

Managing Risk at Times of Pandemic: Whose Responsibility?

by

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## **Abstract**

The Canadian healthcare system has become increasingly decentralised as a result of neoliberal policy leanings. Many responsibilities have shifted from federal to provincial to regional health authorities. As a result of their heavy workloads and strained budgets, these regional health authorities have begun striking up new community partnerships. This thesis examines the role that lay institutions play within the Canadian healthcare system via a case study of Dalhousie University's handling of the 2009/2010 H1N1 pandemic. Document analysis and participant interviews reveal how the institution worked to protect the health of its population, why it was inclined to take on this responsibility, and how doing so impacted the everyday work of Dalhousie University employees. Based on this case study, the thesis argues that the capacity of lay institutions and their employees to respond to health crises is likely to depend on a number of factors, which has important public health implications.

## **List of Abbreviations Used**

CHST	Canada Health and Social Transfer
CDHA	Capital District Health Authority
DUIDPP	Dalhousie University Infectious Diseases Preparedness Plan
DFMPCP	Department of Facilities Management Pandemic Contingency Plan
EPF	Established Programs Financing Act
FAQ	Frequently Asked Questions
GNP	Gross National Product
PHAC	Public Health Agency of Canada
PR	Public Relations
RA	Residence Assistant
RHA	Regional Health Authorities
RLM	Residence Life Manager
SCSCIRRP	Student Community Services Communicable Illness Residence Response Plan
WHO	World Health Organization

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## **Chapter One: Introduction**

Beginning in the late 1970s, Canada and other parts of the world started to employ neoliberal ideologies of governance promoting the decentralization of many services, including healthcare. The federal government passed down responsibilities to the provincial government who in turn placed them upon regional health authorities to manage. This was the result of constrained provincial budgets and heavy-handed federal spending power. The federal government alone decides the amount of money that provincial governments receive for healthcare and it has decreased steadily over the past few decades (McIntosh, 2004). As such provinces struggle to provide the same level of services with less money.

Given these fiscal constraints, provinces saw regionalization as the answer. Regionalized health policy gained political popularity out of the notion that a healthcare system governed closer to communities was more desirable and would ultimately be more cost effective. New regional health districts work within their own realms of autonomy, yet at the same time remain subordinate to provincial governments (Lewis & Kouri, 2004). However, critics argue that decentralization out of fiscal constraint also implies that more responsibility and greater workloads are assigned to the regional health authorities without appropriate funding levels. Given their huge workloads, they are encouraged to strike up new community partnerships for support. This has translated to a need to build partnerships with lay institutions both inside and outside of medical settings. As a result of new demands and constrained budgets, regional authorities rely heavily on community partnerships and informal supports.

Partnerships with lay institutions also led to legislative ambiguity. As it stands, public health in Canada is multi-governed; both the provincial and federal governments

play a role in a “collaborative” system (Wilson, McCrae-Logie & Lazar, 2004. p.178). Provincial governments are responsible for the delivery of essential medical services and hospital care but are held accountable to the federal government for upholding certain standards according to the *Canadian Health Act*. Public health is considered to be the responsibility of the province, though it is not explicitly mentioned in the Constitution or the *Canadian Health Act*<sup>1</sup> (Frank & Di Ruggiero, 2003. p.190; Public Health Agency of Canada, 2008. p.10).

Legislative ambiguity creates challenges for policy coordination. For example, there is much confusion over which order of government is responsible for managing public policy at times of pandemic. This is particularly problematic at times of crisis that require the immediate implementation of proper control measures, because a delayed response could mean catastrophic results for health. Ambiguity often results in policy gaps in handling emergent pandemic outbreaks. The lack of a clear statement of responsibility in public health ends up leaving the public without any specific guidance. When there is no guidance from larger authorities this leaves the immediate response up to lay institutions.

Although there are no formal expectations placed on workplaces, schools or other lay institutions, they are recognized as important avenues for reaching the public in what can otherwise be considered a confused system of administration. In Nova Scotia, the provincial response to pandemic outbreaks follows the actions set out in the “Nova Scotia Pandemic Influenza Plan.” The plan was developed in 2008 by the Departments of Health

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<sup>1</sup> Section 92(13) of the *Constitution Act*, which assigns the provinces responsibility for property and civil rights, is often interpreted to also include public health. Further provincial authority in this area may be drawn from Section 92 (16) which gives provinces control “over matters of a local or private nature (section 92(16)” (Wilson, 2004. p.409).

and Health Promotion and Protection. According to this document, the Government of Nova Scotia views the Department of Health as the mediator of information between District Health Authorities, the Public Health Agency of Canada (PHAC) and other provincial governments and departments. However, the Nova Scotia Pandemic Influenza Plan explicitly states that there is an expectation that educational institutions, as well as small and large businesses, will assist with communications efforts and conducting internal surveillance and education campaigns. As such, in this thesis I will examine the ways in which a lay institution, Dalhousie University, takes on responsibilities for the health of its population. More specifically, my thesis aims to address three main research questions:

1. What did Dalhousie do to manage the health risks of its population?
2. Why did Dalhousie take on these new responsibilities?
3. How did this impact the everyday work of the institution and those involved in its efforts?

In addressing these questions, I focus on the experiences of workers at Dalhousie University, who actively attempted to mitigate the risks facing the university's population at the time of the 2009 H1N1 pandemic.

In Chapter Two, I explore the current Canadian public health system in a broader political and economic context. I examine the link between the decentralization of healthcare in Canada and neoliberal political-economic ideologies, as well as the rise of the new public health movement. Furthermore, I consider how notions of risk and risk management operate within this decentralized system and how workplaces and lay institutions are being called to action to manage risk.

In Chapter Three, I describe the methods employed to explore the above mentioned research questions. These methods include a document analysis of Dalhousie's key institutional preparedness plans, which were developed both before and after the outbreak, and in-depth interviews with those who were directly involved in pandemic preparedness planning at the university. Together these methods seek to capture Dalhousie's place within the larger Canadian public health system, how the institution took on responsibilities for health and how this endeavor affected the everyday work of those involved.

Chapter Four will summarize the findings, which emerged out of the document analysis and the in-depth interviews. The chapter reports the development of Dalhousie's response to the H1N1 pandemic and specific courses of action taken by the university, focusing on the dissemination of information, the administration of healthcare services and the efforts made to institutionalize a response. The chapter then outlines the issues and challenges that arose out of these efforts, which can be broken down into the institutionalization of a response through policy creation, the motivating factors behind the university's involvement and the effect taking on these initiatives had on the everyday work of institution's employees.

In Chapter Five, the findings from Chapter Four are used as the basis for the argument that though Dalhousie's response was modeled after the efforts taken by larger public health authorities (regional, provincial and federal), the response was ultimately shaped by the university's workplace politics and the institution's history, culture and characteristics. I will also examine the implications the response had on the daily work of those involved in the institution's efforts.

In Chapter Six, conclusions are offered. Although many scholars have examined the constitutional challenges that emerge out of the structure of the Canadian public health system, or have looked at the system theoretically through the works of the new public movement, which broadly addresses issues arising out of neoliberal policy leanings. By employing a case study to examine the role played by lay institutions within the public health system, my thesis fills a gap in the literature by looking at the public health system from the institutional level. It examines the role that can be played by lay institutions in health promotion and protection within their communities. Though my case study will be unique, I hope my findings will be helpful for the planning initiatives of lay institutions in the future. Furthermore, this work will provide insight — regarding the capacity of lay institutions to be partners in health —to governments who call these institutions to action at times of crisis.

## **Chapter 2: Placing the Canadian Public Health System within a Sociological Context**

This chapter links the decentralization of healthcare in Canada to neoliberal political-economic ideology and the rise of the new public health movement, offering a way of thinking about this shift and its implications. I will focus on how notions of risk and risk management operate within a decentralized healthcare system in Canada and consider how this system has created an expectation that workplaces can become sites of health promotion. This will set the stage for my study which examines how it is that workplaces take on responsibility for the health of their population during a public health emergency, and what compels them to take on this endeavour.

### **2.1 The centralization and decentralization of healthcare in Canada**

Government involvement in health increased with the democratization of health services in the mid-twentieth century. At this time, the Hall Commission (1961) pushed for a comprehensive universal health service program (Bernier, 2003. p.26), and in 1966 the Medical Care Act was passed (Marchildon, 2005b, p.20). These changes were intended to improve health equity across the country, by creating a universal system that was publicly administered, comprehensive, portable, and publically funded (Marchildon, 2005b, p.23). The system was built upon a “cost sharing setup,” which was based on a formula that required the federal government to match provincial health expenditures through transfer payments (Marchildon, 2005b. p.24).

In the late 1970s the costs of centralized healthcare quickly spiralled out of control, eventually running higher than the gross national income (Bernier, 2003. p.27). As a result, the federal government began ‘block transfers’ to provinces in 1977 in an

attempt to limit spending.<sup>2</sup> This arrangement allowed the provinces greater flexibility with how funds could be spent, while the federal government was “able to cap its growth in health transfers to the growth in the economy” (Marchildron, 2005b, p.24). Block transfers thereafter became the preferred spending mechanism and with them came the decentralization of responsibility for healthcare in Canada.

According to the work of political scientist Greg Marchildron (2005) there were two key phases of healthcare reform in Canadian history which brought about cuts in healthcare spending, eventually leading to an emphasis on preventative medicine and health promotion. During the first phase, from 1988-1996, spending cuts mostly came in the form of hospital closures (in the name of consolidation), human resource cutbacks, and the development of regional health authorities (RHAs)<sup>3</sup> (Marchildron, 2005a. p.106). The Canadian public supported the later development— regionalization— because they saw it as an opportunity to have more control over the healthcare system (Armstrong & Armstrong, 2003. p.2). Policy makers and advisors interpreted this as a desire for a more ‘community-based’ approach to health. This public sentiment, its political interpretation, and the government’s desire to cut costs effectively created a context which allowed for the decentralization of health services and the regionalization of the healthcare system at provincial levels. These reforms were made “in the name of both cost-saving and life-

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<sup>2</sup> In 1977 the Established Programs Financing Act (EPF) was introduced. It replaced the original federal cost-sharing, and instead transferred cash and federal tax to provinces, which was linked to growth in GNP and population (Marchildron, 2005b, p.20). Though, EPF allowed the provincial governments greater flexibility with how the funds were spent, it also allowed the federal government to cap its cash transfers, by basing the amount on the growth of the economy rather being “tied to a formula that required federal health transfers to match provincial health expenditures” (Marchildron, 2005b. p.24)

<sup>3</sup> RHAs were made responsible for the distribution of resources according to the needs of regional populations. Under this system, there was but one administrative organization—the RHA— responsible for the improvement, coordination and administration of health care services in each region (Marchildron, 2005a. p.107).

saving, claiming to maintain quality and equity while cutting costs” (Armstrong & Armstrong, 2003. p.3).

This first phase of healthcare reform drew to a close when the Canada Health and Social Transfer (CHST) was set up and when cash transfers to provinces were subsequently drastically reduced in 1995-6 (Marchildon, 2005. p.110). In the place of additional funds, the federal government granted the provinces tax credits, which effectively created a system in which provinces received reduced funds for health and social services together in a block transfers. This development marked the beginning of Canada’s second stage of healthcare reform, which Marchildon claims is ongoing. He describes this current phase of healthcare reform in terms of continuing concern about the fiscal sustainability of the healthcare system and increased spending on public health initiatives.<sup>4</sup> Although some policy-makers and advisors have argued that the solution lies in privatization and market-based reforms, federal and provincial governments have attempted instead to promote preventative medicine, through the establishment of health protection and promotion initiatives. This is done with hopes of reducing spending on the treatment of illness within healthcare systems in the future.

## **2.2 Neoliberalism and the ‘new public health’**

These shifts in policy mirror broader changes taking place within the global economy driven by neoliberalism. Neoliberalism refers to a political-economic ideology

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<sup>4</sup> During the second phase, in an attempt to ease federal- provincial tensions created by past funding cuts, the federal government began increasing transfer payments but demanded greater accountability in return (Marchildon, 2005a. p.111). As a result, the CHST was split into the Canadian Social Transfer along with the Canadian Health Transfer in an effort create greater transparency when it comes to health care funding. It is important to note the federal health funding transfer is not only cash. The federal government allows tax credits to the provinces and counts their value as part of their fifty-percent health payment (Marchildon, 2005a. p.116). These changes have forced provinces to take on greater amounts of responsibility for health care, without out guaranteeing that there will be enough liquid cash transferred down to them to run these programs.



whose proponents argue for a political system that supports free markets, free trade, strong property rights, and short-term, contract-based employment (Harvey, 2005. p.2). In economic terms, neoliberalism involves cost-cutting at the level of the state or governments through the decentralization of social services, corporate tax breaks and tax cuts (Harvey, 2005. p.26).

Neoliberalism is arguably the overriding rationale behind cuts to healthcare spending, as well as the emergence of preventative medicine, or the ‘new public health’ (Peterson & Lupton, 1995; Bunton 1999). In line with neoliberalism, the new public health promotes “flexible and diverse approaches to the production of health,” encouraging community involvement and informal partnerships over direct government involvement (Bunton, 1999.p.29). It does so by framing health problems as socially—rather than biologically—determined, through the rhetoric of the ‘social determinants of health’ (Petersen & Lupton, 1995. p.4). These discourses suggest that health problems should be addressed via preventative measures (Ashton & Seymour, 1988 as cited in Petersen & Lupton, 1995. 4), for example via the formation of “healthy public policies,” such as banning smoking in public spaces.

Underlying the new public health is also the belief that individuals, communities and institutions can and should engage in various health promoting activities (Petersen & Lupton, 1995. p.ix). This emphasis on individual responsibility for health is what distinguishes the movement from the old public health approach, which in its early stages, focused on primary care, the treatment of the sick and sanitation at a broad societal level (Goraya & Scrambler, 1998). The new public health, in contrast, aims to bring about the voluntary participation of individuals, institutions and communities by fostering awareness about the importance of good health. Within new public health discourses is

often an implicit expectation that individuals will “take responsibility for the care of their bodies and to limit their potential harm to others” (Petersen & Lupton, 1995. p.ix).

According to Peterson and Lupton (1996), people are no longer thought of as passive subjects who are “‘acted upon’ by their environment;” they are instead understood as engaged in an “interactive relationship with the external environment and their own inner self” (Lindheim & Syme, 1983. p.337 as cited in Petersen & Lupton, 1996. p.116).

### **2.3 Risk and risk management**

A key feature of the new public health is its emphasis on risk management (Petersen & Lupton, 2005. p.2). Most public health policies are designed to minimize or address the “risk factors” that characterize particular individuals and/or groups vis-à-vis health. The notion of risk is central to the new public health, as it is an avenue through which individuals are encouraged to take on responsibility for health. We operate under the notion that we have a role to play in managing risk, and that we can ultimately have some control over our health. As such, the concept of risk is an essential element on which preventative medicine is based (Peterson & Lupton, 1996). While the term ‘risk’ once captured the probability of gains and losses, it is now perceived as synonymous with ‘danger’ and is associated with feelings of fear, anxiety and uncertainty (Carter, 1998. p. 135; Lupton, 1999a, p.12, as cited in Wilkinson, 2001. p.5). According to Wilkinson (2001), the term is “used exclusively to evoke the threat of hazard, the fear of damage, the failure of ‘progress’ and a loss of confidence in the security of the world” (Wilkinson, 2001. p.6). This shift is apparent in the way many health promotion campaigns are designed to draw our attention to the environmental dangers that threaten us.

