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PERCEPTIONS OF THE EFFECTIVENESS OF HEALTH PROMOTION PROGRAMS ON OLDER ADULT PARTICIPANTS

by

Patricia Evelyn Campbell

B.A., Simon Fraser University, 1984

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ABSTRACT

Health Promotion is the process of enabling people to increase control over and to improve their health (W.H.O. 1989). The purposes of this study were to: 1) investigate the effectiveness of health promotion programs for older adults from the perspective of program participants, facilitators, and referring professionals; 2) determine if these programs reflect the W.H.O. approach to health promotion.

This exploratory case study investigated the effectiveness of health promotion programs delivered at six sites in Vancouve. in 1989. Programs were selected according to varying lengths of operation. Methods of investigation included questionnaires and focused interviews with participants, questionnaire-based interviews with program facilitators, questionnaires mailed to referring professionals who were invited to respond by mail or phone interview, and investigator observation of programs and related special events.

Findings included: 1) a profile of program participants; their perceptions of their well-being, self-efficacy and social support; their views of program effects; 2) the perceptions of facilitators of program effectiveness as compared to referring professionals and program participants; 3) a range of factors related to helping individuals achieve control over or improve their health; 4) the continued influence of the "medical model" and factors that hindered participants from taking leadership roles in programs.

The conclusions drawn included identification of the educational needs of program facilitators; the needs of referring professionals for information about programs; the influence of policy makers and program

administrators on program effectiveness through funding, space allotment and hiring practices; the community development model as the most promising approach in health promotion programs for older adults.

The study also identified future research areas. These areas included assessing factors that enable participants to take control of their health in relation to their involvement in program planning and delivery, measuring changes in levels of independence as a result of program involvement, identifying how beliefs and practises of policymakers and administrators affect program delivery and effectiveness, exploring ways of reaching 'hard to reach' clients, and identifying men's needs for health promotion programs.

DEDICATION

I dedicate this Thesis to my aunt, Hattie McLachlan-Egan, an independent lady of 92 and all the Wellness program participants in this study, as well as participants of the Choosing Wellness program at Eagle Ridge United Church, the first wellness group I facilitated.

ACKNOWLEDGMENTS

This Thesis topic developed from a goal I had set for myself twelve years ago when I started teaching in the Long Term Care Aide program. The goal was to discover effective ways of promoting optimal health and independence of older adults who lived in or outside of institutions. During the ensuing years, a number of colleagues, students, and older adults provided further insights into this subject. I wish to thank Marcia Aitkens, my mentor, and all the others who contributed to my understanding of, and fostered my curiosity about, ways of achieving this goal.

I would like to express my gratitude to the many educators and health professionals, colleagues, my family and friends who shared their knowledge, encouragement, and support through the process starting with the birth of the topic idea, to the completed Thesis.

This process has been an important part of my personal journey and has increased my understanding of what promoting health and independence for older adults means. The responses of those involved and other curious individuals who asked about the Thesis topic and shared their insights have been an invaluable contribution to the process. This sharing of insights has refined and shaped my understanding of what promoting health and independence means for any individual.

I also wish to thank the Canadian Association of Gerontology, and its President, Dr. Gloria Gutman, the Norcen Internship Committee, and Norcen Energy Resources Limited for granting me The Norcen Internship Award in Applied Gerontology in 1989. This award allowed me to spend a four-month internship in a health unit working with the coordinator of health promotion programs for older adults. This experience allowed me to see many of the older adults who took part in wellness programs in this study in other activities such as volunteer organizations, and as committee members and/or participants of other groups. The internship provided access and a richness to the research experience that could not be achieved in any other way.

A special thanks is directed to Dr. Jack Altman for his good humored support and direction in the internship, research and Thesis preparation; Judy Curran and Sharon Martin for their willingness to share their time and valuable knowledge of working with seniors in health promotion; the research subjects who shared their time and candid responses; Dr. Michael Manley-Casimir, my graduate study supervisor and Thesis advisor who showed great patience and support in all stages of my graduate student experience; Shirley Heap who patiently transcribed all the audiotapes; Hilda Mackey who skillfully typed the thesis; Donna Stephens, Theresa White and Anielia Fedow who provided editorial assistance.

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Chapter I

BACKGROUND AND STATEMENT OF THE PROBLEM

"Let us cherish and love old age; for it is full of pleasure, if one knows how to use it" . Seneca

Rising health care costs and concerns for quality of life in the later years have stimulated the federal and provincial health ministries to search for ways to provide health promotion programs to address the needs of older adults. Two of the key factors central to this situation are the rapidly increasing number of older adults in the Canadian population, and the fact that at present a significant portion of health care dollars are spent on a small portion of these older adults each year. It is the challenge of health promotion programs to assist older adults in maintaining or regaining their health and independence for as long as possible. Studies are needed to assess the effectiveness of these programs on Canada's population of older adults.

Canada's population of individuals 65 and over was 6% in 1931 and 11% in 1986. This trend is in part the result of increased life expectancy and reduced birth rates. Current projections based on this trend and the aging "baby boom" generation, predict that "by the year 2021 the percentage of persons over 65 will rise to 19% - one out of every five Canadians". (Canada's Seniors: A Dynamic Force, 1988, p. 6)

Aging and poor health are <u>not</u> synonymous; seniors, however, account for 49% of hospital patient days and 72% of long term care facility occupancy. Only a small portion, however, of persons over 65 require long term care at any one time - 2% of the 65-74 age group, and 15% of those 75 and over (Ibid, p. 19). The 80 plus age group is the fastest growing segment of the senior

population: 20% in 1986. "Twenty-eight per cent of men aged 85 and over lived in institutions, compared to 40% of women in that group." (Ibid, p. 11).

The majority of seniors are able to function independently even though 85% of them have at least one chronic health problem. Despite the fact that 80% of seniors requiring care are cared for by family and friends, health care costs for seniors represented 40% of Canada's health care expenditures or ten billion dollars in 1981 and seventeen billion dollars in 1987. (Canadian Medical Association, 1987). Therefore, the increasing number of seniors in the population, especially with the increase in those aged 80 plus, results in serious increases in health care costs and concerns about the quality of life for older adults both now and into the foreseeable future.

Purpose

Health promotion programs for older adults have developed rapidly throughout North America in the 1980's. These programs have not usually assessed their effectiveness on participants. Another undetermined aspect of these programs is the most efficient way of achieving program aims while respecting and promoting the participants' right of choice. Many of these programs focused on disease control or prevention through life style changes but research data from two of the most frequently quoted studies showed minimal long term effects. (Kemper D. et al. 1983, and Hooyman N. 1985)

The definition of health promotion has evolved from the disease centred approach to self responsibility for healthful lifestyles (LaLonde 1974), to the current view expressed by the World Health Organization (W.H.O. 1984) as the slow "Process of enabling people to increase their control over

and to improve their health". This views health as a positive resource and addresses many aspects of health and well-being. An important aspect of health and well-being is self efficacy (the individuals perceived expectancy of obtaining valued outcomes through personal effort) regarding the individual's health and supporting social networks.

Studies are needed to evaluate the effectiveness of health promotion programs as they evolve from earlier approaches to today's concept of health promotion. Another area of investigation needed is to see if a match exists between W.H.O.'s (1984) definition of health promotion and content and process of these programs. The invitation "....to the research community to respond to the information needs of health promotion practitioners and policy makers" (1988, p. 20) was issued in the Health & Welfare discussion paper. (Sept. 9, 1988).

The purpose of this thesis is to assess the effectiveness of health promotion programs offered through neighbourhood community or seniors centres for older adults living in Vancouver. The specific areas it addresses include perceptions of: 1) participants' about the program's changes and role in promoting their self efficacy and supporting social networks; 2) program facilitators regarding effectiveness of programs on participants and changes in program content and delivery; and 3) referring professionals regarding program effectiveness on clients and program change.

The questions this study addresses are: 1) What is the demographic profile of persons who take part in these programs? 2) What attracts them to the programs? 3) Why do they stay? 4) Why do they leave? 5) Do participants perceive changes in their supporting social networks as a result of their participation? 6) Do they have opportunities for involvement in decision making during the program? 7) Does the program achieve its

objectives and if so, how? 8) What are the facilitators' and referring professionals' perceptions of health promotion and the program and its effectiveness?

Definition of Terms

Efficacy - the individual's perceived expectancy of obtaining valued outcomes through personal effort. Fuller et al. (1982)

Health - the complete state of physical, mental and social well being and not merely the absence of disease or infirmity. (W.H.O. 1984) Health originated from the old English word "hael" which means health, whole, and hello. Health encompasses our social relationships and our ability to utilize our resources and respond effectively to our environment and the stresses that we encounter.

Health Promotion - the slow process of enabling people to increase their control over and to improve their health. (based on W.H.O. 1984)

Older Adult - a person aged 55 or over.

Quality of Life - the opportunity to make choices and to gain satisfaction from living. (Epp 1986 p. 3)

Senior - a person aged 65 or over.

Self-care - those activities individuals undertake in promoting their own health, preventing their own disease, limiting their own illness and restoring their own health. (Lewin & Idler 1983 p. 181)

Supporting Social Networks - the relationships that enable the individual to meet the challenges and stresses in their lives. When these networks are working effectively they promote independence through interdependence.

Wellness - is a way of life. A lifestyle you design in order to achieve your highest potential for well-being. (Fisher 1986 p. i)

Wellness Programs - program developed to promote health of participants. In this study Wellness programs are aimed at those aged 55 or over.

Historical Perspective of Health Promotion

The National Incentive in Health Promotion

In 1974 - Marc LaLonde, the then federal Minister of Health and Welfare, began the shift from the disease-centred model toward a new approach to health promotion in his report, "A New Perspective on the Health of Canadians". LaLonde acknowledged that health was influenced by a number of factors. The emphasis at that time was on healthier lifestyles and responsibility for one's own health.

The year 1986 was another landmark in the history of health promotion in Canada for three reasons:

1. The Ottawa Charter of Health Promotion (1986) supported the World Health Organization's (1984) definition of health promotion as "the process of enabling people to increase control over and to improve their health." The Charter went on to state that "to reach a state of complete physical, mental and social well-being, an individual or group must be able to realize aspirations, to satisfy needs and to change or cope with the environment."
   (The Ottawa Charter of Health Promotion, 1986, p.1)

2. The first Canadian Conference on Health Promotion and the Elderly was held in Hamilton, Ontario (1986) under the sponsorship of the Canadian Public Health Association.

3. Achieving Health for All: A Framework for Health Promotion (1986) was released by Hon. Jake Epp, Canada's Minister for Health and Welfare.

   Achieving Health for All: identified three national health challenges. These challenges are:

   i) reducing inequalities in the health of low versus high income groups in Canada;

   ii) finding new and more effective ways of preventing injuries, illness, and chronic conditions and their resulting disabilities; and

   iii) enhancing people's ability to manage and cope with chronic conditions, disabilities, and mental health problems.

The health promotion mechanisms proposed were self care, mutual aid, and "healthy" environments. The strategies for implementation were - - "fostering public participation, strengthening community health services, and coordinating health public policy." (Epp, 1986, p. 9)

Subsequently, on February 9, 1988, Hon. Jake Epp, then Minister for Health and Welfare, announced a thirty million dollar annual contribution to help improve the quality of life for seniors in Canada. The Seniors Independence Program received two-thirds of this allocation to support: (1) community groups whose membership is mainly seniors; (2) groups in which seniors are actively involved in defining their needs and establishing projects to promote independence and quality of life for seniors; and (3) special needs groups such as older women and seniors in remote areas (Epp, 1988). The development of health promotion programs for older adults has been one of the approaches to promote the health and independence of Canadian seniors.

Health Promotion Programs for Older Adults in Canada

Since the 1980's health promotion programs for seniors have sprung up throughout Canada. These health promotion programs for older adults include St. John's Ambulance national program - Healthy Aging (1984); Living Younger Program for Seniors (Ontario, 1986); Fully Alive (Alberta, 1986); and Choosing Wellness (British Columbia, 1988).

British Columbia Demographics

In 1988 12.5% of British Columbia's total population was 65 years of age or older. This figure is higher than the national percentage of 11%, partly because seniors migrate to the province at the rate of about 3,600 per year.

Men make up only 43% of the province's seniors. Women outnumber the men more than 2 to 1 among seniors aged 85 and over.

In British Columbia the majority of persons 65 or over live independently in the community, while only about 8% live in institutions. Of the 85 and over population 60% of the women and 70% of the men live in private accommodation. Despite the larger number of seniors who live in the community independently, services to seniors account for nearly half of the B.C. Ministry of Health's expenditures. These services are most frequently used by a small number of seniors in the final years or months of their lives. This trend is clearly demonstrated by the fact that "less than 2% of the 65-74 age group receive facility care, while 36% of those 85 and over are institutionalized (Toward a Better Age, 1989, p. 41).

The three geographic areas with the highest concentration of British Columbia's seniors, (70%), are Greater Vancouver, Greater Victoria and the Okanagan. In the city of Vancouver, seniors make up 15.5% of the population, well above the national and provincial ratio.

The Provincial Incentive for Health Promotion for Seniors

Five health promotion programs for older adults have developed over the last decade in British Columbia. Historically these programs were: "Well Aware", "Be Well", "Keeping Well", "Keep Well", and "Choosing Wellness".

Vancouver health promotion programs

"Well Aware" - 1981 - a health promotion program initiated by seniors and funded by New Horizons project funds. This program included exercise, blood pressure checks and health information.

"Be Well" - 1983 - another health promotion program initiated in another part of Vancouver by seniors with some funding resource and similar program content.

"Keeping Well" - 1985 - this program was initiated by Vancouver's Special Council Committee on Seniors who successfully persuaded city council that community health programs need to deal with prevention as well as illness. This led to the formation of the Vancouver Health Department's Wellness Program (1984), and the creation of four Seniors Wellness Coordinator positions in 1985.

The focus of Keeping Well was provision of adequate health information to seniors along with regular social and physical activity. This program is based on the belief that people feel better, and have more energy when they: "are learning about themselves; are physically active; are involved in activities with other people; and have an opportunity to participate." (Keeping Well, Feb. 1988) The Keeping Well brochure defines "wellness as an attitude. . . . a way of living". (Ibid.p. 1)

Other health promotion programs

Health promotion programs have been launched in other lower mainland areas. Keep Well - 1986 - a program modeled after Be Well (1983) and piloted by Nancy Hall-Nelson (1986) in New Westminster.

Choosing Wellness - 1988 - a province wide wellness program developed from the Keep Well program piloted in New Westminster. This program is sponsored by the British Columbia Ministry of Health and is called Choosing Wellness: An Approach to Healthy Aging (1988).

The Choosing Wellness Program "focuses on people and the community and on what they can do for themselves and others." It promotes "independence by nurturing interdependence" and its facilitator manual claims it has "the potential of getting the existing system of support working more efficiently." (British Columbia Ministry of Health, Choosing Wellness Facilitators Manual, 1988, pi).

Methodology

This exploratory case study, about the effectiveness of health promotion programs offered in six neighbourhood drop-in centres in Vancouver, began in the spring of 1989. The programs were all located within a health unit catchment area which had 18.2% of its total population over age 65 and 32.4% of all Vancouver seniors. The criterion for selection of programs was based on the length of program operation. The sample included programs that had been in operation various lengths of time: more than five years, two years, one year and less than one year.

The method of investigation includes questionnaires and individual focused interviews. All six program facilitators were given questionnaires and interviewed. Referring professionals were mailed a questionnaire followed by telephone contact designed to elicit their candid responses and improve response rates. All program participants were asked to complete the

questionnaires and information sheet. Participants were also asked to take part in a individual interview to discuss their involvement in the program. All interviews were conducted by the investigator. The investigator took part in the programs during the course of the study by observing program content and action. Demographic information is reported, along with the rest of the data, in Chapter 4, and Appendixes D to H. The data collected regarding participants, facilitators and programs was analyzed, coded, and reported by the use of portraiture writing (Lightfoot, 1983).

