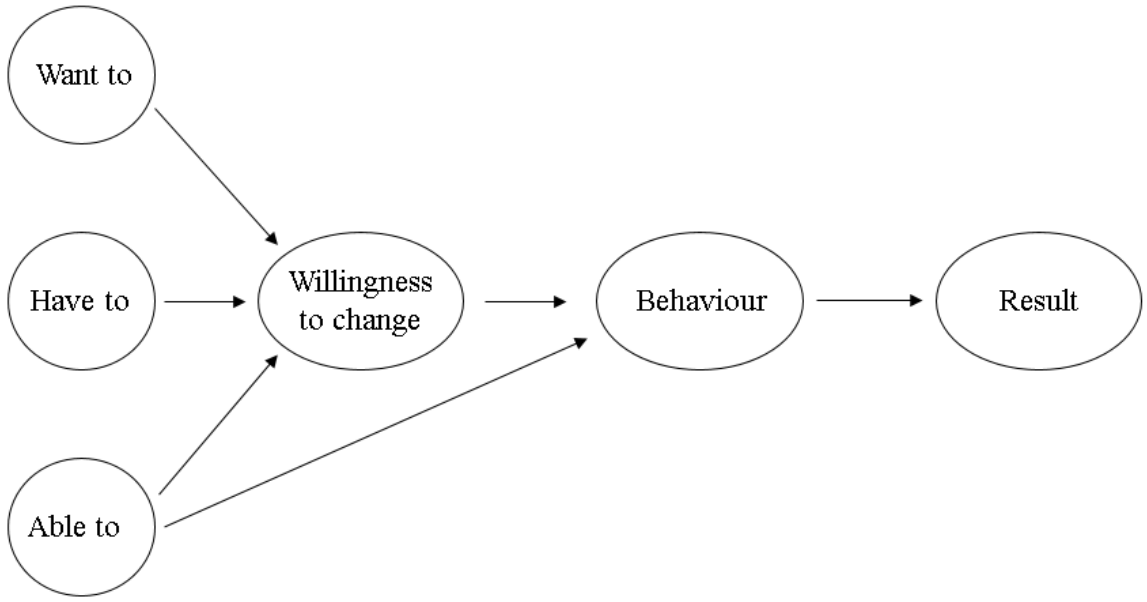

Figure 4: DINAMO-model (Metselaar, Cozijnsen, & Delft, 2011)

In the construction and validation process of the DINAMO-model different variables for the three determinants are identified (Metselaar E. E., 1997). Over time these variables are adjusted to new insights (Metselaar, Cozijnsen, & Delft, 2011). The most up-to-date variables are discussed based on the three determinants. In figure 5 all aspects relating to the willingness to change are illustrated.

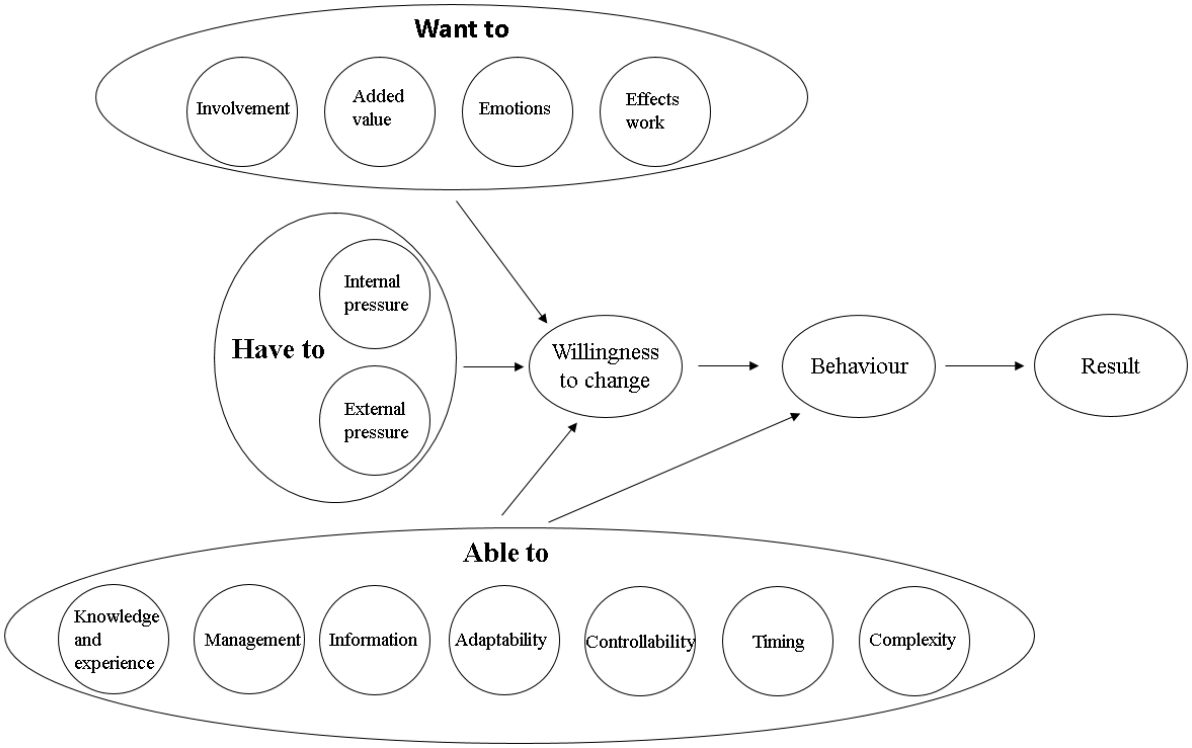

Figure 5: Evidence Based DINAMO-model (Metselaar, Cozijnsen, & Delft, 2011)

For "wanting to" change (attitude) it is about the own conception of a person towards the change (Brug, et al., 2000). The variables are based on the cognitive and affective reactions. The cognitive reaction is the thoughts about the effects of a change (Ajzen & Timko, 1986). For an organizational change this means at first, what are the expectations of the effects of the change for the person itself: what are the expectations of the effects of the change on their own work. Thereby emotions are important to take into account. The affective reactions are the emotions that arise with the specific change (Ajzen & Timko, 1986). The third aspect is about the added value of the change, in the perception of the employee. Thereby the involvement in the process is important for the influence on the intention. This can depend on the approach that is used, top-down or bottom-up (Metselaar, Cozijnsen, & Delft, 2011). "Wanting to" is based on different perceptions, like logical reasoning and rational considerations. Besides these aspects, there are other aspects like underlying habits and irrational beliefs that create a part of the attitude and so for the determinant "wanting to change" (Brug, et al., 2000). The attitude, and thereby "wanting to change", is an important determinant to the intention of a behaviour, because no matter if a change is a good change, when the employees do not like the change, it will fail (Weber & Bulger, 2005).

The second determinant, "have to" (subjective norm), depends on the pressure from other employees in the organization: for example colleagues, managers and the board. The basis for this determinant is the assumption that the ignorance of the social environment entails social sanctions. The subjective norms are established in two beliefs, the normative belief and the motivation to comply. Not only the expectation of the social environment influences the norms, also in extent into

which way somebody attracts these expectations (Brug, Assema, & Lechner, 2007). In an organizational setting this is described as the internal pressure. Besides the internal pressure there is the presence of external pressure, external pressure is about the commitment of the organization to change. This depends on trends and developments in the environment of the organization. (Metselaar, Cozijnsen, & Delft, 2011)

The last determinant, “able to” (perceived behaviour control), depends on more variables. This last aspect is about the possibilities for the employees to change. Knowledge and experience is an important factor for the intention to be able to change (Titzer, 2014). The more the change resonates with the current knowledge, the easier the change will be (Berwick, 2003). Thereby the management relating to the change has to set realistic targets and divide the change in phases. The information provision has to be complete and in time, in order to prevent insecurity for the employees. Another aspect that can delay the implementation of change is the flexibility of a structure. The more hierarchal an organization is, the more difficult it will be for an implementation of a change. Another organizational aspect is the controllability. This is about contingent factors, like market failure in the organizations’ environment. The opposite of these factors are predictable factors. So the timing of a change has to be in line with the time management of an organization. At last the complexity of a change is an influence aspect in the DINAMO-model. The more complex a change is, the more difficult controlling the change is. (Metselaar, Cozijnsen, & Delft, 2011)

As shown in the figures 4 & 5, there are two relations identified from the determinants. The first is the relation of the three determinants to the willingness to change. The other relation that is only identified from the third determinant, able to, has directly influence on the behaviour of an employee, just as the perceived behaviour controls in figure 3. This can be interpreted as when there is a high intention for willing to change it is still possible due to a barrier the change still will not occur (Metselaar, Cozijnsen, & Delft, 2011). A possible barrier can be knowledge. In different theories the aspect knowledge is connected with the aspect attitude. When the attitude is positive for a change, but there is no knowledge in order for the capacity and skills to change, the change will not happen. Opposite from when the knowledge to change behaviour is present it is also not certain the change will actual happen, due to the attitude. (Brug, Assema, & Lechner, 2007).

All of these described aspects are important for the three determinants of willingness to change, and so they are important for the behaviour and the final results of a change. For that reason the aspects used in this study to measure the willingness to change of the employees in the Public Health Service Twente are related to the change towards the concept Positive Health. The development of the questionnaire is described in paragraph 3.3.2.

3. Methodology

In this chapter the methodology was set out in different paragraphs. First, the case which was used for this study was lined out (3.1). Followed by the research design for this case (3.2), the methods (3.3), population (3.4), selection procedure (3.5), and the data analysis (3.6).

3.1 Public Health Service Twente

This study was executed in the Public Health Service Twente. This organization is one of the Public Health Services which are working on the integration of the concept Positive Health, and thereby want to face the challenge of change. This study was part of the adapting process of the concept Positive Health in this organization. The Public Health Service Twente is an organisation with approximately 370 employees. The organisation is split in three departments, namely Public healthcare, Youth healthcare and the Staff department (GGD Twente, 2016). Within the general tasks the Public Health Service Twente wants to focus on the self-efficacy and the empowerment of the citizens. Thereby the organization wants to focus on the integral view of health, Positive Health (GGD Twente, 2015a). For that reason, a guiding coalition has been set up in the organisation representing all three of the departments. So far the coalition has achieved the Management Team has set the concept Positive Health onto the agenda. Thereby different events took place for all the employees about the concept of Positive Health (GGD Twente, 2015b). For a small part of the department Youth healthcare a study was conducted about the support by the employees, and their present activities with Positive Health last year (Backhaus, Lamers, & Cornelissen, 2015). Despite of all these activities and events related to Positive Health, the Public Health Service Twente wants to explore how this concept can be embedded in the daily activities of the employees (GGD Twente, 2015b). And so the department Public health wants to make the concept for its own department more specific just as the organization and more organizations in the Netherlands. For that reason this study focussed on this specific department.

The Public healthcare is a department which consists of nine sub-departments, namely; 1) secretariat, 2) infectious disease control, 3) inspection & hygiene, 4) environment & health, 5) public mental healthcare, 6) sexual health, 7) tuberculosis , 8) forensics and 9) disaster relief plan (GGD Twente, 2016). The main tasks of these sub-departments are set out in appendix A. In Appendix B the organogram is shown, where the sub-departments of the staff department and the Youth healthcare are left out.

3.2 Research design

This study has an explorative design. This design is appropriate to explore issues in order to generate scientific knowledge (Plochg, et al., 2007). In this explorative research a mixed method research was used, that means there was a combination of qualitative and quantitative research (Teddlie & Tashakkori, 2011). With a mixed method study the two separate parts can, at the end, complement each other (Johnson, Onweugbuzie, & Turner, 2007). In complex phenomena's in healthcare the

mixed-method research had shown that it can be particularly useful (Östlund, Kidd, Wengström, & Rowa-Dewar, 2011). Due to the lack of scientific research this was an appropriate design for this study. Thereby this design could help to highlight similarities and differences between the sub-departments in this study (Bernardi, Keim, & Lippe, 2007). The quantitative research focussed on the willingness of change by the employees on the concept of Positive Health. Thereby the extent to which the employees thought they work according to the concept Positive Health is measured in the quantitative research. In the qualitative research the focus was on how the employees recognize the concept Positive Health in the methods of working and where the possibilities for future implementation were. In both methods the similarities and differences between sub-departments were taken into account. In this Mixed-method research the design of a parallel triangulation strategy was used (Plochg, et al., 2007). That means the quantitative and qualitative process was carried out separately from each other. This technique is illustrated in paragraph 4.5.

3.3 Research methods

In this paragraph the quantitative and qualitative research is lined out separately. Following in every paragraph the conduction of the instruments belonging to the relating research part are described. The used research methods are presented per research question in table 1.

Table 1: Research methods used per research question

Research question		Research Method	
		Qualitative	**Quantitative**
1.	To what extent are the employees of the Public Health Services willing to change towards the concept Positive Health?		Online questionnaire
2.	How is the concept Positive Health reflected in the daily work activities of the employees of the Public Health Services?	Semi-structure/focus-group interview	Online questionnaire
3.	What possibilities and difficulties do the employees of the Public Health Services see for integration of the concept Positive Health in their daily work activities?	Semi-structure/focus-group interview	
4.	What are the differences and similarities towards the concept Positive Health between the sub-departments in the Public Health Services?	Data of research question 2 and 3	Data of research question 1 and 2

3.3.1 Quantitative research

The quantitative research was performed with an online-questionnaire. There was chosen for an online questionnaire because the expectation was that the response would be higher because participants can complete the questionnaire where and when he or she wants (Lefever, Dal, & Matthíasdóttir, 2007). Research has proven that people prefer a questionnaire on the internet instead of an interview taken by the telephone (Hogg, 2002). Thereby the answers were directly imported in the system, so the chance on mistakes was less than when the researcher has to enter the data in the system by himself. The

questionnaire was based on two different methods. The first method was to identify to what extent the employees think they work according to the concept. This was based on the method of Huber (2016), the online questionnaire of the study in the Public Health Service Twente department Youth healthcare (Backhaus, Lamers, & Cornelissen, 2015) and the 32 aspects of covering Positive Health (figure 2) (Huber M. , et al., 2016). The second method to measure the willingness to change was focused on the DINAMO model (Metselaar E. E., 1997).

3.3.2 Online questionnaire

The questionnaire consisted of six questions, contained a total of 63 sub-questions, and was divided in three parts, namely: 1) general questions, 2) positive health related to their work procedures and 3) the willingness to change towards Positive Health. The second and the third part were based among others on the sources of Huber (2014) and Metselaar (1997). In the first part three questions were asked concerning the background variables. With the sex and age the generalizability could be identified. Furthermore it was asked in what sub-departments the respondent is working.

The second part consisted of one question towards 32 aspects. This question was based on the structure of the research of Huber (2014) and the study that was conducted, concerning Positive Health, on the Youth healthcare of the Public Health Service Twente (Backhaus, Lamers, & Cornelissen, 2015). In this part the extent to which the employees thought they work according to the concept was measured. The question was about in what extent the respondent is thinking statements of Positive Health were recognized in their work activities. For this question the thirty-two aspects (figure 2) of the six dimensions of Positive Health were presented as statements. Because the questionnaire was conducted in Dutch the thirty-two statements of Backhaus (2015) were used. In her study she translated the statements from Huber (2014) reliably. For every aspect the respondent was asked to fill in, on a 9 points Likert scale, to what extent he or she thinks the aspect is related to their work activities, where 1 is very low related to the question and 9 very high. The six dimensions were: Bodily functions (5 items), Mental functions & perception (6 items), spiritual/existential dimension (4 items), quality of life (7 items), social & societal participation (6 items) and daily function functioning (4 items). (Huber M. , 2014)

For the third part of the questionnaire the willingness to change was measured. Therefore the DINAMO model of Metselaar (1997; 2011) was used. In this model the determinants regarding the willingness to change identified were as: want, have to and are able to change. These determinants were operationalised to be measured in a questionnaire. In every determinant different aspects were identified, see figure 5. Because the original questionnaire of Metselaar was not available for this research the questionnaire was based on other studies where the DINAMO-questionnaire was used (Roovers, Witte, Delft, & Vermeeren, 2008; Wortelboer & Metselaar, 1996; Peek, Zomer, & Becker, 2011). For every question in these studies it was considered to which extent the question was relevant for this study, because the change relating to Positive Health was still vague for employees. After

conducting the questionnaire and considering every question there where 31 items left, divided into twelve different aspects: effects work (5 items), emotions (4 items), added value (3 items), involvement (2 items), internal pressure (4 items), external pressure (2 items), knowledge and experience (1 item), management (2 items), information (1 item), adaptability (0 items), controllability (3 items), timing (2 items) and complexity (2 items). To give more insight of these items an example of the aspect "effects work" is given: I am convinced the change will increase the quality of my work. The aspect adaptability is left out due the non-relevance in questions for this organisation at this moment. These items were asked on a five points Likert scale, where 1 is the lowest extreme and 5 the highest extreme (Metselaar E. E., 1997). Because it was possible the concept was still vague for some employees the option "I do not know" was adopted in the questionnaire. The questionnaire was conducted in Dutch and was adopted in appendix C.