Some scholars argue that perceptions of health risk have also been shaped by modern technological developments. Peterson and Lupton (1996) argue that part of the

reason perception or awareness of risk is growing in contemporary society arises from the fact that the “world is getting smaller.” In other words, events in very distant geographical locations now have the potential to affect us and vice versa. People are now much more aware of and connected to technological and environmental risks as a result of globalization (Shilling, 1993. p.73 as cited in Petersen & Lupton, 1996. p.22). Pandemic outbreaks, such as SARS, serve as a reminder that threats from very far away can quickly become localized. Geographic distance is no obstacle for a superbug in a globalized world.<sup>5</sup>

One of the ways in which risk is managed is by drawing upon expertise, which is in turn used to develop public policy (Taylor-Goody, 2000. p.1). The role of experts then is to stay ahead of the curve and “tame the chances” (Hacking, as cited in Wilkinson, 2001.p.93). Experts within the medical community are relied upon to identify and manage the risks that face society, and to provide technical expertise and knowledge to provide us with a set of best practices which are conducive to health (Alaszewski, 2006.p.161; Brownlie & Howson, 2006.p.435 ). As such, expert knowledge has become the authority in the policy world as governments strive to make evidence based decisions (Alaszewski, 2006; Wilkinson, 2001).

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<sup>5</sup> Sociologist, Ulrich Beck, goes so far as to claim that we are now living in a “risk society,” which he depicts as a “shadow kingdom” (Wilkinson, 2001.p.116). Here risks are created by societal advancements and contemporary everyday life itself. These risks are incalculable, as they are created by the very nature of our everyday lives as new technologies are developed and put to use (Holloway, 2004. p.40). Beck asserts that the more risk conscious we become, the more anxiety we experience (Beck, 1992. as cited on Petersen & Lupton, 1996. p.95). This is modernity’s paradox; technology grants us more knowledge, and the very knowledge of risk makes us more aware of possible dangers thus causing anxiety (Wilkinson, 2001. p.101). With our technological advancements, in other words, modern societies are essentially “manufacturing uncertainty” (Giddens, 1999. as cited in Higgs, 1998. p.177).

## **2.4 Neoliberalism, public health and governmentality**

Foucault coined the term “governmentality” to describe the way the body, health and population are managed through both formal and informal processes in liberal societies (Brownlie & Howson, 2006.p. 435). Liberal societies seek to influence behaviour through both coercive and non-coercive measures, but abide by the ideals of choice and autonomy, or that individuals ought to act for their own benefit (Lupton 1995 as cited on Higgs 1998, p.185). Central to the practices of governmentality, however, are processes of normalization, whereby particular behaviours become characterized as either within or outside societal norms. Subjects are thereby paradoxically encouraged to exercise their autonomy via self-regulation, by altering their behaviours to better comply with expected norms (Lupton, 1999.p.61). For Foucault, therefore, governmentality is a means of disciplining and regulating the population “without direct or oppressive intervention” (Flynn, 2002. p.163), via the “conduct of conduct” (Nettleson 1997 as cited in Higgs 1998. p.185).

Rose (1993) further develops Foucault’s concept of governmentality in his analysis of ‘post-welfare,’ or advanced liberal, states. He suggests that while welfare states once “sought to govern through society,” they now seek “to govern without governing society” (p.298). Rose argues, in other words, that current welfare states have less overt and more decentralized role in arenas such as health. They continue to influence health outcomes, however, by shaping the ways in which the public perceive health risks and their role in health protection. Individuals, as well as society more largely, now understand themselves as having an important role to play in risk management.

A number of health researchers have drawn on these ideas to explore the ways in which public health initiatives seek to guide behaviour and lifestyle choices (Higgs, 1998; Flynn 2002; Minkler, 2000). Health promotion discourses often represent “good citizens” as those who engage in the behaviours and practices which experts have identified as conducive to good health (Covey, 1998 and Crysanthou 2002, as cited in Brownlie & Howson, 2006. p.435). This, in turn, shapes the way people perceive their responsibility to lead healthy lives, producing conformity to public health initiatives voluntarily, out of self-interest (Petersen & Lupton, 1996. p.64). This call for public participation, in turn, fits ideally within a neoliberal agenda that calls for more active ‘community’ participation and ‘public-private’ partnerships in health.

## **2.5 Workplaces and health promotion**

Most of the work examining the new public health has focused on concepts of *individual* responsabilization within this new neoliberal regime. Very little work has looked at how institutions take on responsibilities for health under a decentralized system that calls for active citizenship in the context of neoliberal reforms to healthcare and the proliferation of public health. In the next section, I explore how the role of lay institutions— specifically workplaces— might be changing in this regard, influenced by the growing emphasis on health-promoting workplaces and the “settings-based” health promotion movement.

Workplaces tend to focus on health protection and disease prevention through safety initiatives rather than actively promoting good health (Midha & Sullivan, 1999. p.224), but a growing body of literature has begun to advocate for broader workplace ‘wellness programming’ and occupational health (Chu, Driscoll & Dwyer, 1997, Midha & Sullivan, 1999). This literature outlines reasons why it is advantageous for workplaces to

promote health, and characterizes existing approaches as reactionary rather than preventative, as workplaces tend to develop programs in reaction to an emerging situation within the workplace. This characterization is also due to the fact that workplaces often fail to develop health goals independent of “health threatening agents in the workforce” (Wynne, 1992. p.17-8 as cited in Midha & Sullivan, 1999. p.224) and are “limited to small efforts such as information pamphlets or weekly emails” (Chu & Forrester 1992; Simpson & al, 2002 as cited in Allender, Colquhoun & Kelly 2006. p.131). It also describes previous workplace health promotion programs as “haphazard, semi-professional, ambiguous and poorly evaluated” (Seedhouse, 1996, as cited in Allender, Colquhoun & Kelly, 2006. p. 132). The message is clear within this body of work, that workplaces are an important site for health promotion and require more “wellness programming.”

Workplaces are also encouraged to become involved in the promotion of health out of their own self-interest, to maintain high rates of productivity (Chu, Driscoll & Dwyer, 1997. p. 377). According to Midha and Sullivan (1999) workplaces can promote health and intervene in three key ways. Firstly, they provide information to their employees in an effort to educate them on health issues and inform them of health risks associated with certain lifestyle choices (Midha & Sullivan, 1999. p.223). Secondly, workplaces promote health through policy development; policies are created within the workplace to help regulate or eliminate aspects within the working environment that are associated with illness or health risks (for example, through smoking bans) (Midha & Sullivan, 1999.p.223). Thirdly, workplaces intervene by implementing organizational changes, “changing aspects of the organizational environment that might otherwise lead to take up particular lifestyles” which lead to ill health (Midha & Sullivan, 1999. p.223).

Midha and Sullivan argue that all three levels of intervention are required for successful and comprehensive health promotion to occur in the workplace (Midha & Sullivan, 1999. p. 224).

The World Health Organization's *Ottawa Charter for Health Promotion* of 1986 has also helped to promote the notion that lay institutions can and should become more formally involved in larger public health initiatives. The Charter led to the establishment of a series of 'settings-based' health promotion strategies "where specific health-related settings were accorded special attention" (World Health Organization 1986 as cited in Whitehead, 2006. p.59). These settings include workplaces, schools and other community spaces (Whitehead, 2006. p.59). According to the World Health Organization (2011) settings such as workplaces can become "vehicles to reach individuals," for example by providing workers with access to health promotional material and knowledge that they may not have encountered otherwise. Since the establishment of the settings movement, a number of additional settings have been added to the list, including universities and prisons (Whitehead, 2006. p.59).

The 'settings' based approach to health promotion has initiated much more activity over the last two decades in the U.K than elsewhere; in Canada, for example, partnerships between the health system and settings have not been formalized in the same way as they have been in the UK. There may be some parallels between the two countries, however. As services and responsibilities for public health are downloaded onto lower levels of government, regional health authorities in Canada, lay institutions—specifically, workplaces— might be encouraged to play an informal, but increasing role in targeting certain populations through public health initiatives. In Canada and elsewhere, workplaces— along with schools and other community spaces— might be in

the process of becoming valuable ‘partners’ in the larger health system (Chu, Breucker, Harris, Stitzel, Gan, Gu & Dwyer, 2000. p.155). They are certainly seen as important sites for health promotion insofar as they can be sites for the spread of infectious disease or other harms (Chu, Driscoll & Dwyer, 1997. p.377).

## **2.6 Responsibilizing workplaces: What are the implications?**

It appears as though the everyday work environment is going through a process of responsabilization in relation to health, at the same time as governments reconfigure their role as healthcare providers to align with dominant neoliberal policy leanings.

Workplaces are increasingly encouraged to take on new responsibilities to ensure health and safety become a more significant part of workplace culture (Champ 1997 as cite in Danna & Griffin, 1999. p.368). They are also encouraged to set out to regulate and standardize behaviour or lifestyle choices.

From a critical perspective, these strategies can be viewed as a “form of conformative action to ensure employer control of the employee within the organization” (Midha & Sullivan, 1999. p.226). In other words, workplace health promotion can be seen as a means through which workplaces attempt to force employees to comply with workplaces strategies in an attempt to meet management goals. Some suggest that these initiatives are “political exercises laden with strategies and relations of power” (Cheek, 2000; Seedhouse, 1996 as cited in Allender, Colquhoun & Kelly, 2006. p. 132). As Allender, Colquhoun and Kelly argue, the motivations behind workplace health initiatives are complex, carrying many social and political meanings (2006, p.132). They point out, however, that there has been little research examining governance through health and work (Allender, Colquhoun & Kelly, 2006, p.132). There have also been few studies that consider how workplaces see their position or roles vis-à-vis the health of their



employees. These gaps in the research are significant given that much of people's lives in late modernity are lived within the confines of institutions and secondary agencies like workplaces (Peterson, 1997, p.191 as cited in Allender et al, 2006. p.132).

Workplace health promotion can also be seen through the governmentality lens, as a means of disciplining and regulating populations. Parallels can also be drawn between these strategies and concepts of governmentality operating within the new public health. Indeed, critics of workplace health promotion strategies have similarly drawn on the work of Foucault, Armstrong (1995) and Lupton (1995) to highlight the regulatory aspects of these health promotion strategies, which seek to guide employee behaviour (Daykin, 1999. p.13). I will use this work as a basis to examine how workplaces see their role in shaping employee (and also in the case students') perceptions of health and risk. In what ways do workplaces see themselves as responsible for the health of their population and in what ways do they take on a responsibility for the health? Why do workplaces take on these initiatives and how does this impact the work of those involved in planning these initiatives?

### **Summary**

The literature reviewed clearly outlines how economic and political shifts have influenced current approaches to healthcare in Canada. These shifts have transferred more responsibility onto provinces and, in turn, onto regional health authorities. Regional health authorities, as well as the public health system, in turn, have encouraged new community partnerships to be made in the name of health promotion.

Community and individual involvement in health care provision is encouraged through public policies and a broader discourse of risk and risk management. Involvement in risk prevention is now seen as the mark of good citizenship and

responsibility. Lay institutions like workplaces also appear to be implicated in new public health strategies. They are encouraged to help manage the risks facing their populations and to become health promoting agents through the use of both coercive and non-coercive means within their populations.

My thesis will offer unique insight because it attempts to examine the influence neoliberal health policies may have had on the healthcare system from the perspective of workplaces and the newly responsabilized worker. Most of the literature in this area has not examined the impact neoliberal shifts have had at an institutional level, or how institutions are answering the call for active citizenship within public health. Some scholars have examined the impact this system has had for workers, but there is no research to be found looking at the implications these shifts have had on administrators who have been assigned to develop and implement workplace strategies. This is the aim of this project. Through the use of a case study I will examine how Dalhousie University worked to protect the health of their population during the H1N1 outbreak.

In the next chapter I will outline the methods used to explore my research questions. In Chapter Four, I will present the findings of my research. I will use this material, in Chapter Five, as a context from which to draw upon and analyze my findings, considering why things at Dalhousie played out the way they did.

## **Chapter 3: Methods**

My project explores the processes in which Dalhousie University, as a lay institution, got involved as they worked to provide health care services and how these practices affected the daily operations of the university. In doing so, I conducted a case study, examining how Dalhousie University responded and coped with the H1N1 outbreak in 2010 and what shaped its course of action. I reviewed Dalhousie's institutional documentation and conducted 10 in-depth interviews with participants who were directly involved in planning Dalhousie's institutional response at the time of the H1N1 outbreak. Together the data provide rich information which captures a holistic picture of Dalhousie's approaches to dealing with a pandemic situation.

### ***3.1 Dalhousie as a research site***

Dalhousie was chosen as the research site for this case study. It represents a case of a lay institution taking on responsibility for health during a public health emergency. The use of the term "lay institution" was adopted from the term "lay healthcare provider," which Lipp (2011) defines as "a member of the community who has received some training to promote health or to carry out some health care services, but is not a health care professional" (Lipp, 2011. p.243). In keeping with this definition, the term "lay institution" then refers to an institution which takes on the responsibility for the health of its population, though it does not have an officially legislated responsibility for health, nor is it an institution which directly delivers health care services as a part of its usual work. That is, Dalhousie, as a university, holds its primary mandate as an educational and research institution, yet took on substantial responsibility to provide healthcare-related services during the H1N1 outbreak.

The appeal of using Dalhousie as a site of study lies in the fact that it has multiple functions in society. The university depicts an institution which operates as a place of employment as well as a place of study, yet a part of its mandate is to provide a safe environment for employees as well as students. Dalhousie is more than a school to students and a workplace for employees, it is also a research institute that provides training and knowledge to health professionals and policy makers. This multi-responsibility, to academic development, students and employees, was appealing when selecting a case study because it provides insight into the role that could be played by many lay institutions.

Dalhousie is engaged Dalhousie as a research site to answer my research questions through a case study. I understand a case study to be “a detailed examination of one setting, or a single subject, a single depository of documents, or one particular event” (Bogdan & Biklen, 2004, as cited in Berg, 2007.p.283). Following this definition, my project looks at how Dalhousie handled the H1N1 outbreak in 2009/2010, and does not in any significant way examine its response to previous outbreaks or the responses taken by other institutions during the H1N1 outbreak. Since this project looks at this subject through a single case study, I understand that the findings may not be broadly generalizable to all institutions. However, I hope that they will offer some insight into the role played by lay institutions and the impact their involvement has on their everyday work, especially for similar institutions such as universities, colleges, and schools.

### ***3.2 Document Analysis***

A document review was conducted in order to determine what Dalhousie, as an institution, believed to be its responsibility for the health and safety of its employees and students. This review included an analysis of institutional plans which were developed

before, as well as a result of, the 2009/2010 H1N1 outbreak. The documents that I reviewed were the *Dalhousie University Infectious Diseases Preparedness Plan* (DUIDPP) — which was in draft form at the time of data collection and was introduced many months after the outbreak had ended, the *Student Community Services Communicable Illness Residence Response Plan* (SCSCIRRP), drafted in August 2009, and the *Department of Facilities Management Pandemic Contingency Plan* (DFMPCP), from September 2009. All materials posted to Dalhousie’s Flu Website ([www.flu.dal.ca](http://www.flu.dal.ca)), the university’s official space for announcements and information about the outbreak, were also reviewed.