Limitations

Some difficulties inherent in research involving older adults who participate in health promotion programs identified by Rakowski (1986) and Arnold et al (1986) are relevant limitations in this case study. Rakowski (1986) stated that literature on personal health behavior suggests that almost any well-reasoned health promotion strategy will work for someone. "Personality characteristics,.....perceived control over health, future outlook - prior lifestyle health habits, skill level in dealing with health matters, and strength of informal social supports, all need to be investigated as they interact with characteristics of health promotion programs" (p. 314). This interaction produces multi-dimensional effects that are difficult to single out. It is beyond the scope of this study to measure the multi-dimensional effects.

The fact that participation in this study was optional, coupled with the small sample size, limited the ability to generalize findings. Because of history, continuing change of social context, maturation, and attrition of participants as well as facilitator changes and program evolution, it would be difficult to replicate the study.

This study provides some useful information about perceptions by participants, facilitators and referring professionals of the current effectiveness of these programs. This information may confirm, correct, expand, or refute current knowledge and beliefs about the content and process of programs relative to W.H.O.'s 1984 definition of health promotion. An example of this is participants' perceptions and involvement in program planning and delivery relative to facilitators' perceptions and approach to planning and delivery. These two groups' perceptions and actions are compared with enabling approaches suggested by W.H.O.'s definition of Health Promotion and supported in Achieving Health for All. An important component of community health education and health promotion programs is accountability to the clients and their needs.

One purpose of program evaluation in this context is to "enable health professionals to be responsive, but also to demonstrate that responsiveness to the needs of the target population." Dignon et al (1987), p. 153. This case study will provide information which may validate current practice and/or lead to further understanding and modelling of the community development process in health promotion drop-in programs for older adults. The community development process is supported in the literature by Epp (1986, 1988); Labonte (1987); Martin et al (1988); B.C. Ministry of Health (1988) in Healthy Communities: The Process; W.H.O. (1984) and Sterling et al (1989).

Organization of the Thesis

This thesis is organized into five chapters. Chapter I outlines the problem, purpose, definition of terms, historical perspective, methodology, limitations and organization of this thesis. Chapter II contains the literature review. Chapter III describes the methodology used in the research. Chapter IV first reports the data collected on program participants, facilitators and referring professionals by answering the eight research questions, and discussing facilitator approaches to program delivery; then it highlights the findings by presenting portraits of programs, participants and facilitators. Chapter V contains the conclusions and implications of this research.

Chapter II

LITERATURE REVIEW

"I know of no safe depository of the ultimate powers of society but the people themselves, and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion" . Thomas Jefferson

Several underlying and evolving concepts relating to health and health promotion occur in the literature. These concepts have a significant influence on health policy, health promotion program development, and the view of the public and the health care providers of programs' expected effectiveness. This chapter first addresses the historical perspective of evolving concepts relating to health and health promotion along with their evolving strategies. Then it looks at key concepts of health and well-being including factors in change such as health beliefs, self-efficacy, empowerment and social support. Finally, it looks at health promotion programs for older adults and related literature regarding their content, process and evaluation of effectiveness.

Historical Perspective

Evolving Concepts

According to Harvey (1988) three concepts of health have evolved over this century. These concepts were the ecological concept, the social ecological concept and the holistic concept.

Ecological Concept

The first of these was the ecological concept based on the germ theory. This view was common around 1900 when infectious diseases were a major health threat. According to the ecological concept of health at that time, a state of equilibrium exists among the germ, the host, and the environment. Once the balance is upset disease is inevitable. In this view there was a single cause and effect relationship. This concept was helpful at the time, singling out the causative organisms of infectious diseases but failed to be applicable in dealing with chronic diseases.

Social Ecological Concept

The second concept of health, identified by Harvey, gained recognition in the 1920's when it was recognized that many factors influence the health of individuals. The social ecological concept of health recognized personal behavior as well as environmental contributing factors in the development of one or many diseases. In 1948 the World Health Organization (W.H.O.) proposed an addition of mental well-being to their social ecological concept of health. W.H.O.'s definition for health was "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity." (Hoffman,1988 p.19) This heralded the trend toward more multidimensional concepts of health.

Holistic Concept

The third health concept Harvey identified was called holistic health. This concept gained recognition in the 1960's and 1970's. The significant document which incorporated this multidimensional concept was "A New Perspective on Health of Canadians" by LaLonde (1974). This document described the epidemiological evidence for the importance of lifestyle and environment relative to health and illness. The most popular component of health promotion at that time focused on individual responsibility for lifestyle which was translated into behavior changing initiatives to reduce risk factors.

The evolution of the concept of health in this century reflects the change in society from a dominantly agrarian one with infectious diseases such as tuberculosis and acute infections being the major health threats, to a more industrial society with chronic diseases such as cardiovascular and respiratory diseases becoming a major threat to health. The strategies used to promote health from these three conceptual perspectives have evolved from the prevention and treatment models.

Evolving Strategies

Ecological Concept Strategies

Strategies developed to achieve health promotion goals are based on the concepts of health and illness care. In the early ecological concept based on the germ theory the strategies used to achieve health were dependent on health professionals. Immunization, sanitation, and hygiene education were

the types of services provided. The role of the health professional at that time was to pass on their expert knowledge to an uninformed and passive public.

Social Ecological Concept Strategies

In the social ecological concept of health the strategies incorporate the individual's responsibility for health. Life-style choices of the individual become a significant factor. The mechanistic perspective was prevalent at this time. The mechanistic perspective views the human body as a complex machine which malfunctions at times. When this happens the strategies used were to fix the malfunctioning part to restore the balance. It is this perspective that Cannon (1939) supported in The Wisdom of the Body when he explained his theory of homeostasis.

Medical scientists such as Dr. Hans Selye (1977) found that the human body responds in a predictable manner producing biochemical changes which are intended to cope with any type of increase in demands. These non-specific responses may not be effective if the human machines energy supply is depleted resulting in ineffective reactions and deficiency diseases which may become chronic physical diseases or psychosis.

Lamb (1988) observed: "....if Selye's concept of limited individual energy lies at the base of illness beliefs under the mechanistic perspective, it is not unusual that cure is thought from without" (p. 5). So the view of lifestyle as causality supports the role of the individual's thought and behavior patterns as responsible, in part, for health or illness. The traditional strategies for treatment of illness are incongruent with individual responsibility. On the one hand, prevention is the individual's responsibility, yet treatment is in

the hands of professionals and healing comes from outside the clients sphere of power.

Incongruents of medical model strategies

The strategies used in health promotion are a direct outgrowth of the medical model of treatment. "The underlying theme of the medical model is that appropriate treatment for disease can be prescribed and administered only by technically competent specialists - that is the physician" (MacNeil and Teague, 1987, p. 40). This model views clients as uninformed and passive recipients of care. While the strategies for lifestyle change in the social ecological concept of health use the rhetoric of individual responsibility for healthful lifestyle choices, the actual approach used maintains significant control by professionals in prevention and treatment. This approach limits the amount of control and decision making on the part of the individual.

Minkler & Checkoway (1988) report that a barrier to health promotion for the elderly is "the continued dominance of the medical model, with its focus on treatment and curing diseases" (p.283). They go on to say that this model is counter-productive in the effective implementation of approaches that stress health maintenance and promotion, particularly when these approaches are directed at the elderly" (p.283). To illustrate this point of view, one needs only look at the role played by health professionals in health promotion programs.

Health promotion programs typically include introduction, health assessment, prescription, intervention and evaluation. The role of the professional in these programs is often patterned on the medical model approach. This approach maintains a strong external locus of control even

though the participants are held responsible for their own health behaviors in order to reduce the risk factors. Blood pressure monitoring is a common component of health promotion programs. This activity is typically carried out by retired nurses who volunteer their time. These expert volunteers tell the clients how their health status is relative to the current blood pressure reading. It is a very popular component of programs and is often better attended than other aspects of the program. Blood pressure reading by expert volunteers in health promotion programs keeps older adult participants focused on illness and treatment, rather than health and their influence on it.

LaLonde referred to environmental factors in "Achieving Health for All Canadians" (1974) but little attention was paid to this aspect until Brown (1976) published an article entitled "Alternative Approach to Health Promotion". Brown criticized the victim blaming approach to health promotion, and emphasized the influence that social forces such as television and industrial policies played in the healthful behaviors of individuals. He supported the development of health promotion policies and activities that would provide healthful environments and social structures rather than the ineffective counter-productive and conflicting actions that focus on blaming the sick individual and fail to look at the holistic interactive view. Brown believed that self-care, self-help and social advocacy were more productive concepts than placing the sole responsibility for health on the shoulders of the individual. He also expressed the view that there should be related policies in health promotion, health protection, and health care which would be applicable to other areas such as education, agriculture, housing, transportation, and environments.

Allen & Allen (1986) reviewed a number of studies which had evaluated self-help and support group based health promotion programs. They found that while people were motivated to attempt life style changes, more than 80% were unable to sustain these changes. The Allens' attributed the high drop out rate to the fact that these programs made no effort to change the norms of the environment in which participants lived. They stated that "health norms of the various cultures to which we belong

- family, organizations, social groups, neighbourhoods, community - have strong norms for health risk behaviors: - - creating healthy lifestyles has to be done in violation of the unwritten rules of our own culture" (Allen & Allen, 1986 P.42) An example of this is the pressure to eat fast foods which are usually high in fat, salt and sugar. They go on to say that we can make positive lifestyle changes for a short time but tend to slip back to the cultural norm over time. They criticized the tendency to practise victim blaming when participants failed over the long term, and expressed the belief that this practice is the most serious risk factor of all, that it is a threat to mental health because of negative self-image.

The Allens' (1986) describe the normative systems model as the basic strategies for change. This model is based on the action research strategies of Kurt Lewin (1951). There are four phases of the normative systems model for organizing change, cultural analysis, and objective setting (analyzing the existing culture); systems introduction and involvement (experiencing the culture); systems implementation (modifying the existing culture); and, systems feedback and education (sustaining the desired culture).

Success of the normative system depends on strategies which involve:

1) all the individuals affected

2) adoption of a no-blame approach

3) establishing mutually acceptable and beneficial solutions

4) incorporating tasks and goal clarification of short and long term goals

5) clarifying participants' roles in the process of change

6) integrating achievement concerns of individuals and the group

7) developing the program to meet specific client group needs

8) developing multi-change strategies at the organizational, community and national level

9) fostering a sense of community by building interpersonal connections of the people involved to sustain change

"Systematic cultural change strategies can reinforce norms for health enhancement for group empowerment and cooperative change" (Allen & Allen 1986 p. 49). These normative change strategies were supported by research and application in Lifegain programs Allen & Linde (1978). Healthy Communities (1988) is a British Columbia Ministry of Health publication which supports the normative system model for organizational and community change proposed by Richard Allen in his book Lifegain (1978). The normative change strategies could be categorized with those strategies that reflect a holistic perspective.

Holistic Concept Strategies

The holistic perspective of health and health promotion incorporates strategies that are compatible with a synergistic ideology. Synergism "is the joint action of different substances in producing an effect greater than the sum of the individual effects of the substance", --- it is derived from the Greek word "synergos" which means working together" (Funk & Wagnalls 1980, p. 820). The holistic perspective incorporates the mind, body and spirit as interrelated and equally values all aspects of the individual. The holistic orientated health care approach views the individual as a whole person and as one who is constantly interacting with others and the environment. The balance of all aspects of the individual is valued equally.

The wellness movement is a direct result of the holistic concept of health which became active through the writings of Dunn (1961), Ardell (1977 & 1979) and Travis & Ryan (1981). "....a significant aspect of the wellness movement was its deemphasis on the treatment model and medical system dependency" (Harvey 1988, p. 42). Therefore, the evolution of strategies which incorporate the mind body spirit connection also focused on more independence on the part of individuals in defining health, finding what they need to know and taking appropriate action individually and collectively. This is what McNeil and Teague (1977) refer to as "cooperative control - the delegation of tasks without relinquishing authority" (p. 41).

The holistic view is of health and illness considered within the context of the unique individuals and their life situations. Illness is seen as an opportunity for growth. The role of the health professional is one of the active partnership with the client. Responsibility for healing, growth, and

change are shared and learning is experienced by both practitioner and client. (Becke, Rawlens & Williams, 1988). This calls for new skills, and expertise on the part of professionals and lay persons, as well, as a pooling of resources to promote health (Harvey, 1988).

Labonte & Penfold (1981) expressed the view that ill health is a conditioned social phenomenon which required strategies of social change through collective forms of action. The role of the health professional was to help individuals become aware of their collective power and regain control over their health through critical awareness of social, economical, and sex discriminatory conditions.

In 1984 W.H.O. proposed a new health promotion strategy which directed the focus of health promotion towards determination of causes of health rather than the risk factors of illness. W.H.O. supported the views expressed by Brown (1976),and Labonte & Penfold (1981) that health promotion required "close co-operation of sectors beyond health services, reflecting the diversity of conditions which influence health--- and that government, at both local and national levels, has a unique responsibility to act appropriately and in a timely way to ensure that the 'total' environment, which is beyond the control of individuals and groups, is conducive to health" (Then and Now, 1987, p. 4).

Robinson (1985) incorporated living conditions and psychological experience as important aspects of health and illness in his vision of a health paradigm. Robinson envisioned using enabling strategies with self-help groups. Through consciousness raising activities individuals would be able to find ways to provide self-help, and mutual aid. They would also bring about changes in social and physical environments.

Self-care is supported as a valued and necessary component of holistic health strategies. Health is seen as a resource to be utilized in the process of striving to achieve one's optimal potential of functioning. It achieves a balance among all aspects of self, relationships to others and the environment.

Epp (1986) outlined the health promotion mechanisms as "self care, mutual aid, and health environments". He identified the three major strategies as "fostering public participation, strengthening community health services and coordinating healthy public policy" (p 9).

Health promotion strategies in the 1980's were designed to achieve the holistic concept. These strategies included the community health promotion planning model presented by Labonte (1987) in which communities were to define their own problems and concerns relative to health. This strategy empowers communities by allowing individuals to influence their own community by extending their own health and is supported by the popular education approach that provides opportunities for collective learning via strategies such as active participation, and avoids the barriers set up by experts and the teacher-student power base.

Community development strategies have their roots in two models. Saul Alinsky of Chicago defined community in the geographic sense of the word and promoted a confrontational approach which included formation of groups and developing natural leaders within the group to address single issue community problems such as poverty.

The second model of community development has its roots in Paulo Freire's popular education approach. In this context, community is meant to refer to "affinity of interest". (Labonte,1987, p 31). This approach "encourages

the development of skills and powers of critical analysis among those involved in community-based organizations" and "supports coalition-building and favors the idea of working simultaneously on many issues" (Labonte, 1987, p. 32).

Labonte (1987) envisions community development as a strategy that enables people to take charge of their own health and empowers communities to control their programs.

While terminology is slightly different, the common theme which occurs in the recent approaches to health promotion discussed in this chapter is one that incorporates strategies designed to enable people to take charge of their own health individually and within social and environmental context.

This public empowering strategy is more effective than the approach which views the health promotion program as belonging to health agencies. Strategies for empowerment Minkler and Checkoway (1988) identified are: consciousness raising activities, mutual aid groups, and various community approaches. They view health promotion as not merely personal behavior but as a process of community development that involves other people and the places where they live, institutional interactions, daily activities, shared values and social structures, patterns of participation and distribution of power.

McLeroy et al (1988) outlined what they call an ecological perspective on health promotion programs. They believe this ecological perspective provides an all encompassing view which includes environmental interventions that can support behavior change. Environment, according to their definition, includes social and physical aspects that are relevant to the health of individuals such as unemployment, discrimination, genetic and

toxic physical environments. "The process of using ecological strategies is one of consensus building" (p. 369). They go on to say that strategies which involve the target population in problem definition, change choices, implementation and evaluation are important strategies to reduce opportunities for "coercion and paternalism" (p. 368).