3.3.3 Qualitative research

The qualitative research was performed with focus-group interviews. Because there was a need to explore data on the topic of Positive Health, it was a good way to use focus-group interviews. In contrast with an individual interview this method generates more creative solutions due to the interaction of the employees with each other (Plochg, et al., 2007). Because there currently was very little scientific research about the generation of specific activities for employees on the concept of Positive Health, creative input from a focus-group interview was important. Therefore this study focused on the activities of employees of the department Public healthcare, and more specifically the sub-departments, for that reason a focus-group interview was the designated method to generate information of a collective conception of the employees (Groenland, 2007). For every sub-department one focus-group interview was conducted. As presented in the next paragraph (research population), some sub-departments were very small and a focus-group interview was not feasible. For this reason in the small sub-departments semi-structure individual interviews were used. This method was used as well to explore data from this subject (Plochg, et al., 2007). In contrast with a structured interview it was not about how many or how much, but more about why and in what way. Just as in an unstructured interview it was free to vary, but in a semi-structured interview there are some topics and questions the interviewer wants to talk about. In order to point the conversation in a certain direction the interviewer sticks to the questions thought of prior to the interview. For this reason this is a good way to explore data relating to this study as well. For every sub-department where a focus-group interview cannot be conducted there was a minimum of one semi-structured interview. Using both of these interview methods this study is used to find out what the employees have experienced so far and how they feel about the concept. Both of the interview methods were used to be a good complementation of the quantitative questions in the questionnaire (Fylan, 2005). In the focus-group and semi-structured interviews the data collection from the employees took place in order to search in

what way they already work with the concept Positive Health and what possibilities and difficulties they saw.

3.3.4 Interviews

For both types of interviews (focus-group and semi-structured) the same topic list was used. The purpose of the interviews was to generate qualitative data in accordance with the current work activities and possibilities and difficulties for activities related to the concept of Positive Health. The interviews were recorded in order to get in a reliable transcription for the analyses. To maintain structure in the interviews the format of Positive Health with the six dimensions was used as guidance (Huber & Jung, 2015). For every dimension a very short introduction was given, by the researcher, following two questions. One question regarding the current activities and the other question regarding to what the employees saw as possibilities or difficulties for that specific dimension. After completing the six dimensions the employees were asked if they think one of the dimensions was more or less important than the other dimensions. At last the questions for the dimension were asked towards the whole concept of Positive Health. To prepare the interviews the researcher read about the work plan (shortly summarized in appendix B) of that specific sub-department. This way it was possible to keep the conversation active with relevant questions to their activities in their function.

For the focus-group interview the very short introductions were supported by a digital presentation conducted with the program Microsoft Office PowerPoint. With this support tool the interviewees were constantly faced with the aspects related to the dimension where they talk about. This way it was attempted to discuss the right subject. In the focus-group interviews the researcher was the moderator of a group discussion. In this role the researcher had to make sure the conversation stays active. For example, after answering by an interviewee the moderator could ask what other interviewees thought about this comment. The guidance of the focus-group interview was conducted in Dutch and was adopted in appendix D.

For the individual semi-structured interviews support of the aspects of every dimension was also used, because it is an individual interview the aspects were given in a handout. In contrast with the focus-group interview the researcher was not a moderator but an interviewer in this type of interview. In this interview the few questions were a guidance for the interview in contrast with the focus-group where it was a guidance for different group discussions. The guidance of the semi-structured interview was conducted in Dutch and was adopted in appendix E.

3.4 Research population

The target population were all the employees of the department Public healthcare of the Public Health Service Twente, except the sub-department environment & health. This was determined in a conversation with the head of the department. This sub-department was working for different Public Health Services and was working on another location most of the time. For this reason there was

decided to exclude this sub-department in this research. The total population consists of 62 employees who were active in this department (table 2). These employees were classified in different sub-departments which are mentioned in paragraph 3.1.

Table 2: classification of the employees of the department Public healthcare in sub-departments

Sub-department	**N**
Infectious disease control	12
Inspection & hygiene	15
Forensics	3
Disaster relief plan	1
Public mental healthcare	2
Sexual health	12
Tuberculosis	10
Other*	7
Total	62

*Other consist of: secretary, chief of different sub-departments and chief of the department

For the quantitative research the entire target population was involved in the study. In this way, with a high response, the data was assumed be representative for the department (Zuidgeest, Boer, Hendriks, & Rademakers, 2008).

For the qualitative aspect of the study the minimum number of employees for the focus-group interviews was set on six (Boendemaker, Schippers, & Schuling, 2001). For the individual semi-structured interviews one interview per sub-department was conducted, except for "other". For "other" two interviews were conducted, one with the secretary and one the chief of the department, to include the overarching view of the department towards the concept. There was chosen for just one interview per sub-department because of the limited time of this study. Depending on the number of employees per sub-department a focus-group interview or semi-structured interview was conducted. This resulted in focus-group interviews for the sub-departments infectious disease control, inspection & hygiene, sexual health and tuberculosis. For the forensics, disaster relief plan and public mental healthcare and "other" semi-structured interviews were conducted.

The data collection procedure was at the Public Health Service Twente. Because in this situation there was no travel distance and with that reason the expected feasibility of the participation would be higher (Plochg, et al., 2007).

3.5 Selection procedure & recruitment

For the participation in the online-questionnaire by the employees of the department Public healthcare of the Public Health Service Twente e-mail was used as distribution method. The questionnaire was open for fifteen (working) days. A reminder after one week was sent. Without sending a reminder the

response would plausibly be lower (Luiten, 2009). To get the highest possible response the e-mail was send by the head of the department. Using this way of spreading the questionnaire it was more likely that the population filled in the questionnaire because they knew the person who spreads it (Harinck, 2010). Assuming the head of the department with 62 employees was a familiar face for everyone, this person was the appropriate person to spread the online questionnaire.

For the participation of the employees in the focus-group interviews the target population were contacted by the secretary, because this person has oversight which moments were the most practical moment to complete the focus-group interviews. For the individual interviews the employees were contacted by the researcher himself. The selecting procedure was responding to the invitation. So there was a combination of purposive and opportunistic sampling (Plochg, et al., 2007). Purposive sampling was the case with selection of the employees of the Public Health Service Twente department Public health and opportunistic sampling was the case with accepted the invitation of the employees.

3.6 Data analysis

As written before in this mixed-method research the design of a parallel triangulation strategy was used (Plochg, et al., 2007). So there was, just as the data collection, a parallel data analysis. The quantitative and qualitative analysis were carried out separately. At the end of the analysis the data was combined for an interpretation of the data towards the research questions (Östlund, Kidd, Wengström, & Rowa-Dewar, 2011). This combined interpretation is described in the concluding chapter (discussion). Assumed with this design the two separate parts did not influence each other during the analysis. And in the concluding chapter it was assumed the results with the interpretation of both analysis's supplement each other. This analysis was done by the interpretation of both separate analysis's. These analysing techniques are illustrated in figure 6.

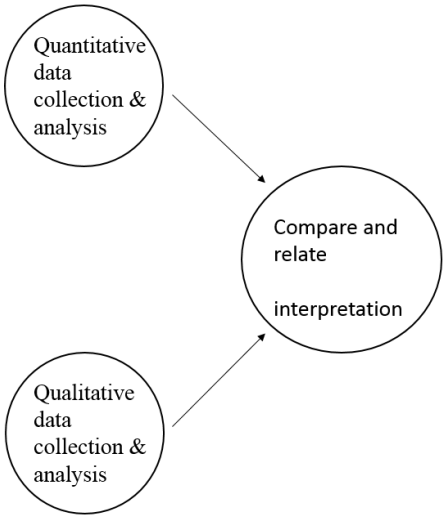

Figure 6: Parallel data triangulation strategy based on Östlund, et al. (2011)

3.6.1 Quantitative data analysis

The analysis of the quantitative data consisted of descriptive statistics. Because the research population was the same as the target population the differences that were found were the differences that were present, and there was no added value for testing on significance.

For the online questionnaire the program Lime Survey was used. The output for this data was analysed with the statistical programme SPSS. Before starting the analyses, the output of two constructs, controllability and complexity, were recoded so they had the same output as the other with the five point Likert scale questionnaire. Because questions in the questionnaire were used with continuous variables descriptive statistics summary sizes were used (Twisk, 2010). To get an overview of the extent to which the employees thought they work according to the concept (question four) and to which extent the employees showed willingness to change (question five) the following descriptive statistics were used: number of people per sub-department (N), mean and standard deviation. The respondents which answered "I do not know" on a question were left out of that specific analysis. For the analyses of the willingness to change the means below 3.0 were assumed as negative and the means 3.0 or higher as positive.

For the questions five and six different items to measure one construct were used. To ensure the reliability of the constructs in the questionnaire the corresponding items were tested on the Cronbach's alpha (Tavakol & Dennick, 2011). The reliability makes sure that other research with the same measurements and population got the same results (Pijenborg, Braspenning, Berg, & Kallewaard, 2004). With a $\alpha>0.700$ the reliability of the constructs can be seen as reliable, when the $\alpha>0.800$ the constructs can be seen as highly reliable (Tilburg University, 2016). For that reason 0.700 was taken as the minimum value for the Cronbach's alpha. When the Cronbach's alpha is lower than 0.700 the researcher evaluated the construct with the corresponding items. For question four it applies the six separate dimensions of Positive Health. Thereby the Cronbach's alpha of all 32 items were measured together, to measure the rating of the total construct Positive Health. All of the constructs of Positive Health could defined as reliable (table 3).

Table 3: The seven constructs of Positive Health with the corresponding Cronbach's alpha (α) and the number of respondents (N)

Construct	**α**	**N**
Bodily functions	0.858	36
Mental functions & perception	0.885	36
Spiritual/existential dimension	0.920	36
Quality of life	0.955	36
Social & societal participation	0.917	36
Daily functioning	0.734	36
Positive Health	0.980	36

The other question was divided per aspect of the DINAMO-model (table 4). The Cronbach's alpha of three constructs was relative low (α<0.700). Therefor these constructs were evaluated a second time. This resulted into the constructs management, controllability and timing being presented with the different items separately and the construct complexity was reduced from two items to one.

Table 4: constructs of DINAMO model with the corresponding Cronbach's alpha (α) and the number of respondents (N)

Construct	**α**	**N**
Want to		
Effects work	0.898	36
Emotions	0.902	36
Added Value	0.723	36
Involvement	0.813	34
Have to		
Internal pressure	0.745	34
External pressure	0.723	34
Able to		
Knowledge and experience*	-	34
Management	0.580	34
Information*	-	34
Controllability	0.529	34
Timing	0.461	34
Complexity	0.474	34

*These constructs consist of one item, Cronbach's alpha inapplicable

3.6.2 Qualitative data analysis

Analysing the qualitative data the data the steps of Plochg, et al. (2007) were followed. These consisted of 1) order and making it readable to analyse, 2) obtain a global overview, 3) start of detailed analysis, 4) deepening of the analysis, 5) searching for a meaningful presentation and 6) interpretation of the analysis as a whole.

After conducting and executing the interviews they were transcribed in the first step. After this the researcher got a general overview of the results in the second step. In the third step the data was coded and organised the obtained data. First the data was coded with provided codes. Per dimension of Positive Health there were three codes: 1) work activities, 2) possibilities and 3) difficulties. Besides these three codes per dimension the three codes were used for other mentioned work activities, possibilities or difficulties related to Positive Health but not relating to one of the six dimensions. After this first coding process the next step was open coding. Per one of the three provided codes, new more practice related codes were created. Next the researcher analysed the data and interpreted the answers in the context of the research question. In the fifth and sixth step there was an interpretation of the total data of all the interviews in the light of the research question. The most important data were described different paragraphs per sub-department.

For the presentation of the results the nature of the sub-departments were taken into account. Some sub-departments have more direct client contact than other sub-departments. Because of less client-contact for the sub-departments inspection & hygiene and disaster relief plan these are presented together. The interviews with the head and secretary of the whole department are presented together to show a more organizational view on the concept. The other five sub-departments with more client-contacts are presented in one table.

Furthermore the first coding step was executed by as well a supervisor in a sample. After this step the observer agreement could be measured. From an agreement value of 0.61 or higher the coding can see as substantial reliable (Landis & Koch, 1977). In this research this comparison resulted in an observer agreement of 0.69. This implies that the codes have substantial reliable. After these results the codes were compared to see what the differences were and take these differences in mind for the analyses to keep the reliability as high as possible.

The software program Atlas.ti was used to analyse the qualitative data. With the aim that this made the analyse process more systemized, ordered, transparent and accessible (Plochg, et al., 2007).

4. Results

In this chapter, the results are presented in four different paragraphs: 4.1) overview of respondents, 4.2) the willingness to change towards the concept Positive Health, 4.3) the work activities and 4.4) the possibilities and difficulties towards the integration of the concept Positive Health in the work activities of the employees.

4.1 Overview of respondents

Because of the two parts of this study, quantitative and qualitative, there were two groups of respondents. These are presented separately.

4.1.1 Overview of respondents regarding the online-questionnaire

60 respondents started the online-questionnaire, not every respondent completed the questionnaire. Respondents which didn't complete a full set of questions, for example the construct bodily functions (which consists of five items), were excluded. After excluding these respondents, 36 respondents remained (60%). Table 5 shows that there was no respondent of the sub-department disaster relief plan, for that reason this sub-department is left out the quantitative research. There were in total 30 (83,3%) women and 6 (16,7%) men included in the study. The average age of the respondents was 47.

Table 5: Respondents of the online-questionnaire classified per sub-department

	Sub-department								
	Infectious disease control	Inspection & hygiene	Sexual health	Tuberculosis	Disaster relief plan	Forensics	Public mental healthcare	Other	**Total**
N (total)	12	15	12	10	1	3	2	7	**62**
N (respondents)	11	7	6	3	-	2	3*	4	36
Gender									
Woman (N)	9	6	4	3	-	2	3	3	30
Men (N)	2	1	2	-	-	-	-	1	6
Age in years (SD)	47 (12)	51 (12)	44 (12)	57 (4)	-	44 (9)	46 (16)	42 (10)	47 (11)

*due to difference in classification by the organization and the employees themselves

4.1.2 Overview of the interviewees

The qualitative section of this research consisted of 34 interviewees. These interviewees were spread over four focus-group interviews (N=29) and five semi-structured interviews (N=5), which is shown in table 6.

Table 6: Interviewees classified per sub-department

Sub-department	**N**
Focus-group interviews	29
Infectious disease control	9
Inspection & hygiene	6
Sexual health	7
Tuberculosis	7
Semi-structured interviews	5
Disaster relief plan	1
Forensics	1
Public mental healthcare	1
Other	2
Total	34

4.2 Willingness to change

The extent to which the employees are willing to change is presented is table 7. Overall the employees are semi-positive about willing to change towards the concept Positive Health. The determinant “have to” was rated the highest, employees expect that colleagues want to change and saw necessity to change. Three out of the seven sub-departments did not expect positive effects of the change towards their work activities (“effects work”). The clearness about what the consequences of the change would be was rated as well in average negative, varying between the sub-departments from 2.0 to 3.5 (“information”). The extent to which employees expected the change is in control of their potential was rated the lowest, in average varying the items from 1.9 to 2.5 (“controllability”). Where most of the sub-departments especially rated the items of controllability negatively. Inspection & hygiene and public mental healthcare rated four aspects negative, out of the aspects of the construct controllability.