Documents were analyzed for the ways in which they presented Dalhousie’s role in health promotion and protection and for the way in which the university positioned itself within the larger healthcare system. Formal coding techniques were not used for the document analysis, but were instead examined to identify themes of responsibility.

The documents were reviewed to gain insight into how the institution portrayed its role and place within the larger public health system to its public. The response plans also provide insight into how the institution positioned itself within the larger public health system, its perceived responsibility, capacity and limitations. The analysis also considered how information borrowed from public health officials influenced Dalhousie’s response. Reviewing institutional documentation offers rich insight into the organization’s interpretation of its role. According to Forster (1994) these are important forms of data, not only for the obvious information they contain, but also as they “are one of the principal by-products of the interactions and communication of individuals and groups, at all levels, in organizations” (Forster, 1994. p. 148). The institutional documentation

pertaining to the response is a tool by which verbal accounts of informants can be compared.

Though it may seem that institutional documentation comes with biases, as it may provide an opportunity where institutions can create a front through which they can portray a false image for their publics, Forster (1994) explains that most internal documentation is not written to be promotional public relations (PR) material. Institutional documents are rarely written in such a way that they expect to be read by an outside audience. This is the case with Dalhousie's planning documentation, which was developed for internal use by university administrators.

Nevertheless, materials taken from Dalhousie's website could be considered to be PR materials. They were written by the institution's communications department to portray the outbreak and the university's actions in a positive way. Even if these documents contain a PR element, they remain equally important sources of information as they are telling of the "image" Dalhousie is trying to convey to its public. The information collected from these sources was used to complement the data collected from internal documentation.

All documents included in the document analysis were publicly accessible. Participants often provided me with the planning documents when they discussed their role in the development of these documents, or directed me to where I could find them. Information on Dalhousie's Flu website was easily accessible as it was meant to be a reachable hub for all students, faculty and staff. Information on the pandemic remained available online for many months after the outbreak was over.

### ***3.3 In-depth Interviews***

In-depth, semi structured interviews were conducted with 10 Dalhousie University staff members who participated in the H1N1 pandemic preparedness initiatives at the university. These participants were considered key stakeholders in Dalhousie's preparedness planning, and were selected based on their direct involvement in the institution's response during the H1N1 outbreak. Participants were, for the most part, mid-to high-ranking administrators and managers within the university community. The purpose of conducting interviews with individuals who were involved with the response initiative was not only to gather information about the planning process at Dalhousie, but also to examine the impact preparing for a public health emergency has had on their everyday work and on the Dalhousie community more largely. How had their position changed? What were the implications of these changes?

Participants were recruited through email (see Appendix I: Recruitment Email). The names of potential participants were collected from Dalhousie's flu website. From there, additional participants were recruited through snowball sampling. Participants often told me who else worked with them on the planning committee and suggested that they also be contacted. It was not difficult to contact these individuals, as they were public figures within the university community and their contact information was readily available.

After ten interviews were conducted, I stopped recruiting participants. It became difficult to recruit participants as the number of administrators who had participated in a significant way in the planning process was limited. Additionally, I had reached saturation with interview information. Following Bowen's (2008) definition of saturation, which he describes as "data replication or redundancy" (Bowen, 2008. p.140), I ended the

interviewing process once themes began to be repeated, assuring me that the information that had been collected was accurate and valid. For this project, the number of interviewees was less important than ensuring those who were interviewed were an appropriate fit for the project and were able to speak about their direct contributions to the planning process at Dalhousie.

In-depth interviews were semi-structured. I prepared an interview guide (see Appendix II: Interview Guide) but was willing to hear about and explore areas that were brought up by participants. Participants were asked to begin by describing their regular everyday work, how they became involved with the pandemic response planning at Dalhousie, how they feel about their, as well as Dalhousie's, involvement with the H1N1 pandemic outbreak. Although I began with the questions indicated in the interview guide, depending on the flow of interviews, further questions were asked. These questions were mainly to clarify the previous answers or ask for more detail.

Interviews were conducted in the summer of 2010, in person and generally lasted between 30 and 45 minutes. They were recorded with a digital audio recorder so that they could be transcribed and analyzed later. I also took notes during the interview, mostly jotting down things that I may want to return to. Since participants were all Dalhousie employees, all interviews were conducted on campus. Two interviews were conducted in common rooms at the Killam Library and all others were conducted at the participants' offices. I offered to book alternative spaces for all interview participants in case they did not want to talk about what could be considered sensitive information in their office but no other participants requested this.

Interview recordings were transcribed verbatim. According to the work of Poland (1995) transcribing interviews verbatim assures not only that the quality of data but also



the quality of the analysis and interpretation is uncompromised (Poland, 1995. P.290).

Once the interview recordings had been transcribed, they were coded and analyzed using Atlas ti. 26 codes were uncovered as topics were repeated pertaining to my research questions (see appendix IV for themes). These codes can be further categorized into 6 main themes: policy-making process, successes, challenges, effects on everyday work, confidence in response capacity and scope (degree to which participant felt their involvement fell within the scope of their position). After coding the interview data, I analyzed by code in order to identify how participants described the planning process, why things happened the way they did at Dalhousie and how this affected their everyday work.

### ***3.4 Ethical Considerations***

Before conducting the interviews, I obtained approval from Dalhousie University Social Sciences and Humanities Human Research Ethics Board, which is a requirement for studies involving human participants at Dalhousie, as well as the Nova Scotia Health Research Foundation who funded the project. In order to obtain ethics approval for my project I submitted a detailed description of the project which outlined the objectives of my research, the methods I would employ and a list of any possible harms this work could cause participants. The most significant foreseeable harm was the risk of participant identification for those who may hold views that do not coincide with the official position of the university. If this risk were to be realized, it had the potential to harm the reputation or employment status of the participant.

Since participants are part of a small policy community, anonymity also needed to be safeguarded. Therefore, I protected participant identities by not revealing their names or descriptive features of their positions. I had originally intended for participants to be

identified and named if they explicitly expressed this wish on their consent form, however permission to be identified by name was only granted by one participant. Since only one participant agreed to be identified, I made the decision not to reveal any identities, since the population from which the participants were recruited is very small and doing so could have led to the identification of other participants who wished to be identified by a pseudonym. Therefore, all participants in this thesis are identified by a pseudonym and I was careful not to reveal any identifying characteristics about their departments or positions. Since no one will be identified by their real name, this mitigates the risk for the entire group.

The only other significant risk for participants was potential feelings of discomfort or anxiety if participating in the pandemic preparedness planning was an especially stressful experience for them. As participants discussed their employment and the scope of their position during a time when anxiety within that community was high, some participants may have felt a bit anxious or uncomfortable if they were not in agreement with the way the situation was handled, or their work life was negatively affected. In order to mitigate this risk, participants were able to skip any questions which they felt uncomfortable answering. Furthermore, questions were very open ended, which was meant to spur conversation. The questions were broad enough that the participant may avoid negative emotions or recounting experiences that they did not wish to talk about. However, if a participant wanted to speak out against the way a situation was managed or share a view that may have been against the official position of the university they were be given the opportunity to do so.

### ***3.5 Informed consent***

Initial recruitment emails included a brief description of the study and the participant's potential role within it. Once participants agreed to meet and be interviewed, a time and location for the interview was selected. At the time of the interview, participants were presented with the consent form (see Appendix III: Project Consent Form) and asked to review it. Participants were given the option of being recorded as well as being identified. I requested that all participants provide signed consent before the interview could begin. All risks were outlined in the consent form.

## **Chapter 4: What did Dalhousie do to manage the health risks of its population?**

In this chapter, I will describe the main findings of my fieldwork, which involved ten in-depth interviews as well as a document review. In doing so, I have summarized the material into two key sections. The first section will report the context and development of the H1N1 pandemic, as well as describe specific courses of actions that Dalhousie took during the pandemic outbreak. Of the many initiatives that took place, I will highlight three specific areas of action: information dissemination, administering health care services, and efforts to institutionalize pandemic control as a responsible social organization. These descriptions outline the unique position in which Dalhousie University was situated throughout the pandemic, as a lay institution. Second, I will provide information with respect to the issues that arose out of these efforts. Essentially, these issues are grouped into three themes: the institutionalization of a response through policy creation, the motivating factors behind the institution's involvement, and impact these new initiatives had on the everyday work of employees. Together, the information collected from the document review and participant interviews will provide the basis for the argument that though Dalhousie's response was modelled after larger public health initiatives it was shaped by the university's workplace politics and institutional culture and had important implications for those involved in the efforts, which will be discussed in the next chapter.

### **4.1 Outlining the steps Dalhousie took to protect the health of its population**

H1N1 pandemic planning at Dalhousie University began April 29<sup>th</sup>, 2009 when the first cases of the infection were identified at King's Edgehill School in Windsor, Nova Scotia after a class trip to Mexico. Windsor is close to Halifax geographically, and so it

quickly came under the radar of the university. Also, the laboratory of a Dalhousie immunologist identified the first case of infection. Since this discovery, there was ongoing planning among various sections of administration at Dalhousie University. There were various stages of organizational development: initial stage, gradual growth period, and formalized/institutionalized stage.

According to the participants of this study, the initial planning stage was very informal and consisted of discussions which were held among a small group of a few key administrators. Namely, the Vice-President of Student Services and the Vice-President of Finance and Administration got together out of a “gut feeling” that a dialogue at the university should begin. This small gathering started the planning process. Along with these conversations, a small informal committee was established. The committee was largely student-focused, though there were also representatives from Human Resources to represent the interests of faculty and staff.

As the planning process got underway the committee grew larger; new people were included to represent different areas of interest, communities, and departments within the university. Participants agreed that there were often 12 to 14 people present at meetings. The growing size of the group produced some difficulties. It became difficult to manage the various interests represented (i.e. students, staff, and faculty). There was also much confusion about who was in charge and about which department should be leading the response. As a consequence of this confusion, by September the large group had broken down into three subcommittees: academic continuity, infection control and communications.

The *academic continuity group* was in charge of ensuring that the academic mission of the university remained operational throughout the response. This subcommittee consisted of representatives from each faculty, IT, and the office of the VP Academic and Provost. This group discussed and provided input on issues pertaining to the continuation of academic mission, such as policies dealing with sick notes, absenteeism and alternative course management strategies.

The *communications group* was responsible for the development and maintenance of both internal and external communication channels. This group was made up of individuals from Dalhousie's Communications and Marketing Department as well as Student Services and was responsible for the dissemination of information. Its main objective was to keep the population informed, while ensuring the university's message was clear and consistent with the messaging from larger public health authorities.

The *infection control group* was responsible for the practical medical objectives of the university's response, namely controlling the spread of the illness. This group was comprised of medical professionals from Dalhousie's medical faculties as well as representatives from the university's office of Environmental Health and Safety. Representatives of this group helped navigate the university's medical response, by working to translate medical and scientific knowledge to the larger planning committee. They worked to inform initiatives surrounding the administration of healthcare services which comprised of infection control, setting up vaccination clinics, and surveillance. They helped ensure that the medical aspects of the university's response were in line with larger public health initiatives and helped sort out conflicting information.

These three subgroups (the academic continuity group, the communications group and the infection control group) reported back to the larger committee made up of administrators who guided the committee's overall response. By mid-summer the committee was meeting regularly and in the height of the response in the fall of 2009 it was meeting weekly if not more. This intensified workload was very time-consuming for those involved. Yet, everyone seemed to make a concerted effort to meet the organizational needs of the response and a governance structure was established. They worked on these new tasks as part of their mandate to provide education in a safe environment.

In the next section I turn my attention to specific initiatives taken up by these committees with an emphasis on communication and infection control groups. It is important to underscore the fact that the processes surrounding the development of organizational responses emerged as a reaction to meeting the academic mission. However this response, to the newly anticipated needs of their population, ended up expanding the scope of operations, creating substantial overlaps with the mandates of public health authorities.

#### **4.1.1 Disseminating information to Dalhousie's public through an educational communications campaign**

For Dalhousie, just like any other public institution, communication to its population was crucial to taking control of the pandemic. According to the *Dalhousie University Infectious Diseases Preparedness Plan (DUIDPP)*, which was drafted by members of Student Services in the summer of 2010 as a result of the H1N1 outbreak, it was in the university's best interest to provide information regarding an outbreak to its

employees and students in a timely and ongoing manner from the beginning of the planning process throughout the outbreak. This was done in an effort to minimize rumours and misinformation around campus and throughout the Dalhousie community more broadly. The university hoped that if information was provided clearly and consistently people would remain calm, act cooperatively and help others who may be caught off guard or anxious about the situation. Additionally, information provision will foster the university community's confidence in the administration's plans.

Communication media such as on campus and email bulletins, web messages and employee meetings were used as forums to promote educational messages. To reflect the importance, the communications group put together a fairly exhaustive communications plan early on, developing rigorous internal and external campaigns.

Internally, the main responsibilities of the communications group were to educate and inform the university's population. News of a potential pandemic outbreak stirred up great concern in many communities and the reaction of the general public often involves creating myths, or misinformed practices. As such, efforts to provide accurate information about the disease, as well as proper information to prevent infection were the group's top priorities. One participant, Geoff, who worked in the communications group, echoed this point. He said that it was "about awareness-raising, more than anything else, that was our biggest challenge and there was a lot of miscommunication around H1N1 from the very beginning..."

To reflect his concern, during the time of the pandemic, the campus was saturated with banners, part of the university's education campaign, as they worked to bust myths about the pandemic just as much as they encouraged healthy habits. The communications



group promoted health initiatives such as good hand washing practices and coughing etiquette in addition to promoting vaccination clinics. They also worked to streamline the university's messaging on their website [www.flu.dal.ca](http://www.flu.dal.ca).

Throughout these efforts to advertise proper information about the virus, and how to prevent or cope with infection, participants faced various challenges. Some participants identified one of the main challenges as confusion surrounding administrative responsibility. They found that it was very difficult to deal with the situation as it was often unclear which department was in charge of managing the messaging for staff and students on the website, which was supposed to be a one stop information hub. Participants expressed the sentiment that through their communications and education campaign the university wanted to help faculty, staff and students navigate the continuous stream of information that was coming out. Yet, the lack of formal organizational structure provided barriers for workers in different units to provide a concerted effort to do so.

This difficulty was further exacerbated by constantly changing facts and information. Many participants said this was challenging as the information changed quickly, and the university, as well as the general public, often received mixed messages. Janice explained that,

the challenge in our population of course with H1N1 is, you know, a lot of shifting research of whether or not our population was particularly vulnerable and research ...actually kept shifting because people were actively researching ... as it was happening.

As many health care facilities gathered new information about the disease on a daily basis, the information disseminated from research units increased, often contradicting previously circulated information.

In an effort to keep up with this constantly shifting stream of information, the university used its website, “[www.flu.dal.ca](http://www.flu.dal.ca)” as its main medium to communicate its message. The site was set up to be the institution’s information hub for students, faculty and staff. The university updated the site regularly as new information became available and incorporated external links to larger government lead public health initiatives.

The site offered links to other agencies such as the Government of Nova Scotia’s H1N1 page, Nova Scotia Health Link, and the Public Health Agency of Canada where readers could get more information about the pandemic. It also offered downloadable resources such as the “Flu Symptoms Decision Chart,” which was designed in an effort to help staff and students decide when to stay home sick, and encouraged them to consider and manage the risks that they might pose to others (see Appendix V). Additionally, the website offered information about the campus’ vaccination clinics and the vaccine itself, and attempted to ‘bust’ myths that were or may have been circulating about the risks associated with the vaccine.