Health in this context refers to a holistic perspective encompassing the mind-body-spirit connection, as well as the ecological perspective which places a strong emphasis on social and physical environmental influences. The overlap in these concepts is evident in the many similarities in mechanisms and strategies they use, such as normative systems (Life gain model), community development models and documents which support their strategies at international (W.H.O. 1984), national (Epp 1986) and provincial (Healthy Communities, 1988) levels. As these models evolve, their accompanying strategies have not always been clarified or taught to persons working in the field and delivering health promotion programs.

Health & Well-being

Historical Perspective, Health and Well-being

The remainder of this chapter reviews health promotion programs for older adults and related literature regarding their content, process and evaluation of effectiveness.

Successful aging is the achievement of the optimal level of functioning that is possible at each stage of older adulthood rather than the achievement of the average. Weiler (1988) believes that if we follow "the concepts of health

promotion and disease prevention, we may be able to support a successful aging process and increase our active life expectancy" (p.vii). A common aim of health promotion programs is to enhance the health and well-being of participants. It is for this reason that the research into subjective well-being and health are reviewed here. Other key factors that influence change are health beliefs, self efficacy, empowerment and social support.

Subjective Well-being and Health

There is a significant body of literature regarding subjective well-being and health. Funk & Wagnalls (1983) define well-being as "a condition of health, happiness or prosperity" (p.925). Subjective well-being is the individual's perspective or subjective view of the individual's own state of health, happiness, prosperity and satisfaction with life.

Past research has shown a consistently stable link between health and well-being (Larson, 1978, Thorne et al, 1986, and Stull 1987). Larson's review of thirty years of research on subjective well-being of older Americans revealed that the level of education, occupation status, marital status, availability of transport, housing and social interaction are also related to perceptions of subjective well-being. He reported that persons of lower social economic status tended to have lower subjective well-being.

Maddox (1985) identified "social location"---as a strong predictor of "health & well-being in later life" (p.1028). He found that "social risk factors are known to be correlates, if not determinants or mediators of the effects of personal characteristics on health and well-being" (p. 1028).

These risk factors include: "being impoverished, ignorant, and isolated". Maddox believes those factors are more important risks for older adults than behavior and lifestyle which frequently tend to be the focus of health professionals and health promotion programs.

Subjective well-being does not decline with age as supported by Larson (1978) and Costa et al (1987). Costa et al (1987) found that psychological well-being in adulthood tends to remain stable and that enduring personality disposition and process of adaptation in determining levels of well-being are important considerations.

Levkoff et al (1987) compared aged and middle aged adults' self appraisal of health. They found a strong association between perceived poor health and depressive symptoms among the aged compared to middle aged adults.

Another study by Kozma and Stone (1987) found that there is a general tendency of individuals to overrate their psychological well-being. But they believed that, as long as this tendency is true for all groups, there isn't a major threat to validity of well-being measures.

The most important fact in subjective well-being according to Kirchman et al (1982) is how individuals feel about themselves. Kirchman et al shared Campbell et al's (1976) view that personal interpretation of life experience most often determines quality of life.

The Encyclopedia of Aging (1987) identified a number of factors in subjective well-being such as happiness regarding current events, life satisfaction, moral (optimistic or pessimistic) and emotional state or mood.

Thorne et al (1986) identified three conceptual categories of health and well-being from analyzing data from interviews with fifteen community-

dwelling well seniors. The seniors' "health and well-being" were experienced at three levels of awareness:

1. comfort and abilities

2. connectedness (social involvement) and competence (productivity); and

3. sense of meaning (Thorne et al, 1986, p. 16)

These recurring themes appear in the literature and research on health and well-being in health promotion programs.

Ruffing-Rahal (1989) interviewed community dwelling older adults attending a health promotion program - regarding their well-being experience in every day life. (Community dwelling means that they live outside institutions.) A content analysis of the interviews revealed three themes of well-being which include activity, affirmation - a positive expression of life meaning and synthesis - the coming together of experience of a lifetime. The participants were asked several lifestyle questions. These questions included self-rated: health status; assessment of current state of happiness; life satisfaction and comparison of self to others. They saw themselves as much better off 44%, or better off 37%, or about the same as others 19%. They described themselves as satisfied with life completely 41%, quite satisfied 22%, satisfied 19% and don't know 19%. Forty-one percent described themselves as very happy, while 50% were pretty happy. Their self-rated health was very good 44%, good 33% and fair 22%. None of the 27 participants of this study rated themselves as worse off than others, dissatisfied with life, unhappy or rated their health as poor.

Many health promotion programs for older adults examine subjective well-being and/or incorporate well-being enhancing activities into their programs. An example of this is the Alberta program for older adults called Fully Alive. They found that "Resisting change - looking at aging as a fading rather than a growing process - can be a barrier to well-being and self esteem" (Fully Alive - Community Initiative 1988, p. 27). They incorporate program content that examines this statement and carry out activities which counteract these barriers.

Factors In Change

A number of factors that influence change have been identified and relate to changes in thought and behavior of participants of health promotion programs. These factors include health beliefs, self efficacy, empowerment and social support.

Health Belief Model

Janz and Becker (1986) reviewed twenty-nine Health Belief Model (H.B.M.) articles published between 1974-1984 and checked the findings of seventeen studies conducted prior to 1974. The summarized 46 H.B.M. studies contained 24 studies that examined preventative health behaviors. The Health Belief Model is based on the premise that behavior "depends upon two variables: (1) the value placed by an individual on a particular goal; and (2) the individual's estimate of likelihood that a given action will achieve that goal" Janz & Becker 1986, p.2).

Rosenstock (1974) explored the history of health beliefs. He observed that the combination levels of susceptibility and severity of disease provided the incentive to change. The perceptions of benefits minus barriers provided a likely direction for action. Cues that trigger action include: media campaigns, advice from others, reminders, illness of family members and articles in the newspaper and journals. Janz and Becker's findings were that: H.B.M. dimensions are important contributions to the explanation and prediction of individual's health-related behaviors, and prospective studies were as supportive of H.B.M. as retrospective ones. Perceived susceptibility (to disease) was the most significant factor contributing to an understanding of preventative health behaviors while perceived severity had the least significant effect with poor association with preventive health behaviors. They concluded that there was a lack of "experimental designed research evaluating the efficacy of different interventions in modifying H.B.M. dimensions to achieve the desired health behaviors" (Janz & Becker 1986, p.45).

However, Janz and Becker did identify the two strongest barriers to changing health beliefs, low self-efficacy and lack of social approval - it is to the concept of self-efficacy that focuses on beliefs about capability to change behavior that this thesis will explore next.

Self-Efficacy

The concept of self-efficacy is defined by Fuller et al (1982) as "the individual's perceived expectancy of obtaining valued outcomes through personal effort" (p.7). Many aspects of well-being and life satisfaction in later

years have been linked to good health and lifestyle management. A study by Bolton helps identify the role of efficacy in lifestyle management.

Bolton's (1985) thesis statement is that middle and older aged individuals who have not discovered the efficacy of education and who have not assumed a proactive approach to living, have yet to realize the potential of lifestyle management.

Wellness includes a continual striving to stay healthy and/or become healthier. Therefore, knowledge of lifestyle management must be preceded by educational efficacy and a proactive approach. Knox (1977) stated that "A person with a high sense of educational efficacy believes that through further education the individual can gain greater mastery over his/her surroundings and that further education has practical consequences and utility" (p.186). Bolton (1985) observed that seldom do educational program planners consider that it is necessary to convince middle aged and older adults that educational achievement is possible and that barriers to learning can be overcome. This has significant implications for health promotion programs designed to promote changes in older adults and may provide some answers for those who wish to explore further the common belief that programs do not reach those that need them the most.

Bandura's social learning theory is one approach that predicts and explains behavior relative to incentives, outcome expectation and self-efficacy expectations. The efficacy expectations are learned from four sources according to Bandura (1977). These sources are performance accomplishments learned through personal experience, vicarious experience learned through observing life events and the modeling of others, verbal persuasion and physiological state.

Bandura (1977 & 1982) suggested that a individual's assessment of his/her capability to carry out behavior (self-efficacy) was a significant factor in facilitating behavior change. Changes in self-efficacy are not always related to performance because differences can exist between actual and self perceptions of performance (Bandura & Adams, 1977). The assessment of self-efficacy includes questioning people about what they can do rather than what they hope to do (Bandura, 1977).

Self-efficacy differs from similar concepts such as health locus of control and learned helplessness. Health locus of control is a general expectation about how health is controlled either by individual control over behavior (internal locus of control) or the degree to which forces external to the individual (external locus of control) are believed to control behavior and health related outcomes (Strecher et al, 1986).

The concept of learned helplessness refers to deficits in thought, emotion and motivation that result from experience with uncontrolable events. The two types of learned helplessness are personal and universal. Personal learned helplessness occurs when the individual believes that only others could control their response to the situation. In the belief of universal learned helplessness the individual is still failing to provide the effective response, while believing that no one else can either (Strecher et al, 1986). Personal helplessness is comparable to Bandura's view of efficacy while the concept of universal helplessness is comparable to outcome expectancy.

Strecher et al (1986) reviewed twenty studies into self-efficacy relative to health practices. The health practices were in the areas of: smoking (12 studies), weight control (2), contraceptive behavior (3), alcohol abuse (1) and exercise (2). They found that self-efficacy was a consistent predictor of short

and long-term success for all 20 health related studies they reviewed. They observed that the Chambliss & Murray study on efficacy attribution, locus of control and weight loss (1979) found that self-efficacy manipulation was only effective for individuals with an internal locus of control.

Kaplan et al (1984) found quite different results in a study of specific efficacy expectations that influenced compliance in patients with Chronic Obstructive Pulmonary Disease. The changes in self efficacy increased with walking compliance over three months. Locus of control was not significantly correlated to walking although self-efficacy shows a significant correlation.

The McIntyre et al (1983) and Jeffery et al (1984) studies reviewed by Strecher and his colleagues support the belief that a high level of self-efficacy is necessary to maintain behavior change. It was also found that efficacy is often enhanced through a series of performance accomplishments, which motivate attempts to take on more difficult tasks" (Stretcher et al, 1986, p 90).

Strecher's findings reinforce the need for health promotion programs to involve participants in activity which enhance their accomplishments and motivate them to take on other tasks which continue to enhance their health, well-being and self-efficacy. This involvement or empowerment is "the ability to choose", or "to increase one's capacity to define, analyze and act upon one's problems" (Kent, 1988).

Empowerment

Earlier in this chapter the concept of empowerment as a significant strategy in health promotion was identified. The basis for this is empowerment education is sometimes referred to as popular education; it was developed by the Brazilian educator, Paulo Freire, (1973) in his writings and programs on literacy for the poor. Empowerment education based on Freire's ideas is used successfully world wide in a number of programs such as literacy, English as a second language, health education and community development (Wallerstein & Bernstein, 1988).

Groups and individuals can only empower themselves. The role of health professionals/educators is "to nurture this process and remove obstacles" (Labonte, 1989b).

Labonte, (1989a & b) & Wallerstein & Bernstein (1988) believe that the power of defining health belongs to the people experiencing it. Wallerstein & Bernstein (1988) see empowerment characterized by achieving power to act with others. They see empowerment education as a new approach to health promotion that uses gaining control as one strategy for health and that facilitates individual and/or group structural change. Bernard (1988) describes self-empowerment as a "process of becoming" where "individuals increasingly take charge of themselves and their lives," (p.90). He recognized that this process is not restricted to any one age group.

Factors in self-empowerment

Factors which facilitate self-empowerment health behavior were identified by Bernard (1988). These factors include:

1) awareness of one's own worth and uniqueness

2) working out goals one is committed to

3) clarifying personal values

4) ensuring that they are consistent with the process of identified goals and plans for action

5) maintaining an openness to information which aids in keeping options open

6) developing health skills which aid in promoting awareness

7) setting goals and action plans

8) identifying values and applying information

9) access to facilities, services and opportunities to explore their view regarding maintaining health and well-being

10) reviewing options

11) social support to change goals into actions.

Success in this approach to health promotion has been reported by a number of researchers such as Labonte (1987) with a nutrition program in Toronto, and a drug and alcohol program in New Mexico. (Wallerstein & Bernstein, 1988).

Barriers to empowerment

Barriers to empowerment occur when programs with preset content have expectations for participants' compliancy with health practices defined by professionals. Educators' expectations of preset outcomes also fails to recognize the true intent of the word empowerment as outlined by Freire (1973). Freire describes empowerment in terms of the group's ability to raise their themes from mutual reflection. Zacharatis-Jutz (1988) supports this view of empowerment as an event which "occurs when oppressed people come together and initiate collective action" (p.46). Clearly this process requires support from the group members and facilitator (educator) and others to bring about the desired change.

Social support networks play a key role in empowerment. It is the literature related to social supporting networks that this thesis will now explore.

Social Support

Several studies relate social network and social support to health and well-being. Social networks are the basis for social support. Social supporting networks are "that set of personal contacts through which the individual maintains his (or her) social identity and receives emotional support, material aid, services, information and new social contacts" (Minkler, 1981, p. 148).

Berkman & Syme (1979) identified the importance of social support in mediating health status in a nine year study of residents of Alameda Country California. Those with fewer social ties were 2.5 times more likely to die sooner than those with many social and community ties. Social isolation did not predict mortality. The groups most vulnerable to disease were widows, people living in environments dominated by social disorganization, poverty and career mobility, or frequent moving (Berkman 1983).

A 1979 United States national telephone survey of personal health practices of persons aged 20 to 64, was the basis of analysis for Gottlieb & Green (1984). They examined the relationship between life events, social networks, lifestyle and health. A personal correlation for men and women identified income, education and social support to be positively related and age and life events to be negatively related to lifestyle and health practices.

"Age and life events were more strongly correlated with health behavior in women than men----the only significant paths to the number of lifestyle health practices were the direct effects of education and social networks and the indirect effects of income and age through social networks" (Gottlieb & Green, 1984, p. 96).

They believed that social support reduced psychological distress and physical symptoms from job stress or loss. An exploratory case study by Hawley & Klauber (1988) tested the hypothesis that an association between elders' perceptions of their social support and their health practices could be found. The sample included sixty-four individuals age 60 to 75. They found

that those who were satisfied with their relationships with others were involved in more health practices than those who were dissatisfied.

Health practices had a stronger association with satisfaction and social support than the number of support persons. Men showed a higher correlation between health habits and satisfaction with social support through sharing than women. Elders who were house-bound had a lower correlation between health practices and social support than more active groups.

Hubbard et al (1984) review of literature on social support identified several common factors including communication of positive emotions, a sense of belonging and elements of reciprocity. The purpose of their study was to explore the relationship between what people do to promote healthy lifestyles and how they view their level of social support.

The sample consisted of two volunteer groups: - Group one - aged 55-90 N=97 attended a seniors centre. Group two - aged 15-77, N=133 attended a health fair. The findings showed that social support related to health in both samples. Group 1 married individuals scored higher on the personal resources inventory than non-married older adults in that sample. Also women scored higher on social support and health practices then men (there were 57 women and 40 men in the sample).

Statistics Canada investigated health and social support of Canadians in 1985. They found most people aged 55 or older living outside of institutions were able to carry out the activities of daily living without assistance. Three in ten required some help with yard-work, one in five reported having or needing assistance with heavy housework. Two out of three persons 65 or over provided support to organizations or persons outside their household, while one half of this age group provided financial support to organizations

and others. One in six babysit or provide transportation for others. Saunders (1988) reported that older adults contributed as much or more social support than they receive. "Seniors who have many social activities report being happier and healthier than those with few activities, even when compared to those of similar health status" (Statistics Canada Health & Social Support in 1985, 1987, p. 16).

Thorne, Griffin & Adlersberg (1986) interviewed seniors in Vancouver. The study participants expressed the belief that a sense of connectedness to others was essential for their sense of well-being. Thompson, 1989, studied 337 people age 56 and older in Victoria B.C. about their supportive social networking in relation to the caretaker, helper, confidant and advisor roles. Thompson found only 1/5 of the respondents did not have support in one or more role areas. People with only fair or poor health expressed the need for more people in their support network while those who felt they were in good health felt no need for more people. Thompson found widowed females over age 74 were the group most in need of social supportive networks.