Table 7: The extent of willingness to change, classified in the three determinants: Want, Have to and Able, on a five points Likert scale

		Sub-department							
		Infectious disease control	Inspection & hygiene	Sexual health	Tuberculosis	Forensics	Public mental healthcare	Other	**total**
	N	11	7	6	3	2*	3	4*	**36***
Want to									
Effects work	N	10	1	5	2	2	2	3	**25**
	Mean (SD)	3.3 (0.6)	2.6 (-)	3.1 (0.4)	3.3 (0.4)	2.4 (2.0)	2.1 (0.4)	3.1 (0.7)	**3.0 (0.7)**
Emotions	N	11	3	6	3	2	2	3	**30**
	Mean (SD)	3.9 (0.39)	3.8 (0.14)	4.0 (0.5)	3.8 (0.9)	2.1 (1.6)	3.5 (0.4)	4.4 (0.3)	**3.8 (0.7)**
Added value	N	9	3	6	2	1	1	3	**25**
	Mean (SD)	3.7 (0.5)	3.9 (0.2)	3.9 (0.6)	3.5 (0.2)	4.0 (-)	3.7 (-)	3.7 (0.3)	**3.8 (0.4)**
Involvement	N	11	5	6	3	1	2	3	**31**
	Mean (SD)	3.6 (0.5)	2.8 (0.57)	3.7 (0.5)	3.8 (0.6)	4.0 (-)	4.0 (0.0)	4.3 (0.6)	**3.6 (0.6)**
Have to									
Internal pressure	N	7	1	6	3	1	1	2	**21**
	Mean (SD)	3.7 (0.25)	3.0 (-)	3.6 (0.5)	3.8 (0.3)	4.0 (-)	3.8 (-)	4.3 (0.7)	**3.8 (0.4)**
External pressure	N	10	3	6	3	1	2	3	**28**
	Mean (SD)	3.8 (0.3)	3.3 (0.3)	3.6 (0.6)	3.7 (0.6)	5.0 (-)	4.3 (0.4)	3.7 (0.6)	**3.8 (0.5)**
Able to									
Knowledge and experience	N	10	3	6	3	1	2	3	**28**
	Mean (SD)	4.0 (0.5)	3.0 (0.0)	3.5 (0.8)	4.0 (0.0)	5.0 (-)	4.5 (0.7)	4.0 (1.0)	**3.9 (0.7)**
Management									
Direction	N	10	3	6	3	-	2	3	**27**
	Mean (SD)	3.2 (0.6)	3.7 (0.6)	3.8 (0.4)	4.3 (0.6)	- (-)	3.5 (0.7)	3.3 (1.1)	**3.6 (0.7)**
On time	N	11	4	6	3	-	3	3	**30**
	Mean (SD)	3.0 (0.8)	4.0 (0.8)	3.7 (0.5)	4.0 (1.0)	- (-)	3.0 (1.0)	3.3 (1.1)	**3.4 (0.9)**
Information	N	9	1	6	2	-	2	3	**23**
	Mean (SD)	2.6 (0.9)	2.0 (-)	3.0 (1.1)	3.5 (0.7)	- (-)	2.0 (0.0)	2.3 (0.6)	**2.7 (0.9)**
Controllability									
Big effort	N	9	1	6	2	1	1	3	**23**
	Mean (SD)	2.2 (1.0)	5.0 (-)	2.7 (1.0)	2.0 (0.0)	2.0 (-)	3.0 (-)	2.3 (0.6)	**2.5 (1.0)**
Dependence	N	10	4	6	3	1	2	3	**29**
sources	Mean (SD)	1.8 (0.4)	2.0 (0.0)	1.7 (0.5)	2.0 (0.0)	1.0 (-)	2.5 (0.7)	2.0 (0.0)	**1.9 (0.4)**
Other changes	N	10	2	6	3	1	2	3	**28**
	Mean (SD)	2.5 (0.7)	3.5 (0.7)	2.6 (0.5)	2.6 (0.7)	1.0 (-)	2.5 (0.7)	2.0 (0.0)	**2.5 (0.7)**
Timing									
Ready to it	N	11	4	6	3	1	3	3	**31**
	Mean (SD)	3.5 (0.9)	2.0 (0.8)	3.3 (0.5)	3.3 (0.6)	4.0 (-)	3.0 (1.0)	3.0 (1.7)	**3.1 (1.0)**
Good moment	N	10	2	5	3	1	1	3	**25**
	Mean (SD)	3.6 (1.0)	3.0 (0.0)	3.2 (0.8)	3.7 (0.6)	4.0 (-)	4.0 (-)	3.7 (1.5)	**3.5 (0.9)**
Complexity	N	11	2	6	3	1	2	3	**28**
	Mean (SD)	2.8 (1.0)	3.5 (0.7)	3.3 (1.0)	3.3 (1.0)	5.0 (-)	2.5 (0.7)	2.7 (1.2)	**3.1 (1.0)**

The missing respondents of an aspect (N) have answered one of the questions of the construct with "I do not know"
*For forensics and "other" both: one respondent has left the questionnaire after the construct added value

4.3 Daily work activities

In this paragraph, the work-activities related to the concept Positive Health are described. In the first paragraph the qualitative results are discussed followed by the paragraph with the quantitative results.

4.3.1 Qualitative results

The number of mentioned work activities is presented in table 8 per sub-department and per dimension. Mentioned work activities were most frequently related to the dimensions bodily function and mental functions & perception, the least related to the dimensions quality of life and daily functioning. The sub-departments forensics, disaster relief plan and secretary were not able to mention work activities for every dimension. Daily functioning was not mentioned by all of these three sub-departments. The sub-department sexual health had mentioned by far the most and most different work activities relating to Positive Health. The dimensions mental functions & perception and the quality of life were mentioned by every sub-department in contrast to the other four dimensions. Despite most of the mentioned activities were sub-department focused, there were some corresponding activities mentioned by the sub-departments related to the concept Positive Health. Sub-departments working directly with clients mentioned the possibility to refer to other caregivers. Most of these sub-departments mentioned the work activity to anticipate in the first contact with the client on the complaints and pains as well. The sub-departments that have more indirect client contact mentioned the focus on prevention in their work activities. At last, talk about the hygiene of clients was also a common mentioned activity by the sub-departments sexual health and tuberculosis. In the following paragraphs, for each sub-department, the most frequently mentioned result(s) are presented. The interviews with the head of the department and secretary are presented in one paragraph. All of the mentioned work activities are presented per sub-department in tables 9, 10 and 11.

For the sub-department sexual health the most work activities were mentioned relating to the dimensions social & societal participation and bodily functions, the least for quality of life. Most frequently mentioned work activity was the first contact moment with clients when they present their complaints. A respondent described this contact moment as follows: *"currently, when people mention a complaint, you make an appointment, they arrives at the consultation hour, we are going to look at the complaint. You're going to do medical examination, making diagnosis and if necessary a treatment" (bodily functions).* This sub-department mentioned that Motivational Interviewing is in line with Positive Health: *"Our aim is to make people think and see where knowledge is lacking and where can you do something, just that feeling of that sense of self-management, which is based on Motivational Interviewing"(other).*

Most work activities mentioned by the sub-department tuberculosis were related to the dimension daily functioning. The most mentioned work activity was to focus on the therapy adherence of clients, especially mentioned relating to the dimension mental functions & perception. Take into account the low literacy of some clients is also an important part of their work activities.

The spiritual/existential dimension was mentioned the most frequently by the sub-department infectious diseases, the dimension daily functioning the least. Most frequently mentioned work activity was to inform clients about perspective and acceptance of a disease, for example: *"You try to provide information, they have something, there are still many opportunities, they do not misfit within society. They can still do lots of things, kids can still play. Children can go to school, play sports, so I think raising their awareness and transferring knowledge is important" (spiritual/existential dimension).* The broader view of Positive Health was assigned by referral clients if necessary: *"If someone says to me, I'm really not happy in my life. Then, I think it's wise that you are going to talk with your general practitioner"(quality of life).*

The forensics mentioned that most work activities relate to the dimension bodily functions, for daily functioning no work activity was mentioned. Just as for the sub-department sexual health, the first contact with the clients when they present their complaints and pain was the most mentioned work activity in the interview. For example the physician mentioned about a client which has some problems with sleeping: *"It is not pleasant in this place, and so you can get something to sleep well tonight"(bodily functions).* Besides the medical tasks the physician mentioned to pay attention to other aspects of life and asking for their background: *"…I do often try to get a grip on how a person lives his or her life. How did you perform at primary school, did you do high school. Often people been in a boarding school. I sometimes ask: what are your goals for your life in the future? In what activities did you experience fun? … Because when you give it no words, it is not there" (social & societal participation).*

Work activities relating to the dimension daily functioning were mentioned the most by the sub-department public mental health. For example talking about the hygiene of a client: "*If someone arrives at the consulting hour and has a smell of sweat around him, or feet that stink very much, when it is not mentioned by the patient himself, then I bring up the subject"(daily functioning).* The social medical consultation hour was mentioned as broader than a normal consultation hour: *So it is broader than just the physical health. You look in a broader perspective. How someone in a social level can improve his situation"(other).*

For the sub-department inspection & hygiene work activities were mentioned the most frequently, indirectly, relating to the dimension bodily functions, relating to the dimension quality of life the least. Most of these work activities were mentioned relating to the functioning of the professional. For example: *"So you look especially if he or she can deliver that care"(bodily functions).* Other activities that were mostly mentioned relating to testing different aspects of Positive Health in their inspection.

Disaster relief plan related the most activities to the dimension mental functions & perception, for three dimensions no activities were mentioned. The most frequently mentioned activities were activities related to one part of the disaster relief plan, namely the psycho social care team. The respondent was mentioning the activity to focus on prevention. In contrast with the focus on

prevention of the aspects of the concept of Positive Health the interviewee mentioned the prevention on the opposite of these aspects: *"In this dimension all terms are like experiencing happiness, enjoyment, perceiving health. But for me it is more about if the people do not, or as little as possible, experience the opposites of these terms. You can't prevent if something happens and they suffer from it, that's a normal reaction. But you can make sure that it doesn't pursue people. And you can still make sure people have a starting point to get out there. And that's roughly the aim of the conversation"(Quality of life).*

For the head of the department and the secretary, the mentioned activities were more focussed on the organization. The head of the department mentioned the most activities related to the dimensions societal and social participation and bodily functions. Focus on sustained employability was mentioned the most frequently as activity by the head of the department. The secretary mentioned activities that were more focused on helping the colleagues. The mentioned activities were relating most frequently to the dimensions mental functions & perception and quality of life.

Besides the mentioned work activities the respondents often gave reasons for why they do certain work activities relating to a specific dimension of Positive Health. Two most frequently mentioned reasons were that respondents think specific aspects are just important in their job and that specific aspects just were a task of their job. For example a respondent of the sub-department inspection & hygiene mentioned: *"It is all about well-being, and there where you go more deeply into it, that's the basis of your entire inspection".* The tables relating to the reasons for the work activities can be found in appendix F.

Table 8: number of work activities per dimension mentioned per sub-department

	Sub-department									
	Sexual health*[1]	Tuberculosis*[1]*[2]	Infection diseases*[1]	Forensics*[3]	Public mental health*[3]	Inspection & hygiene*[1]	Disaster relief plan*[3]	Head of department *[3]	Secretary*[3]	**total**
Dimension										
Bodily functions	17	1	7	7	4	12	3	4	0	**55**
Mental functions & perception	7	3	8	5	6	9	10	3	4	**55**
Spiritual/existential dimension	13	2	13	1	4	8	0	1	2	**44**
Quality of life	4	3	10	2	6	3	3	3	4	**38**
Social & societal participation	21	3	7	1	5	5	0	4	1	**47**
Daily functioning	10	4	6	0	8	5	0	3	0	**36**
Other	12	2	0	1	1	1	1	1	5	**24**
Total	**84**	**18**	**51**	**17**	**34**	**43**	**17**	**19**	**16**	

*[1] Concerns a focus-group interview
*[2] based on a summary of the focus-group interview due to technical failures
*[3] Concerns a semi-structured interview

Table 9: Mentioned work activities relating to Positive Health by sub-departments with direct client contact

Sexual health	**N**	**Tuberculosis***	**N**	**Infection diseases**	**N**
Work activities					
Anticipating on the complaints (BF)	10	Therapy adherence (MF,PH)	4	Inform; perspective, acceptance (ED)	8
Talk about hygiene (DF)	7	Spend time; low literacy (SP)	3	Inform; possibilities (QL)	8
Talk about daytime activities (SP)	6	Referral to other caregivers (QL)	2	Risk inventories (SP)	5
Talk about aspects (ED)	5	Transporting clients (DF)	2	Referral to other caregiver (BF,QL,DF)	4
Talk about emotions (MF,QL)	5	Pay attention on aspects (DF)	2	Inform; practical consequences (DF)	4
Talk about Homosexuality (ED,SP)	5	Looking at aspects (BF)	1	Assist clients (ED)	3
Motivational Interviewing (OT)	5	Talk about esteem (MF)	1	Spend time; low literacy (SP,DF,MF)	3
Talk about perspective (ED, QL)	4	Talk about acceptation (ED)	1	Talk about emotions (MF)	2
Talk about use of condom (SP)	4	Talk about perspective (ED)	1	Talk with clients (MF)	2
Medical test to be sure (BF)	3	Listening to client (QL)	1	First contact with medical fact (BF)	1
Patient centred approach (OT)	3			Project: “Q-support” (BF)	1
Holistic view (OT)	3			Discuss complains and pain (BF)	1
Doing medical tests (BF)	2			Using Newsletter (BF)	1
Referral to other caregivers (ED)	2			Monitor clients (BF)	1
Use positive approach (QL)	2			Talk about Esteem (MF)	1
Use of chat function (SP)	2			Focus on self-management (MF)	1
Search volunteers (SP)	2			Pay Indirect attention on aspects (ED)	1
Discuss energy (BF)	1			Continue questioning (QL)	1
Doing observations (BF)	1			Inform environment (SP)	1
Talk about esteem (MF)	1				
Name aspects of dimension (MF)	1				
Focus on self-management (MF)	1				
Careful first contact (ED)	1				
Give phone number (ED)	1				
Talk about social contacts (SP)	1				
Giving support (SP)	1				
Talk with prostitutes (SP)	1				
Gave food (DF)	1				
Transporting clients (DF)	1				
Offer inexpensive condoms (DF)	1				
Follow-up patients (OT)	1				

BF=Bodily functions, MF=Mental functions & perception, ED=Spiritual/existential dimension, QL=Quality of life, SP=Social & societal participation, DF=Daily functioning and OT=Other
*based on a summary of the focus-group interview due to technical failures

Table 9: Mentioned work activities relating to Positive Health by sub-departments with direct client contact

Forensics	**N**	**Public mental health**	**N**
Work activities			
Anticipating on the complaints (BF)	5	Talk about hygiene (DF)	5
Diagnostic, observations (BF, MF)	4	Advise; social environment (SP)	4
Asking to background (SP,ED)	2	Give practical solutions (QL)	3
Talk about emotions (MF)	1	Anticipating on the complaints (BF)	2
Focus on reassurance (MF)	1	Advising on medical complains (BF)	2
Referral to other caregivers (MF)	1	Referral to other caregivers (MF)	2
Discuss aspects of dimension (QL)	1	Focus on Empowerment (MF)	2
Calling with clients (QL)	1	Striving for aims with client (ED)	2
Take context into account (OT)	1	Helping with balance in life (QL)	2
		Advising illegals (MF)	1
		Give primary care (MF)	1
		Care to avoid recurrence (ED)	1
		Clients helping with each other (SP)	1
		Work with municipality (QL)	1
		Helping with furnishing (DF)	1
		Advise Care givers (DF)	1
		Discuss cooking (DF)	1
		Social medical consult (OT)	1

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 10: Mentioned work activities related to Positive Health by sub-departments with indirect client contact

Inspection & hygiene	**N**	**Disaster relief plan**	**N**
Work activities			
Test; Functioning of professional (BF,MF)	9	Team psycho social care (MF)	4
Test; aspects to children (MF, ED,QL)	7	Keep aspects in mind (MF)	3
Test; mission and vision (ED)	6	Prevent opposite of the aspects (QL)	3
Test; social contacts children (SP)	5	Take into account with planning (MF)	3
Focus on work environment (DF)	3	Thinking preventive (BF)	2
Pay attention children's energy (BF)	2	Pay attention on energy (BF)	1
Risk inventories (BF)	2	Keep connected with care givers (OT)	1
Test; cognitive, emotional (MF)	2		
Pay attention children's development (DF)	2		
Talk about aspects (ED, PH)	2		
Test; emotional (MF)	1		
Test; self-respect (MF)	1		
Test; development (MF)	1		
Pay indirect attention to aspects (ED)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 11: Work activities related to Positive Health by the head of department and secretary

Head of department	**N**	**Secretary**	**N**
Work activities			
Focus on sustained employability (BF)	3	Helping employees mental (MF)	4
Personalize balance work/private (MF)	2	Indirect influence to healthcare (OT)	4
Communicative skills in function (SP)	2	Zest for life by employees (QL)	3
Therapy adherence tuberculosis (DF,MF)	2	Acceptance by employees (ED)	1
Signalling medical facts (BF)	1	Perspective of employees (ED)	1
Perspective of the organization (ED)	1	Project "clean safe school" (QL)	1
Pay attention to work environment (QL)	1	Social contacts of employees (SP)	1
Secondary prevention in organization (QL)	1	Discuss employees matters (OT)	1
Consulting interviewing (QL)	1		
Select the right projects (SP)	1		
Present importance of participation (SP)	1		
Referral to other caregivers (DF)	1		
Work with asylum seekers (OT)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other.