One section of the website focused specifically on students, featuring “frequently asked questions” (FAQ). The FAQ addressed a wide range of issues that directly affected students’ daily lives, from class-related information, such as changing sick note policies, excused absences, and cancellation, to advice on medical treatment and resources. There was also a section designated for faculty and staff which looked at issues surrounding academic continuity, sick note policies for the classroom and alternative course delivery

methods, as well as syllabus flexibility. Employees were directed to the human resources website for further workplace information.

The communication group's attempts served the entire Dalhousie community, providing information about both academic issues, and substantive medical issue. In fact, at the time of the H1N1 outbreak, the continuation of academic mission became inseparable to coping with the disease and protecting students from infection. For example, the university helped students with flu symptoms decide whether or not they should go to school. The university's website "flu.dal.ca" aimed to help staff and students navigate these simple decisions. This information was especially important for students in residence who, unlike students who commute from home, may not have anyone else to turn to for advice. The lack of information or misinformation could potentially lead to a wide spread outbreak. As a result, residence administration made efforts to educate students about the difference between regular cold and flu symptoms and H1N1. Sally explained that at the time, the biggest resource was a 'decision-making guide' that was borrowed from McGill University. The guide broke symptoms down into three different categories according to body temperature, and was intended to help students decipher their illness from a regular cold and flu symptoms. The guide then advised whether or not to seek medical attention or just stay home from school and work.

In addition to providing medical information to help staff and students make decisions about their health, the communications campaign also frequently promoted public health initiatives and risk management strategies. Posters displaying messages about hand washing and the use of hand sanitizer were distributed around campus. The university's communications team created their own messaging in addition to using

materials provided by Nova Scotia's Department of Health Promotion and Protection, for instance their "Hand Washing!" poster (see Appendix VI).

Following larger public health messages, as well as information from other similar institutions, Dalhousie communicated to students, staff, and instructors. Despite the fact that their efforts were largely geared towards their primary mandate — academic continuity— their practices (through their communications campaign), seem to significantly overlap with public health advocacy. While this point will be explored further in the next chapter, this overlap can be directly highlighted throughout Dalhousie's vaccination campaign.

#### **4.1.2 Administering health care services**

While the communications group established and maintained open channels of communication with the Dalhousie community in correspondence with information coming from the external health authority, the *infection control group* was responsible for administering the medical aspects of the response. Through the group's initiatives, Dalhousie ended up providing three primary health care services during its H1N1 response; infection control, vaccination clinics, and surveillance.

In an effort to control infection, Dalhousie took a wide range of measures from preventative, to provision of care, to residence students. Preventative procedures included stockpiling appropriate equipment and supplies such as hand sanitizers, face masks and thermometers. In addition to this preventative equipment, Dalhousie also provided services to those who became ill. For example, in residences the most explicit forms of additional medical service was provided as staff were asked to provide comfort, support

and care to students who were not be able to go home, and had no one else to depend on, if they fell ill.

The largest medical service that Dalhousie provided was the establishment of vaccination clinics. The university hired an outside medical services company, Lifemark, to administer the vaccine to faculty, staff and students free of charge. Clinics were held in the Student Union Building, and according to Frank, Dalhousie provided the vaccine to 7,000 people. Dalhousie paid for the clinics out of its own operating budget, at a cost of roughly \$55,000 and \$65,000. Referring to the cost absorbed by Dalhousie, he also mentioned, “65,000 dollars of a multimillion dollar organization is a very reasonable cost to put all of our community feeling like we are managing this crisis well.” This demonstrates that the university saw the clinics not only as an investment, which could positively impact the health of their population, but could also have positive returns in regard to the confidence the population had in the administration. A financial commitment from the university showed the population that the university was making an effort and was committed to health protection.

Responses from participants indicate that vaccination clinics were positively received by faculty, staff and students. Many participants perceived that it was the university’s most successful accomplishment. In fact, clinics went so well that officials from the Provincial Department of Health used Dalhousie as an example for other institutions. Since 7,000 people were inoculated, one participant boasted that the campus had a higher level of inoculation than in the general public. One participant, Frank, explained that “on our third day Capital District Health showed up at our vaccination clinic and said ‘what are you folks doing?’...we were getting people in and out in about

fifteen to twenty minutes, and fifteen minutes of that was the mandatory wait they have to do to leave.” According to Frank, Dalhousie had one of the best run vaccination clinics in the province. Thus, vaccination clinics seem to have been not only well received among the Dalhousie community but also outside health authorities.

In addition to stockpiling preventative supplies and holding vaccination clinics, Dalhousie also engaged in medical surveillance, which was a large part of Dalhousie’s management strategy. Measures were put in place to monitor levels of sickness in the classroom and the workplace; sick staff and students were encouraged to stay home. Any unusually high levels of absenteeism were to be reported to local public health officials as required. Staff members were made accountable for watching and reporting levels of absenteeism and infection within their respective areas. In addition to developing academic continuity plans, faculty members were also asked to report noticeable levels of absenteeism in the classroom to the department. Department heads were then asked to track absenteeism among their departments (staff and students). This was done so administration could target areas where there were particularly high levels of sickness. Surveillance was especially important for students living in residence. Residence Assistants (RAs) were responsible for reporting the number of sick students on their floor to a residence administrator, as well as the Residence Life Manager (RLM) on a weekly basis and on a daily basis if infection rates increased. RAs were also asked to enter new cases of infection in the Student Information Database. The RLM in turn reported infection rates to the appropriate higher-ups.

Through the work of the infection control group, Dalhousie administered various preventative initiatives. According to the some of the employees who were involved in

this process, Dalhousie possessed some unique characteristics as a lay institution. While most of the group's planning practices were in keeping with the university's primary mandate — provision of academic training— some actions taken by Dalhousie went far beyond it. The provision of information about flu, managing students in residence, and installing health protecting supplies were things that other educational institutions can generally practice. However, practices like organizing and paying for a vaccination clinic seemed to go beyond its regular mandate. Taking such an active role in the health protection of its population was a result of the university's financial situation, as well as the medical advice the committees had access to. One of the factors which put Dalhousie in a unique position was the presence of medical experts throughout the planning process.

As previously mentioned the infection control group was made up of university administrators as well as invited experts from the Faculty of Medicine. Dalhousie's ability to form such a specialized group, as well as take on various tasks taken up by this group, highlight its position as a unique lay organization distinct from other organizations. The university is unique among institutions because it has numerous medical professionals on staff, due to its medical and health science faculties. Many other universities would not have the same in-house expertise. As a result, the university had access to scientific information as it became available that had not yet been made public. Some medical experts on Dalhousie's planning committee were also members of larger response committees for larger public health authorities. The presence of experts brought merit, as it allowed insight and advanced noticed as to which direction larger responses might take. This expert knowledge ultimately shaped the medical aspects of the response and helped ensure that it was in line with larger public health initiatives.

The expertise brought to the planning committee by in-house medical professionals was described as an invaluable resource by participants. At times, however this expertise added to the confusion by providing more information, or conflicting information. Reconciling conflicting information was a very difficult task throughout the response. In some situations, the infection control group made recommendations to larger overarching planning committee as to what should happen with regards to infection control and transmission. In that context, it was important that their response and communications remained consistent with external organizations such as Capital District Health Authority (CDHA), Nova Scotia's Department of Health Promotion and Protection and the Public Health Agency of Canada. Yet, it was very difficult to reconcile information which varied from one source to another, and day by day. One respondent explained:

...there was lots of information coming out from the health agency and that agency itself had a number of committees and then... there was information coming out from Health Protection and Promotion and then there was some information coming from the Capital District Health Authority, when it came to things like clinics and vaccination and those sorts of things that were Capital Health related. All of those things needed to be coordinated and those other sources of information needed to be monitored so that we didn't make any missteps and head in directions different or give contradictory information about things like infectiousness, or mask use, or the role of hand washing or the role of disinfectants and those sorts of things and the prioritization for vaccination (Robert).

The information within the larger public health system was often conflicting and quickly changing. However, it is apparent that Dalhousie's infection control group worked to extract the dominant message out of the complex web of changing information. Despite the fact that information was continuously changing, there was a concerted effort to align the university's response with what larger public health initiatives, at regional,



provincial and national levels were promoting. Participants reported that it was advantageous that some of the members of this subcommittee were also on the committee guiding CDHA's response and were well-connected professionally with provincial and federal public health initiatives. One participant explained the effort to engage with medical experts throughout the response was done to ensure that "there was a sort of consistency... we weren't creating our own message or interpretations we could go to the authority sources" (Yvonne).

Thus, the presence of experts on the planning committee seemed to have both positive and negative impacts. On the one hand, some participants felt that having experts led to a flood of information and added more pressure to do things correctly; yet at the same time they felt that the presence of experts on the committee provided legitimacy to the operation and made decision making easier.

#### ***4.1.3 Institutionalizing Pandemic Control***

The planning process ended just as quickly as it had begun. Participants reported that committee meetings came to an end once Dalhousie held its third round of vaccinations in December, 2009. At this point, with the 50% inoculation rate, respondents felt that it was pretty much over. They sensed that they had done all that they could do. One participant described it as a time of "pandemic fatigue." The university's administration had been dealing with the pandemic for eight months, since May 2009. As a result, the overall planning committee decided to wrap up and start fresh in January 2010. However, it was only in late March/ early April that a team (namely the debrief committee) was pulled together again. The main mandate of this committee was to

evaluate the institution's response and put together a new infectious illness report. This report eventually became the *Dalhousie University Infectious Disease Prevention Plan* (DUIDPP), which was drafted in the summer of 2010.

The debrief committee was made up of key members of the pandemic planning committee who are expected to act as key participants in a future outbreak. The committee was kept small, as the most common complaint during the H1N1 planning process was that the committee had become unwieldy. Consequently, most participants interviewed were not part of the debriefing process. Some felt that for the most part they had fallen out of the loop once the response had come to an end in December. One of those participants said,

I'm not sure what ongoing planning there is, perhaps they're simply waiting for the new occupational health person to come in to pick up where things have left off and that would be entire appropriate if that's the case...but...I'm not sure that the debriefing part of this has really has taken place as it should have (Robert).

Participants who were not included in the debrief process were not kept informed nor were they updated as to what the new group was working on. The former planning committee was unaware that a draft of the DUIDPP had been created after the response had come to an end. Perhaps this is because they were interviewed before the draft was finalized. At the same time, it seems peculiar that some participants were completely cut off after a certain point in the planning process and were not consulted during the debriefing process. This meant that, for the most part, participants were largely unable to talk about what was happening with Dalhousie's public health initiatives at the time of their interviews, in the summer of 2010 months after the response planning had ended.

The debrief committee reviewed what had worked, what had not and what some frustrations were. Participant, Jacob who was involved in the debriefing process, explained that as a follow up to the event the university had written up a list of recommendations and considerations. They asked senior management to review and comment on the actions that were taken, as well as prioritize the university's needs when dealing with these types of challenges for the future. The debrief participants —the few who could speak to that point— expressed that there were a lot of things that the university had done well in the grand scheme of the response; namely the vaccination clinics, programs run through student services for residence students, and commended the open dialogue that was happening among the committees and the enthusiasm of participants. They also identified certain areas to be improved. For example, participants felt that they need to be clearer about central communications vetting, keeping the group's size manageable and clearly outlining who is in charge of the response and who calls the final shots.

The planning process and debrief process are very polarized. The planning process was very inclusive, to the point that too many people were involved and it was difficult to manage the group. Meanwhile the debrief committee and subsequent response plan development committee were exclusive to the point that many participants could not speak to the issues. The challenges in both committees remain the same: it was not clear for those not involved in the debriefing process who was managing the final pieces of the response or the aftermath.

## **4.2 Issues that emerged out of Dalhousie's response to H1N1**

In the previous section, I described the processes, in which Dalhousie engaged to cope with the issues of H1N1, starting with the emergence of planning committees, creation of subcommittees, and specific operations that they implemented to cope with the emerging situations, and how it came to an end. The previous section highlighted what Dalhousie did in order to maintain its institutional mandate, which is primarily to provide academic training, and providing a safe environment was part of accomplishing this mandate. Yet, some aspects Dalhousie's response went beyond what other universities could offer. Obviously, Dalhousie is unique in so far as it is a university with medical school, which begs the question, to what degree do Dalhousie's processes resemble those of other lay institutions? Because my research does not involve comparative case studies, these questions are not directly answerable. However, detailed descriptions of how this pandemic planning and response process took its course at Dalhousie would contribute to future theorizing. Thus, in this section, I will demonstrate how this process unfolded. In doing so, I will focus on three main issues, which correspond to some implications driven from the literature: 1) Institutionalization of response to health threat through policy creation, 2) motivating factors, and 3) implications on the daily operation of employees.

### **4.2.1 Institutionalizing a response through policy creation**

Universities, like many other large institutions, have a sophisticated organizational structure. Generally, there is the office of the President, then a large number of departments undertaking specific tasks to operate as a coherent organization. For Dalhousie—as a university whose primary mandate is to provide academic training to students, as well as producing knowledge through research— departments within the

university are often constructed around functions such as education and research. Following this general mission, protecting workers and students is part of the university administration's concern; and this becomes a salient issue among departments when a pandemic, such as H1N1, hits the community. Given the fact that Dalhousie has dealt with a number of pandemic threats in the past, one would expect that the university would have already been equipped with certain protocols to handle such a situation. Yet, participants informed me that this was not the case. In fact, much of the confusion in response planning to the H1N1 pandemic derived from the lack of such an institutional mechanism. The interview findings suggest that it was only after facing H1N1 that Dalhousie finally established a policy protocol to manage a pandemic outbreak.

Historically, Dalhousie has dealt with public health outbreaks on a case by case basis, taking on a very reactive, ad-hoc approach. Though Dalhousie had dealt with public health emergencies in the past, a response plan and individual or departmental responsibilities for health were not formally documented until the H1N1 outbreak. For example, the university had dealt with the Norwalk virus and Mumps, but had no overarching response prepared to look back on. Each department may or may not have its own set of plans which led to a very fragmented history both in documentation and recollection. While some participants knew of past plans within their departments, all participants expressed that there was not an institution-wide plan in place, when H1N1 struck. Given the existing organizational structure of the university, with well-trained human resources, it was surprising to learn that there was no emergency protocol already established.

A few of the participants provided information on why this was the case. There had been pressure on the university's administration for a while to have planning documentation institutionalized. One participant explained that preparing a general emergency response plan was on the agenda when she arrived at Dalhousie six years ago. She explained that it was on the university's "to do list," "mainly because public health departments were all trying to do these plans ...and (there was) lots of pressure to do a formal plan here." In other words, in 2009, before H1N1 came onto the agenda a small group of administrators (some of whom later sat on the H1N1 committee) at the request of Student Services were actually in the process of pulling together plans from each department with the goal of producing a coherent, comprehensive Communicable Illness Plan. However, during this time, cases of H1N1 started to emerge, so the group's focus shifted from the development of this document to actually dealing with the H1N1 pandemic.