Supporting social networks and health promotion.

Israel et al (1984) identified functions of social networks that link them to the concept of social support. The characteristic functions they identified were effective support, instrumental support (money, food & care) maintenance of social identity, and social outreach. They found that:
1) different types of supportive social networks are needed at different times and that 2) increased intensity and provision of emotional support were significantly related to psychological well-being.

The implications of these findings for health education programs outlined by Israel et al included: 1) social network analysis to identify network characteristics in use and needed; 2) identification of the stage of crisis or tasks and the individual's need for different functional network characteristics and receptiveness in using network resources; and 3) the need for health educators to educate professional and policy makers about networks and their functions.

Snow & Gordon (1980) reported that network analysis was necessary to identify appropriate intervention strategies for the elderly. They identified structural features of social networks. They also identified the relationship of the individual's perspective of the network, behavior, and effect of significant life events.

Interventions suggested include friendship groups that can develop as an outgrowth of well planned seniors' programs.

Hibbard (1985) in a randomly selected sample of 2,603 adults found

> .....that having social ties, being more trusting of others and perceiving control are all related to having better health--while having a larger social network is more important to those less able to utilize the resources available in their network effectively. (p. 23).

Hibbard suggested, in light of her findings, that health education program aims should include activities which increase participants sense of control and increase and mobilize their supporting social networks.

Health Promotion Programs

The literature reveals several underlying conceptual views of health promotion. These views influence the focus of developing programs and the way developers and the public health community view and measure the programs' success.

Taylor (1982) referred to several theories of causality. First, the lifestyle model that focuses on individuals and personal lifestyle choices as cause of health or illness. Critics of this approach refer to it as the "victim blaming" approach. Strategies in the lifestyle model include education, activities designed to get individuals to take responsibility for and change their self-destructive habits.

Social environmental model

The second model Taylor identified was the social environmental model which views the causes of illness in light of environmental threats such as poverty and pollution. In this social/environmental model strategies involve people working individually and collectively to bring about social reconstruction and environmental adaptation.

Measuring program effects

Some issues identified by Weiler (1986) regarding health promotion programs for older adults include: finding ways to measure program effects; deciding whether program goals are attained when a high level of wellness and functional independence in the community are attained or when a delay or prevention of disease or disability is achieved. Weiler believes that "the

dilemma in dealing with health promotion outcomes for the elderly is trying not to expect too much nor hope for too little" (p.77).

The literature on health promotion programs for older adults reviewed for this thesis provides a variety of objectives and approaches to deal with that dilemma. There seems to be as many ways of measuring program outcomes as there are programs. In reviewing this body of literature specific to programs for older adults, more detail is included for research relevant to this thesis and reported in the literature.

The SAGE Project

One pioneer program in health promotion for older adults is the SAGE Project developed in Berkley, California, 1974. SAGE is an acronym for Seniors Actualization and Growth Exploration. The group formed by Luce, Dychwald, and Gerrard, developed and staffed by psychologists, physicians, breathing, movement and art therapists; and, specialists with extensive training in a variety of human arts. The first group of 12 older adults met weekly for nine months. The goal of the program was to generate a positive image of aging by demonstrating that people over age 60 can experience personal growth and overcome the negative expectations of our culture. The program content included physical exercise, massage, sensory awareness, meditation, information sharing, and discussions.

The participants were actively involved in learning exercises, relaxation skills, and selecting discussion topics. Graduates from the program went out to be co-leaders after taking a training program. A well known graduate from that first program was Helen Anseley, a 74-year-old widow.

Helen went on to team teach with young professionals at a community college in Bellevue, Washington, give guest lectures around the country, and write about her SAGE experience (Anseley 1976).

The SAGE project was deemed a success after the first year as a result of a number of measurable and observable changes in participants. These changes included: increased mobility and flexibility; reduced blood pressure and physical complaints, and radical changes in outlook, appearance and social participation.

The program continued to evolve and expand by incorporating a number of programs in institutional settings, like nursing homes, professional training, research, national development and networking (Dychtwald, 1978). While there were references to research, only qualitative data was presented in articles available for review here.

The Tenderloin Seniors Outreach Project

A pioneer health promotion program that focused on the social/environmental perspective of health promotion was the Tenderloin Seniors Outreach Project (TSOP), initiated in San Francisco in 1977. TSOP was a community oriented health promotion program that helped low income elderly in the inner city identify their own health priorities and develop a power base around their immediate health needs and interests.

The program focused on social support, individual health, improvement and community level changes. This expanded perspective is based on the work of Paulo Freire (1973) and Saul Alinsky. Freire's book "Education for Critical Consciousness" provided the base for the

organizational process used to attain the goals of empowerment and social change at the macro and micro-level through a process of looking at underlying problems. The project used relevant components of Alinsky's community development approach. This approach focused on the belief that: 1) there must be an increase in the problem solving ability of the community, 2) that all members of the community must be involved in realizing power to collectively deal with issues and, 3) that fostering leadership within local group members is necessary in achieving these goals (Minkler, 1985).

The program outcome reported in case study by Minkler (1985) and Wechsler & Minkler (1986) describes the increase in social support and community health promotion efforts undertaken by the groups over a six year period. The residents of the various hotels within the project formed groups in an interhotel coalition called the "Tenderloin Tenants for Safe Streets". Other accomplishments included a Safe House project, and various nutritional projects including a food advisory service, common kitchen, roof top gardens, mobile mini-market, and cooperative food purchase clubs.

An identified number of group members trained as volunteers to co-facilitate TSOP groups along with trained health students. The program succeeded in demonstrating ways of involving some formerly isolated elderly in action organizations.

While these activities helped achieve the goals of the project a number of problems remained unresolved. The TSOP project had several problems related to funding, leadership and application of Freire's approach (Minkler, 1985). One problem with funding was the time lag between people identifying

a problem and having a sense of initiative to deal with it, and approval of funding.

The second funding problem was asking for funds for a specific project and finding that the group's perceived needs had changed by the time funds were received.

A leadership problem was the loss of trained volunteer co-leaders. Many volunteer co-leaders left their position for a variety of reasons that included: their involvement on boards, agencies and task forces within the community; health problems and decreased energy compared to increased commitment and energy demands of the growing project. Others left because of opportunities that arose from the project for jobs and improve life experience that required moving outside of the Tenderloin Community.

Minkler (1985) felt that the Freire approach worked best when it was applied in a flexible way, addressing the unique cultural and social group context in conjunction with other organizational approaches.

Longitudinal Studies of Program Effects

Two studies dealing with program effects over time are Growing Younger (Healthwise, 1983) and the Wallingford Wellness project (Lalonde et al, 1988). Both of these programs evaluated program effects in relation to behavior change and health care. Both programs provided information, content and process utilized in developing and delivering of programs in Canada. (Growing Younger, Kitchener, Ontario. ; Keep Well, New Westminster, B.C.; Choosing Wellness, B.C. 1988; Fully Alive, Alberta 1986).

Growing Younger

Healthwise developed the Growing Younger 1981, a health promotion program for older adults in Boise, Idaho. Participants were older adults, age 60 or over. They were invited to a neighbourhood party where they were encouraged to take part in a series of four workshops. The program's aim was to lower participants health age through a series of four workshops which focused on fitness, stress management, nutrition and self-care.

A study was conducted from 1981 to 1983 with a non-randomized sample of 1,468 persons age 60 or over. The average age of participants was 70.3 years and 76.95 % were women. There was no control group. Pre-program and post-program questionnaires were given to monitor changes in self-reported behaviors and biometric measures. The questionnaires addressed health behaviors, relative to exercise, nutrition, stress management, social/medical care management and dangerous behaviors. The biometric measures included: blood pressure; weight; percentage of body fat; flexibility, pulmonary function; cholesterol, triglycerides and H.D.L. levels.

The results of the questionnaire were a significant increase in positive changes in four of the five behaviors measured. The one area in which no improvement was reported was in dangerous behaviors such as smoking, drinking, and seat belt use. A 1 tailed T test showed significantly at .05 level in relation to nutrition practices such as reduced sugar and salt intake and increase in water consumption. The biometric measures that improved were flexibility (T-value 5.79), weight loss (6.73), blood pressure (2.93) and cholesterol (4.21) (Healthwise Inc., July, 1983).

While this program failed to demonstrate self-reported changes on dangerous behaviors, it was proclaimed a success by Healthwise because of the significant number of the community members who took part in the program, the continual growth of the program, and the resulting development of other groups such as the Happy Hoofers (a walking club) and a phone support group called ECHO.

Wallingford Wellness Project

The second program that incorporated a follow up assessment of program participants health practices was the Wallingford Wellness Project (Lalonde et al, 1985) which measured changes in participants over a two year period.

The research incorporated a randomized sample of voluntary participants in the research group (N=90) and control group (N=44). The ages of both groups were 54 and up with researchers reporting little differences in demographic characteristics of the two groups. Effectiveness of the program was measured in health behaviors, information, risk reduction and status and services utilization.

This health promotion program was 21 weeks long and included information on nutrition, fitness, stress management and environmental awareness. The approach was holistic. Lalonde et al (1988), supported by Fallcreek & Stam (1982), described "a synergetic effect in promoting a whole greater than the sum of its parts" (p. 97).

The learning model used in this program was participatory while the behavior change was facilitated by group process. The format included three

hour sessions over a seven week period regarding health information and skills. The content on environmental awareness and action ran the full 21 weeks of the program.

A pre- and post-test design, plus evaluation at six months and two years after graduation, were used to assess effects. The questionnaire addressed questions such as: demographics; measures of health knowledge; attitudes toward health; mental social health; risk to heart disease and stroke; behavior change; number of reported health problems; and number of reported prescription medications.

Health behaviors included the number of doctor visits over one year and the number of hospital visits, nursing home admissions days in one year, and morbidity rates over six months.

The shorter version of the original questionnaire was the Rand Mental Index - 46 items scale remeasures on anxiety, depression, positive well-being, emotional ties and emotional stability.

The questionnaire results showed that the experimental group improved in all lifestyle habits and health information at post-test and six months. The benefits declined from the six months to two years follow-up assessment in mental health, responsibility for health and risk factors to heart attack and stroke.

The experimental group showed improvement in health habits relative to physical fitness, stress management, nutrition compared to the self reported pre-program behavior, all behavior changes in life style habits declined after the six months.

The experimental group sustained health information levels achieved at post-test and six months in all areas except nutrition, which declined from

post-test levels (Lalonde et al, 1988). The experimental group demonstrated greater knowledge on information related to physical fitness, stress management, nutrition and environmental awareness than the control group.

While the benefits of behavior change were not sustained in the long term, Lalonde et al (1988) recognized the need for intermittent interventions to sustain the changes.

Canadian Developed Health Promotion Programs

Keep Well

Keep Well (1984) was a three year pilot project which assessed needs and developed programs for seniors in New Westminster, British Columbia. The goal of the project was to help the community develop a supportive context for aging well and to help independent community dwelling seniors to maintain their well-being. Keep Well project developers planned to do this by involving the community and strengthening informal support networks and services. Activities that grew out of the project were peer counselling groups, a seniors' resource centre, and personal shopping program, seniors' column in the newspaper, wellness workshops, health fairs and a weekly health drop-in program.

The participants of the health drop-in program were asked to assess the programs effects by filling in a self-reporting questionnaire (King, 1987). This was a non-randomized sample, with 24 program participants out of a population of 60. Not all respondents attended the program weekly. There

was no control group. The age range of respondents was 65-85 with a 9-1 ratio of women to men.

Participants were asked what they liked best about the program. They stated they liked the social aspect most, then the instruction and finally the exercises.

Their perceptions of the program benefits were changes in exercise, diet, blood pressure (11 respondents). Nine respondents did not indicate change while one said "not yet" and three said "no". Twenty-two respondents said they came to hear speakers, 16 for exercise, and 12 for massage, nine for resources and information and 16 for health counselling.

The program was deemed successful because of the continued participation of seniors and the development and expansion of other related activities such as peer counselling (Petty & Cusak, 1989).

Fully Alive

Fully Alive is a health promotion program developed in Alberta in 1985. It is based on the holistic concept and claims a synergetic effect. The program was developed over a three year period for individuals aged 55 and older. The project and program were developed and organized in a way that gave ownership of the program to older adults, not professionals or the government. A number of broad objectives were identified:

- to encourage participants to see the inter-relatedness of body, mind and spirit
- to help participants learn to use their mental, emotional, physical, spiritual and social powers to enhance their well-being

- to help participants identify barriers that interfere with their well-being and develop plans of action to overcome the barriers individually or as a group

- to foster a balance between caring for self and caring for others and our universe

- to plan life activities relative to wishes and current capabilities

In the first year of the project 14 facilitators aged 55 or over (12 female and 2 male) were trained. They co-facilitated the program in pairs. The program was presented in a series of ten two hour weekly sessions with a group of 12 to 16 older adults. The program was offered in one seniors centre, a senior apartment building, and a lodge which served meals and provided accommodation.

The content of programs included nutrition, fitness, stress management, personal and community self-help and other topics identified by the group as meaningful. The participants played an active collaborative role in the program by providing feedback or content, and acting in an advisory capacity throughout the development phase of the project.

The program was evaluated at the end of the first year and again in the second year of operation.

During the first year the program was offered at three sites with 42 participants aged 55-74. A total of 37 participants completed the ten week program. Information was collected during the program, and at the end, from participants and facilitators by means of interviews with the intent to make necessary changes.

The revised program was offered at four new test sites in Calgary in the fall of 1986. A total of 56 participants with average age ranging from 55 - 85 took part in the program. Females made up 86% of participants. An outcome evaluation was conducted using a non-equivalent control group design. The experimental group N=56 and the control group N=72 had similar characteristics with an age range from 55-85 + and a dominantly female sample (control group males - 20%). Both groups were tested one week before the program started and three and one half months after the program was completed. There were 18 from each group who did not complete the follow-up questionnaire.

The questionnaire covered the following areas:

- demographics
- program procedures and protocol
- nutrition
- fitness
- social activities
- psychological well-being as assessed with a self esteem scale (Rosenberg , 1985)
- Affect Balance Scale (Bradburn (1969)
- General well-being schedule (Fazio, 1977, Hammelfarb and Murrell, 1983, McDowell & Newell, 1987)
- Attitude opinions about (older) people scale (Mangen & Peterson, 1982)
- Control Over Life Events Index (California Department of Mental Health, 1979)

Findings in this study reported by Larsen (1986) were a strong evidence of the programs effects on psychological well-being. However, statistical findings were more ambiguous about health behavior, physical and social well-being and on attitude.

The two groups were statistically assessed by means of the Mann-Witney U two tailed test and compared between initial and 3 1/2 month program follow-up. All significant only in a positive direction were found in the experimental group. Participant questionnaire responses showed: increase in water consumption (P. 2.01), deep breathing exercises (P. 2.05), satisfaction with leisure time (P. 2 .057), self esteem scale (P. 2.05), General Well-being schedule (P. 2.01).

The participants' views of program success were generally positive with self reports of increased water consumption, more satisfying use of leisure, increased companionship and friendship, as well as feelings of self confidence.

Program facilitators play an important role in program delivery and participant satisfaction. The evaluation in this study of the facilitators role was carried out by use of open-ended questions presented in an interview with all 8 facilitators. In these interviews both facilitators and coordinator identified characteristics of an effective facilitator. These characteristics were summarized in three categories which included "interpersonal skills", "personal resources", and "practical traits". (Larsen 1988 a, p. 45). Their findings were that it was helpful for facilitators to have similar backgrounds and age as that of participants', although participants ages ranged from 55 to 85. and could provide a significant "generation gap" with different experience and beliefs. Another finding was that facilitators with professional

backgrounds tended to "relate to participants in a dictatorial or authoritarian manner, which is totally contrary to basic principles and objectives of the Fully Alive program" (Larsen, 1988a, p.46). They also preferred to work with others to co-facilitate.

The project advising committee reviewed the evaluations and research used in the project in the first two years and recommended that a community development model be used to implement the Fully Alive program in a neighbourhood.