4.3.2 Quantitative results

The average of the employees self-given score regarding their thoughts on how they were working according to the concept Positive Health varies between the sub-departments (table 12). Four sub-departments scored an average from 4.4 to 5.9. Of the other three sub-departments, inspection & hygiene and forensics scored low regarding their appliance of the concept Positive Health, while tuberculosis scored high. Figure 7 gives a visual representation of the differences between the sub-departments per dimension in a six-point diagram. Most sub-departments remained consistent with their score for the different dimensions. However the sub-departments sexual health and "other" showed a relatively low score for the dimension daily functioning regarding their average on the concept Positive Health. Compared to the high scores of the sub-department tuberculosis, they were shown a considerably lower score for social a societal participation. This sub-department rated the dimension bodily function to be their highest score, what was the highest score rated overall. Averages of all respondents was taken per dimension, the averages were rated from 4.2 to 4.9. Spiritual/existential dimension and daily functioning were rated the lowest, mental functions & perception the highest. At last, the sub-department inspection & hygiene relatively had a lot of employees who filled in "I do not know" for different statements.

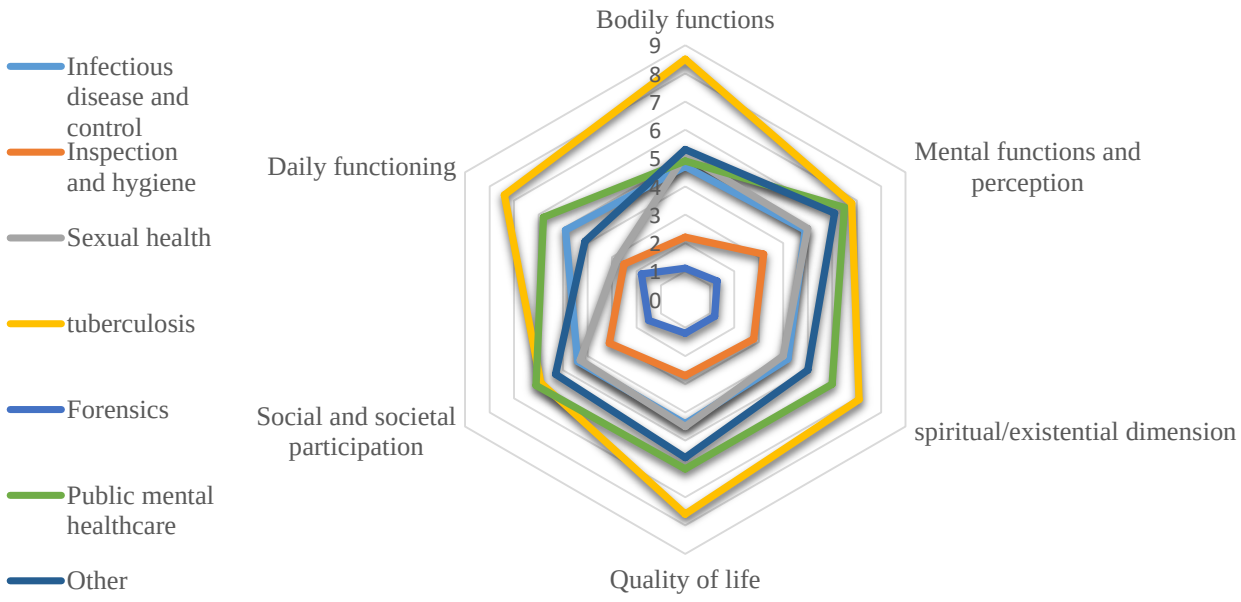

Figure 7: Extent employees think they work according to every dimension per sub-department

Table 12: The extent employees think they work according to the six dimensions of Positive Health on a nine points scale

		Sub-department							
		Infectious disease control	Inspection & hygiene	Sexual health	Tuberculosis	Forensics	Public mental healthcare	Other	**total**
	N	11	7	6	3	2	3	4	**36**
Dimension									
Bodily functions	N	11	4	6	3	2	3	2	**31**
	Mean (SD)	4.7 (2.0)	2.2 (1.8)	5.1 (1.7)	8.5 (0.6)	1.1 (0.1)	4.9 (2.9)	5.3 (1.3)	**4.7 (2.5)**
Mental functions & perception	N	11	5	6	3	2	3	2	**32**
	Mean (SD)	4.9 (2.1)	3.2 (2.6)	5.0 (1.9)	6.8 (1.6)	1.3 (0.4)	6.5 (0.7)	6.1 (0.7)	**4.9 (2.3)**
Spiritual/existential dimension	N	11	5	6	2	2	3	2	**31**
	Mean (SD)	4.2 (2.2)	2.8 (2.3)	4.0 (2.1)	7.1 (0.1)	1.2 (0.3)	6.0 (0.5)	5.0 (0.8)	**4.2 (2.3)**
Quality of life	N	11	5	5	2	2	3	2	**30**
	Mean (SD)	4.4 (2.2)	2.7 (2.4)	4.5 (2.6)	7.6 (0.1)	1.2 (0.3)	6.0 (0.9)	5.6 (1.5)	**4.4 (2.4)**
Social & societal participation	N	11	5	6	3	2	3	2	**32**
	Mean (SD)	4.4 (2.4)	3.1 (2.7)	4.3 (2.1)	5.9 (2.6)	1.5 (0.7)	6.1 (1.3)	5.3 (2.5)	**4.3 (2.4)**
Daily functioning	N	11	4	6	3	2	3	2	**31**
	Mean (SD)	4.9 (2.1)	2.5 (1.9)	2.8 (1.6)	7.4 (2.1)	1.8 (1.1)	5.8 (1.7)	4.1 (0.2)	**4.2 (2.4)**
Positive Health	N	11	4	5	2	2	3	2	**29**
	Mean (SD)	4.6 (2.1)	2.5 (2.4)	4.4 (2.1)	7.8 (0.1)	1.3 (0.5)	5.9 (1.1)	5.3 (1.3)	**4.4 (2.3)**

The missing respondents per dimension (N) have answered at least one of the questions of the construct with “I do not know”

4.4 Possibilities and difficulties

The possibilities and difficulties relative to the application of the concept Positive Health in the daily work activities of the employees of the Public Health Service Twente are presented in paragraph 4.4.1 and 4.4.2.

4.4.1 Possibilities

The majority of the mentioned possibilities were relating to the general concept Positive Health and were classify as "other" (table 13). The possibilities related to the six dimensions were most frequently related to the dimension mental functions & perception, the least frequently to the dimension daily functioning. Six and seven sub-departments, respectively, had not mentioned any possibility related to the dimension bodily functions and the dimension daily functioning. The head of department mentioned by far the largest number and most different possibilities. The most corresponding possibilities in the interviews were the method of Motivational Interviewing, looking organisation broad regarding the concept instead of per team, pay just some attention besides your main task and improve the intern and extern collaboration. All of the respondents gave patient-centred possibilities, where focus lies on the individual. The mentioned possibilities per sub-department are presented in table 14, 15 and 16. The most frequently mentioned possibilities per sub-department are discussed in the upcoming paragraphs.

The sub-department sexual health proposed the most possibilities regarding the concept in general (other). The most suggested possibility was to ease the process of making an appointment, for example by using the internet: *"You should integrate what is suggested in the client satisfaction surveys, make an appointment online" (other).* Regarding the dimensions, most possibilities were mentioned relating to mental functions & perception. One such possibility is to focus more on the lower educated target population: *"We would still like to have some more low educated people, I think it is a tough group" (mental functions & perception).*

The most frequently mentioned possibilities for the sub-department tuberculosis were as well related to the general concept of Positive Health (other). One possibility they mentioned was concerning Motivational Interviewing as it contains more potential than it currently utilizes.

At the infection diseases sub-department, they assigned most of their possibilities to the spiritual/existential dimension. Most possibilities were about the assistance of clients or organizations, for example: *"If someone else doesn't pick it up, you have to as Public Health Service, but they are discussing a lot who has the responsibility, and what is the best party to do this, is it the Public Health Service or not, or are you more a coordinating organization, and not the literal assistance, but you have to remember, it should be done" (spiritual/existential dimension).* Another possibility that related more to the concept of Positive Health is to focus more on the needs of the client. A respondent underpinned this with the following statement: *"It is not always about what you have to say, it's about what he can do with it" (other)*. Two dimensions were not brought up at all.

The sub-department forensics mentioned the most possibilities affecting the mental functions & perception dimension. The most frequently mentioned possibility corresponding to this dimension was to focus on the lower educated target group. The overall most frequently mentioned possibility was to improve the link between different caregivers in the healthcare section: *"Well I think we have to be more like a link, we pay more attention to the right care, setting, general practitioner, after we have seen people. And there's just no communication yet… and now we see them and go back where they came from, and we have no insight… That missing piece of information could be more" (quality of life).* Again two dimensions were not acknowledged at all.

The sub-department public mental health mostly brought up possibilities for the dimension quality of life. Regarding this dimension, they mostly brought up to improve the collaboration with the coaches from another organization who are responsible for a specific district. In general, the respondent referred the most to paying attention to the social environment of the clients: *"You know it can be positive, so now with the participation in society, you can do it together, that's connecting with Positive Health" (social & societal participation).* This time, three dimensions remained undiscussed.

The sub-department inspection & hygiene only focused on the possibilities for the overall concept Positive Health, without diving into a specific dimension. The most frequently mentioned possibility was to improve the collaboration in the organization and to focus more on the personal view of employees towards life, for example: *"If you look at inspections, it has to do with your humanity" (other).*

The last sub-department, disaster relief plan, mentioned the most possibilities related to the dimension mental functions & perception, all other mentioned possibilities were related to the concept of Positive Health in general (other). Relating to the team psycho social care, the publicity towards other stakeholders was mentioned most often: *"I think it is particularly important that we are involved on time. This has partly to do with publicity" (other).*

Both interviewees, head of the department and the secretary, mostly mentioned possibilities concerning the concept Positive Health (other). They frequently talked about the improvement of the sustained employability. On the subject of work activities, they mentioned to pay attention towards other aspects besides the regular tasks of your job: *"If you can, besides your tasks, do some piece on how a person looks at his own life, that would be nice" (other).* According to the secretary, the most frequently mentioned possibility to work towards to the concept was to make the transition more natural. She stated: *"if you say you must ensure that you communicate Positive Health, I do not believe it will works. Therefore, I say, it should be automatic" (other).* In both interviews it was brought up to make the term Positive Health more specific and clear. For example, the head of the department said the following about the term health skill: *"Want it to be successful you'll need to think of another term" (other)*.

Table 13: number of possibilities per dimension mentioned per sub-department

	Sub-department									
	Sexual health*[1]	Tuberculosis*[1]*[2]	Infection diseases*[1]	Forensics*[3]	Public mental health*[3]	Inspection & hygiene*[1]	Disaster relief plan*[3]	Head of department*[3]	Secretary*[3]	**total**
Dimension										
Bodily functions	4	0	5	0	0	0	0	10	0	**19**
Mental functions & perception	5	0	1	7	1	0	5	6	0	**25**
Spiritual/existential dimension	2	1	9	2	0	0	0	1	3	**18**
Quality of life	2	1	2	4	4	0	0	7	1	**21**
Social & societal participation	2	0	0	1	2	0	0	5	2	**12**
Daily functioning	3	0	0	0	0	0	0	3	0	**7**
Other	7	2	8	4	2	9	2	19	11	**63**
Total	**25**	**4**	**25**	**18**	**9**	**9**	**7**	**51**	**17**	

*[1] Concerns a focus-group interview
*[2] based on a summary of the focus-group interview due to technical failures
*[3] Concerns a semi-structured interview

Table 14: Mentioned possibilities relating to Positive Health by sub-departments with direct client contact

Sexual health	N	Tuberculosis*	N	Infection diseases	N
Possibilities					
Making an appointment easier (DF,PH)	6	Possibilities in organization (ED)	1	Assistance of clients/organizations (ED)	5
Focus on lower educated functioning (MF)	3	Listening to the client (QL)	1	Improve prevention policy (ED)	3
Improve waiting times (BF)	2	Relationship with client (OT)	1	Focus on needs of client (OT)	2
More attention on sexual problems (BF)	2	Motivational Interviewing (OT)	1	Improve contact GP (BF)	2
Start the conversation about aspects (ED)	2			Improve contact hospital (BF)	2
Use positive approach towards sex (QL)	2			Need for all dimensions (OT)	2
Motivational Interviewing (MF,PH)	2			Improve extern communication (BF)	1
Focus on high educated functioning (MF)	1			Dependence of law (MF)	1
Focus on social media of clients (SP)	1			Focus on perspective (ED)	1
Pay attention daytime activities (SP)	1			Pay attention awareness (QL)	1
Change priority of money clients (DF)	1			Pay attention besides task (QL)	1
Asking to problems (OT)	1			Collaborate with Youth healthcare (OT)	1
Focus on prevention (OT)	1			Visit clients (OT)	1
				Replace brochures by videos (OT)	1
				Change disease orientation (OT)	1
				Change as whole organization (OT)	1

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other
*based on a summary of the focus-group interview due to technical failures

Table 14: Mentioned possibilities related to Positive Health by sub-departments with direct client contact

Forensics	N	Public mental health	N
possibilities			
Improve link between caregivers (QL)	4	Pay attention to social environment (QL,SP)	3
Focus on lower educated group (MF)	3	Improve district coaches (QL)	2
Improve collaboration (OT)	3	Focus on asylum seekers (MF)	1
Improve interfering care (MF)	2	Create trustful network for clients (QL)	1
Pay attention besides task (ED,PH)	2	Use “Humanitas” consultation hour (OT)	1
Take responsibility (MF)	1	Create healthy environment (OT)	1
Approve helping institutions (MF)	1		
Name the problems of clients (ED)	1		
Pay attention daytime activities (SP)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 15: Mentioned possibilities related to Positive Health by sub-departments with indirect client contact

Inspection & hygiene	N	Disaster relief plan	N
Possibilities			
Improve Collaboration (OT)	2	Maintain publicity (MF)	3
Focus on personal view employees (OT)	2	Preparation of casus (MF)	2
Dependence commodities act (OT)	1	Different parts in Public health (OT)	1
Employees think in Positive Health (OT)	1	Others responsibility (OT)	1
Ask questions with direction (OT)	1		
Change as whole organization (OT)	1		
Just when clients contact present (OT)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 16: Mentioned possibilities related to Positive Health by the head of department and secretary

Head of department	**N**	**Secretary**	**N**
Possibilities			
Improve Sustained employability (BF)	7	Make Positive Health naturally (OT)	3
Pay attention besides task (QL,PH)	6	Positive mind-set (ED,PH)	2
Focus on prevention (OT)	4	Focus on awareness (OT)	2
Translating the concept (OT)	3	Improve vague term (OT)	2
Talk carefully about other health issues (BF)	2	Focus on therapy adherence (QL)	2
Improve patient centeredness (MF)	2	Improve contact sexual health (ED)	1
Get more insights in sub-departments (MF)	2	Potential added value (ED)	1
Mirroring employees on clients (ED,QL)	2	Referral to other caregivers (SP)	1
Improve interfering care (DF)	2	Caution communication skills (SP)	1
Not that new, already familiar (OT)	2	Indirect influence (OT)	1
Possibility for travellers vaccinations (BF)	1	Responsibility of the client (OT)	1
Promote Lunchbreak employees (MF)	1		
Focus on sexual violence (MF)	1		
Improve openness between colleagues (QL)	1		
Experiencing quality of life (QL)	1		
Good interviewing (QL)	1		
Emphasise meaningful work (SP)	1		
Caution communication skills (SP)	1		
Pay attention homosexuality (SP)	1		
Improve health promotion (SP)	1		
Creating daytime activities (SP)	1		
Use LEAN (DF)	1		
Motivate employees (OT)	1		
Conversation with the board (OT)	1		
Deliver quality (OT)	1		
Improve influence municipality (OT)	1		
Improve the vague term (OT)	1		
Discuss impact of concept (OT)	1		
What is who's responsibilities (OT)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

4.4.2 Difficulties

The majority of the mentioned difficulties touched the concept Positive Health (other) (table 17). Within the boundaries of the six dimensions, the most difficulties mentioned were related to the dimension bodily functions. The dimension Daily functioning was mentioned the least. Three sub-departments mentioned the most difficulties, sexual health, infection diseases and the head of the department. Tuberculosis and public mental health were mentioned the least. The most important corresponding difficulties included the time, opinions that state that some dimensions should not be the task of the employees, the vague nature of the concept's term, indirect influences towards the clients and language barriers to communicate more aspects of the concept Positive Health. The mentioned difficulties are presented per sub-department in table 18, 19 and 20. The most frequently mentioned possibilities per sub-department are discussed in the following paragraphs.