In fact, before the outbreak (about three years prior), there had been a working group assembled by the former Director of Safety to develop a provisional organizational response plan just as a precautionary measure as they were "due for an outbreak," according to one participant. The plan was described as not detailed, but meant to start discussions as to what issues may arise when organizing a response to a public health emergency for an institution as large as Dalhousie. The working group compiled a series of recommendations for the Vice President of Student Services (at the time). They conducted an environmental assessment and a situation analysis to identify the areas would require extra concentration, although this was very limited. The provisional organizational response plan may not have provided a practical framework but it did get

the group used to working on these sorts of planning initiatives. The response plan, however, had not been discussed until H1N1 arrived on the scene years later.

Another participant explained that there was an even older institutional document that was meant to deal with a public health emergency, but it was so outdated that it was not useful. She explained, “it wasn’t at the calibre that you would see nowadays from an organization...it was probably created in who knows when the 80s or 70s, I don’t know but there was one ... it needed to be updated it wasn’t that useful” (Elaine). Though terribly outdated, this document offered an initial list of services considered to be imperative to the operations of the university.

The development of this provisional organization response plan suggests that Dalhousie did have the initiative to develop documentation after dealing with various emergent situations in the past, but none ever fully materialized. Although the administration’s last attempt came very close to establishing an institutional protocol, it was not completed until after the H1N1 outbreak.

How did the lack of documentation affect the planning process at the time of the H1N1 outbreak? Many participants expressed that the lack comprehensive documents and structural protocol created many challenges for their response. One participant explained that part of the challenge of dealing with H1N1 was the fact that the university’s reactions to previous outbreaks had not been documented. She explained,

we had developed the protocols and the procedure through the mumps etcetera but we had never written all of them down...our facilities department had written theirs down and our residence group are not a bunch of writers— they’re doers, so they did everything, but in terms of writing everything down... it was just about the documentation of it (Janice).

Another participant felt that lack of documentation or emergency protocol made Dalhousie's response to H1N1 outbreak "reactionary," rather than proactive. He summed up this sentiment nicely when he said, "we were not making policy at that time, we were completely in response mode and management mode and... in one word, we were in response" (Frank).

Underlying these sentiments was the notion that there was some sort of emergency protocol institutionalized, in some objective form, though not documented. Obviously, when a pandemic hit the community, it was not necessarily the best time for administrators to go back to the drawing board and come up with a coherent policy. It was instead time to face a crisis whose situations changed daily, as new information was developing, and there was a demand for a quick response. As such, in the midst of dealing with the rapidly changing situation, a formal acknowledgement of responsibility was generally perceived by the university's administration. This responsibility was reflected in various courses of actions taken by the institution. Some participants referred to these actions as policy, while others did not.

One participant described this process as a "grassroots" policy making process. She said that the group was, "very careful to ensure that we got information from those that were directly involved with students and from students themselves...I would say grassroots in a sense in terms of the information that should influence policy" (Yvonne). In other words, she sensed an institutional responsibility to create a response that reflected the experience and addressed the needs of as many sectors of Dalhousie's population as possible.



Other participants argued that the committee really was not making policy; the only real institutional policy that was changed was the “sick note policy.” During the outbreak, the policy was amended so that student absences from classes, along with missed assignments and tests could be excused without a medical note. This was introduced in an effort to relieve (or at least not add more) stress to already overwhelmed health clinics. The university did not want students needlessly sitting in clinics infecting others, or becoming more ill just to get a note when many times the symptoms were treatable without medical attention.

Perhaps participants did not disagree about the actions that were being taken, but rather the language that was being used to describe their efforts. Despite disagreements about whether or not institutional policy was being created at the time of the pandemic, all participants agreed that the university was developing a campaign to protect the health of faculty, staff and students. Facing critical issues with time-sensitivity, along with the lack of institutional protocol, the university made decisions which entrenched the response into the daily operations of the university throughout the outbreak and formalized the university’s involvement in future outbreaks. This formal acknowledgement of responsibility is what I refer to as the ‘institutionalization of the response.’ Such institutionalized responses were also later reflected in formal documentation.

As a result of the H1N1 outbreak Dalhousie developed three plans; *The Dalhousie University Infectious Diseases Preparedness Plan (DUIDPP)*, which was drafted as a result of the H1N1 outbreak; the *Student Community Services Communicable Illness Residence Response Plan (SCSCIRRP)* drafted in August 2009, and the *Department of*

*Facilities Management Pandemic Contingency Plan (DFMPCP)* from September 2009.

The DUIDPP is perhaps the most comprehensive overarching plan, which addressed planning efforts and preparedness strategies for Dalhousie as a whole; however the SCSCIRRP and the DFMPCP are complimentary, adding more detail in their respective areas. Together these plans outline the university's response to public health and infectious disease outbreaks as they formalize the university's involvement in public health initiatives and work to institutionalize as response.

According to its institutional documentation, in the future the university will have two groups responsible for organizing and carrying out an institutional response; the *Emergency Management Group* and the *Emergency Policy Group*. The *Emergency Management Group* will be a proactive operational group that comes together prior to an outbreak and will focus on emergency planning and response (taking on measures to limit risk) as well as a business continuity management. The *Emergency Policy Group* will be the president's core crisis team; their role is to provide guidance and support set to priorities, direct the campus response and recovery activities. Ultimately, their role is to create an administrative plan of action.

The university's documentation intends to add efficiency to the planning and response process for the next outbreak, by clearly outlining the responsibilities of the university's administration. However, this clearly articulated responsibility also entrenches the responsibility for public health during an emergency outbreak within the everyday work of the university's staff while formalizing the responsibility and expectation of a smooth response.

#### **4.2.2 Why did Dalhousie take on these new responsibilities? Motivating factors**

Information that I collected suggests that there are both external and internal forces that shaped Dalhousie's response to the H1N1 pandemic. Externally, pressure from the media affected the way the university took on new responsibilities for the health of students, and internally there were evident mandates and expectations from those in the Dalhousie community. However, the findings from the document review reveal some interesting twists within external and internal pressures.

When H1N1 hit a media frenzy erupted. Planning at local, provincial and national levels was a hot topic in the media, making the news daily. The university received many media inquiries as to how it was going to protect its large and diverse population. In early stages of the planning process, the university had organized very informal meetings among key administrators and were relying on popular media, just as the general public was, for its information. At the same time, the media asked the university for a plan. This put the university in an interesting situation, in which there was an additional expectation without additional information. One participant explained,

it ramped up, the urgency that (we) better have a plan in place and that...came from, I wouldn't say pressure from administration but ... there was calls coming in from the media, you know, essentially scouting out the different universities and the public systems. What is the plan, what's the response, what are you going to do, you know, really stoking the fire (Frank).

At this time the university was in the same confused situation as the general public, but there was an expectation that it would take initiatives to gain access to additional information and develop a strategy to protect the health of its population.

Pressures came also from within the university. Many administrators and managers had inquiries from their staff as to what plans were in place to protect staff and students. Staff members were looking to administration for departmental guidance. Concerns were especially high among the professional faculties of Medicine, Dentistry and Nursing who had additional responsibilities to their students, because they were in and out of the healthcare setting as part of their training. One participant, Frank, said that these requests for information were challenging. Though the administration had past experiences to look back on there was no official plan or guidelines to turn to. He explained that,

they were looking for a plan, okay, there was no plan the university had an emergency response plan and it had the experience with the Mumps, but there was not pandemic plan per se... that we could go and reach for the binder off the shelf (Frank).

Though there was not a centralized plan, there was a strong sense among participants that the university should have one and the administrators involved really wanted there to be, or at least for it to seem as though there was a centralized response prepared. Thus, one form of internal pressure came from the expectation to respond to demands from certain departments. However, it was not the only internal motivating factor.

Dalhousie claims that it reacted out of its own sense of responsibility for the campus community, as well as the Halifax community more largely. The DUIDPP states that the university's "'duty of care' is to ensure that we take every precaution reasonable, given the circumstances, to protect all students, employees, faculty and staff in and around the university" (DUIDPP, 2001. p.1) The document also stated that it was the university's responsibility to help manage health risks of its population, as they recognized, "the impact of public health

emergency including an influenza pandemic will put extreme pressure on Nova Scotia's provincial and national health care system" and saw it as a time for "individuals and organizations to do all that they can to prevent the spread of the virus and mitigate or reduce the economic and societal disruption on a broad scale" (DUIDPP, 2010.p.1). Thus, the university engaged in precautionary measures to limit the impact an outbreak might have on teaching and research communities, as well as on the larger Halifax community. The documentation notes that it is imperative that they have a plan of action that took into account "preparedness and response to all phases and degrees of severity of infectious diseases from a single case to widespread pandemic illness" (DUIDPP, 2010.p.1).

Thus, internal pressure for Dalhousie to take responsibility was driven from the actual demands stemming from internal departments, as well as a sense of obligation to be a "responsible" social institution. Although Dalhousie is a university, not a health care institution or provider, its might have acted as such out of this sense of "responsibility" or projection of such an image. However, its vague status as a "quasi" provider also meant that its authority was not completely defined which lead to an ambiguous position with malleable parameters.

The university's efforts were meant to parallel the works of the World Health Organization (WHO), the Public Health Agency of Canada (PHAC), Health Canada, the Nova Scotia Department of Health Promotion and Protection, the Nova Scotia Emergency Management Office, and Capital District Health Authority (CDHA), as they worked to mitigate risk and control the spread of the outbreak. Like these other health authorities, the university promoted good health

practices and worked to educate its population. However, Dalhousie's relationship with public health is complex; on the one hand the administration recognizes that they have a responsibility for their population and should not depend on outside assistance. The DUIDPP stated that,

the University should not rely on upper levels of government to provide policy direction before or during a pandemic nor should it assume that assistance will be provided during a pandemic, given the wide-scale demands and limitation of resources. The university should plan to make its own decisions on policy collaborative planning and personal/professional networks that might provide assistance during an emergency outbreak (DUIDPP, 2010. p.15).

On the other hand, the plan recognizes that the university's authority and autonomy over healthcare responsibilities are limited and can be taken away at any time. It states that "in a pandemic situation, processes and actions in Dalhousie's plan are likely to be taken out of the direct control of the University by Capital Health District/ or external emergency response agencies" (DUIDPP, 13). Dalhousie then has a very ambivalent and overtly contradictory position within the healthcare system. They see themselves as responsible, yet at the same time as possessing no real authority.

Such contradiction was also sensed among participants. They unanimously expressed that the university had a responsibility for the health and wellbeing of its faculty, staff and students. It was clear that they believed there to exist an extra duty to care during a public health emergency. The institution employs more than 3000 staff and has a student population between 16,000 and 20,000. Participants reported that under the university's mission, they are responsible for all staff, faculty and students, despite the fact that under the Occupational Health and Safety Act they are only responsible for employees. However, participants explained that students fall under their perceived duty

to care under the departmental mandates of Security and Student Services. Participants reported a sense of obligation to students, particularly due the large student population from around the world who may not have had another support network in place. Additionally, Dalhousie has a large number of students (approximately 2300) in residences or alternative forms of campus housing. When asked if employees have a responsibility for students during the outbreak one participant explained,

Well, I mean it depends on your role but yeah they're responsible. We've got students here on our campus who not only have come here to study, but have come here to live and one of the things that we're aware of here is we have mainly a first year population in our residences but there's a whole other huge population that are renting in the peninsula here that are not local students they have come from another province... (Janice).

There was a clear concern for the entire student body that extended well beyond their academic success. Since students have moved their lives to Halifax to attend Dalhousie University, and in return the university seems to feel that its responsibility to these students extends beyond their studies into other areas of their lives.

Institutional documentation and interview findings reveal that Dalhousie took on the responsibility to manage the health risks of the population as a result of a sense of internal and external pressures and expectations. Though the university's sense of responsibility was clearly articulated, the university administration's sense of authority and place within the larger public health system was not as clear cut.

#### **4.2.3 Changing workplace expectations and practices among the planners**

The administration sought to respond to the internal and external pressure to provide reliable information while figuring out their position with external health authorities. All of this happened within a context where there was no institutionalized

protocol to follow. Meanwhile, the administration of the response was taken on by university employees who already carry regular workloads to ensure the primary missions of the university are met. Not only were these planning initiatives added to their workloads, employees were also community members who were subjects to the risk of H1N1. Moreover, they have families who faced the same risk. This leads to some obvious questions. How did employees perceive the situation of the H1N1 outbreak? How did they handle this situation with extra pressure and expectations coming from outside and within the university community, when there were no clear guidelines to consult?

According to the DUIDPP, as the new responsibilities that are placed upon employees become institutionalized, human resource policies are changed to reflect these new expectations and the “the realities of the workplace during a pandemic” (DUIDPP, 2010. P.17). The university’s documentation implied that the “realities of the workplace during a pandemic” may include added responsibility to employees’ daily work which might extend well beyond working hours. As such, employees are encouraged to have a plan in place which allows them to balance their family life, without interfering with their increased workload. The plan notes that because some workers will need to miss work because of family obligations if a pandemic strikes, in the future the university “needs to encourage employees to address issues of childcare, family communications and transportation prior to the emergence of a pandemic” (DUIDPP, 2010. p.14). All three of the university’s preparedness plans, DUIDPP SCSCIRRP and the DFMPCP, acknowledge that the positions and daily work of some university staff (and residence workers) would be greatly affected by the outbreak of communicable illness. For example, according to the DUIDPP there are ten areas within the university that have



been identified as “critical infrastructure” that must be maintained. Administrators’ portfolios were extended as they became responsible for particular areas of “critical infrastructure.”

It is not only administrators who will have an increased workload during a university response, but also many front-line workers in residence and facilities management. Employees are expected to take on new responsibilities such as coordinating daily objectives, redistributing labour to accommodate high levels of absenteeism, monitoring risk assessment and financial impacts to the university in addition to their daily work. New responsibilities for residence workers include disseminating information, surveillance and reporting to the appropriate higher-ups, in order to meet the university’s new reporting requirements, make tactical and strategic decision about resources and risk management, deciding when to cancel student activities, arrange for sick students to get food and hydration packs delivered to their residence room, setting up quarantines when necessary and even sending a “We Care Card” to sick students, according the institutional documentation.

Interestingly, the document analysis reveals that there was a double-standard in the expectations placed upon administrators and student workers. The documentation recognizes that residence assistants or cluster leaders are responsible to help accommodate sick students and play “key role in the delivery of residence services and support.” The document also states that the university “holds the individual needs of each student as a high priority,” and emphasizes that they are “students ‘first’” (SCSCIRRP, 2009. p.13). This implies, then, that the responsibility placed on residence workers is secondary to their own success and health as a student. Residence workers are not asked

to compromise their own needs for the sake of sick students on their floor. However, there is no mention of a limit on the responsibility allocated to administrators and other staff. This begs the question, what are the limits for other employees, as this is not outlined in the documentation?

At the beginning of each interview, participants were asked to begin by giving a “job description” of their “everyday work” at Dalhousie. Participants each described his or her role as a position of administration or management of either staff or students. Employment roles included responsibilities for the Dalhousie community in the areas of environmental health and safety, student services, information technology, communications, human resources, or as a faculty member. When each participant was asked to describe their everyday work, public health was not mentioned in their job descriptions. Nonetheless, when later asked if they felt that acting in this capacity was outside the scope of their position, they all responded that they did not.