The Growing Younger program (Kemper & Giuffre, 1984) had successfully recruited 10% of the elderly population by the community development approach. The Fully Alive steering committee was confident that using this approach would improve recruitment of facilitators and participants. Contact was made with the formerly hard-to-reach adults in the community and involvement in maintaining activities beyond the formal 10- week program (Larsen, 1989a, p.58).

Effects of Health Promotion offered in a Seniors Centre

One relevant study by Cox & Monk (1989) assessed effects of health education on older adults delivered in a seniors' centre in New York City. Cox & Monk used an experimental and control group approach in evaluating the effects of the program for older adults. The study was carried out over an 11 month period in 1985 and 86 and used a quasi experimental method.

A post-test was given to a non-randomized sample of participants (N=104) and to a control group (N=30). Criteria for selection of participants

was involvement in health promotion programs over the preceding 12 months. The control group attended a seniors centre that did not have a health education program.

The questionnaires administered to participants and control groups addressed the following topic areas: health status, health-risk behaviors, health care practices, health attitudes and beliefs. Program participants of the health drop-in programs were also asked about level of interest in specific health education classes, their experience, utilization and satisfaction in use of health education classes in the seniors centre. Program administrators were also interviewed.

The findings showed that:

- self perceptions of health differed significantly between participants and control groups
- the control group felt more in charge of their health than participants ($P<.02$)
- participants with higher incomes felt more positive about their health care, ability to control their illness than those with lower incomes ($P<.01$)
- both groups had actively sought medical care and preventive care within the past year
- both groups reported low risk behaviors while participants believed they got regular exercise

- participants reported more changes in health behavior over the past 12 months than controls. Changes in diet ($P<.006$), weight ($P<.05$) and exercise ($P<.001$). (This change contributed to participants preference for nutrition and exercise classes and less interest in blood pressure assessment, stress management and vision care.)

- there was no significant difference between participants beliefs or attitudes resulting from levels of participation. There were also no differences between high and low participants in their perceptions of health status or attitudes toward health and health care (Cox & Monk, 1989, p.20). The researchers attributed the lack of differences to the fact that participation is not necessarily "an accurate indicator of learning or health knowledge" (p.20).

The shortcomings of the study were acknowledged by the authors to be related to the differences in the two groups in country of origin, education and income. Other limitations from the non-randomized sample was the fact that there were no pre-test; therefore, reported changes were difficult to substantiate. The authors further noted difficulty to assess similarities in program content and delivery because of non-specific curriculum. Classes were more spontaneous and groups self determined their interest in content thus "instructors needed to adapt to day-to-day emerging interests and concerns of their changing participants groups" (Cox & Monk, 1989, p. 21). This program approach while not labeled by the authors as "enabling" did provide opportunities for participants to take part in content that interested them on a drop-in basis.

Assessing Who Benefits From Health Promotion Programs

A frequently asked question in health promotion efforts relates to who benefits most by attending programs. Fitch & Slivinske (1988) did a study in which they tried to recognize the factors that identified persons who were most and least likely to benefit from wellness programs for older adults. They randomly selected 84 participants from a retirement community. The average age was 77.5 years and they had, on the average, 14.8 years of schooling, 39% were married, 45% were widowed, 73% were female, with an average income of $16,485. Fitch and Slivinske's randomly assigned 48 to the experimental group and 36 to the control group. Married couples were placed in the same group. Both groups were measured at the beginning and twenty weeks later. The experimental group took part in the pre- and post-program conference with a team of professionals and took part in classes in physical fitness three times per week. Classes also provided information on nutrition, stress management, environmental awareness, self responsibility and spirituality. The control group discussed current events and played cards for an equal time period of the experimental group.

Wellness was measured by an 82-item Wellness Index and perceived control was assessed by the 35-item Perceived Control Scale. Both these measures were self administered. The Krause-Weber Fitness Test, administered by professionals, was used to measure muscular strength and flexibility. A two group stepwise discrimination analysis was performed to identify the relationship among variables that identified those (experimental and control) with above- and below-average wellness scores in the baseline assessment. Those with above average scores on wellness at the beginning of

the study were married, younger and had a higher income and level of perceived control than others in both groups. Those with the lowest levels of wellness scores were not married, older, poorer and perceived a lack of control over the environment. The second discriminate analysis conducted at the end of the program with both groups identified that increase wellness was associated with higher yearly income, better muscular strength and flexibility and higher levels of perceived control and participation in the wellness program. Those in the control group had decreased wellness, had lower incomes, less muscular strength and flexibility and lower levels of perceived control.

Current Seniors Wellness Programs in Vancouver

The final study reviewed in the literature was conducted in Keep Well programs which were used in data collection for this thesis. Houldson (1989), selected five seniors wellness - drop in programs in the Vancouver Health Department district to conduct her study. Thirty two participants of the five programs (3 male and 29 female) volunteered to respond to three questions. The age range of participants was 55 - 83, and most women were reported as married, whereas all 3 males were married. The method used to collect data was observation of program activities and conversations with program participants that focused on the following questions: 1) "Why do you attend this program?", 2) "What difference does attendance make in your life?" 3) "How are these programs organized and run?" The author also identified who attended the programs.

The responses to why participants attended programs fit into three categories of well-being. The response categories in order of frequency were: 1) to maintain physical well-being by exercising, 2) to maintain social well-being by talking with friends and others, 3) to maintain mental well-being by learning relaxation techniques and by contributing to doing for others (Houldson, 1989, p. 61). The response to the question regarding what difference attendance of programs makes, identified expressed fulfillment needs such as finding ways of living in harmony with self and "developing a philosophy and psychology in aging and how to be helpful in volunteer activity". (Houldson, 1989, p.61)

The program organization and process was described as similar in all sites and included exercise, discussion and social time. Lecture discussion covered health promotion topics. Groups were run by community and senior centre staff, volunteers and the V.H.D. Wellness coordinator. Direction was usually requested from participants as to content. The author concluded that programs "promoted the social, mental and physical well-being of older adults. Also, many educational needs of older adults targeted at the meaning level (Le Clerc, 1985) are fulfilled" Houldson, 1989, p.62). Two of the program sites used in Houldson's study were used in the research for this thesis.

Summary of Literature Reviewed

The preceding review of the literature has illustrated the evolving concepts of health to the current holistic perspective which encompasses the mind-body-spirit connection, and the ecological perspective that incorporates

the social and physical environmental influence on health issues of people individually and collectively.

Health promotion approaches reviewed here demonstrate support internationally (W.H.O. 1984), nationally (Epp 1986) and provincially (Healthy Communities 1988) for community development models. Community development models utilize strategies that promote participants' empowerment through supporting the process which enables them to define their health and related issues. A review of studies of programs that support this approach included Minkler (1985), Labonte (1987), Wallerstein and Bernstein (1988) and Larsen (1988a). Studies of programs that promote participants' involvement in selecting program topic content included Cox and Monk (1989) and Houldson (1989).

The literature reviewed here demonstrated the importance of self-efficacy and social support in changing health beliefs (Janz and Beck, 1986) and promoting health and well-being through empowerment (Strecher et al, 1986). Kent (1988) views empowerment as "the ability to choose", while Bernstein (1988) describes it as "a process of becoming where individuals increasingly take charge of themselves and their lives" (p.90) Wallerstein and Bernstein (1988) describe empowerment as "the ability to act with others".

The role of educators supported in community development models identified by Labonte (1989b) is "to nurture the process of empowerment and remove the obstacles". However, only three studies reviewed here - SAGE (1974), Minkler (1985) and Larsen(1988), identified the importance of training facilitators. While several studies refer to the need for trained facilitators, it is not clear from the literature that community development strategies have been taught. Health care professionals are traditionally indoctrinated in the

medical model approach which does not promote the empowerment of individuals.

The literature demonstrates the trend in health promotion which promotes the process of people empowering themselves, however, studies that assess program effectiveness have not fully addressed this. Program effectiveness as assessed by studies of programs reviewed in the literature address the issues of participants' improved health status, knowledge level regarding program content as well as participants' involvement in other groups as a result of program participation, King (1987), Growing Younger (1988), and Houldson (1989).

The following chapter will describe the methodology used in this study to assess the perception of the effectiveness of health promotion programs on older adults, from the perspective of participants, facilitators and referring professionals, and determine if these programs reflect W.H.O.'s definition of health promotion.

Chapter III

METHODOLOGY

> *"A case study is an empirical inquiry that:*
> *Investigates a contemporary phenomenon within its real life context; when*
> *the boundaries between phenomenon and context are not clearly evident; and in which*
> *multiple sources of evidence are used."*
> *(Yin 1981a & 1981b)*

The purpose of this exploratory case study was to investigate the effectiveness of health promotion programs for older adults being delivered at six sites in Vancouver. It was designed to examine the perceptions of program effectiveness on participants from the perspective of those participants, program facilitators and referring professionals. This study identified the demographic profile of program participants, looked at programs that had been in operation over different lengths of time, examined whether approaches were used to "enable" program participants to take charge of their own health relative to program planning and delivery. This chapter contains the methodology used to assess programs effectiveness, described under the following headings: research design, sample, procedures for administering questionnaires and interview guides, description of development of instruments (A, B & C), reporting data and the use of portraiture.

Research Design

The exploratory case study approach used in this research incorporates a number of instruments and activities to answer the questions set out in Chapter I.

Program participants were asked to answer a questionnaire which includes questions on perceptions of their health, sense of efficacy and supporting social networks; and to complete an information sheet providing demographic information. Then program participants were asked to take part in a focused interview which asked questions about their involvement in the program.

Program facilitators were asked to answer a questionnaire which deals with the program history and present program content. Questions about health, health promotion and the role of facilitator and participants in program planning, content selection and delivery were also asked.

The referring professionals were asked to respond to a questionnaire which asked questions about their understanding of health, health promotion and wellness programs for older adults. It also asks about their knowledge of persons attending wellness programs, benefits to these individuals and changes in program content and delivery.

The investigator began by sitting in on a number of sessions of each of the programs throughout the four months of the study. Discussions with Parks and Recreation staff involved in programs and with several former participants provided additional information. This provided a more holistic view of programs included in this research.

Sample

Program Sites

The sample for this research consists of participants from (Health Promotion) Wellness programs operating within a Vancouver Health Unit catchment area. The sites were selected on the basis of the length of operation of each program. The programs had been in operation for 8 years, 6 years, 1 1/2 years, 10 months, 6 months and 4 months. Five of the programs were located in community centres and in residential areas of greater Vancouver. The sixth program was located in a seniors' centre adjacent to a shopping centre.

All programs in the study were advertised as wellness programs for seniors. The age for inclusion was 55 years or more. All programs are available to participants on an ongoing basis. Participants were free to drop in to each program when they wish. Most programs were in operation weekly while two programs met every second week. Several of the programs closed down for two to eight weeks during the summer. One program discontinued the discussion group part of the program during the study.

Program Participants

All program participants present at the time of the investigation were asked to take part in the study by filling in questionnaires, information sheets which provided demographic data, and taking part in the interview. Fifty-three program participants filled in the questionnaires and information sheets. Forty-two of those program participants also agreed to take part in

personal interviews. Participation in the study was not mandatory, therefore this represents a sample of convenience.

Program Facilitators

Facilitators of each of the six programs selected were asked to take part in the study. All program facilitators took part in the study, therefore this is a non-randomized sample.

Facilitators of programs have various job titles and defined roles. One was a programmer and coordinator of a seniors centre. Three were fitness instructors that were responsible for seniors programs at community centres. One was a volunteer fitness instructor that worked in programs at two centres. The sixth facilitator was the health promotion coordinator for seniors programs in the health unit. She advised programmers and facilitators, and facilitated in five of the six programs in this study from time to time.

Referring Professionals

Referring professionals in this study were persons who were in a position to inform and recommend that clients attend wellness programs. The selection of referring professionals contacted in this study was based on information obtained from program participants and facilitators on how older adults hear about and become involved with wellness programs. A list of names of community support agencies involved with older adults within the health unit catchment area provided additional contacts. Therefore, letters and questionnaires were mailed to ten home support agencies, and four

special services agencies that provide community service to the Vancouver Long Term Care Program.

The three Geriatric Short-Stay Assessment units located within the area where participants of the programs involved in the study lived were contacted. The supervisors of each of the units gave direction as to which staff members would be able to appropriately answer the questionnaire. These staff members were nurses and social workers working on units in the summer of 1989.

The third group of professionals included in this study were health unit staff directly involved with older adults living in the community. They included home care nurses, long term care assessors, a nutritionist and director of volunteer services for the health unit. The referring professionals contacted were a non-randomized sample because participation in the study was not mandatory.

Procedures

Development of Instruments

The questionnaires, and interview guides were developed specifically for this study by the investigator. A variety of resources were used to develop the questions including the investigator's personal experience as facilitator of two groups of older adults taking part in the Choosing Wellness Workshops. Two seniors' health promotion co-ordinators in Vancouver and three program facilitators in the greater Vancouver region were consulted in the process of developing questions. Literature related to wellness programs, questionnaire development and interview protocol in general and specifically

with older adults was reviewed and impacted on the design and questions chosen. Several referring professionals with health and social service backgrounds were asked for feedback on the questionnaires for referring professionals. Other health professionals and several seniors not involved in the programs in this study were also asked to give feedback on questionnaires and interview format and content.

Program participants letter of transmission, consent forms, questionnaire, information sheet and interview guide appear in Appendix A.

Program facilitators letter of transmission, consent form, and questionnaire used as interview guide are located in Appendix B.

Referring professionals letter of transmission, consent form and questionnaire appear in Appendix C.

Procedures for administration of questionnaires, information sheets and interview guides for the three groups included in this investigation are described separately.

Program participants

All program participants present at the time of the investigation were asked to take part in the study by filling in the questionnaire and information sheet during a designated time at the program site. The investigator was present to give directions and answer any questions for the purpose of clarification. Because of a small number of participants attending programs in the late spring and summer, all participants were asked to be interviewed.

Several participants not present at the first session filled out the questionnaire and information sheet at the time of their interview. Five other program participants who were physically disabled asked the investigator to assist them in filling out the questionnaire.

Program participants were interviewed at a time and a place that was convenient for them. Thirty-five participants were interviewed at the centre where they attended the program, six in their homes and three by telephone. Three program participants refused to have the interview recorded by audiotape. The three telephone interviews were also not recorded on audiotape.

Program facilitators

All program facilitators were contacted to ask permission to carry out the research in the program they were facilitating. They were given the letter of introduction and questionnaires once permission was granted. An appointment was made at a time and place convenient to them, to conduct an interview based on the questionnaire. Interviews took approximately one hour. All were conducted at the program sites and recorded on audiotape.

Referring professionals

Three groups of professionals contacted in this study were given letters and questionnaires. If they consented to take part in this study they had the option of returning the questionnaire or answering it by way of a telephone interview.

Letters and questionnaires were mailed out to 10 home support agencies and four special service agencies.. All agencies were contacted by phone and asked four questions:

1) Had they received the questionnaire?; 2) Were they willing to take part in the study?; 3) Did they wish to return the questionnaire in the self-addressed and stamped envelope provided?; 4) Did they prefer to respond per telephone interview? This approach provided the information that 5 agencies had not received the questionnaire and a second mailing was necessary. Eight responses were received by mail.

The three Geriatric Assessment units were contacted in order to direct the introduction letter and questionnaires to the appropriate persons.

Letters and questionnaires were then sent to the nursing and social service staff that the department supervisors indicated were appropriate. Four questionnaires were completed and returned.

The third group of professionals were health department staff directly involved with older adults living in the community. The investigator attended department meetings and requested participation in the study by staff who were: 1) aware of clients and their family or caregivers who attended programs; 2) had informed clients, families or caregivers about wellness programs. Five home care nurses and five long term care case managers accepted questionnaires. They were contacted two weeks later if questionnaires were not returned. One home care nurse, five long term care case managers, a nutritionist and director of volunteers returned questionnaires.