Mentioned by the sub-department sexual health the difficulties were mostly ranged under the dimension bodily functions and towards the concept in general (other). And relating the least to the dimension quality of life. The most frequently mentioned difficulty for integration of the concept Positive Health was the time, one respondent mentioned: *"There are still times when you actually want to go further in the conversation. And you just have no time" (other).* Another difficulty that was often mentioned are that some aspects are just not the priority in their work towards the clients.

The majority of difficulties mentioned by the sub-department tuberculosis were relating to the concept Positive Health (other). Just as for sexual health, less time for the patients was mentioned most often as a difficulty. Employees mentioned as well that some aspects were not part of their regular jobs.

The sub-department infection diseases brought up the most difficulties relating to the dimension bodily functions and the general concept of Positive Health (other). Most often it was mentioned that some specific aspects of the concept Positive Health were not the responsibility of these employees, an example of this mentioned difficulty was: *"That is not an issue, if someone has a meaningful daily activity – no idea, it doesn't interests really me." (social & societal participation).* Another often mentioned difficulty was the incidental contact moments with the clients: *"You do not have time for all. For five minutes I have someone on the phone, then I really do not look for example if someone is happy" (other).*

At the sub-department forensics, difficulties were mostly mentioned relating to three dimensions, mental functions & perception, quality of life and towards the general concept of Positive Health (other), for the dimension daily functioning no difficulties were mentioned. The most often mentioned difficulty was about the target group of lower educated: *"Actually we have little insight into, how to deal with that group of people and what we can offer them"(mental functions & perception).* Just as mentioned by the employees at infection diseases, the physician mentioned the incidental contact is a difficulty when the focus has to be on several aspects: *"You see people incidentally. That makes it difficult"(mental functions & perception).*

Difficulties were most brought up relating to the dimension social & societal participation by the public mental healthcare, no difficulty was mentioned relating to the dimension daily functioning. One of the most frequently mentioned difficulties was that the interviewee mentioned they already work according to the concept of Positive Health, underpinned with following example: *"I think we always work this way... If you do not, then you cannot reach anything with this target group"(other)*. Furthermore critics were mentioned about the policy towards the self-management of the clients, an example that was mentioned when it went wrong: *"Someone was not able go to the store but had friends who were addicted. But then he gave money to those friends, but they often bought drugs instead of his grocery. Then you have to explain it to someone of the municipality, you can still meet the participation law, if someone's network is not reliable, then there is no sense, he will still not eat"(social & societal participation).*

The sub-department inspection & hygiene mentioned the most often difficulties related to the concept Positive Health (other), followed by the dimension spiritual/existential dimension. Most often mentioned was that different aspects are not the responsibility of these employees. As example an employee mentioned: *"We just have an entirely different task, a different position within the Public Health Service than the other sub-departments. What you have at sexual health, inform, cure or, we do not have those aspects"(other).* A possible cause for this mentioned difficulty: this sub-department mentioned they work only indirectly with clients.

The most frequently mentioned difficulties were also for the sub-department disaster relief plan related to the concept Positive Health (other), daily functioning was mentioned the least. Just as other sub-departments this interviewee mentioned: *"It is just simply not my job"(other).*

The head of the department mentioned the most difficulties regarding to the dimension bodily functions, the secretary to daily functioning and the concept Positive Health (other). Also in these interviews the difficulty that specific aspects are just not the responsibility of the employees was mentioned. The head of the department most often mentioned as example that the employees have to focus on their primary task: *"I think it is not up to us to really have a big role in the existential dimension. Most of all we need to trying to solve the problems of the client. And trying to solve the problem as well is not recurring. But meaning of life, and esteem, pursuing ideals, I find it outside our area of work"(spiritual/existential dimension).* Thereby both interviewees mentioned the terms of Positive Health were vague and difficult.

Table 17: number of difficulties per dimension mentioned per sub-department

	Sub-department									
	Sexual health*[1]	Tuberculosis*[1]*[2]	Infection diseases*[1]	Forensics*[3]	Public mental health*[3]	Inspection & hygiene*[1]	Disaster relief plan*[3]	Head of department*[3]	Secretary*[3]	**total**
Dimension										
Bodily functions	12	1	10	2	2	5	5	13	1	**51**
Mental functions & perception	4	3	3	6	4	3	6	1	1	**31**
Spiritual/existential dimension	7	3	9	1	2	8	5	5	3	**43**
Quality of life	1	1	9	6	1	1	2	7	0	**28**
Social & societal participation	7	1	3	2	5	3	4	9	3	**37**
Daily functioning	5	1	5	0	0	1	1	5	5	**23**
Other	13	4	10	6	1	11	8	10	5	**68**
Total	**49**	**14**	**49**	**23**	**15**	**32**	**31**	**50**	**18**	

*[1] Concerns a focus-group interview
*[2] based on a summary of the focus-group interview due to technical failures
*[3] Concerns a semi-structured interview

Table 18: Mentioned difficulties related to Positive Health; sexual health, tuberculosis and infection diseases

Sexual health	N	Tuberculosis*	N	Infection diseases	N
Difficulties					
Not enough time (BF,ED,PH)	9	Not enough time (ED)	3	Outside their responsibility	11
No priority of the work of clients (SP)	6	Outside their responsibility	3	(BF,ED,QL,SP,DF)	
Cannot reach the appointment (DF,PH)	6	(MF,QL)		Once contact with clients	9
Not the assistance task (ED,PH)	4	Culture barriers (DF,PH)	2	(BF,ED,QL,DF,PH)	
Not always prevention possible (OT)	4	Motivational Interviewing (OT)	2	Not the assistance (BF,ED)	6
Unasked problems of client (ED)	3	Vague; aspect energy (BF)	1	Focus on society, not patient (QL,PH)	5
Known as STD care by societal (BF)	2	Short contact time (MF)	1	Report of other professionals (BF)	3
Less attention "Sense" poli	2	Language barriers (SP)	1	It is clients responsibility (MF,PH)	2
Once contact with clients (MF)	2	Unclear what is the change (OT)	1	What is who's responsibility (ED)	2
High educated thinks they know (MF)	2			Vague; existential/spiritual (ED)	2
Dependence guidelines (BF)	1			No influence on day activities (DF)	2
Vague; aspect energy (BF)	1			It is disease oriented (OT)	2
Mental not priority (MF)	1			Impossible; Self-management (OT)	2
Depend of employee (SP)	1			Only for chronic diseases (OT)	2
Priority of clients is STD (DF)	1			Short contact time (MF)	1
Language barrier (DF)	1			Cannot check the clients (MF)	1
Savings by the government (OT)	1				

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

*based on a summary of the focus-group interview due to technical failures

Table 18: Mentioned difficulties related to Positive Health; forensics and public mental health

Forensics	N	Public mental health	N
Difficulties			
Help needed lower educated (MF,SP)	4	Permission required (BF)	2
The professionalization of healthcare (OT)	3	Think they do it already (MF,PH)	2
Incidental contact (MF,QL)	3	Illegals target group (MF)	2
Not enough time (ED,PH)	2	Outside their responsibility (SP)	2
Vague aspect energy (BF)	1	Self-management not always possible (SP)	2
Focus aspect esteem and self-respect (BF)	1	Vague concept (MF)	1
No control of life (MF)	1	Hopeless situations (ED)	1
Need improve helping institutions (MF)	1	Need of social environment (ED)	1
What is who's responsibility (MF)	1	District coaches; depends of person (QL)	1
Irrelevant (QL)	1	Feel too comfortable at Humanitas (SP)	1
Communication in care needs better (QL)	1		
Dependence of protocols (QL)	1		
Needs for sharing (QL)	1		
Curative care (OT)	1		
Communication needs better (OT)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 19: Mentioned difficulties related to Positive Health; inspection & hygiene and disaster relief plan

Inspection & hygiene	N	Disaster relief plan	N
Difficulties			
Outside their responsibility (MF,ED,QL,SP,PH)	13	Outside their responsibility (BF,MF,ED,SP,DF,PH)	16
Only indirect (BF,MF,DF,PH)	7	Only indirect (BF,MF,ED,QL)	7
Difficult concept (BF,PH)	5	What is who's responsibility (MF,PH)	2
Dependence of the law (BF,PH)	2	Occasionally (MF)	1
Not an advising role (ED)	2	Every casus differs (MF)	1
Collaboration needs better (OT)	2	Changes in core team (MF)	1
Aspects are too deep (MF)	1	Only as final outcome relevant (OT)	1
		Focus on society, not patient (OT)	1

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

Table 20: Mentioned difficulties related to Positive Health; inspection & hygiene and disaster relief plan

Head of department	N	Secretary	N
Difficulties			
Focus on task (BF,MF,ED,SP,PH)	11	Outside their responsibility (DF)	5
Difficult terms (ED)	4	Difficult terms (ED,PH)	2
Aging of the employees (BF)	3	Employees life's stays private (SP,PH)	2
Other responsibilities (SP)	3	Difficult influence municipality (OT)	2
Not the responsibility of the employees (SP)	3	Just advise employees (BF)	1
Translation of the concept to reality (BF)	3	No client contact (MF)	1
Management is focus on finance (BF)	2	Focus on task (ED)	1
Sustained employability (BF)	2	Make organization lively (ED)	1
Always medical focused (QL)	2	Clients just for STD (SP)	1
Late involvement in process (DF)	2	Differs per sub-department (SP)	1
Difficult influence municipality (DF)	2	Static organization (OT)	1
Not enough time (ED)	2		
Difficult for inspection & hygiene (QL)	2		
First give the good example (BF)	1		
Bureaucratic organization (BF)	1		
Focus on task (MF)	1		
Need for openness between employees (QL)	1		
Just for direct client contact (QL)	1		
Overestimate possibilities of concept (QL)	1		
Making prevention meaningful (SP)	1		
Competition in care (OT)	1		
Time of consultation hour (OT)	1		
Less health promotion in organization (OT)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning and OT=Other

5. Discussion

This study focused on the views of employees of the Public Health Service Twente towards the concept Positive Health in their daily work activities. The study is split in four research questions, which resulted in the following main results: 1) The employees were willing to change towards the concept Positive Health but they felt the change was not fully in their control. The expected influences on the work activities were not always regarded as positive and the information provided about Positive Health was not always sufficient. The sub-departments inspection & hygiene and public mental health are willing to change to a lesser extent. 2) Employees identified the highest number of work-activities related to the dimensions bodily function and mental functions & perception, the least for quality of life and daily functioning. The sub-department sexual health identified the largest number and most different work activities. The extent to which employees thought they work according to the concept was rated in the middle on a nine points Likert scale. Tuberculosis rated higher and inspection & hygiene and forensics lower. 3) The most corresponding possibilities mentioned in the interviews of the sub-departments were the method of Motivational Interviewing, looking organisation broad to the concept instead of per team, looking beyond your main tasks and improve the intern and extern collaboration. The most difficulties mentioned were the duration of consults, the opinion that some dimensions were not the responsibility of the employees, vague definitions within and of the concept, indirect influences towards the clients and the language-barrier with some clients that makes the communication towards more dimensions difficult. And 4) The sub-departments with indirect client contact had less identification with the concept Positive Health than the sub-departments with direct client contact.

5.1 Evaluation of the results

In general, the employees are willing to change towards the concept Positive Health, but there were some aspects which need some extra attention. A possible reason that some aspects need extra attention was that some sub-departments were not well-known with the concept.

Suggested from the results is that a higher number of mentioned activities relating to a dimension in the interviews is not related to higher scores of the dimensions in the online questionnaire. For example, sexual health, which mentioned the most work activities, had scored themselves third lowest of all sub-departments on the overall construct Positive Health. A possible explanation might be that employees were more likely to agree with a dimension when all aspects were presented than when a specific aspect is presented in a single statement, like in the online-questionnaire. Furthermore, the nature of the mentioned work-related activities depended on the specific sub-departments, some were more direct, indirect or collegial focused.

Just as described in the literature, the method of Motivational Interviewing was mentioned as possibility for integration of the concept Positive Health. Other mentioned possibilities were focussing

with the concept more on the total organization instead of trying to integrate the concept in every specific sub-department and pay attention to the internal and external collaboration. These possibilities for the integration of Positive Health were not described earlier in the literature. A possible explanation of these possibilities were nevertheless mentioned, is the broadness of the concept. Because employees didn't always see all the dimensions and aspects in their own activities but could imagine other sub-departments, departments or organizations had more to do with a specific dimension or aspect. That is endorsed with the mentioned work activity referral. The patient-centred possibilities were in line that patient centeredness being an extensively promoted approach in healthcare for recent years (Saha, Beach, & Cooper, 2008).

Some sub-departments mentioned that not all specific aspects of Positive Health are the responsibilities of the employees. The head of the department mentioned this difficulty as well, this could be explained because the concept Positive Health was put on the agenda by the Management Team, of Public Health Service Twente. This was achieved by the workgroup of Positive Health in the organization, and not by the head of the department himself. After concluding that some sub-departments were less in contact with clients than other sub-departments, the difficulty of indirect influence was expected by the researcher. The definitions within the concept were mentioned as vague by some employees. A possible reason could be that the concept is new. The first impression could give the image that the concept is only about a positive approach of health, nevertheless the concept is much broader: the six dimensions of Positive Health, focus on the empowerment and focus on how someone would gain energy. The mentioned difficulty of the language-barrier was not that strange. The Public Health Services are responsible for the health of the whole of society. With that reason it is obviously that some clients, for example asylum seekers, do not speak the Dutch language (Duijnhoven, et al., 2016).

All of the three research objects, work activities, possibilities and difficulties were most often mentioned in the interviews of sexual health, infectious diseases and head of the department. The data of both sub-departments were collected in a focus-group interview, which could be the reason why there was received more input compared with the other sub-departments. The head of the department mentioned the most possibilities and difficulties. This could be a result of the head of the department thinking more about all of the departments, instead of focussing on a single one.

A discussion point would be the reasons why the concept Positive Health is established, as described in the introduction. In the end, the healthcare costs have to be feasible. At this moment there is no research known that confirms the benefits relating to these societal aspects, but the same could be said about the disadvantages. Despite this, the concept was among others created to anticipate on the raising healthcare costs, but this is not proven at the moment.

5.2 Previous research

This study was the first to explore the willingness to change and the work activities, possibilities and difficulties relating to the concept Positive Health on this specific department Public health, of the Public Health Services. Earlier research for the Public Health Services focused on a small part of the department Youth healthcare. Despite the differences in methodology between both studies, some comparisons can be made. As presented, the willingness to change was overall positive towards Positive Health. The study of the Youth healthcare also showed a positive attitude towards the concept. Notable were the differences in the ranking of the 32 aspects of the concept. In this thesis the question relating to the 32 aspects of Positive Health was about the employees' work activities in contrast with the previous studies, where the question focused on the employees' perception of health (Backhaus, Lamers, & Cornelissen, 2015; Huber, Vliet, & Boers, 2016). The respondents of this research towards the department Public Health scored the statements in average two points lower (on a nine points Likert scale) than in previous research. This could indicate the difficulties that employees of the Public Health Services see for the concept relating to their own work activities. Just as in the study of Huber (2016) daily functioning was rated the lowest by the respondents.

Research of Huber (2014) towards the 32 aspects of Positive Health shows the presence of the broader view towards health of nurses and the more bodily focus of physicians. Despite the absence of identifying and analysing the differences of these two stakeholders in this study, there were no remarkable differences noted by the researcher in the perception towards the concept and health in the focus-group interviews. A possible reason that was mentioned in the research of Backhaus (2015), could be that the employees of a Public Health Services were more focused on the society than the physicians in a hospital, which could result in a broader perception of health for the clients (GGD GHOR Nederland, 2016).

At last, the collaboration between caregivers, inside the Public Health Services Twente and external with other organizations, was mentioned frequently by different respondents. This in accordance with the described necessity of collaboration of caregivers to achieve a more patient-centred care, just as Positive Health (Verhoef, 2013).