Participants generally understood how the university’s initiatives fit within the realm of their work. When asked if acting within this capacity was within the scope of his position, one participant replied that it was both “within and beyond the scope” of his position and explained “it was fine because...everybody was asked to do more, if everybody had stuck to their job descriptions we would have had tragedy” and went on to explain that “I don’t think it’s within any job description right now for somebody to deal with a pandemic... it takes a team of people to do that... all other duties as required.” One participant said that an emergency call people’s values into question, their daily work quickly becomes more about doing the right thing during a time of need rather than doing only what is within the scope of their position. Janice says, “in an emergency it’s about

...people's decision making moral centers...it becomes a question of not whether it's my job or not but it's about your role in a civil society." For her the issue was larger than just her job, it was about doing the right thing and helping out where she could.

While most participants expressed the importance of serving the community, the only area where there was some disagreement about the "scope" of work was around students in residence. Who would take care of sick students who could not go home? Some felt that it was the responsibility of those at the Dalhousie Health Clinic; meanwhile others felt that it should be residence workers and resident assistants, many of whom are upper year students.

Regarding the changes in workload, most felt that their work was multiplied, and described it as an intense time of work overload. Overall, participants felt comfortable taking on these new responsibilities. However, some felt at times stressed because their usual everyday work was not getting done, as their regular responsibilities were shifted to the backburner. One participant noted that it would have been helpful to have someone help out with his regular work duties so that he could have focused primarily on the "crisis," and explained that it is "stressful when you're taken out of your role and managing stuff that's just blindsided you...you get concerned what is not being done in your day to day operations...and that adds another level of stress."

Likewise, for many administrators their new role overtook their everyday responsibilities and some felt that it was hard to maintain a balance. One participant explained "when you move into true emergency status many people have to start making choices between their family obligations and their professional obligations, I'm paid to

put my professional obligations first. I'm a senior leader and I know that. How well (other) people know that, I don't know," implying that as a senior level administrator taking on this extra work was very much expected, though not explicitly expressed.

Participants who took up extra duties that fell outside of their expertise, generally felt confident in their ability to manage their new responsibilities and guide the university's response. They noted that they were, for the most part, assembling a series of best practices and could rely upon expert knowledge to make their decisions. They felt well-resourced in terms of money and access to the right information. Guidance was taken from Dalhousie's own medical experts, the Public Health Agency of Canada, the government of Nova Scotia, Capital District Health Authority as well as the practices being adopted by other universities.

However, one participant noted "we were always questioning ourselves. Are we in conflict of some other policy that might be related to this?... We were questioning, certainly second guessing policies that were made, it slowed things down a little bit but we made decisions with the best information that we had at the time." Confidence was built upon the sentiment that they were in this together. One participant said that they were confident, however they,

would never see this as a one person show...it's a team effort, and I was relying on other individuals to feed me information who had the expertise that I didn't have. But there's no question that the piece that I was confident about was that we would be able to connect with our leaders across campus that we would be able to identify if we needed to changed practices around sick leave or whatever I was confident that we would be able to do that, we had a good communication lines with our unions and employee groups I wasn't worried about stick handling that... (Elaine).

Another source of frustration was the committee's decision making processes. Elaine said "it's a complex organization, there's many layers...Dalhousie's not know for its

nimbleness it definitely played itself out in this pandemic I think the challenge for me was who's leading, who's accountable for actually putting this plan together." Another participant explained that administrators were accustomed to a much more collaborative decision making process where agreements are reached in much slower fashion once everyone's opinions had been voiced, but this was not conducive to emergency planning. She explained,

when you're handling an emergency it means that you have to make decisions and make them quickly with good input and advice but you don't have time to go onto approval procedures and the people handling the emergency have to make the decisions. You can't make a critical health decision and say that university senate is going to make that decision—it's the wrong kind of body (Janice).

In addition to feeling confident in the response, participants seemed comfortable with the medical approaches (vaccination being the largest) being promoted by the university. There was only one participant who was critical about the information the university was providing and promoting. Participant, Sally indicated that she felt her role in her particular area of administration was to present all of the information surrounding vaccinations with a neutral tone and students could make their own decisions about it. She explained that students "were told about the clinics, they were educated about the plusses and the minuses and then it was their decisions. We didn't herd them over...I think some people wanted us to do that, we didn't see this as our role." However, for most participants, promoting vaccination was synonymous with health promotion and protection.

The changing expectations and practices during pandemic response planning had important implications for the everyday work of those involved in the university's efforts.

Though many workers understood how these new responsibilities fell within the scope of their work, the processes did at times add additional stress and pressure to their workdays.

## **Conclusion**

In an effort to protect the health of its population during the pandemic outbreak Dalhousie pulled together a response that was built around information dissemination, administering healthcare services and institutionalization of a response by officially documenting its planning processes. The university took on these new responsibilities as a result of media pressure, internal expectations and a feeling of institutional responsibility for the health protection of its population. Employees agreed that the university had an important responsibility to its population that could not be shirked, and participants noted that they were very willing to take on additional responsibilities. The effects of these added responsibilities on the daily work of those who were involved will be examined in the next chapter. I will also look at how Dalhousie's own particular organizational history and imperatives, as well as its capacities as an institution shaped its response and the ways in which tasks were carried out.

## **Chapter 5: Why did things at Dalhousie happen the way they did?**

This chapter examines why the response at Dalhousie took shape the way it did. It looks specifically at the institutional dynamics that shaped the university's response and what the implications were for those working within the institution. It suggests that Dalhousie took on a responsibility for the health of its population as a result of various internal and external pressures. Its response modelled initiatives taken on by larger health authorities, but was tailored to meet the unique needs of the university's community. Given its close connection with medical and research communities and its financial resources, Dalhousie had many advantages in developing a response. The university also faced unique challenges, however, as workplace politics and institutional culture acted as obstacles to some initiatives.

### **5.1 Understanding Dalhousie's position within the public health system**

Dalhousie took on a responsibility for health during the H1N1 pandemic by supporting larger public health initiatives, providing essential medical services, organizing vaccination clinics and a communications campaign. Moreover, the university adopted a new organizational perspective on health during the outbreak, as the administration institutionalized a response. By this, I mean the university incorporated its response into its everyday workings. Most notably, the university changed its institutional policies in an effort to create a space that was conducive to health protection at the time of the outbreak. The example of the new sick note policy, the largest policy change (or temporary amendment) taken up by the university, illustrates this well. Although the university's objective was to ensure its primary mission — academic continuity— was achieved, this represented a major change in official priorities, whereby promoting health became more important than maintaining routine academic standards of practice.

Dalhousie University clearly took on responsibility for health during the H1N1 pandemic in order to ensure that its own interests were served. The administration understood that the university could quickly become the site of a large scale outbreak, a ‘breeding ground’ for infection, given its size. It also understood the impact that this could have in terms of the productivity and daily operation of the university. According to Chu, Driscoll & Dwyer (1997), Danna and Griffin, (1999) and Midha and Sullivan (1999), such concerns are what motivate most employers to take on responsibility for their employees’ health and well-being. Most understand that absenteeism can have a major impact on an organization’s daily operations, bringing about significant losses in productivity (Danna & Griffin, 1999, p.375-6). Many also recognize that the workplace environment can put employees at risk (Chu, Driscoll & Dwyer, 1997, p.377).

Those involved in addressing the H1N1 pandemic at Dalhousie University did not see the university as a typical workplace, however, nor did they see themselves as responsible for maintaining productivity and daily operations alone. For example, the university’s communication efforts provided substantive medical information as well as information about academic issues at the time of the pandemic. The campaign included information about how to limit the spread of the virus and to prevent infection. It also encouraged those who were sick to stay home for the benefit of their peers. The university took its health promoting campaign very seriously, as demonstrated by its financial commitment to hosting in-house vaccination clinics. Furthermore, participants explained that a very deliberate and concerted effort was made to ensure that the information provided in its campaign mirrored that which was set out by federal and provincial health authorities— namely the N.S. Department of Health Promotion and Protection and the Public Health Agency of Canada.



Likewise, establishing a vaccination clinic on site at Dalhousie surpassed the mandate of the university as an academic institution. It was possible for the institution to administer the H1N1 vaccine on campus because of its financial capacities of the university. While doing so might be seen as advantageous from a workplace standpoint—indeed one participant described the vaccination clinic in these terms precisely—it is nonetheless significant that the university bore this financial and administrative burden. Establishing a vaccination clinic, actively promoting vaccination, and successfully inoculating 50% of students, faculty and staff was a great achievement according to many participants, in part due to the kudos they received from Capital District Health and the Provincial Department of Health for doing so.

In these and other ways, Dalhousie University took on an active role as a lay health care provider during the H1N1 pandemic. According to its own documentation, the DUIDPP, the institution saw itself as having a mandate to do all that it could to support an already strained public health system in times of crisis. By taking on this responsibility, Dalhousie positioned itself as an agent and part of the larger public health system. The participants in this study believed that H1N1 could be a major threat to the institution, as well as to its employees and students. They also believed that the risks associated with the virus were manageable and that they could play an active role in helping to mitigate these risks. They made substantial efforts to stay ahead of the infection curve and to “tame the chances” (Wilkinson, 2001.p.93) that the disease would spread among the university population and beyond.

The university worked to protect the health of its population by taking on an approach which combined notions of health and self-governance while normalizing behaviours that were conducive to meeting its objectives (Coveny, 1998 and Crysanthou

2002 as cited in Brownlie & Howson, 2006. p.435). Instead of offering incentives for healthy behaviours (as discussed in Taylor-Goody, 2000, p.1) the university instead offered time off without question. These efforts to guide lifestyle and health choices of employees and students are not unlike Foucault's conceptions of "governmentality" where states guide behaviours, through both formal and informal processes, by encouraging them that it is in their own best interest to act in a particular way that complies with state objectives (Rose, 1993.p.286; Minkler, 2000. p. 6; Brownlie & Howson, 2006. p.435).

As outlined in the introduction, the Nova Scotia Pandemic Influenza Plan (2008) makes explicit the expectation that lay institutions participate in health promoting activities during times of a pandemic. Interestingly, however, none of the participants mentioned this document during the interviews, nor did any mention any direct or indirect instruction from the government to become involved in pandemic planning. Participants more frequently explained that the needs and expectations of the "university community," as well as mounting "public concern" about H1N1 (expressed in the form of increasingly insistent media inquiries) propelled them into action. These findings suggest that the Nova Scotia Pandemic Influenza Plan legislation was not enforced. They also seem to suggest that research participants were unaware of the extent to which the provincial government might have been relying on the active involvement of institutions like Dalhousie to participate in a "community-based approach" to health care and decrease pressures on formal health care services (Armstrong and Armstrong, 2003, p.2).

In other words, Dalhousie's efforts were in keeping with the expectations placed upon lay institutions operating in neoliberal healthcare regimes (Peterson & Lupton, 1995). The decentralization of health care services and neoliberal influences on federal

and provincial governance have resulted in communities, lay institutions and individuals being encouraged to take on collective responsibilities for health. Dalhousie became an ideal partner in this system, willing to take on new responsibilities to support the larger healthcare system without being directly asked or forced to do so, out of a sense of responsibility and trust in larger authorities (Peterson & Lupton, 1995). This allowed the larger healthcare system to share some of the burden of responsibility for managing the H1N1 pandemic.

The position of lay institutions like Dalhousie within a decentralized healthcare system mimics the relationship between the province and regional health authorities, and the relationship between provincial and federal governments, insofar as responsibilities are downloaded but authority is not. In the case of H1N1, the university recognized both its duty to respond and that, in responding, it was acting outside of its jurisdiction and had no real authority in the grand scheme of public health planning and response. Throughout the pandemic, the university understood that it was subordinate to larger authorities and could be subject to the control of the CDHA or other external agencies. When the university did respond, it was in no way contending with larger authorities, but rather intended to support them.

This shift is based on the belief that environmental health risks can be managed by communities and lay institutions (Peterson and Lupton, 1996). It assumes that these institutions have the resources available and are prepared to take on a certain amount of responsibility for the health of the population. The next section will explore the limitations and challenges that faced the university when taking on these new responsibilities and the influence Dalhousie's history, culture and institutional characteristics had on their initiatives.

## **5.2 Factoring in the influence of Dalhousie's history, culture and institutional characteristics**

Dalhousie has a particular history with public health, a workplace culture as well as certain institutional characteristics which, together, shaped the university's capacity, as well as the ways in which they were able to respond the outbreak.

### *History*

The university's history with public health has been very "stop and go" and interest in health promotion has been known to fall off the administration's agenda just as quickly as it comes on to it. Historically, the university has done a poor job of documenting its past experiences and lessons learned. For years, the university had the creation of an emergency plan on its "to do list." One participant justified this with the explanation that often emergency decisions cannot be made ahead of time. Participants reported a lot of confusion and uncertainty surrounding the university's history with health endeavours, as well as its institutional documentation. Some participants were aware of working plans that had been developed for specific areas, but all agreed that the administration needed to come together to create an official institution wide plan.

A working plan had not been kept up to date, nor had a set of institutional best practices, from previous incidents, been compiled—that is, until the summer of 2010 as a result of H1N1 outbreak. Though it seems that this situation may not have changed much, even with the outbreak of H1N1, participants were still not clear by the end of the committee meetings whether or not an official document had been developed, and most could not speak to the progress of the current plan (the DUIDPP). In addition to stressing the importance of having a plan in place, the H1N1 outbreak also highlighted the need for a more permanent public health presence at Dalhousie and it was even suggested that a

permanent occupational health nurse be hired. Though planning seems to have fallen to the wayside, and again participants did not seem to know if an occupational health nurse had been hired, or if there were plans to hire one in the future. This, I would argue, has been the case as dealing with these sorts of public health initiatives has not fully been integrated into the regular everyday work of the university. This clearly demonstrates how public health has not consistently remained a priority, or even on the agenda at Dalhousie. The institution's history has shown that though the university has had a lot of experience dealing with public health emergencies, they do not remain on the agenda long enough after an outbreak for the documentation to be updated and a response plan to be created in order to ensure that a proactive approach is in place for next time.

This struggle, to keep public health or health promotion initiatives on the agenda, is not unique. The literature in the area of workplace health initiatives claims that workplace approaches to health can often be characterized as reactionary rather than preventative, as they react to perceived health threats instead of developing health goals independent of "health threatening agents in the workforce" (Wynne, 1992.p17-8 as cited in Midha & Sullivan, 1999.p.224). Since this is not the focus of their everyday work, workplace health promotion programs are often criticized for being "haphazard, semi-professional, ambiguous and poorly evaluated" (Seedhouse, 1996 as cited in Allender, Colquhoun & Kelly, 2006. p. 132). Though Canada is not operating under the 'healthy settings' model, the challenges faced by Dalhousie are consistent with the challenges faced by institutions operating under the UK's healthy settings initiative— as they struggle to keep health promotion sustainable in these "settings" for extended periods of time (Dooris 2000 and Poland et al, 2001. p.26 &347as cited in Whitelaw, Baxendale, Bryce, Machardy, Young & Witney, 2001. P.339). The involvement of "settings," or in

this case Dalhousie as a lay institution, in public health is still relatively new so institutions just like the workers within them are still working to find their place within the larger system. But this remains challenged by the fact that there is very little guidance for institutions on these new roles that are expected of them; meanwhile participation in voluntary and the costs of the initiatives are at their own expense.