Reporting Data

Program Participants' Data

Data collected regarding the 53 program participants responses to the questionnaires and information sheet was summarized and reported in tables in Appendixes D and E. Data collected from interviews with 42 program participants was summarized and reported in tables in Appendix F.

Program Facilitators' Data

Data collected from guided interviews with the six program facilitators was summarized and reported in tables in Appendix G.

Referring Professionals' Data

Data collected from 20 referring professionals responses to questionnaires was summarized and reported in tables in Appendix H.

Answers to the Research Questions

The answers to the research questions presented in Chapter I are reported using descriptive data from the study sample responses to questionnaires and interviews and appears in Chapter IV. When the data is reported in numbers and summarized into percentages, the percentage is rounded to one decimal place so that the total adds up to 100%.

Portraiture

The data collected regarding participants, facilitators and programs is analyzed, coded, and reported by the use of portraiture writing (Lightfoot, 1983). The portraits are used to illuminate the data and include anecdotal comments that were collected from program participants, facilitators and other staff perceptions. The observations and perceptions of the investigator during the interviews and attendance at sessions of the six programs is also a part of analysis.

In her book "The Good Highschool", Lightfoot developed a form of inquiry "that would embrace many of the descriptive -- and experiential dimensions -- (1983, p. 6). Portraits are designed to express the essence of what is being explored. In this thesis the essence of wellness programs and their participants is captured in the moment of time in which the study took place via portraiture.

The six program sites identified in this study as site 1 - 6 are presented in portraiture as Elderberry Centre, Blackberry Centre, Blueberry Centre, Roseberry Centre, Huckleberry Centre, and Mayberry Centre. The portraitures are composites of the six sites and do not represent individual programs. They depict typical and atypical program sites, program activities, program participants and facilitators. The themes they address and issues they illuminate help breathe life into the essence of the descriptive data from this study.

Chapter IV

CASE STUDY FINDINGS

"Health signifies that one's life force is intact, and that one is sufficiently in harmony with the social, physical and supernatural environment to enjoy what is positively valued in life" Bantu African Thought

This exploratory case study has focused on a sample of wellness programs for older adults in Vancouver. The purposes of this study were to: 1) investigate the effectiveness of health promotion programs for older adults from the perspective of program participants, facilitators and referring professionals; 2) determine if these programs reflect the W.H.O. definition of health promotion. The findings are reported by first answering the eight questions outlined in Chapter I. Approaches to program delivery are also reported. The chapter then presents composite portraits of sites and of typical and atypical program participants and facilitators. These portraits highlight the differences among sites, leadership styles and participant roles, as well as the differences in perceptions between participants and facilitators. A brief summary of findings completes the chapter.

The Study Questions

The questions that this study initially addressed were:

1) What is the demographic profile of persons who take part in these programs?

2) What attracts them to the programs?

3) Why do they stay?

4) Why do they leave?

5) Do participants perceive changes in their supporting social networks as a result of their participation?

6) Do they have opportunities for involvement in decision making during the program?

7) Does the program achieve its objectives and if so, how?

8) What are the facilitators' and referring professionals' perceptions of health promotion and the program and its effectiveness?

1. *What is the demographic profile of persons who take part in the program?*

Profile of Program Participants

The demographic data provided by 53 program participants from programs at six sites provides interesting profiles of older adults who attend wellness programs. A summary of this data is presented here, while a detailed summary of all sites is presented in Appendix D and E.

Sex, Age, and Country of Origin

Females made up 92.5% of the study sample while 7.5% were males. Males in the study were from three of the six program sites. The average age of all program participants was 71.2 years, with an age range of 59-88 years. Widows made up 44.3% of the sample, 34.6% listed their marital status as married, 1.9% described themselves as single and 1.9% divorced. Canadian-born participants accounted for 77.3% of the sample, while 17% were British

and 5.7% came from Europe. English was the first language spoken by 84% of the sample, while 5.6% named German as their first language. A small 1.9% each identified their first language as either French, Welsh, Polish, Romanian or Norwegian.

Location and Type of Living Arrangements

A notable 77.7% of the sample lived in the neighbourhood where the program was offered and 24.5% lived in adjacent neighbourhoods. Only 3.8% of participants from two sites lived in distant communities. Participants sampled had lived in their current neighbourhoods for 6 months to 67 years with an overall average of 27.8 years. Despite an increasing trend toward living in apartments, only 43.3% of the sample stated that they were living in apartments and 52.9% lived in houses, while 1.9% reported living in a townhouse. Slightly more than half, 58.5% of the sample reported living alone, while 30.2% lived with a spouse, and 7.5% lived with other relatives. Only 1.9% reported living with a friend, and 1.9% did not respond to this question. Pet owners made up 37.7% of the sample with dogs, cats, and birds being the most common pets.

Current Occupation and Activities

The majority of program participants, 92.4%, described themselves as retired, while only 2% said they were semi-retired, and 5.6% were working. When asked what they were currently working at, 38.6% said volunteering,

15.1% hobbies, 11.3% were enjoying life, 7.5% reported being housewives and 5.7% said they cared for grandchildren. Current interests identified by program participants included volunteering, 51.8%, involvement in clubs 43.4%, church work, 17%, and recreational activities, 71.2%. Recent educational experiences within the past 12 months were reported by 20.8% of the sample. Their activities varied from Fine Arts courses 7.5%, completing high school 3.8%, elderhostel 3.8%, health 1.9%, photography 1.9%, and computer courses 1.9%.

Education and Occupation

Formal education background reported by 88.7% of the sample showed that 49% had completed high school, while 18.8% had less than grade twelve, 24.5% had attended college or trade school, and 26.4% had completed post-graduate studies. The most frequently reported occupational backgrounds were secretarial 17%, teaching 15%, health care 13.2%, sales 13.2% and housewife 13.2%. Other careers reported by one to three participants included telephone operators, managers, social workers, and a mechanic, psychologist and missionary.

Financial Status

When program participants were asked if their current income was sufficient to meet their needs, 84% said yes, 5.7% said no, and 9.4% chose not to respond. In response to the question "To what degree do financial

resources cause you stress?", 30.3% said never, 36% said seldom, 20.6% said occasionally stressful, while 13.2% of the sample chose not to respond. Fifty-one participants responded to the question about their current sources of income. Their responses showed that pensions accounted for 79.2% of income, followed by money from assets 45.2%, and spouses 5.7%. Twenty-eight point three percent (28.3%) of the sample chose not to respond to the question about total household income from all sources before taxes in 1988. Of those that did, 35.8% said their income ranged from $13,000 - $25,000 in that year. Only 5.7% said their income was $10,000 or below, while 15.1% reported an income range of $10,000 - $12,000; 5.7% had incomes from $25,100 - $39,999; and 9.4% reported incomes of more than $40,000.

Perceptions of Program Participants

The Meaning of Health

The most frequently used word to describe what health meant to participants was "well-being" (15 respondents). This was described as "mental and physical", "mind, body and soul" or included "being at peace with oneself". Other descriptions included:

- feeling well enough to enjoy life, work, hobbies and social activities (8)
- not having any major problems or freedom from illness
- balanced lifestyle and "being happy with self and others"
- self care
- being active and being with positive thinking people
- living longer actively

Self-rated Health

Participants were asked to rate their health, life satisfaction, self-efficacy and supporting social networks. They responded with factors known to contribute to promote health and well-being. Self-rated health reported by participants was: Excellent 8%; Very Good 46%; Good 34%; and fair 12%. Participants' were asked for their views of their personal health compared to others of the same ages. They responded that their health was: much better than others - 12.5%, better than most - 66.7%, about the same as others - 20.8%. The majority, 65.3%, said they were usually satisfied with their current life, while 24.5% were completely satisfied. Only 4.1% stated that they were seldom satisfied, while 6.1% said they didn't know.

Health Maintenance Activity

Participants stated that the most important things they did to maintain good health were:

- get a balanced diet (low in calories with plenty of vegetables and fruit)
- exercise regularly
- get adequate rest
- maintain interests for mental stimulation & social contact
- think positively
- maintain good friendships

Self-Efficacy

An important aspect of wellness is the individual's perceived expectancy of obtaining valued outcomes through personal effort. A majority of program participants in this study, 83%, said they felt in control of their lives, while 43.4% said they were able to influence others and 71.7% responded affirmatively to the statement that they felt able to make choices that positively influenced their well-being. A small 7.5% said they usually felt unable to influence others, while 11.3% said they felt unable to take charge of situations that arise in their lives. When participants were asked what were the most important things they did to improve or maintain good health they listed the following activities: exercise 77%, dietary practices 75%, rest 13%, maintaining mental and social interests 9.4%, thinking positively 5.6% and maintaining friendships 3.7%.

In response to an open-ended question, participants reported on what they valued about their independence. Their comments included "choosing to follow my own interests" (7); "handling my own problems" (2); "good health and peace of mind" (2); "having a flexible lifestyle" (1); "not accounting to anyone" (3); "free of the clock" (4); "privacy" (2).

Participants were asked to identify the things they wished they could do. They reported the following:

- travel more (8)
- walking, swimming, skiing or dancing more (6)
- further education (1), learn to drive (2), play the piano (1), read (1)
- have a garden or volunteer type job (3)

- do things faster (1)
- rest more (1)
- accept things as they are (2)
- accept myself as I am (1)
- stay the same (1)
- wished I didn't get down (1)
- wished I was more mobile and could garden, and enjoy other outdoor activities (3)
- have an escort (2)

Social Support

When participants were asked if they ever worry about being dependent on others, 47.1% said sometimes, 30.1% occasionally, 16.9% said never, while 3.8% said frequently, and 1.9% said always. Fifty participants responded when asked if they knew people who would help them on an ongoing basis, if it were necessary. A majority of the sample, 73.6% said "yes" that others would help them, 11.3% were "unsure", and 9.4% said "no".. When program participants were asked if they were helped by others 64.1% said they were helped by neighbours, while 84.9% were helped by family and 81% by friends. Activities reported as helpful included:

- sharing entertainment, meals, travel, volunteering, garden produce and clothes (11)
- always being there for them (8)
- home care and maintenance (6)

•transportation (5)

•shopping (5)

•threading needles or writing letters (2)

•advising on matters they can't manage (1)

The majority of the sample, 84.9% reported helping neighbours and friends while 77.4% reported helping family members. Activities they reported helping others with included:

•child care (16) 10 - grandchildren)

•shopping (11)

•transportation (9)

•household chores and maintenance (9)

•doing social activities together - clubs, trips and volunteer work (9)

•baking (6)

•visiting the sick (5)

•checking on others (5)

•checking on others properties(5)

Participants were asked to identify people important to them. Ninety point five percent (90.5%) identified family members, 83% mentioned friends and 70% said neighbours while 5.3% included other significant individuals. The number of persons important to individual participants ranged from none to 159. The range for the number of persons identified as closest to participants was 9 to 156, while the most distant were 0 to 10.

Frequency of social contact showed that participants had daily contact with neighbours most often, followed by family and friends. They were most satisfied with contact of friends 91%, followed by neighbours 84.9%, family members 81%, physicians 75.4%, program participants 68%, and other professionals 50.9%.

2. *What attracts participants to the program?*

A number of questions were asked of participants to see what attracted them to wellness programs. These questions included how participants heard about the program, what they do there, and if they come to the program with anyone. Forty-one participants of wellness programs in this study reported that they had heard about the program through the following ways:

personal contact	32%
community or seniors' centres	29%
newsletter or advertising	19%
fitness activities	15%
referring professionals	5%

The majority of wellness program participants in this study took part in the discussion group (93%,) or exercise group (76%), while 81% of that group took part in both exercises and discussion. A small number reported coming to have their blood pressure checked while 12% reported taking part in shoulder and neck massage which was offered at three sites.

Social contact is an important factor in attracting participants to those programs as reported by facilitators and participants themselves. Participants reported that 60% came alone, and 33.3% came with friends or neighbours, while only 5% came with relatives. The majority of the participants in the

samples (90%) said they had made new friends or acquaintances in the program.

Facilitators were asked how new members are attracted to programs. Four of them responded as a result of special events (2), the walking club (1), word of mouth (3), newsletter or pamphlet (3). The other two groups were not growing. One was static and the discussion group was discontinued part way through the study at site number 4.

3. *Why do participants stay in the programs?*

Participants ongoing involvement is due to a number of factors. Fifty-seven percent of respondents to the questionnaire said their lives had changed since coming to the program. These life changes fit into four recognized areas of human needs: physical, social, spiritual and intellectual. Benefits they identified were:

Physical	-	increased energy, breathing, mobility and reduced inches
Social	-	increased social networks, enjoying people and feeling close to people, social support and feeling reinforced by action of healthy choices
Spiritual	-	feeling great with a reason to get up in the morning
Intellectual	-	learning new things, understanding

The 43% of participants who said their lives had not changed since coming to the program qualified this with the following comments: they were always active, had no change in health status, just enjoyed the people or were unsure.

Fifty-two per cent of participants stated they were involved in wellness programs as a result of attending other activities, such as exercise groups,

other activities at community and seniors' centres, and other types of clubs or church groups. Slightly fewer participants, 48% reported becoming involved in other activities as a result of being members of the wellness program. These activities include: Nutrition Neighbours, Seniors in Action, Seniors Strut, Concerned Citizens for Affordable Housing, other wellness programs, volunteering, weekly supper group, walking clubs, and responding to the Healthy Aging report. It is clear that whether or not participants become involved in wellness programs first or as a result of attending other groups or activities, the opportunities for expanding their social networks and finding purposeful and pleasurable activity are common results of their involvement. Program involvement also helps sustain their interest.

4. *Why do they leave?*

This question resulted in a range of responses from current program participants who attended sporadically, to those who no longer attend. Participants were asked about the frequency of their attendance; Thirty-one percent (31%) from two sites attended the exercise part of the program more than once a week, while 67% representing 5 sites stated they attended weekly. One group met only biweekly, therefore 14% of the sample said they attended biweekly. Another 17% of participants from 5 sites said they attended occasionally and 2% said they never attended either the discussion group or the exercise component of the program.

Currently Attending Participants

Participants of the study currently attending wellness programs stated that the reasons they were not regular attendees were:

- illness of self or significant other
- other commitments during the program time
- not interested in current topic or already knowledgeable about that topic
- feeling that one or two people monopolize the discussion
- too many people talking at once which makes it hard to hear
- tension within the group and/or the centre
- feeling unwelcome by group members and/or leader
- poor attendance of group for guest speaker was embarrassing

Former Program Participants

Three former wellness program participants from two sites agreed to be interviewed. They were met by the investigator by chance meetings at the centres where two programs were located. The reasons they gave were similar to participants who attended groups sporadically. Both women attended programs at two different sites. One woman reported leaving because of health and other commitments. While she intended to return, she had delayed for several reasons related to tension within the group and centre as well as the presence of several members who, she felt, were not respectful of her expressing her opinions in the group discussion. The second woman attended the exercise class, but not the discussion group. She had received a poison pen letter that suggested she had an outspoken manner and poor

English. She was of European origin and had worked as an interpreter, therefore, felt her English was more than adequate. She further described the group leadership as controlling by some group members and the facilitator, and did not feel welcome.

Former Male Participants

The male interviewed, who was a former program participant, left the group because his wife had moved to a more advanced exercise group. He found that the discussion group was predominantly female, and that he had very little in common with the few elderly males who occasionally attended. His insights into the issue of poor male representation at the program were that a few women monopolized the discussion, that women tended to expect the few males who did attend to take on responsibility for various tasks or organization automatically, that the presence of the opposite sex inhibited the discussion of some health problems, and that some of the women's discussion were boring.