5.3 Generalizability

The quantitative research was based on the questionnaire of 36 respondents. The group respondents consisted of 83% women, which was in accordance with the high percentage of women in the organization. It is stated that in the working population in healthcare the women comprise over 75% of the workforce in the Netherlands (Department of Human Resources for Health, 2008). Because the Public Health Services are a piece of the healthcare organizations it is not remarkable the percentage women working in the Public Health Service Twente was high as well. The average age of the total department was 47, which was in line with average age in the organization, where most of the employees (32%) are in the range of 45 and 54 year.

Because in this study Public Health Service Twente was used as a case for all of the Public Health Services in the Netherlands, it is important to take the differences between the Public Health Services into account. For all of the Public Health Services it is mandatory they execute at least the tasks which are described in the law of public health. Despite the general tasks, supplementary tasks are present, which are imposed by the corresponding municipalities (Rijksinstituut voor Volksgezondheid en Milieu, 2014). Moreover an aspect to take into account are the differences between the regions in the Netherlands. In the more urban environments in the Netherlands there are other health issues than in the more rural regions, like Twente (Verheij, 1999). Because of the similarity of the general tasks, the differences in the supplementary tasks and the differences between the populations, the results can be generalized for the other organizations, but with caution.

5.4 Strengths and limitations

This explorative mixed method research was the first research on Positive Health in the department Public health of the Public Health Services. The design gave the possibility to gather a lot of, previously unknown, data. Before this study there was no information available about the view of the employees towards the concept Positive Health on the work activities. With the use of mixed method design the two methods could give each other more strength. To ensure the validity in this study, the used instruments were based on valid sources. One part of the questionnaire was based on an extensive study (Huber, Vliet, & Boers, 2016). The other part of the questionnaire was based on the evidence-based questionnaire of Metselaar, which was held up to date through the years (Metselaar, Cozijnsen, & Delft, 2011). To guarantee that the questionnaire of this study was valid as well, the questionnaire was thoroughly inspected on accuracy and relevancy to the study. This way, there was ensured that the questions measured that which they were designed to measure. Secondly the interviews were based on different sources as the dimensions and earlier held interviews related to the concept Positive Health (Backhaus, Lamers, & Cornelissen, 2015; Huber M. , et al., 2016).

The focus-group interviews are reliable because the presence of a minimum of six employees per focus-group and there was random sampling of the employees per sub-department. For the semi-structured interview it is important to take into account that there was just one interview per sub-department. For that reason, the results need to be carefully interpreted for the whole sub-department. Despite of the invitation by the head of the department, the answers in the interviews were not expected to be social desirable, because this person was not imposing the change. Thereby the nature of the interviews was indicated as open by the researcher. The quantitative response was 60%, and differs between the sub-departments from zero respondents for disaster relief plan, till 92% for the sub-department infectious disease control. When interpreting the results, the influence of the bigger sub-departments on the average scores have to be taken into account. Due to the incomplete response it is important to be apprehensive for selection bias. It is possible employees who are positive about the upcoming change are more likely to fill in the questionnaire than employees who are negative

towards this change. The other way around it is possible employees who are negative about the upcoming change are more likely to fill in the questionnaire to give their opinion about the change. For this reason selection bias has to take into account.

As presented in the result section the sub-department inspection & hygiene answered relatively often with the answer “I do not know”. A possible explanation is that these people think the concept is vague and indirect for their work activities and with that reason filled in “I do not know”. The true reason remains unknown, because the respondents were not asked for an explanation.

The qualitative research was conducted with two interview types, namely focus-group and semi-structured. Because of the presence of more respondents in a focus-group interview it is plausible this type generated more output. Unfortunately, the transcription of the interview with tuberculosis was not possible due to technical failures with the recording during the interview. For that reason the coding is based on a summary of the researcher who conducted the interview. These two aspects have to be taken into account with the interpretation of the qualitative results.

Finally, not everybody is convinced by the concept, it actually faces quite some criticism. For example it has been mentioned that the focus of Positive Health is too much on the behaviour of the human instead on the health of a person. Also is mentioned that these ideas are not that new as presented sometimes. Without joining one side in the discussion, it is clear not all the scientists are that enthusiastic about this “new” concept (van der Stel, 2016).

5.5 Recommendations

In this paragraph two recommendations are presented, practical recommendations and recommendations for further research. The first recommendations are for further integration of the concept Positive Health in the department Public health of the Public Health Service Twente. Similar Public Health Services can use these recommendations as well.

First, based on the mentioned possibilities of improving the collaboration and looking at the broader picture, instead of focussing on sub-department individually, a meeting with the head of the department and representatives of every sub-department can be organised. In this meeting they can talk about in which way they complement each other on the concept Positive Health and give each other more examples how they work according to the concept. In a later stadium, external organizations can be involved in this meeting as well.

Second, based on some results of the willingness to change, the focus can be on two aspects: it can be shown what the added value of the concept is for a specific sub-department and what is their influence is on the change. This can be done for example by organising meetings per sub-department, and involve the employees. To be sure the approach of Positive Health will discussed in the right way, it is important that an “expert” participates this meetings. This “expert” can be seen as someone of the workgroup Positive Health in the organization. It is important during the meetings, that nobody creates

the impression the employees are the problem, because the professionals are highly motivated to provide the best care (Bodinson, 2005). Casuistry can be used and prepared by the "expert".

A third recommendation is to make clear what the concept of Positive Health involves, based on the results the concept was sometimes mentioned as vague. This can be done by promotion, the most extensive attention has to be towards the dimensions daily functioning, quality of life and spiritual/existential dimension. This recommendation can be combined with the mentioned possibility to provide only specific information. Because of the vague definitions it is an option to create different and more corresponding definitions for the employees. Another option is to avoid the definitions and communicate the ideology of the approach to health. When the approach of Positive Health becomes more of a standard there is less effort necessary to explain the adduced terms. This in turn makes it less about changing the mind-set of the employees and more about the awareness of what means health for the clients.

The fourth recommendation is about the mentioned method of Motivational Interviewing, that is meant for sub-departments with client contacts in their work. The sub-departments which already work with the method can improve working following this method and in the other sub-departments the method can be introduced. With this working method, it is easier to accomplish that clients change their behaviour towards a more (Positive) Healthier behaviour.

Finally, the last recommendation relates to time. It is important to study whether the transition to the concept Positive Health actually takes or saves time. Followed by that study it can be considered if more time is necessary and feasible for some activities.

For further research, a few recommendations can be made. In this study the willingness to change is measured in a quantitative research. To improve the willingness to change of the employees it is necessary for the Public Health Services to know why some aspects are rated lower than other aspects. The difficulties which are identified could be elaborated in a qualitative research. For example, how employees look at the effects of the concept concerning their work activities. This way the outcomes of the DINAMO model can give more practical words for further integration.

Because this research gave starting points for integration of the concept Positive Health in terms of the willingness to change, work activities, possibilities and difficulties, a next step could be the implementation of the concept. Because the implementation of a concept is a complex process the eight steps model of Kotter can be used (Kotter, 2012). For example the missing added value for some sub-departments can be used as an input for the first step of this model: establishing a sense of urgency.

A last recommendation, as mentioned in the discussion the societal benefits are unknown at this moment. A long-term case-control study can give more insights in the effect of this concept in the healthcare. Two comparable organizations can be monitored for a period, where one organization is

focusing on health in the traditional way and one organization is more focussing on the approach of Positive Health. The feasibility of this study has to be considered.

The results of this study can be used for input for different healthcare sectors, and look for their specific sector what the corresponding work activities, possibilities and difficulties are for the integration of the concept Positive Health.

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Appendices

Appendix A: Summarized work plans

The main tasks for the sub-departments are described here shortly.

Inspection & hygiene

Different locations should be inspected on hygiene according to different laws of the Netherlands. The Public Health Service has several target groups for these inspections:

- the citizens of Twente
- day-care for children and host parents(agencies)
- shops that are involved with invasive skin activities like tattoo-shops, permanent make-up and jewellery
- sex institutions

Secretariat

For this sub-department the main tasks are the secretarial work. Examples are assist and prepare work for the head of the (sub-)department, maintain the agenda and answer phone calls and e-mail messages. Furthermore some of this department's activities are other projects in the organization.

Infectious disease control

Identifying, preventing and control infectious diseases is the main task of this sub-department. An upcoming task is the early identifying of new and regular infectious diseases. This department always closely follows the preventing or control of epidemics.

Sexual health

For this sub-department the main target is a sexual healthy population, with promoting pleasant, safe and voluntary sexual relationships. Hereby several tasks are connected. The entire process of sexually transmitted diseases and interventions, offering of sexuality care and approachable public information about sexual health. Furthermore the supporting task of professionals who are involved with groups at risk. Thereby monitoring problems of sexual health, groups at risk, trends with the help from research.

Public mental healthcare

There are two main tasks for this sub-department. Being the reporting point for property pollution. This is to reduce the hazards for the public health. Thereby there is consultation hour for homeless people. In this hour the sub-department assume they make the primary care more approachable for these citizens.

Forensics

The forensics physicians have to do the (external) autopsy of citizens who passed away with no natural death, or when the connected physician is not convinced the death was natural. These physicians are also involved in the autopsy of people who commit euthanasia. Thereby a main task is the care for arrested people. When an accident happens, violence or crime is committed to a victim this physician has to investigate the injuries for the prosecutor. And at last the forensics takes material of bodies that are involved in traffic accidents, only when it helps the research of the police.

Tuberculosis

There are two main tasks for this sub-department. At first prevent the population for the tuberculosis bacterium. The other task is the curative part of tuberculosis, when citizens are infected with the bacterium treat and assist them.

Disaster relief plan

Educate, train and practice employees for possible disaster is the main task of this sub-department. When there is a disturbance of the public order or safety this sub-department has the responsibility that everyone is well prepared. This is about a disaster but also about a possible disaster, think about events with a high risk for the public safety. In principle it is about their region, but when it is something bigger there would be for example collaboration with this departments in the entire Netherlands.

Appendix B: Organogram Public Health Service Twente

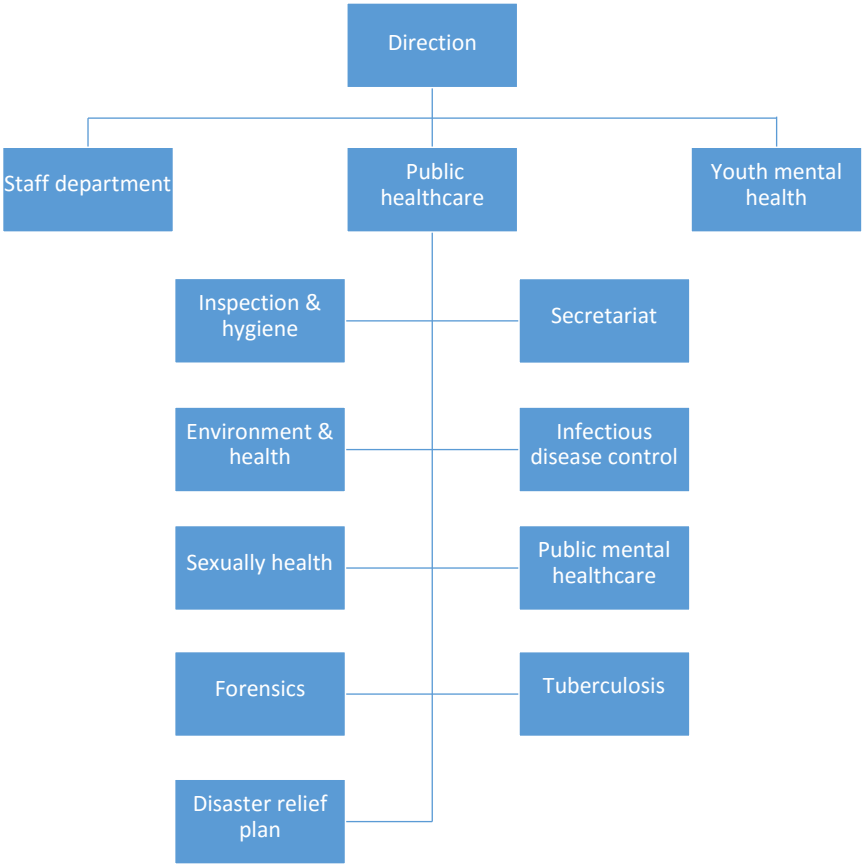


Figure 4: Organogram Public Health Service Twente (GGD Twente, 2015)

Appendix C: Online-questionnaire

This online-questionnaire is conducted in Dutch.

Betreft: onderzoek naar het begrip gezondheid

Geachte medewerker van GGD Twente,

Graag wil ik u uitnodigen om deel te nemen aan een kort vragenlijstonderzoek. De vragenlijst gaat over uw mening over het begrip Positieve Gezondheid in relatie tot uw werkzaamheden en de kanteling van medisch naar holistisch denken over gezondheid.

Door deze vragenlijst zal in de toekomst een beter beeld gevormd kunnen worden over de medewerkers met betrekking tot dit onderwerp.

De vragenlijst is bedoeld voor alle medewerkers die werkzaam zijn op de afdeling Algemene Gezondheidszorg (AGZ).

Het invullen van de vragenlijst duurt ongeveer 10 minuten.

Deelname aan dit onderzoek is geheel vrijwillig en u kunt op elk gewenst moment uw medewerking stopzetten.

Al uw gegevens zullen vertrouwelijk worden behandeld en anoniem worden verwerkt en zijn daarom niet te herleiden tot u als persoon.

Dit onderzoek maakt deel uit van mijn afstudeeronderzoek voor de Master Health Sciences aan de Universiteit Twente. Heeft u vragen over dit onderzoek neem dan contact op met mij via T.Berkenbosch@ggdtwente.nl

Met vriendelijke groet,

Triston Berkenbosch, student Health Sciences

Algemene gegevens

1. Bent u een man of een vrouw?
    - Man
    - Vrouw

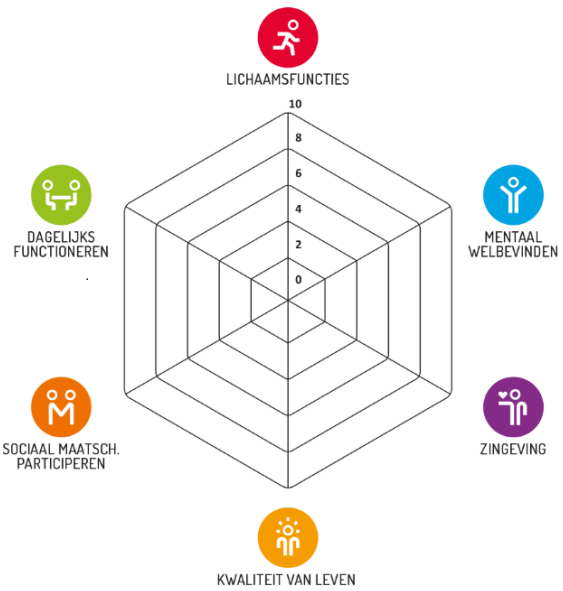
2. Wat is uw leeftijd?

. . jaar

3. In welk team bent u werkzaam in de Algemene Gezondheidszorg (AGZ)?
    - Infectieziekte bestrijding
    - Inspectie en hygiëne
    - Milieu en gezondheid
    - Openbare geestelijke gezondheidszorg
    - Seksuele gezondheid
    - Tuberculose
    - Forensische dienst
    - GGD rampen opvang plan
    - Overig, namelijk

Positieve Gezondheid

Steeds meer mensen hebben een ziekte of aandoening, maar zijn daarmee niet persé beperkt of ongezond. Niet alleen het voorkómen en beperken van ziekte en ongezondheid is belangrijk, maar juist het stimuleren van de factoren die bijdragen aan gezondheid.
Hiermee is de term positieve gezondheid geïntroduceerd; dit begrip staat voor een brede kijk op gezondheid en welbevinden. Hierin wordt gezondheid niet meer als statische conditie beschouwd maar als dynamisch vermogen van mensen om zich met veerkracht aan te passen, en zelf regie te voeren over hun welbevinden. Positieve gezondheid wordt dan ook gedefinieerd als: 'gezondheid als het vermogen zich aan te passen en een regie te voeren, in het licht van de fysieke, emotionele en sociale uitdagingen van het leven.'
Vanuit deze gedachte zijn er zes verschillende pijlers geïdentificeerd, die het begrip gezondheid omvatten en samen bepalen in hoeverre een persoon zich gezond voelt. Deze zijn te zien in het figuur.
Door gebruik van Positieve Gezondheid zullen professionals die in contact komen met patiënten meer de focus hebben op 'gezondheid' in plaats van 'ziekte'. Ook beleidsmakers kunnen hierdoor anders denken over de invulling van beleid en de preventie in de zorg.
Steeds meer mensen en organisaties in de zorg omarmen deze ideeën en zo is Positieve Gezondheid ook opgenomen in de bestuursagenda van de GGD Twente.