### *Culture*

The university's capacity to respond was also largely determined by the institution's culture and administrative practices. Most felt that there was a lack of leadership within the planning committee, as no one took on the role of ensuring the response was run efficiently and it was unclear who was ultimately responsible for development and delivery of a response. Participants blamed this lack of leadership on the fact that Dalhousie's administration was used to gentler decision making processes that allow every voice to be heard before a decision is made. It was difficult to move from this collaborative usual process—one that relies on consensus and member contribution—to one where decisions needed to be made quickly. This lack of leadership had a significant impact on the response, as it often resulted in a bit of a power struggle between departments as they worked to keep their messaging consistent while meeting the needs of their individual target groups. Since the university had a responsibility to many different groups, but did not have clear leadership, initiatives did not run as smoothly as they could have. These challenges are not uncommon according to the literature, it is not unusual to have numerous stakeholders when creating workplace health initiatives and it is often a challenge to balance multiple interests (Allender, Colquhoun, Kelly, 2006. P.132). It was clear from the response that without proper documentation and procedures in place, the administration had a hard time pulling together an organized group

efficiently. Moreover, Dalhousie's institutional culture and regular decision making models were not conducive to the ad hoc planning processes that come along with emergency planning.

In addition to having a unique culture of administration the university also has a unique workplace culture which adopts a fairly laid back approach to tracking faculty time. Faculty often have the freedom to work from home or other locations when they are not teaching. This presented unique challenges when it came to tracking sick time and time away from the university. For example, a faculty member may not have been in the office but that does not necessarily mean that they were out sick, perhaps they were just working from home or somewhere off campus. Normally administration and departments are not concerned with tracking the difference (unless absences are continuous), so it was difficult to get faculty used to calling in sick, and in turn having departments keep track of sick time. Additionally, workplace cultures vary by department; each department is fairly autonomous and has its own culture and way of doing things. For example, when it came to response documentation from past outbreaks, some departments had plans drafted while others did not. This was justified by their specific work cultures where one group was described as "writers" and the other group as "doers."

#### *Institutional Characteristics*

Participants all agreed that the university was well resourced in terms of money (as they paid for vaccination clinics out of its own operating budget), as well as access to information. The university was constantly referring to government agencies, as well as other institutions for guidance and were well connected with the PHAC and Government of Nova Scotia through its faculty of medicine. Participants expressed that the university's personal connections to the medical and research community, health experts

and leading authorities over health were invaluable resources and particular advantages of their institution. The university was able to have experts sit on its planning committee which gave them access to information as it became available, often before the general public. Although it was noted that at times the group was privy to too much information or conflicting information, which added to the confusion. But, ultimately access to this additional knowledge gave many committee members a sense of confidence in their decision making practices, as experts helped them navigate health information that might be outside of everyday reading. This was tremendously advantageous, given the authority and trust placed on expert knowledge in today's system of health policy creation. These connections helped the university remain consistent with larger authorities not only in terms of its messaging, but also in terms of its methods of policy creation, as medical authorities and technical expertise have become integral to identifying risks for society (Alaszewski, 2006. p.161) and the practices of evidence based decision making (Aleaszewski, 2006; Wilkinson, 2001), which added a level of credibility to the university's campaign. These were particular advantages of the university and other institutions without these connections may have had very different experiences aligning their campaigns with those of larger authorities.

Dalhousie may have had an easier time than other institutions making the transition from educating (their everyday responsibility) to health promoting, as their administration is already largely involved in the private lives of many students through residence programming. Perhaps this new role came more easily to Dalhousie than other institutions due to the fact that a number of students live on campus and thus the university has an established responsibility to its students that extends beyond academics. Their public maybe have been more open to receiving messaging from an institution



where a good number of them already live and they have an established relationship. This would be an interesting area for further study, but is beyond the scope of this study.

### **5.3. Implications of taking on these new responsibilities from an employee perspective**

My findings and the literature indicate that taking on new responsibilities for health have important implications for the institution, as well as for the daily work of those involved in its efforts. Employees took on these new responsibilities, outside of their everyday work, out of an expectation from their employer, as well as out of an internal sense of obligation from their own areas of administration. Participants did not seem to mind taking on additional responsibilities and for the most part seemed to have only added responsibilities during their regular working hours and did not seem overly concerned about overtime or pressure to put in additional time.

Nevertheless, many participants did note that their time at work was much more chaotic, and putting their regular responsibilities aside was stressful. It is not surprising the workers found the additional work to be stressful as research has shown that the most commonly cited attribute of workplace stress is lack of time or an excessive workload (Williams, 2003. p. 1). Additionally, feeling stressed from “too many demands” is highest among professionals and managers according to the 2000 *Statistics Canada General Social Survey* (Jackson, 2000. p. 82). One participant spoke about her responsibility as a senior administrator who is paid to put her professional obligations first should it be required. Though this was not a common concern for administrators in this study, Michie (2002) found that an organizational culture of “presenteeism” or where unpaid overtime is expected causes stress (Michie, 2002. p.69).

Literature in the area of workplace health promotion focuses on the experience of the employee working under workplace health regimes, rather than the experience of the administrators working to create workplace health policies. There are many ethical considerations to be made when thinking about the employee as there is the potential for value laden judgements about health to be placed upon them (Allender, Colquhoun & Kelly, 2006. p. 140). There is a concern that when a worker is unable or unwilling to meet the new health expectations of their employer, they will be judged as a result. This is worrisome as it allows the employer to evaluate and discriminate against employees in an area that was before considered private and beyond the grasp of the sphere of work.

Midha & Sullivan (1999), Gray (2009), and Allender, Colquhoun & Kelly (2006) warn about the potential dangers of associating the “good” employee with “the healthy employee,” as boundaries between a realm that was once private (health) become increasingly intertwined with the public realm of work. The responsible employee, in other words, is then regarded as the good employee. Some employees may not be able to take on the additional responsibilities that they are being asked to by their employers; however they feel that in a public health emergency their professional responsibilities trump their personal responsibilities? What happens to the workers who are unable to take on additional responsibilities or extra hours? This also has important implications for boundaries between the personal and the professional. For example, Dalhousie’s human resource policies encouraged employees to have pre-arranged childcare in mind, so that family sick time does not hinder the health goals and the administration of the response at the university.

Generally, participants felt well supported in their endeavours, noting that the university was well resourced and that they had the means necessary to make informed

decisions. I was surprised with their enthusiasm and acceptance of their additional responsibilities. Critical health literature does not engage these issues at the institutional level, though the writings of Bunton (1999), Carter (1998) and Wilkinson (2001) on risk, and the work of Peterson & Lupton (1995) on the new public health had led me to believe that taking on these new responsibilities would be reported as burdensome to the institution and to the employee.

Though it may seem surprising that workers were not upset by the changes in their everyday work, their reported feelings are actually in keeping with the on workplace stress and job satisfaction (Michie, 2002; Jackson 2010). Workers saw value in the work that they were doing and generally felt in control of the project, which provided them with a sense of satisfaction in their work. Many participants boasted about their accomplishments, despite the conditions they navigated. Overall, the group was fairly autonomous; though they were taking on a lot of additional and unfamiliar responsibilities, they were also granted a lot of decision making power over the planning process. According to the literature (Michie, 2002; Welsh, 2004; Jackson, 2010) it is this decision making latitude that is imperative for satisfaction when job demands are high. Workers can gain a sense of satisfaction and accomplishment from challenging or unfamiliar work as long as they still feel in control of their working environment or are autonomous (Michie, 2002. p.69; Welsh, 2004. p.350; Jackson, 2010, p.81).

Though participants did report a feeling of accomplishment, they were also at times frustrated with the lack of leadership on the committee and the ambiguity surrounding their particular roles at times. This follows Michie's (2002) explanation that role uncertainty or unfamiliarity can be a source of dissatisfaction. Situations that bring rise to uncertainty ambiguity or unfamiliarity within the job role, or situations that involve

conflict, loss or changing expectations of their job have been found to be stressful for workers (Michie, 2002. p. 67). Dealing with a public health emergency (rather than schedule health promoting initiatives) has the potential to cause stress among workers, which has been found to stem from unpredictable or uncontrollable working situations. Participants did note that it was stressful to take on work that was outside of their regular workload. Additionally, some administrators may not be comfortable getting involved in the health choices of others, when this is outside the realm of their everyday work.

It is important to note that reported levels of satisfaction among those interviewed may not reflect the feelings of all Dalhousie employees whose work was affected by H1N1. It is crucial to recognize that participants were senior level administrators who were already, for the most part, responsible in some way for faculty, staff or students and accustomed to making decisions for the campus community. Perhaps workers who were regularly less involved in these kinds of decision making processes would not have been in favour of taking on these tasks.

Though my findings and the literature indicate that there is an expectation for lay institutions to become involved in public health endeavours, there are very few supports in place to help them take on this new role. There are no guidelines for institutional involvement and no agreed upon boundaries for their position. To address this issue, Whitelaw et al.(2001), call for a clearly outlined sustainable standard of what is expected of institutions working within the “settings” movement, and suggest that this issue could be partially addressed by offering “settings” or lay institutions a clearly defined starting place with clear objectives that can be easily linked to endpoints, within the larger system (Whitelaw et al., 2001. p.339). The challenges that currently exist as a result of undefined roles are evident in Dalhousie’s own institutional documentation. The institution adopted

a paradoxical responsibility for health which made it both responsible for the health of its population, without the support of the government, while at the same time remaining subordinate to the government should this responsibility be taken out of its direct control. These blurry boundaries were also exhibited in the provincial documentation which outlines the expectation that communities and institutions support government lead initiatives, but does not detail how institutions (who may already have stretched resources) can go about this. This lack of clarity surrounding the university's position and confused involvement are common challenges for settings based health promotion strategies where institutions often struggle to carve out and establish a place for themselves within a larger more permanent healthcare system (Whitelaw et al, 2001).

It was evident in both interview findings and Dalhousie's institutional documentation that the university has had a hard time keeping public health on the agenda once a public health emergency has passed. According to the work of Dooris (2000, as cited in Whitelaw, Baxendale, Bryce, Machardy, Young & Witney 2001) and Whitelaw, Baxendale, Bryce, Machardy, Young & Witney (2001, p.339) this challenge is not uncommon and many 'settings' are finding it difficult to transform health promotion projects into wider, long-lasting achievements that are sustainable over a long period of time. It is important to recognize that health is not the everyday business of these "settings" and their efforts come directly out of their daily work and institutional budget, as was the case at Dalhousie.

## **Conclusion**

Lay institutions take on responsibilities for public health during a pandemic by taking up specific initiatives that may be otherwise outside of their everyday work, and by providing specific services for their community. Though the university, as well as

employees, took on these new responsibilities willingly (out of internal as well as external pressures), this did have important implications for the daily operations of the institution and the daily work of those involved. While Dalhousie was very well equipped to deal with such endeavours, it is important to recognize that the capacity to support these kinds of workplace public health initiatives will vary by institution, as well as by the skill sets and resources available to individual workers within the institution. As such, the implications that taking on these initiatives had on the work of Dalhousie employees are not transferable across other lay institutions. Dalhousie had particular successes and challenges due to unique institutional particularities. Though the university successfully pulled together a response, the literature and this case study suggest that when public health is outside of the everyday work of the institution, it will rarely remain on the agenda and/or be kept up to-date. My findings indicate that though workplace responses do not always run as efficiently as they could, they do make an effort to support larger public health initiatives, while tailoring its response to the needs of its specific population. The extent, to which an institution can do this, however will be dictated by particular institutional characteristics and capacities in important ways.

## **Chapter 6: Conclusion**

As a result of constitutional ambiguity and neoliberal health policies, provinces carry the bulk of the responsibility for health, but download much of the work onto regional health authorities. Critics of neoliberalism argue that these strategies have not paid off, and have not been advantageous to the health of Canadians (Armstrong & Armstrong, 2003). They also argue that the improvements promised by decentralization have not been significant, and the system continues to largely focus on medical intervention rather than health promotion (Armstrong & Armstrong, 2003. p.3). In an effort to look at how this system operates on the ground level, this thesis examined why lay institutions take on responsibility for health, what their involvement looks like and how taking on these new responsibilities impact the everyday work of those involved in the institution's efforts.

Document analysis and in-depth interviews revealed that Dalhousie took on responsibilities for the health of its population as a result of internal and external pressures and expectations. The university wanted primarily to protect the health of its population to ensure academic and business continuity. Though it was expected to protect the health of its population by the provincial government, few Dalhousie staffers recognized this as a significant source of external pressure. The largest sources of pressure, as described by participants, came from media inquiries, as well as internal requests and expectations for a plan to engage the 2009 H1N1 crisis. At the same time, documents like the DUIDPP suggest that university administration was aware of the strain that would be placed on the larger public health system in the event of an emergency and saw the university as having role to play in promoting public health if and when it can.

Out of these pressures and its sense of responsibility, the university organized a group of administrators to pull together a response and take on responsibilities in an effort to manage the risks facing its population. These responsibilities included the dissemination of health related information, the administration of medical services and institutionalization of a response by adopting the identity of a healthcare provider and the institutionalization of a response through documentation.

Throughout the response at Dalhousie, expert knowledge was heavily drawn upon just as it is in public policy more largely. Mimicking how the larger system uses experts, Dalhousie's administration engaged in-house medical expertise to provide technical knowledge, to identify and manage risk (Alaszewski, 2006.p.161), and make evidence based decisions (Alaszewski, 2006; Wilkinson, 2001). In doing so, the university's administration pulled together a response that was in line with and supportive of larger public health initiatives.

### ***What the response meant for employees***

Taking on these additional responsibilities for health had important implications for the everyday work of those involved. Interviews with Dalhousie staff revealed that many workers felt that taking on these initiatives added extra work and stress to their schedules. Additionally, many participants described a lack of leadership and confusion over planning authority, as a source of tension. The planning process was undoubtedly challenged by the university's collaborative culture of decision making which is not conducive to making quick decisions.

Interestingly, participants felt that these tasks fell within the scope of their positions and job description, despite the extra work and the challenges they faced. Ultimately, participants interviewed felt that Dalhousie's had a responsibility to its



population that could not be shirked and that the institutional response was a worthwhile pursuit. They took pride in the work that the committee had done and generally felt satisfied with their efforts. The fact that Dalhousie possessed the institutional capacity and resources to respond to the H1N1 outbreak may have had a profound influence on employees' satisfaction with their efforts.

However, creating a workplace where the “good employee” is the healthy employee or the health promoting employee does raise certain ethical concerns. The goal of workplace health promotion is to guide employees' actions and choices toward the most the most suitable end for the organization, but what happens to workers who are not able to comply or do not wish to promote health in ways advised by the institution? When workplaces become health promoting entities, in other words, new forms employment discrimination might ensue. Moreover, when workplaces extend their jurisdiction into promoting healthy lifestyles— by encouraging employees to make “healthy choices,” for example— they can intrude into employees' personal lives (Allender, Colquhoun & Kelly, 2006. p. 140). Drawing attention to employees' healthy lifestyle choices makes them more likely to be blamed for becoming ill (Daykin, 1999. 13). In the case of Dalhousie, both the “healthy employee” and the “good employee” who promoted health were considered to be doing a valuable service the university as a whole.

Since the outbreak of H1N1, Dalhousie has made a commitment to its role as a partner within the public health system, through the institutionalization of a response. After the outbreak, Dalhousie documented its response process and outlined roles and responsibilities of departments and administrators in preparation for the next outbreak. By outlining and assigning responsibility, the university not only formalized its expectations

of workers and a smooth response, it also normalized its involvement in public health endeavours.