Several men in the centre's men's luncheon group had been involved in the wellness program in the past. They allowed me to speak with them about their group and the wellness program. All nine males in attendance were involved in a number of organizations. They preferred to keep their group informal, and share the tasks in a cooperative manner. They share a meal weekly at the centre, and occasionally planned a day trip to a museum or other places of interest. They did not have speakers, but shared their experiences and whatever interested them at the time. The reasons they gave for leaving or not attending the wellness program at the centre were:

- that wellness groups were attended mostly by women
- women and program facilitators didn't always talk about topics that interested them
- some health-related topics were more easily discussed in just men's or just women's groups
- that some women tended to monopolize the discussion
- they wanted to avoid being organized and have their time committed for them by women (a common occurrence according to men both in and out of wellness programs)
- they enjoy just men's company at times

5. *Do participants perceive changes in their supporting social networks as a result of their participation?*

Participants' perceptions of changes in their supporting social networks were discovered by asking the following questions "With whom do you come to the program?", "Have you made new friends in the program?", and "Do you see them outside of the program?".

Sixty percent (60%) of participants from all sites reported coming to the program alone, while 40% come with others, 17.5% with friends, and 17.5% with neighbours, and 5% with relatives.. The majority of the programs' participants, 90%, said they made new friends, while only 5% said no, and 5% didn't respond. Of those who said 'yes' to making new friends and/or friendly acquaintances, thirty-six percent of participants said they did not see other participants outside the program, while 44% said they did. The types of involvement most frequently stated were chance meetings 23.8%, having lunch 14.3%, meeting with friends in other groups, volunteer activities, neighbours, sharing garden produce and taking seniors' day trips together.

The responses to the question "Has your life changed since coming to the program?", were "just enjoying people", "feeling close to others", "increasing social networks". The comments demonstrated participants' perceptions of program effects on their social support systems.

A substantial 68% of the sample said they were usually satisfied with the frequency of contact with program participants, while only 1.8% said they were occasionally satisfied, and 1.8% were usually dissatisfied. Slightly more than a quarter of the participants, 28.3%, chose not to respond to the question regarding degree of satisfaction with contact of program participants.

6. *Do they have opportunity for involvement in decision making during the program?*

Perceptions of program participants

Participants were asked, during a focused interview, about their involvement in planning or organization of program content or events. One of the respondents (62% said no to this question) said she was willing to help, but her offer had not been acted on by the facilitator. Thirty-eight percent responded 'yes' to this question, and listed suggesting topics (6 sites), phoning speakers (3 sites), chairing the meeting (2 sites), thanking speakers (1 site), serving refreshments (2 sites).

A sizeable 60% felt that suggestions they had about the program were implemented, such as topics to discuss, speakers, day trips and frequency of meeting times. Thirty-six percent (36%) said suggestions they had were not implemented, and 4% were unsure or didn't recall. Of those participants who said that their suggestions weren't implemented, several said they were not

involved enough or didn't make any suggestions because they hadn't been in the program long enough or preferred not to be involved.

When participants were asked if there were people in the group who could take on more or some leadership responsibilities, 69% said 'yes', and 14% said 'no', because of age, or they were uneasy about accepting too much responsibility and didn't know anyone who could. Seventeen percent said they were 'unsure' because they hadn't been there long enough, didn't know participants well enough, felt some people were natural doers and others were not. Only 26% said they could take on more or some of the leadership, while 74% said 'no'. Those that didn't choose to take on leadership responsibilities in the program gave reasons of personal choice, health, being busy in other activities or caring for family members, and not seeing themselves as natural leaders.

7. *Does the program achieve its objectives and how?*

Program Objectives

The Keeping Well Brochure (Feb., 1988) states that "the program is based on the belief that people feel better and have more energy when they are learning more about themselves; are physically active, are involved in activities with other people and have the opportunity to participate". (Vancouver City Health Department, Feb. 1988) The program is specifically for people 55 years of age or older.

Program objectives are to:

1) Give participants information about health

2) Promote the health of participants

3) Give participants opportunities to plan and implement their programs.

The Keep Well brochure (1988) states that this is achieved through exercise, discussion of health issues, learning about resources, meeting other people, supporting each other, reaching out to others, participating in the community and laughing.

Actual Program Activities

During the four months of the study the researcher observed the activity within the programs at six sites. All programs had discussion groups where health information and resources were shared. The topics included foot and skin care, safety in the home and neighbourhood, and the importance of laughter, and friendship for health. Speakers informed participants on the aforementioned topics as well as issues related to environmental awareness, recycling, the affordable housing crisis and any other topic participants expressed interest in discussing.

Promotion of participants' health is achieved in these wellness programs through a variety of activities including exercise at all sites (except site #3). Health information and resources were shared by the facilitators, guest speakers, and program participants. The program provides an opportunity for participants to meet new people. Ninety percent of the participants who were interviewed said they made new friends or acquaintances in the program while only 5% said they had not, and 5% chose not to respond.

When participants were asked if their lives had changed since coming to the program, 57% said "yes". They gave examples such as "improved energy and mobility", "enjoying people", "increasing social networks", "feeling closer to others", "sharing information with others", and "reinforcing their action" by group support.

Some participants reached out to help others. A notable 48% of participants interviewed said "yes" when asked if they were involved in other activities as a result of attending the program. They listed involvement in volunteer activities such as Nutrition Neighbours, Friendly Visiting, Neighbourhood Helpers, Seniors in Action, Red Cross, or seniors' groups or committees such as Seniors Strut, Live Wires, Concerned Citizens for Affordable Housing (see Appendix F-6 for details of these activities for each site).

Perceptions of Participants' Involvement in Wellness Programs

The one objective related to providing seniors with opportunities to plan and implement programs showed a difference of views between facilitators and program participants. While all facilitators said that participants had opportunities to express their views about, and plan for program content, they often viewed participants' roles in programs differently than participants themselves. Facilitators described participants' roles as mostly involving maintenance tasks such as preparing name tags, serving juice, looking after attendance records, suggesting discussion topics, and phoning members to remind them to attend (see Appendix G-14 for specific roles identified by facilitators from each site).

Participants' responses to the question about their involvement in the planning or organization of program content or events indicated that 62%

were not involved. Thirty-eight percent (38%) that said they were involved in suggesting topics, serving refreshments, phoning participants. Participants from sites 3 and 4 referred to arranging speakers while one from site 2 mentioned being chairperson for the group. (see Appendix F-9 for specific site differences)

8. What are facilitators' and referring professionals' perceptions of health promotion and the program and its effectiveness?

Facilitators' view of health promotion

The six facilitators identified their views on health promotion and discussed ways in which the definition had changed for them. The summary of definitions incorporate the concept of helping people change and grow, encouraging their involvement and interest in current events, awareness of health factors such as exercise, social contacts and a comfortable environment. All facilitators said they believed this definition had changed over time because more information was available and needed. One facilitator described the change from a disease focus to a broader view. Another facilitator described the community development approach to health promotion in which people identified their own needs and planned their own programs to deal with issues important to them currently.

Referring professionals' view of health promotion

The referring professionals who responded to this question identified a number of health promoting topics in their definitions ranging from nutrition, exercise, stress reduction to specific disease management. While

10% of this sample did not respond to this question, and another 10% didn't know, the 80% who did respond referred to promoting physical, mental ,and social well-being, responsibility for their own health, and increase in quality of life. Only one of the respondents described health promotion in relation to living free from disease. They viewed changes in health promotion as focussing more on mental health, individual responsibility and choices and disease prevention.

Facilitators' views of the program and its effectiveness

All facilitators believed in the value of the program in relation to meeting needs for older adults. This was assessed in their responses to the question, "What are the needs of participants in relation to what the program offers?" (see Appendix G-12, Summary of Facilitators' responses to this question). They identified the need for information about health, housing, as well as personal contact, sharing, empathy, exercise and fun. All facilitators said that they saw changes in participants since the program started. These changes included being more open to talk, increased networks and interests, improved physical and mental flexibility, more friends, increase in knowledge, more involvement in other events, and increased awareness of current community issues.

Facilitators were also asked "What sort of Community outreach does the program foster?". Facilitators from site 1 and 6 said programs were too new to reach out to the community. Two other facilitators from sites 2 and 5 said participants did exercises for community events such as fairs. At site 3, participants were involved in writing City Hall about neighbourhood and

environmental issues. At site 4 participants were involved as individuals in other community concerned issues.

Four of the facilitators said the program had an effect on the community. They described the effect as healthier seniors, better informed people about seniors' programs, impetus for fund raising for community centres, and lobbying for a seniors centre. They identified the number of seniors' activities which program members were involved in, such as Nutrition Neighbours, Seniors in Action, Seniors Strut, Neighbourhood Helpers, and Concerned Citizens for Affordable Housing. One other facilitator answered "not yet" and a second said "yes, and no", because some individual members were involved in other activities as a result of attending the program but not as a group.

Referring Professionals Views of the Program and its Effectiveness

When referring professionals were asked what they perceived to be the benefits to older adults and the community of this type of health promotion program, 95% of respondents identified the following benefits to older adults:: socialization, networks, feeling in control over their lives, looking forward to activities, information, awareness of a healthy lifestyle, health benefits such as fitness and mental stimulation and contact with health professionals. They identified benefits to the community as reducing acute care admissions, reducing cost of health care for older adults, and influencing older adults to remain active in community life.

Only 45% of the referring professionals sample said yes to the question "Have your client's benefitted from the program?" They identified these

benefits as the result of a good social match. They also said clients benefitted most if they were motivated and able to get to the program. A small number became more active in the community as a result of program participation. Another 40% were unsure of benefits because of lack of follow-up procedures, or because it was too soon to tell if clients who had just started were benefitting. Another 10% did not respond to this question and 5% said no, without explaining their response.

Approaches to Program Delivery

The perceptions of facilitators and their actual approaches to program delivery reflect two views. One based on the medical model and the second based on the community development model.

The Medical Model Approach

Three facilitators seemed to support the medical model approach since they stated that professionals and trained volunteers with professional credentials should be the ones to do such activities as lead exercises, give relaxing massages, and take blood pressures. They identified the need for paid staff and visiting professionals to provide information and leadership, "to put programs on for seniors". Two of the three were in programs that had been running for more than five years, and the third was in a new program and new to the specific job.

They described the participants' role as taking attendance, serving refreshments, and suggesting discussion topics. They frequently referred to "my seniors", my program", "they have worked hard all their lives, they should be able to sit back and be pampered for a change", and "what I say goes."

Community Development Model Approach

The other three facilitators had various degrees of understanding about enabling approaches and community development strategies. They described their role as working with seniors, acting as a resource and planning programs cooperatively with participants. They were all trying to actively involve seniors more in program planning and delivery. Two facilitators talked about utilizing the knowledge and experience of participants by having them share travel and career experiences.

The youngest facilitator raised the issue of being a paid employee who felt it was her job "to do it all". She said when she did it all participants weren't interested in the programs, and there was poor attendance and participation. "Finally I figured it out. I stepped back. They do it now, and I advertise and book the space, and support them in the process."

The most experienced facilitator who practised the community development model approach was described by program participants as a good listener, with a good sense of humor, and a knack for getting people to talk and give input to the program. This facilitator described the need for participants to "share their wisdom and experience with each other, and by being active demonstrating the capacity to direct their own life choices. By

doing so they will explode the myth of aging for themselves and for other generations". This facilitator's education and experience had provided her with knowledge about older adults' needs, community development strategies, and experience with group process.

Portraits of Wellness Programs

The portraits presented here are a synthesis of data gathered from viewpoints of the participants, facilitators, referring professionals, as well as investigators observations of the programs and its people and facilitator actions. Names of programs and subjects interviewed are fictitious to provide anonymity for the real subjects and places involved. The key characteristics and themes that emerge from the analysis of six wellness programs in Greater Vancouver are reflected in the portraits, but do not provide details of every interview or questionnaire respondent. The six program sites are not portrayed individually, but as composites illustrating themes and issues relative to approaches to program delivery, participants' roles and program effects. The portraits that illustrate the composites of program 1 - 6 are called Elderberry Centre, Blackberry Centre, Blueberry Centre, Roseberry Centre, Huckleberry Centre and Mayberry Centre.

The intent of this portraiture is to describe acknowledged effects and concerns about this type of health promotion program for older adults. Lightfoot used portraitures in her 1983 book on "The Good Highschool". I hope to create portraits that inspire shock and recognition - and new understanding and insights . . . " p. 6.

The neighbourhoods which house these programs in senior centres or community centres are also described. These centres and their staff influence and reflect the context and ambience in which participating older adults strive to maintain and/or regain their individual sense of well-being.

Neighbourhood Context

The greater Vancouver area is noted for a unique cluster of neighbourhoods. A tangle of transportation arteries carry the ebb and flow of people as they move about the business of living in a picturesque city with snow capped mountains and salt-water-rimmed beaches. These neighbourhoods are a kaleidoscope which reflect cultural origins, as well as the past and present influences on their residents, including their social-economic circumstances.

PORTRAITS OF PROGRAMS

A New Program

The Program Site

Elderberry Seniors Centre is adjacent to a modern shopping centre located in a neighbourhood of older homes with a few clusters of apartments occupied by adults. This upper-middle class neighbourhood with its tree-lined streets, and manicured lawns is well populated with older adults. One is aware of the neat and new appearance of the seniors' centre when stepping in through the glass doors. There is a young man filling up the coffee maker

and placing freshly baked goods in glass covered trays in order to be ready for the early morning members.

Attending a New program

The first members enter the centre wearing jogging suits and runners. They are four women from the walking club. They get their juice or coffee and sit down at one of the tables to chat about the warm summer weather, the affordable housing crisis and summer sales. Several other women and a visiting couple enter cheerfully greeting the earlier arrivals. They also get coffee and ask what brought the first four members out so early. A discussion of the Walking Club ensues. Two more women enter and ask if the Wellness Program is about to start. Two women get up to leave, explaining they can't stay for the program today. One says her daughter is coming from out of town this morning The other says she has an appointment and then needs to be home when a service repairman arrives. The group move away from the tables and sit on the chairs and couch in readiness for the wellness program to start.

While the ten wellness group members wait for the facilitator to arrive, they start to discuss their plans to visit a restored old hotel next month. Maude, a retired professional woman in her early seventies, starts to report about her research into the cost of the transportation. The facilitator, Kate, arrives on the scene cheerfully greeting the members.. She asks them how they are, and about their discussion. They complete their reporting about the arrangements for the trip and agree on what the group wants to do. Several others volunteer to advertise in the centre newsletter or phone

others who might want to go on the trip. Several reminisce about the last time they were at the hotel for tea.

A new male member of the group asks about Abbeyfield House, the topic for today. The facilitator checks with the group to be sure they are all ready to move on to the housing topic. Then she briefly sketches the history of Abbeyfield Society and discusses their plans for affordable housing for older adults in Vancouver. Kate's talk is followed by a lively discussion regarding housing costs, options, and concerns about Vancouver's current housing crisis.

Throughout the group's meeting, other members of the centre have been arriving for coffee, to talk, or play cards at the the other end of the room. The phone has been frequently answered by a woman who is both a centre member and volunteer. The centre programmer arrives to briefly talk about an upcoming event for seniors, and asks for the wellness group members' advice and support. The hour has passed quickly and some group members leave swiftly in order to meet other commitments. Several linger to talk with each other, or Kate.

Starting a New Program

This wellness group has been added to the Centre's list of activities in the last six months. The programmer from the Seniors Centre contacted the Health Unit's Coordinator of Seniors Health Promotion programs a year before the program started. Initially, the advertising in the newsletter failed to bring in members to the program. Together the Coordinator and the Programmer planned a Tea for seniors. Several seniors who attended the Tea became the first members of the wellness group. Some members came only when the topics interested them or they came with a friend and/or neighbour. At least 50% of members of this group are involved in a variety of programs at other seniors' or community centres. The group is slowly growing and is focusing in on learning about each other and topics that interest them. Both the programmer and the facilitator at this centre agree that the group has not reached out to the community, although as individuals they are actively involved in activities in the community. The event the programmer has asked them to support will be the first outreach activity that the group has decided to help with. Many have other commitments so at this stage only the faithful few have committed their time to the event. As several facilitators of groups have said, programs or special events aren't likely to succeed unless the group takes ownership of the activity.

Participants of the Program

The majority of members of this group are female and have had careers outside the home before retirement. All are English speaking and

Canadian born except for one born in Britain. Their average age is 69, and they have lived in their current neighbourhood, on the average of 20 years. Occasionally, a single male or a husband will come with his wife to the program. Group members occasionally bring out of town visitors to the discussion.