Er zullen achtereenvolgens 32 aspecten worden gepresenteerd. Aan de hand van een stelling wil ik u per aspect vragen om aan te geven in welke mate uw werkzaamheden voor de doelgroep waarvoor u werkt (patiënten/cliënten/bevolkingsgroep) gericht zijn op dat gepresenteerde aspect. <u>Het is niet de bedoeling dat u het aspect op u zelf betrekt, maar echt op uw werkzaamheden ten behoeve van de doelgroep.</u>
Dit kunt u doen door aan te geven op een schaal van 1 tot 9 of uw werkzaamheden op dit aspect zijn gericht. Waarbij 1 staat voor als uw werkzaamheden helemaal niet gericht zijn op dit aspect en 9 voor als deze helemaal wel gericht zijn op dit aspect.

Hieronder volgen twee voorbeelden:

1. *In welke mate zijn uw werkzaamheden erop gericht dat de doelgroep waarvoor u werkt:*

   Zich energiek voelt

   Wanneer uw werkzaamheden helemaal niet op het aspect ‘’zich energiek voelen’’ gericht zijn kiest u voor 1.

2. *In welke mate zijn uw werkzaamheden erop gericht dat de doelgroep waarvoor u werkt:*

   Zich geaccepteerd voelt in de sociale omgeving

   Wanneer uw werkzaamheden helemaal op het aspect ‘’zich geaccepteerd voelen in de sociale omgeving’’ gericht zijn kiest u voor 9.

4. In welke mate zijn uw werkzaamheden erop gericht dat de doelgroep waarvoor u werkt:
   1 = helemaal niet, 9 = helemaal

Helemaal niet	1	2	3	4	5	6	7	8	9	Helemaal	Weet ik niet

1. Een gezonde indruk maakt (huidtint/gelaatsuitdrukking/attitude)
2. Zelfvertrouwen heeft
3. Het vermogen heeft om betekenis te vinden in het leven
4. Het vermogen heeft om van het leven te genieten
5. Het vermogen heeft om sociale contacten te onderhouden
6. Het vermogen heeft om zichzelf aan te kleden en te wassen
7. Niet geplaagd wordt door pijnklachten
8. Zich energiek voelt
9. Grip op het eigen leven heeft
10. Vertrouwen in de toekomst heeft
11. Tot bloei komt
12. Geen eenzaamheid ervaart
13. Het vermogen heeft om te werken (betaald of onbetaald)
14. Verkeert in een positieve stemming
15. Idealen heeft en hiervoor kan leven
16. Het vermogen heeft om het leven te accepteren en er tevreden over te zijn
17. Een hoge kwaliteit van leven ervaart
18. Voldoende ondersteunende sociale contacten heeft
19. Zich gezond voelt
20. Zich geaccepteerd voelt in de sociale omgeving
21. Het vermogen heeft om deel te nemen aan de maatschappij
22. Geen afwijkende resultaten laat zien tijdens een medische check
23. Zich het grootste deel van de tijd gelukkig voelt
24. Mentaal competent is
25. Het vermogen heeft om vervullende activiteiten te ondernemen
26. Het vermogen heeft om persoonlijke omstandigheden te managen
27. Levenslust heeft
28. Het uitvoeren van werk (betaald of onbetaald) dat het als betekenisvol ervaart
29. Het vermogen heeft om een eigen huishouden te leiden (koken/schoonmaken/geld beheren)
30. Gebalanceerd is

31. Het vermogen heeft om medische instructies te begrijpen en deze op te volgen
32. Beschikt over een fysiek vermogen dat adequaat is voor de leeftijd

In de volgende vragen zal het woord verandering, de verandering binnen de GGD Twente naar Positieve Gezondheid betekenen

5. In hoeverre bent u het (on)eens met de volgende stellingen kijkend naar de veranderingen rondom positieve gezondheid bij de GGD Twente, op een schaal van 1 tot 5, waarbij 1 helemaal mee oneens is en 5 helemaal mee eens.

1	2	3	4	5	
Helemaal mee oneens	Mee oneens	Niet eens Niet oneens	Mee eens	Helemaal mee eens	Weet ik niet

1. Ik ben ervan overtuigd dat door de verandering de kwaliteit van mijn werk zal toenemen.
2. Door de verandering zal mijn werkdruk afnemen.
3. Door de verandering zal de verantwoordelijkheid die ik draag toenemen.
4. De verandering zal nieuwe loopbaankansen creëren voor mij.
5. Door de verandering zal ik meer tevreden zijn over mijn werk.

6. Ik ervaar de aanstaande verandering als een uitdaging.
7. Ik ervaar de aanstaande verandering als vertrouwd.
8. Ik ervaar de aanstaande verandering als verfrissend.
9. Ik ervaar de aanstaande verandering als positief.

10. Ik zie meerwaarde in de verandering.
11. Door de verandering zal de organisatie efficiënter worden.
12. Het imago van de organisatie zal door de verandering beter worden naar de burgers toe.

13. Ik praat met collega’s over deze verandering.
14. Ik voel mij betrokken bij deze verandering.

15. De directie staat onvoorwaardelijk achter deze verandering.
16. Ik sta achter de organisatieverandering.
17. Mijn collega’s staan achter de verandering.
18. Mijn leidinggevende staat achter de verandering.

19. Ik zie de noodzaak dat de organisatie deze verandering gaat uitvoeren.
20. De organisatie moet mee in deze verandering om de huidige zorgvraag te kunnen beantwoorden.

21. Ik verwacht dat ik over voldoende kennis en ervaring beschik om de verandering tot een succes te maken.

22. De directie informeert iedereen op tijd over de ontwikkelingen.
23. Ik word op tijd geïnformeerd wat de bedoeling is met de verandering.

24. Er heerst duidelijkheid over de gevolgen van de verandering voor de inhoud van het werk.

25. Er zal een grote inspanning moeten worden geleverd om alle medewerkers op het gewenste competentieniveau te krijgen.
26. Een succesvolle verandering zal afhangen van verschillende middelen (tijd, kennis).
27. Andere veranderingen in de organisatie kunnen deze verandering bemoeilijken.

28. Ik ben toe aan deze verandering.
29. Deze verandering komt op een goed moment.

30. Ik beschouw de verandering als complex.
31. De verandering maakt een logische samenhangende indruk.

6. Als u nog opmerkingen en/of suggesties heeft over Positieve Gezondheid op de afdeling AGZ, dan kunt u dat hier noteren.

Dit is het einde van de vragenlijst. Hartelijk dank voor uw medewerking.

Appendix D: Guidance focus-group interview

The interview is conducted in Dutch.

Focusgroep interview

Allereerst bedankt dat jullie mee willen helpen aan dit onderzoek door middel van dit focusgroep interview.

In mijn onderzoek kijk ik op welke manier het concept positieve gezondheid handen en voeten kan krijgen bij de medewerkers van de Algemene Gezondheidszorg (AGZ). Een onderdeel van mijn onderzoek is het afnemen van een vragenlijst onder alle medewerkers van de AGZ. Daarnaast zullen er per afdeling (focus-groep) interviews gehouden worden.

In dit interview wil ik graag erachter komen op welke manier u al bezig zijn met positieve gezondheid en op welke manier u hier zelf meer mogelijkheden voor ziet.

Om er zeker van te zijn dat ik dit interview goed verwerk zou ik het interview graag opnemen, hierin zal u niet als persoon te herleiden zijn. Gaat iedereen hiermee akkoord?

In dit interview zou ik graag meer te weten komen hoe jullie misschien al bezig bent met positieve gezondheid en op welke manier jullie hier mogelijkheden tot ziet in jullie werkzaamheden. Eerst wil ik daarom wat vragen over jullie werkzaamheden, vervolgens wil ik enkele vragen stellen met betrekking tot het concept Positieve Gezondheid.

Allereerst wil ik een korte voorstelronde doen. Hierin zou ik graag horen wat uw leeftijd is, hoeveel jaar u al werkzaam bent bij de GGD Twente en wat uw functie in dit team is. Allereerst zal ik mijzelf even voorstellen.

Voorstelronde

Wat zijn jullie voornaamste werkzaamheden?

- Laten aanvullen door elkaar
- Grote verschillen in het team?
- Doelgroep

Worden er bepaalde (gezondheids)doelen nagestreefd in uw werkzaamheden?
Zo ja, welke?
Zo nee, vinden jullie dat dit wel zou moeten?

- Hoe kijkt de rest hiernaar?

Wat vinden jullie zelf belangrijke doelen om bewust mee bezig te zijn tijdens uw werk kijkend naar gezondheid?

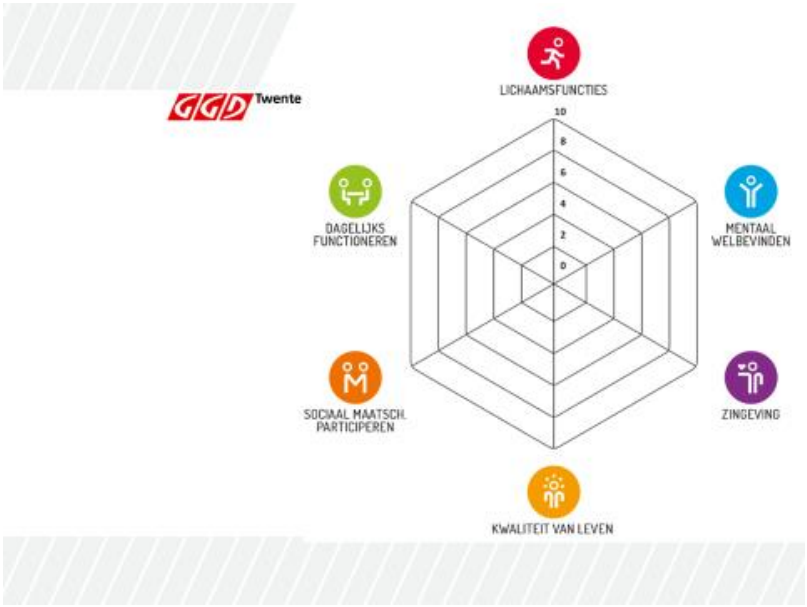
- Mentaal/fysiek/etc.?
- Betrekking op de doelgroep

Dan wil ik nu kijken naar deze werkzaamheden en doelen die u heeft besproken in relatie tot Positieve gezondheid.

Sommige van jullie zullen onderhand wel weten wat positieve gezondheid ongeveer inhoudt maar om zeker te weten dat we over het zelfde praten wil ik dit graag nog even samenvatten.

Steeds meer mensen hebben een ziekte of aandoening, maar zijn daarmee niet persé beperkt of ongezond. Niet alleen het voorkómen en beperken van ziekte en ongezondheid is belangrijk, maar juist het stimuleren van de factoren die bijdragen aan gezondheid.
Hiermee is de term positieve gezondheid geïntroduceerd en staat het voor een brede kijk op gezondheid en welbevinden. Hierin wordt gezondheid niet meer als statische conditie beschouwd maar als dynamisch vermogen van mensen om zich met veerkracht aan te passen, en zelf regie te voeren over hun welbevinden. Positieve gezondheid wordt dan ook gedefinieerd als: ‘gezondheid als het vermogen zich aan te passen en een regie te voeren, in het licht van de fysieke, emotionele en sociale uitdagingen van het leven.’

Vanuit deze gedachte zijn er zes verschillende dimensies geïdentificeerd, die het begrip gezondheid omvatten en samen bepalen of een persoon zich gezond voelt of niet. Deze zijn te zien het spinnenweb.
Met deze verschuiving zullen professionals die in contact komen met patiënten meer de focus hebben op ‘gezondheid’ in plaats van ‘ziekte’. Ook beleidsmakers kunnen hierdoor anders denken over de invulling van beleid en de preventie in de zorg.
Steeds meer mensen en organisaties in de zorg omarmen deze ideeën en zo is positieve gezondheid ook opgenomen in de bestuursagenda van de GGD Twente.



In deze bijeenkomst wil ik het graag hebben over hoe Positieve gezondheid terug komt en kan komen in jullie werkzaamheden. Om dit te doen zullen we de zes dimensies die in de figuur staan per dimensie gaan bespreken. Na deze zes dimensies zou ik graag nog even naar het totale plaatje positieve gezondheid kijken met jullie.

Dan wil ik nu graag beginnen met de dimensie lichaamsfuncties

Het gaat hier om hoe lichamelijk fit is iemand volgens de weergegeven aspecten.

Groepsgesprek lichaamsfuncties

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?

Zo ja kunt u hier een voorbeeld van geven?

En wat levert dit op in jullie werkzaamheden?

Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

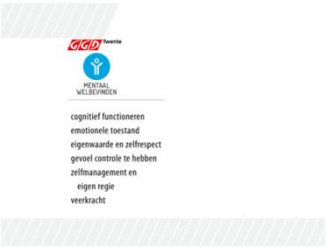
En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?

Waarom niet?

Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?

Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de tweede dimensie: Mentale functies en beleving.
Het gaat hierbij om het mentaal welbevinden volgens de zes weergegeven aspecten.



Groepsgesprek mentaal welbevinden

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in jullie werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de derde dimensie: Spirituele existentiële dimensie / zingeving
Het gaat hier om het leiden van een betekenisvol leven, met persoonlijke doelen, al dan niet voor de toekomst en het tevreden zijn over het leven.

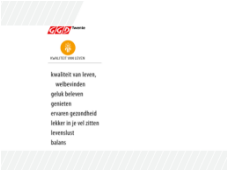
Groepsgesprek zingeving

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in jullie werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de vierde dimensie: Kwaliteit van leven

Het gaat hier om hoe iemand zijn of haar kwaliteit van leven ervaart volgens de weergegeven aspecten in de afbeelding.



Groepsgesprek kwaliteit van leven

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?

Zo ja kunt u hier een voorbeeld van geven?

En wat levert dit op in jullie werkzaamheden?

Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?

Waarom niet?

Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?

Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de vijfde dimensie: Sociaal-maatschappelijke participatie
Het gaat hier om het sociaal betrokken zijn in de maatschappij en daarbij in de zin van de weergegeven aspecten.

Groepsgesprek sociaal maatschappelijk participeren

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in jullie werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

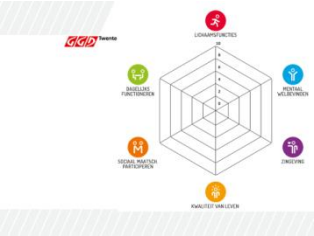
Dan wil ik nu doorgaan naar de zesde dimensie: dagelijks functioneren
Het gaat hier om het in staat zijn om standaard dagelijkse activiteiten te ondernemen voor je eigen gezondheid en het huishouden.

Groepsgesprek dagelijks functioneren

Op welke manier zien jullie deze dimensie terug in het uitvoeren van jullie werkzaamheden? Besteden jullie aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in jullie werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En zien jullie mogelijkheden om deze dimensie (nog) meer toe te passen in jullie dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen zien jullie om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die jullie nodig hebben om dit te kunnen uitvoeren?

We zijn nu alle zes de dimensies bij langs gegaan.



Wanneer er wordt gekeken naar het gehele concept, zijn er dimensies die jullie met betrekking tot jullie werkzaamheden minder of meer belangrijk vinden dan andere dimensies?
En waarom vinden jullie dit?

In de tweede dimensie kwam het al even aan bod, maar hoe kijken jullie aan tegen zelfmanagement, eigen regie en veerkracht.
Hoe ziet u dit in relatie tot jullie werkzaamheden binnen de GGD Twente?

Met wat voor reden vinden jullie dit?

Zijn er nog andere aspecten die jullie belangrijk vinden om in dit gesprek te noemen?

Samenvatting, conclusie, afsluiting

Dan wil ik jullie nu hartelijk danken voor dit gesprek en voor jullie tijd. Aan het eind van mijn onderzoek zal u allen uitgenodigd worden voor een afsluitende presentatie over de bevindingen van dit onderzoek.

Appendix E: Guidance semi-structured interview

The interview is conducted in Dutch.

Semi-gestructureerd interview

Allereerst bedankt dat u mee wilt helpen aan dit onderzoek door middel van dit interview.