***What are the implications of lay institutional involvement in public health?***

Since this project was a case study, the findings are unique to Dalhousie. However, it does shed some light on lay institutions' capacity to respond and become public health partners at times of crisis. The findings of this study suggest that this will be heavily dependent upon the characteristics of the institution. Dalhousie University is a large institution with more human resources and knowledge about health than many private sector workplaces; it is unique, in other words, because of its access to expert knowledge via the medical school. Moreover, Dalhousie University was also financially capable of implementing the measures it did during the H1N1 outbreak. As an educational institution, where student health is part of its mandate, the university was also prepared to do so. These characteristics gave the university a unique capacity to act as a health promoter and protector that not all workplaces will have.

This differentiates the university from many other workplaces, which will each have their own culture and capacity to respond to a public health crisis. Research has shown, for example, that attitudes towards workplace health and safety are very different in small businesses than they are in large companies or institutions, which might have well-established health and safety practices (Eakin, 1992 as cited in Daykin, 1999. p.12). Small businesses might not consider themselves to have legitimate authority to intervene in matters of health (Daykin, 1999. p. 12).

Finally, there is some concern about knowledge translation when workplaces take it upon themselves to convey health information. They will most likely do so in a way that they feel their audience will best understand. Daykin (1999) cautions when

workplaces mediate knowledge they must understand the importance of the language that is being used; those creating health promotional materials must be reflexive and recognize the possible impact of their silences and definitions (Daykin, 1999. p.9). In this case, Dalhousie was well equipped to distribute the message and understood the importance of taking health promoting initiatives. Other workplaces may not have the same capacity to take on these initiatives or see the value in engaging with complex public health issues.

### ***Areas for future research***

This research points to two future areas of inquiry. First, workplace health promotion is more than just an interest in the health of its employees; it can also be seen as a “political exercise laden with strategies and relations of power” (Cheek, 2000; Seedhouse, 1996 as cited in Allender, Colquhoun & Kelly, 2006. p. 132). Critical theorists suggest that health is an avenue through which the population can be governed (Fox 1993 as cited in Allender, Colquhoun & Kelly, 2006 p.132). While researchers have considered the regulation of individuals through general public health initiatives, few examine the relationship of governance through workplace-based health promotion initiatives. This is an important area for future inquiry, given the role of lay institutions in health promotion and protection appears to be expanding. Little is known or understood, for example, about how staff feel about the involvement of their workplace in health promotion and/or the effects that this has on their daily work.

Second, although Dalhousie University successfully pulled together a response, the findings of my research indicate that public health did not remain on the agenda at the university because it was outside of its everyday work. In particular, the findings suggest that a workplace’s response to a public health crisis will be challenged by institutional characteristics, workplace politics, and capacities; while lay institutions might make an

effort to support larger public health initiatives, they will tailor their response to the needs of their specific population. Dalhousie's history has shown that it is difficult, even for large institutions, to consistently keep public health a priority. As such, more research is needed in order to understand how governments can foster a closer relationship with lay institutions and formalize their role within the public health system, while considering their varying capacities to be involved, so that the role of lay institutions can become less ad-hoc.

### **Summary**

Despite these questions and challenges, my research has ultimately shown that lay institutions can be valuable partners at times of crisis. Lay institutions play a very important role that is often overlooked within our “collaborative” public health system (Wilson, McCrae-Logie & Lazar, 2004. p.178). Institutions may get involved in public health out of their own self interest, in maintaining a healthy population, as well as their sense of responsibility towards their community; however, the larger public health system has much to gain from their involvement. My findings have shown that lay institutions can make significant contributions to the healthcare system at the ground level, as they work to manage risk and protect the health of their population. Though these contributions will vary according to institutional capacity, lay institutions have the ability to support initiatives put forth by public health larger authorities and shape the way their community sees its role and responsibility for health. Though taking on these initiatives can have important implications for the everyday work of workers, my findings suggest that the workers most impacted might see their expanded role as lying within scope of their position, and view the institution's endeavors as a worthwhile pursuit despite the many challenges they face.

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### **Appendix I: Semi-Structures interview questions**

1. Please describe your position at Dalhousie.
2. How did you become involved in preparing for H1N1? When did planning begin?
3. How were you trained or briefed on the H1N1 pandemic? Is there a specific model being followed?
4. How has preparing for H1N1 affected your everyday work?
5. How would you describe the policy making process?
6. Did you feel confident in your policy making role?
7. What are your thoughts on these policies?
8. What were some success aspects of the policies?
9. What could have been done differently at Dalhousie?
10. Is there anything that you could have done differently?

## **Appendix II: Recruitment Email**

Subject line: Interview request for Master's thesis project

Dear \_\_\_\_\_,

I am Katherine Connell, a current graduate student doing my Master's degree in sociology at Department of Sociology and Social Anthropology at Dalhousie University. For my Master's thesis, I am conducting a research project that examines the roles that non-governmental institutions (e.g. schools or workplace) play in times of pandemic. To do this I will be examining the H1N1 pandemic preparedness plans at Dalhousie as a case study.

To explore my research questions I would like to interview you and other key players in Dalhousie's health policy community; deans, chairs directors and heads of units— who are directly responsible for emergency preparedness planning and health policy creation. My questions will primarily ask you about your experience during the time of planning and implementing various policies specific to the H1N1 pandemic.

All the information will be kept confidential and participation is completely voluntary and participants may withdraw at any time. Interviews will last approximately 30 minutes to 45 minutes.

If you could kindly agree to do the interview, or would like more information please do not hesitate to contact me. Also, if you need further information about my research and graduate program, you can contact my thesis supervisor, Dr. Fiona Martin.

Supervisor  
Dr. Fiona Martin  
Masters Supervisor, Assistant Professor  
Department of Sociology and Social Anthropology  
Dalhousie University  
6135 University Ave.  
Halifax, NS B3H 3P9  
Email: [f.martin@dal.ca](mailto:f.martin@dal.ca)  
(902)494-6750

Thank you very much for your attention and I look forward to hearing from you soon.

Best regards,

Katherine Connell  
Masters Student, Sociology  
Department of Sociology and Social Anthropology  
Dalhousie University  
6135 University Ave.  
Halifax, NS B3H 3P9  
Email: [KT481276@dal.ca](mailto:KT481276@dal.ca)  
(902)441-2499

### **Appendix III: Project Consent Form**

Project Title: “Managing Risk During Times of Pandemic: Whose Responsibility?”

I, Katherine Connell invite you to take part in a research study being conducted as part of the requirements of my Master’s degree in Sociology, at Dalhousie University. Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about the risks, inconvenience, or discomfort that you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with myself or my thesis supervisor Dr. Fiona Martin.

#### Purpose of the Study

The purpose of this study is to examine the roles that schools and workplaces play at times of pandemic crisis. To do my research, I have chosen Dalhousie University. Essentially, the goal of this study is to understand how workplaces develop health policies to manage the risk that their employees or students face at times of pandemic.

#### Study Design

As a critical component of my research project, I am planning to interview people who are in charge of planning and delivering the security measures to prevent the spread of H1N1 in the Dalhousie community.

#### Who can Participate in the Study

You may participate in this study if you were a dean, chair, director or unit head responsible for providing health and safety leadership and managing the operations of effective health and safety programs within your respective unit during the H1N1 outbreak.

#### Who will be Conducting the Research

I, Katherine Connell, am the principle investigator for the project and will be conducting all interviews myself.

#### What you will be asked to do

In the interview, I will ask questions about your role as a health policy creator at Dalhousie University and your perception of the effectiveness of these policies.

The interview will take about 30 to 45 minutes. All interviews will be conducted in a mutually agreed upon public venue, that is semi-private (meaning not within earshot of anyone else). With your permission, I would like to tape record the interview. Interviews will then be transcribed.

#### Possible Risks and Discomforts

Since, you are part of a small policy community this increases the risk of identification. If the majority of participants opt to be identified, this will compromise the anonymity of the

remaining participants. In order to protect their identity details of their stories and identifying characteristics will be changed. I ensure you that your personal information will be kept strictly confidential unless otherwise requested.

#### Compensation / Reimbursement

It is not expected that any costs will be incurred by participating in this study. Though participation is appreciated, participants will not be compensated or reimbursed.

#### Confidentiality & Anonymity

Pseudonyms will be assigned and revealing details will be changed. Your participation is entirely voluntary and you are free to skip any question that you do not wish to answer and may withdraw from the interview at any time. All the information that you will provide will kept in a secure place until the end of my degree project. Audio files, transcription, and signed consent forms will be stored in password protected files on a password protected computer. Hardcopies of consent forms and transcripts will be kept in a filing cabinet at the researcher's residence.

#### Questions

If you have any questions or concerns about this study please do not hesitate contacting my supervisor Dr. Fiona Martin or myself. The contact information is provided at the bottom. In addition, participants are assured that they will be provided with any new information that might affect their decision to participate in the study.

#### Termination

The study may be terminated at any time by the researcher, but that this will not affect the participant's level of treatment.

#### Problems or Concerns

The following statement must be included at the end of every consent form: "If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Patricia Lindley, Director of Dalhousie University's Office of Human Research Ethics Administration, for assistance (902) 494-1462, [patricia.lindley@dal.ca](mailto:patricia.lindley@dal.ca)"

**“Managing Risk During Times of Pandemic: Whose Responsibility?”**

Please read the following conditions carefully and provide your signature if you agree on these terms.

“I have read and understood the consent form. I have been given the opportunity to clarify any questions and discuss any concerns that I may have. I understand that I am under no obligation to participate, and am free to withdraw at any time. I give permission for the interview to *be tape recorded* and *directly quoted* if needed, and understand that *my identity will remain confidential and will be protected through the use of a pseudonym*, unless otherwise stated below. I hereby give my consent to take part in the above described study.”

If you are not willing to consent to one or more components of the study please indicate below:

I do not consent to having the interview tape recorded

I do not want direct quotations to be used

I would like to be identified by my name

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Katherine Connell: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher: Katherine Connell  
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**Appendix IV: Table of Codes**

<b><u>6 main themes</u></b>	<b><u>26 codes</u></b>
Policy making process	Academic continuity
Successes	Affect on everyday work
Challenges/ what could have been done differently	Challenges
Effects on everyday work	Communications
Confidence in response capacity	Confidence
Scope	Failure /lessons
	General comments
	H1N1 briefing/ education
	H1N1 timeline
	Institutional culture
	Institutional documentation
	Institutional hierarchy
	Job description
	Leadership
	Monitoring/ surveillance
	Occupational health/ public health at Dal
	Participant's background
	Policy influence
	Policy making process
	Protection of staff
	Protection of Students
	Public Health
	Responsibility
	Role on H1N1 committee
	Scope of position
	Successes

**Appendix V:**

# Flu Symptoms Decision Chart

If you have flu symptoms, use the guidelines in this table to help make the best decision for you and your loved ones. Always use hygiene and prevention measures to avoid contamination.

<p><b>Symptoms for an adult or child:</b> No fever (temperature less than 38.5°C or 101.3°F) but has these symptoms:</p> <ul style="list-style-type: none"> <li>• Sore throat</li> <li>• Runny nose</li> <li>• Stuffy nose</li> <li>• Cough</li> </ul>	<p><b>DECISION</b> Probably a cold. Stay home and rest.</p>	<p><b>QUESTIONS?</b> Call 811 (Healthlink) to speak to a registered nurse or email <a href="mailto:TheNurse@Dal.ca">TheNurse@Dal.ca</a> to contact a nurse at Dalhousie Health Services.</p>
<p><b>Symptoms for a healthy, non-pregnant adult or healthy child 5 years of age and older:</b> A sudden fever greater than 38.5°C (101.3°F) with these symptoms:</p> <ul style="list-style-type: none"> <li>• Cough</li> <li>• Sore throat</li> <li>• Headache</li> <li>• Extreme tiredness</li> <li>• Sore muscles and joints</li> </ul>	<p><b>DECISION</b> Probably the flu. Stay home and rest.</p>	<p><b>QUESTIONS?</b> Visit <a href="http://fightflu.ca">fightflu.ca</a> Call 811 (Healthlink) to speak to a registered nurse or email <a href="mailto:TheNurse@Dal.ca">TheNurse@Dal.ca</a> to contact a nurse at Dalhousie Health Services.</p>
<p><b>Symptoms for an adult or child at risk of complications:</b> A sudden fever greater than 38.5°C (101.3°F) with these symptoms:</p> <ul style="list-style-type: none"> <li>• Cough</li> <li>• Sore throat</li> <li>• Headache</li> <li>• Extreme tiredness</li> <li>• Sore muscles and joints</li> </ul> <p>Those at risk of developing complications include:</p> <ul style="list-style-type: none"> <li>• Children under 5 years of age</li> <li>• Pregnant women</li> <li>• People with chronic conditions requiring regular medical care, such as:             <ul style="list-style-type: none"> <li>• Asthma and chronic lung disease</li> <li>• Diabetes</li> <li>• Heart disease</li> <li>• Chronic kidney or liver disease</li> <li>• Immunosuppressed conditions</li> <li>• Blood disorders, such as anemia and sickle cell anemia</li> <li>• Neurological disease and disorders causing swallowing and breathing problems</li> <li>• Severe obesity</li> </ul> </li> </ul>	<p><b>DECISION</b> See a health care provider (doctor, nurse, practitioner or family practice nurse) today.</p>	<p><b>QUESTIONS?</b> Visit <a href="http://fightflu.ca">fightflu.ca</a>. Visit <a href="http://www.gov.ns.ca/h1n1">www.gov.ns.ca/h1n1</a> Call 811 (Healthlink) to speak to a registered nurse or email <a href="mailto:TheNurse@Dal.ca">TheNurse@Dal.ca</a> to contact a nurse at Dalhousie Health Services.</p>
<p><b>Symptoms for a very sick adult or child:</b></p> <ul style="list-style-type: none"> <li>• High fever greater than 38.5°C (101.3°F) for more than three days</li> <li>• Severe persistent chest pain</li> <li>• Severe shortness of breath</li> <li>• Severe or persistent vomiting</li> <li>• Confusion or disorientation</li> <li>• Grey skin color or blue lips</li> <li>• In children, failure to eat or drink sufficiently, sleepiness and difficulty waking, lack of interaction, irritability and no urination in 12 hours</li> </ul>	<p><b>DECISION</b> Go to the emergency room immediately. Call 911, if necessary.</p>	<p><b>QUESTIONS?</b> Visit <a href="http://fightflu.ca">fightflu.ca</a>. Call 811 (Healthlink) to speak to a registered nurse or email <a href="mailto:TheNurse@Dal.ca">TheNurse@Dal.ca</a> to contact a nurse at Dalhousie Health Services.</p>

Stay informed. Visit [www.flu.dal.ca](http://www.flu.dal.ca) for up-to-date information.





Appendix VI:

# Hand Washing!



**1** Wet your hands with warm running water.

**2** Add soap and scrub for 5 to 10 seconds.

**3** Rinse off soap under running water for 5 to 10 seconds.

**4** Dry your hands with a towel.

**5** Turn off tap with a towel.

**Wash all parts of your hands:**

- The backs
- Between fingers
- Under nails
- Thumbs

**Wash your hands:**

- Before eating
- After using the toilet
- Before, during and after cooking
- After changing diapers
- After handling soiled items such as bed linen, commodes, clothing, and toys
- After petting animals

*Washing your hands with soap and water is the best way to reduce the spread of germs.*

Amount dependent on energy

Public Health Services

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Health Promotion  
and Protection

[www.gov.ns.ca/hpp](http://www.gov.ns.ca/hpp)