In mijn onderzoek kijk ik op welke manier het concept positieve gezondheid handen en voeten kan krijgen bij de medewerkers van de Algemene Gezondheidszorg (AGZ). Een onderdeel van mijn onderzoek is het afnemen van een vragenlijst onder alle medewerkers van de AGZ. Daarnaast zullen er per afdeling (focus-groep) interviews gehouden worden.

In dit interview wil ik graag erachter komen op welke manier u al bezig bent met positieve gezondheid en op welke manier u hier zelf meer mogelijkheden voor ziet.

Om er zeker van te zijn dat ik dit interview goed verwerk zou ik het interview graag opnemen, hierin zal u niet als persoon te herleiden zijn. Gaat u hiermee akkoord?

Omdat ik in dit interview graag meer te weten kom hoe u misschien al bezig bent met positieve gezondheid en op welke manier u hier mogelijkheden tot ziet in uw werkzaamheden, wil ik daarom wat vragen over uw werkzaamheden, en vervolgens wil ik enkele vragen stellen met betrekking tot het concept Positieve Gezondheid.

Dan wil ik nu graag beginnen met het interview.

Aller eerst wil ik enkele achtergrondgegevens vragen

Geslacht:
Afdeling:
Functie:
Jaren werkzaam:

Wat zijn uw voornaamste werkzaamheden?

- Uitvoerend/beleidsmatig
- Doelgroep

Worden er bepaalde (gezondheids)doelen nagestreefd in uw werkzaamheden?
Zo ja, welke?
Zo nee, vindt u dat dit wel zou moeten?

Wat vindt uzelf belangrijke doelen om bewust mee bezig te zijn tijdens uw werk kijkend naar gezondheid?

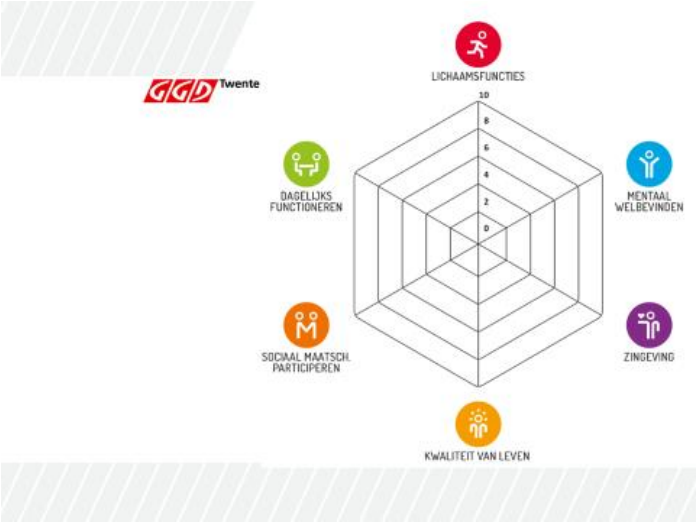
- Mentaal/fysiek/etc.?
- Betrekking op de doelgroep

Dan wil ik nu kijken naar deze werkzaamheden en doelen die u heeft besproken in relatie tot Positieve gezondheid.

Bent u bekend met het concept positieve gezondheid?

Om er zeker van te zijn dat het zelfde beeld bestaat over dit concept wil ik graag heel kort even samenvatten wat positieve gezondheid inhoudt.

Steeds meer mensen hebben een ziekte of aandoening, maar zijn daarmee niet persé beperkt of ongezond. Niet alleen het voorkómen en beperken van ziekte en ongezondheid is belangrijk, maar juist het stimuleren van de factoren die bijdragen aan gezondheid.
Hiermee is de term positieve gezondheid geïntroduceerd en staat het voor een brede kijk op gezondheid en welbevinden. Hierin wordt gezondheid niet meer als statische conditie beschouwd maar als dynamisch vermogen van mensen om zich met veerkracht aan te passen, en zelf regie te voeren over hun welbevinden. Positieve gezondheid wordt dan ook gedefinieerd als: ‘gezondheid als het vermogen zich aan te passen en een regie te voeren, in het licht van de fysieke, emotionele en sociale uitdagingen van het leven.’
Vanuit deze gedachte zijn er zes verschillende dimensies geïdentificeerd, die het begrip gezondheid omvatten en samen bepalen of een persoon zich gezond voelt of niet. Deze zijn te zien het spinnenweb.
Door gebruik van positieve gezondheid zullen professionals die in contact komen met patiënten meer de focus hebben op ‘gezondheid’ in plaats van ‘ziekte’. Ook beleidsmakers kunnen hierdoor anders denken over de invulling van beleid en de preventie in de zorg.
Steeds meer mensen en organisaties in de zorg omarmen deze ideeën en zo is positieve gezondheid ook opgenomen in de bestuursagenda van de GGD Twente.



Per dimensie uit het spinnenweb wil ik graag enkele vragen stellen met betrekking tot uw werkzaamheden, hoe deze al dan niet terug komen in uw werkzaamheden.

Allereerst de dimensie Lichaamsfuncties.
Het gaat hier om hoe lichamelijk fit iemand is volgens de weergegeven aspecten.

Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in uw werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden? Waarom niet?
Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de tweede dimensie: Mentale functies en beleving.
Het gaat hierbij om het mentaal welbevinden volgens de zes weergegeven aspecten.

Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in uw werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

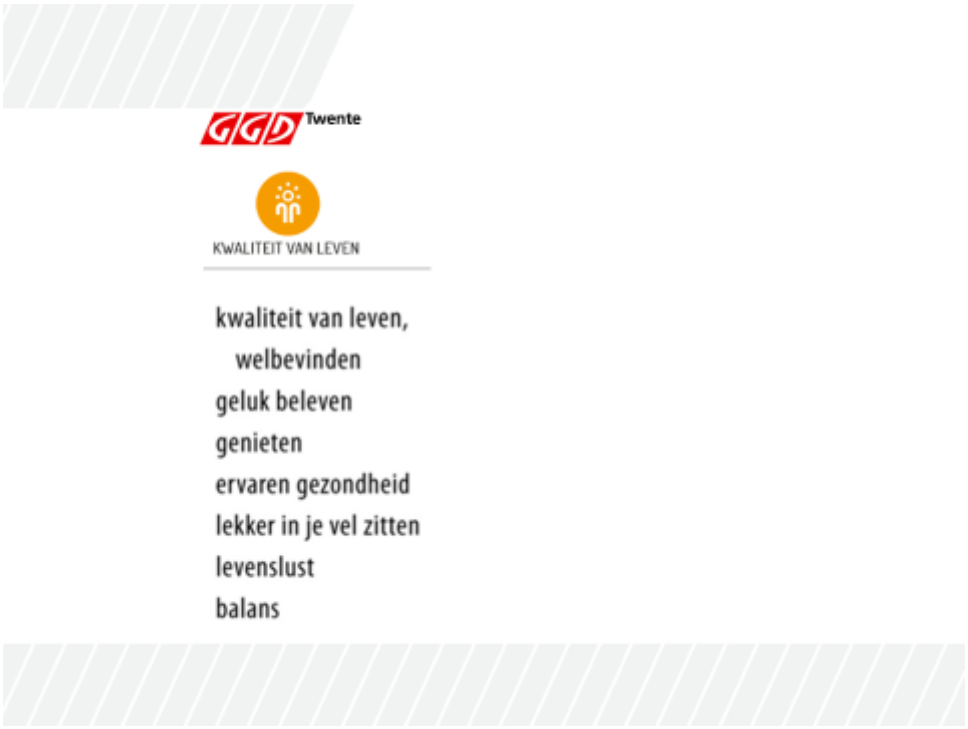
Dan wil ik nu doorgaan naar de derde dimensie: Spirituele existentiële dimensie / zingeving
Het gaat hier om het leiden van een betekenisvol leven, met persoonlijke doelen, al dan niet voor de toekomst en het tevreden zijn over het leven.

Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in uw werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de vierde dimensie: Kwaliteit van leven

Het gaat hier om hoe iemand zijn of haar kwaliteit van leven ervaart volgens de weergegeven aspecten in de afbeelding.



Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?

Zo ja kunt u hier een voorbeeld van geven?

En wat levert dit op in uw werkzaamheden?

Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden?

Waarom niet?

Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?

Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de vijfde dimensie: Sociaal-maatschappelijke participatie
Het gaat hier om het sociaal betrokken zijn in de maatschappij en daarbij in de zin van de weergegeven aspecten.

Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?
Zo ja kunt u hier een voorbeeld van geven?
En wat levert dit op in uw werkzaamheden?
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden?
Waarom niet?
Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?
Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

Dan wil ik nu doorgaan naar de zesde dimensie: dagelijks functioneren

Het gaat hier om het in staat zijn om standaard dagelijkse activiteiten te ondernemen voor je eigen gezondheid en het huishouden.

Op welke manier ziet u deze dimensie terug in het uitvoeren van uw werkzaamheden? Besteedt u aandacht aan deze dimensie?

Zo ja kunt u hier een voorbeeld van geven?

En wat levert dit op in uw werkzaamheden?

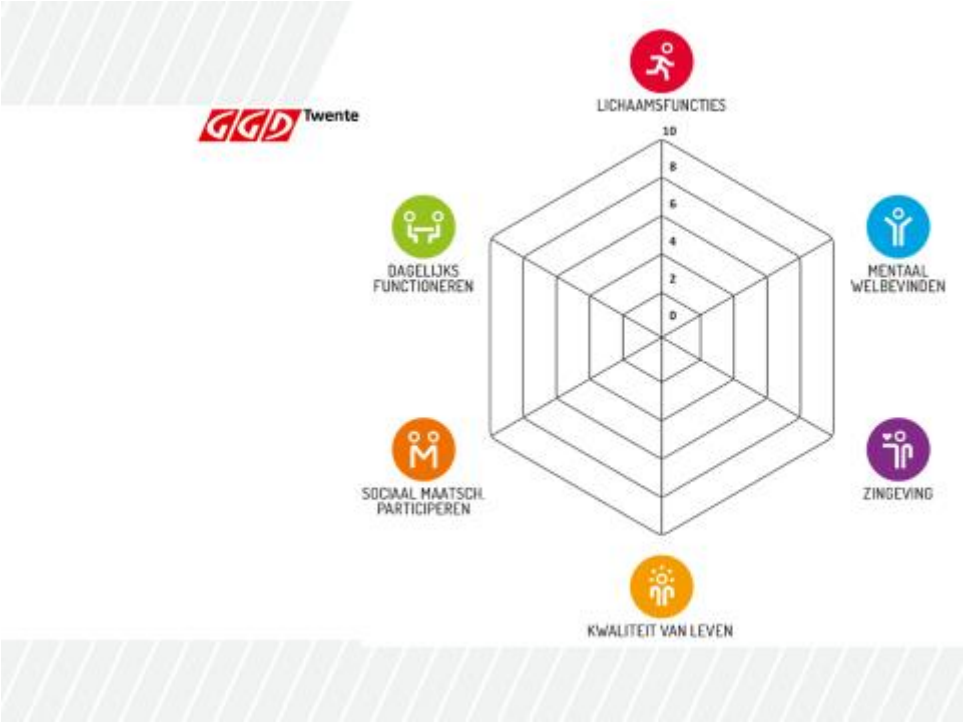
Zijn er nog dingen waar u tegen aanloopt met betrekking tot deze werkzaamheden?

En ziet u mogelijkheden om deze dimensie (nog) meer toe te passen in uw dagelijkse werkzaamheden? Waarom niet?

Welke belemmeringen ziet u om dit terug te laten komen in jullie werkzaamheden?

Zijn er nog middelen die u nodig heeft om dit te kunnen uitvoeren?

Alle zes de dimensies hebben we nu besproken.



Wanneer er wordt gekeken naar het gehele concept, zijn er dan dimensies die u met betrekking tot uw werkzaamheden minder of meer belangrijk vindt dan andere dimensies?

Met wat voor reden vindt u dit?

In de tweede dimensie kwam het al even aan bod, maar hoe kijkt u aan tegen zelfmanagement, eigen regie en veerkracht?
Hoe ziet u dit in relatie tot uw werkzaamheden binnen de GGD Twente?

Als laatste wil ik u nog vragen of er nog andere aspecten zijn die u belangrijk vindt om in dit gesprek te noemen met betrekking tot Positieve gezondheid?

Dan wil ik u hartelijk danken voor dit gesprek en voor uw tijd. Aan het eind van mijn onderzoek zal u uitgenodigd worden voor een afsluitende presentatie over de bevindingen van dit onderzoek.

Appendix F: Reasons for work activities

Table 21: Mentioned reasons for work activities relating to Positive Health by sub-departments with direct client contact

Sexual health	**N**	**tuberculosis**	**N**	**Infection diseases**	**N**
Reasons for activities					
Base Task (MF)	2	Their task (BF)	2	People have diseases (BF)	1
All important (PR)	2	Important (ED)	1	Laws (MF)	1
Important (ED,PH)	2	Context necessary (PR)	1	Important; reassurance (PR)	1
Clients focus on BF (BF)	1	Important to reach aim (OT)	1	Social participation (PR)	1
Contact physical problems (MF)	1				
Broad (QL)	1				
Least bodily functions (PR)	1				
Social/mental functions (PR)	1				
Preventive task (OT)	1				
Twente sexual healthy (OT)	1				

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning, OT=Other and PR=preference

Table 22: Mentioned reasons for work activities related to Positive Health by sub-departments with direct client contact

Forensics	**N**	**Public mental health**	**N**
Work activities			
Complaints and pain (BF)	5	Hygiene (DF)	5
Diagnostic, observations (BF, MF)	4	Advise; social environment (SP)	4
Emotions (MF)	1	Practical solutions (QL)	3
Reassurance (MF)	1	Complaints and pain (BF)	2
Referrals (MF)	1	Advising (BF)	2
Asking to background (SP)	1	Referrals (MF)	2
Discuss aspects (QL)	1	Empowerment (MF)	2
Calling with clients (QL)	1	Striving for aims (ED)	2
Take context into account (OT)	1	Helping with balance (QL)	2
		Advising illegals (MF)	1
		Primary care (MF)	1
		Seeing flourishing (ED)	1
		Care to avoid recurrence (ED)	1
		Helping each other (SP)	1
		With municipality (QL)	1
		Furnishing (DF)	1
		Advise Care givers (DF)	1
		Discuss cooking (DF)	1
		Social medical consult (OT)	1

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning, OT=Other and PR=preference

Table 23: Mentioned reasons for work activities related to Positive Health by sub-departments with indirect client contact

Disaster relief plan	N	Inspection & hygiene	N
Team psycho social care (MF)	4	Important (QL, SP)	8
Keep in mind (MF)	3	Mental functions (PR)	3
Prevent opposite aspects (QL)	3	Base for inspection (QL)	1
Planning (MF)	3	Relationship for inspection (SP)	1
Thinking preventive (BF)	2	Quality of life (PR)	1
Energy (BF)	1	Bodily functions (PR)	1
Connection with care givers (OT)	1	Least spiritual/existential dimension (PR)	1

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning, OT=Other and PR=preference

Table 24: Mentioned reasons for work activities possibilities related to Positive Health by the head of department and secretary

Head of department	N	Secretary	N
Reasons for activities			
Important; sustained employability (BF)	5	Important societal participation (SP)	4
Target group (MF)	4	Important; quality of life (QL)	3
Important; meaningful work (SP)	4	Important; mental functioning (MF,PR)	3
Important; quality of life organization (QL,PR)	4	Important; employees happiness (ED)	2
Rising average age (BF)	2	Important; helping employees (MF,PH)	2
Important; education of employees (MF)	2	Important; Bodily functions (BF)	1
Important; resilience of employees (MF)	2	Appreciated; helping employees (MF)	1
Important; balance work/private (MF)	2	Important; existential (ED)	1
Societal relevance of work (ED)	2	Sexual health; perspective (ED)	1
Important; esteem of employees (MF)	1	Public mental health; consequences (ED)	1
Consulting hours (QL)	1	Important; social aspects asylum seekers (SP)	1
Important; communication of employees (SP)	1	Target group Public mental health (DF)	1
In function (SP)	1	Positive thinking (OT)	1
Important; hygiene of employees (DF)	1	Important; all dimensions (OT)	1
Target group public mental health (DF)	1	Important for employees; daily functioning (PR)	1
Important in function; existential (PR)	1		
Important; Bodily functions (PR)	1		
Important; Quality of life (PR)	1		

BF=Bodily functions, MF=Mental functions & perception, ED=spiritual/existential dimension, QL=Quality of life, SP=social & societal participation, DF=Daily functioning, OT=Other and PR=preference