A helper not a leader

Molly is a sixty-five year old, who attends the Walking Club three days a week, and all the discussion group sessions. She was successfully treated for a heart condition and has a new lease on life. Molly lives with her husband and one grown son. She has dedicated her life to raising her family and now she plans to take some time for herself. She has enrolled in painting classes and attends three centres in the course of a week. Her interest in the discussion group focuses around health information and sharing experiences and learning about retirement and age related changes. Her husband is retiring in the fall, and she has some concerns over how they will adjust to the many changes that will bring.

Molly takes an active part in the group discussion but is not interested in taking a leadership role. She describes herself as a follower and helper, not a leader.

A leader who says no

Sarah is another active member of the group. A retired educator who has spent the fifteen years since retirement involved in arts and professional associations, she has travelled and done many of the things she wanted to do. She has decided that she needs to say 'no' more often regarding leadership and other tasks in the various organization she is involved with. She is an

active member of the Walking Club and, as a single woman, enjoys the discussion group where she can discuss some of her concerns about aging alone, mental changes her elderly sister is experiencing, and current community concerns such as housing. Sarah adds a richness to the group's discussion, but never dominates or criticizes others' views. She, and others in this group, see themselves as working cooperatively to do the work of the group, they don't see themselves as group leaders.

The Facilitators' Perceptions

The majority of the members of this group were described by the programmer and facilitator as active older adults with a positive outlook on life, and active participants in maintaining their health. Several members have had serious life-threatening illnesses, but had made a good recovery. Several others were involved in caring for family or friends who did not enjoy good health. The questions they asked in the group and the information they gathered was shared with those other people, concerns they shared and support they started to provide for each other helped them to explore topics of mutual interest, such as the procedure for admission to nursing homes, signs of Alzheimer's Disease, cancer treatment and euthanasia.

PORTRAIT #2

An Established Wellness Program

The Program Site

Blackberry Community Centre is the site of one of the oldest health promotion programs in the city. While the program started out in rented space in the same neighbourhood, it moved to its present location in the community centre more than five years ago. The Community Centre is located on a quiet tree lined street only a few blocks away from a noisy major thoroughfare in the heart of the city. The centre has a well worn look, like a comfortable shoe. The pool, gym and meeting rooms are usually busy, filled with moms and tots, school-aged children, and middle aged men and women taking classes or just enjoying a leisurely swim.

The seniors who meet regularly at the centre share a lounge with other groups. This same space doubles as a meeting room and office. Like many other community centres built in the early sixties, its physical space is inadequate to meet the increase in population demands for recreation services.

Many of the older homes in this neighbourhood have more than one family living in them now. Many immigrant families have moved into the neighbourhood but not all go to the centre for their recreation. Because of language and cultural differences many would feel uncomfortable there.

A Day in the Program

The wellness program discussion follows the fun and fitness exercise class led by the program facilitator, Jane, a Parks and Recreation Centre employee. Today there are more than the usual dozen participants for the discussion part of the program. A city policewoman has come to talk about being safe in the home and on the street. Several men have joined their wives for the safety lecture. Several women slip in to the back of the room just as the speaker is introduced by the program facilitator. These latecomers slip away as fast as they have arrived with few words for anyone they encounter.

During the presentation three other women talk to each other in loud whispers. Several disapproving looks are directed toward the whisperers but they seem unaware that their talking is disruptive to other group members. Agnes, one of the whisperers, glares back at one of the women who continues to send disapproving looks in her direction throughout the lecture. Later, Agnes confides to the researcher that she feels ostracized by some of the group members because of her accent. She also admits that she sometimes has trouble hearing the speaker. Agnes says her friend Millie, who sometimes gives her a ride to the program in bad weather, tells her what she has missed. It is this talking during the discussion group which is most irritating to other group members, a fact that Agnes seems not to be aware of when asked.

Participants of the Program

Active Program Participants

There is a group of four program participants who seem to be enjoying themselves and take over the maintenance tasks for the group, such as a serving juice after the exercises, taking weights, recording attendance, weight and blood pressure. They also are involved in much of the planning when the group takes part in exercise demonstrations or other seniors' events in the city, such as Seniors Strut and Seniors in Action. They have been in the program and other seniors groups since their inception and are seen by themselves as the doers, the ones who are always involved in the planning and activities. They can always be counted on to do the work. During the years they have built up strong ties with each other, as program members, neighbours, and friends. They make up a clique that some other members of the group resent, and feel intimidated by.

Feeling Ostracized

Agnes is a widow who has attended the program for three years. She has volunteered for some of the program tasks like serving juice, but because of criticism she received from several of the members of the clique she refuses to continue to help out. The one woman of the clique who Agnes said made her feel welcome became ill and moved into a nursing home in a different part of the city last winter. Agnes says she now just comes, and talks with a few of the women and to hear the speakers. Agnes, like several other group members, feels that Jane, the facilitator, is too busy trying to please the members of the clique and disregards or criticizes anyone who disagrees with them.

A Stagnant Group

While all members of the group, including the facilitator, say the group is not growing, they all have different rationale for why new people are not getting involved. The facilitator's view of the lack of program growth is based on a number of factors. Since personal contact is the most common way that people are drawn into the programs, (32% in this study), the loss of program participants who have moved, died or become too ill to attend hinders program growth,in her opinion. The second most common way new people hear about, and get involved in, programs is through attending seniors or community centres. Jane says they have tried to attract other people, but a few, especially men, attend their socials at the centre when food is served and then they vanish until the next Tea or Barbecue.

The group has several participants born outside of Canada. All group members are Caucasian despite a large population of Middle-Eastern and Far-Eastern immigrants in the surrounding community. Jane says they just don't seem to attract these newcomers to the program. She believes the group would make them welcome, but that the newcomers just aren't interested. While Jane encourages group members to hand out newsletters, she says few new people who read them ever come and stay.

There are several others, who, both in appearance and in interviews are described as frail, elderly women, in their sixties and seventies. Jane feels if the centre paid for more of her time she would be able to reach out to more of the frail elderly living in the community and bring them into the program. She also feels that to increase the group's size more time has to be given to facilitators to build the program. Like other facilitators of Parks Board programs, Jane puts in many more hours than she is paid for in seniors' programs.

The Participant Leader

Jewel is an energetic widow, in her mid-seventies, who has been active in the program since it first started. She is one of the leaders of several seniors groups and a dominant member of the clique. Jewel is a pleasant woman who feels satisfied with her life, and the part she plays in helping others. She feels that this and other groups she leads could not do without her. She proudly says people are always telling her how the group would fall apart without her. In Jewel's view, the wellness group isn't growing because people are not interested in committing their time or are incapable of doing the tasks because of poor health. She feels the group would welcome newcomers, including immigrants, but, at the same time, expects them to conform " - - to the way we have always done things here".

A Participant Observer

Stella is one of the more frail program members in her late seventies. While she was a career woman for most of her life, her failing health and several recent stressful life situations have taken their toll on her energy. Stella has been involved in the program for four years, and has lived in the neighbourhood for thirty years. She is not interested in being involved in the work of the group, "I have been involved in working for my professional association, I've had my day". Stella is concerned about what she sees as unfair criticism and treatment of Agnes and another immigrant woman who frequently spoke up in the group, and asked questions. Stella, like several other group members referred to what they call a 'whisper campaign' aimed at women who are not members of the clique who dare express opinions

counter to the leader's and clique members' views. In Stella's opinion Jane's leadership style is controlling, while she asks for input and feedback from the group she only accepts what fits with her views and that of members of the cliques.

A Frail Participant

Ann is a sixty-nine year old widow who came to the program, as a result of a referral from a geriatric assessment unit. She had lived in the neighbourhood for five years, and in her current apartment for one year. Ann's husband, Gordon, had died about eighteen months ago, and her children persuaded her to sell her house and move into the apartment. Ann missed her husband, and neighbours and felt isolated in the apartment. Her health deteriorated resulting in several hospital admissions. Ann feels better now, but still easily breaks into tears when she mentions Gordon's name. Ann attends church with a friend, and goes bowling at one seniors' centre and attends the Wellness Program at Blackberry Community Centre. This gentle and petite lady enjoys the group activities. Her face becomes radiant as she laughs with the group at the completion of a mental aerobics game. Ann discusses what she learned about home safety with her new neighbour across the hall. She seems unaware of any tension in the group and all members who acknowledge her seem to treat her gently. Ann is a timid woman, unlikely to challenge anyone. She is obviously benefitting from group participation. Ann says she is making the acquaintance of one woman in the group. They plan on going on a day trip the centre is sponsoring for seniors this summer. Jane, the facilitator, has arranged the trip for the group.

The Facilitators' Perceptions

The facilitator of this group describes the program participants as mostly women between the ages of 60 and 85 who are moderately active, with health deficits such as arthritis, vision and hearing losses, as well as some with heart and lung problems. She sees the benefits the program provides to participants such as improved mobility, increased social relationships, better understanding of their health and ways of maintaining it. Jane views her role in this as a paid employee to facilitate their learning, and to provide them with experience in making healthy lifestyle choices. Her sense of responsibility and pride in the participants and the program are reflected in her frequent reference to 'my seniors', 'my program' and the sense of competitiveness to be better than other programs. She feels frustrated by the lack of growth but feels the content needs to be changed, rather than anything else.

PORTRAIT #3

A Year Old Program Where Participants Share Tasks

The Centre

Blueberry Community Centre is located in one older residential district of Vancouver, bordered on the north by a busy street and by quiet tree-lined streets on the other sides. The Centre is located on a block of land which houses a playground and playing fields. The Centre, a nondescript two-storey building, is a beehive of activity. An inter-generational blend and multicultural mix of people is evident as one approaches the centre.

A Day in the Program

Searching for the Wellness Program at Blueberry Centre, the researcher is met by the sound of music bounding down the hall from an aerobics class. A smiling young woman with an equally sunny toddler in tow directs me to the room where seven seniors are exercising. The music here is less frantic. Women ranging in age from 55 to 80 are on the floor, doing cool-down stretching exercises at the end of a Red Cross Fun & Fitness Class. One of the program participants is leading the class cool-down exercises. Once the class is finished, the women gently ease themselves up and casually chat with one another. One woman gets orange juice, while another produces disposable cups from a nearby shelf. Then they each help themselves to the juice and move toward the corner of the room where chairs stand in a semi-circle.

The health promotion facilitator arrives and cheerfully greets the women. She skillfully picks up the threads of conversations which revolve around gardening, summer company and the current housing crisis. This group of seven participants and the fitness instructor listen to each other. The conversation flows in a cooperative manner around the group, although not all opinions expressed are supported by all the members.

Concern is expressed for older adults in a nearby neighbourhood who have been evicted from their apartments and who are unable to find affordable housing in the area where they have lived for many years. Skin care is another topic of concern. The women share information and experiences about skin cancer and rashes, treatments and preventative measures. Humorous reminiscences are shared about sunbathing practices and weird and wonderful sun protection remedies used in "the good old days" before the ozone layer became a topic of concern. Once the laughter dies

down, the group reflects on the value placed on suntanning and discusses present views in light of current information and environmental conditions. They also discuss their children's and grandchildren's skin care practices compared to their own.

The hour seems to fly by. The woman participant responsible for arranging the speaker for the next week briefly outlines the speaker's qualifications and topic for discussion. One woman dashes off to meet her neighbour's children as they come home from school. Several women disappear together. Another rides off on a bicycle, two leave in cars, and one other heads for the bus stop across the street. Hattie, the oldest member of the group, walks home to her apartment complex a few blocks from the centre.

An active older program participant

Hattie, an eighty year old widow, finds her loneliness and frustrations are alleviated by participating in two wellness programs. Physical activities and social contact through these programs make Hattie feel valued and cared for.

Hattie frankly states that attending the wellness programs helps her deal with feelings of loneliness. Widowed 44 years ago, Hattie raised her two children by working as a waitress and social service worker. She retired at 64. Her daughters and grandchildren live at the other end of the country. Hattie hopes to move to the community where her daughter will be retiring next year; she has had her name in for housing in that community for several years. Hattie wants to be near her daughter but is frustrated with the wait.

Hattie is particularly anxious to move since a new manager arrived at her apartment complex. Built by a service club, the complex provides subsidized housing, charging rent of one-third of the income of adult residents.

"When you live in subsidized housing, they treat you like you should just be grateful you have a roof over your head. They make changes, and don't explain why. They treat you like you don't have rights or the sense you was born with."

Hattie participates in two wellness programs, one at Blueberry Community Centre and another at a seniors' centre one bus transfer away from her apartment. Hattie enjoys the diverse activities at the two centres. Participation gives her an opportunity to meet and talk with others.

As the oldest member of an exercise group at the Blueberry Community Centre, Hattie does some of the exercises but opts out of others that are beyond her ability. Both Hattie and Olivia, the fitness instructor, remark on how Hattie's balance has improved and how much more easily she moves since attending the exercise classes for the last four months. Hattie enjoys the neck and shoulder massage that participants give each other during the sessions.

Hattie's independence was lessened for a short period last fall after she broke her arm. She received care from a home support worker and some of her food came from Meals on Wheels. An occupational therapist came into her home and showed her where to have grab bars installed in the bathroom. Hattie confided that she appreciated the services, but didn't want to abuse them. "It's good when you need it, but I'd rather be able to care for myself -- to be independent."

The problem with growing older is, states Hattie "lots of your friends die, move away or end up in nursing homes". The neighbourhood centres are places to met new people. Although she doesn't see other program participants outside the centres, Hattie appreciates the contact when she is away or ill. "When I was away because of my arm, either Olivia or one of the women in the group would call me. It's nice to know that there are people out there who care".

Hattie finds the discussion group at Blueberry offers an opportunity to be listened to and to hear what others have to say. She finds it helpful when people speak up: "I used to go to Blackberry Centre, but the speakers wouldn't speak up, and some of the ladies just kept interrupting or talking at the same time. It was a waste of time".

Hattie tries to encourage others to take part in a wellness program. She would like to see one start in her building, because, as she says "the only thing they do there is play bingo and gossip". When she first moved into the complex there was an activity room and lots of equipment, but people seemed too busy or just started whisper campaigns about the new ones or others who "aren't their kind". Hattie feels the people in her building form cliques. In Hattie's opinion, the new manager is too busy being the "resident expert" and trying to "please the old guard". He doesn't consider the needs of all the residents.

Hattie is willing to share her ideas with her neighbours but doesn't want to take on any leadership responsibility. "I've done all that. Let the younger ones have a turn".

The Program Facilitator

A young program facilitator

Olivia is a slender brunette in her early thirties, a young fun and fitness instructor and seniors' programmer at the Blueberry Community Centre. She has been employed by the Parks and Recreation Department for several years as a fitness instructor but has only been working with seniors' programs for the past eight months.

Facilitator education

Olivia has never taken any courses in gerontology. She does have some university courses in business and plans to work toward a teaching

degree once her children are of school age. This spring Olivia attended one of a series of workshops sponsored by Parks and Recreation on working with older adults. She said they were quite good for those who could get there. "I enjoyed the one I attended. I would have gone to others, but this centre wasn't prepared to send me. I can't afford to take the time and money to go on my own as I would like". Many other facilitators at other centres agree with Olivia - that education of facilitators for seniors' programs is a low priority in most centres.

Leadership approaches

Olivia is paid for eight hours a week to work with seniors' programs, as well as extra for the fitness class of all ages that she teaches. Like other facilitators, she works many more hours than she is paid for to do her job. She is struggling with her employer's expectations of her role and the approach to program participants that promotes independence. She frequently consults with others involved in seniors' programs.

Margo, a young programmer at another centre, discussed how she dealt with the dilemma of being a paid employee who felt she was paid "to do it all for them". She realized that when she did all the work, program participants were not interested. "Finally I figured it out. I stepped back. They do it now, and I just advertise and book the space and support them in the process."

The coordinator of seniors' programs from the health unit has come in at Olivia's request to consult and facilitate the discussion segment of the Wellness Group, until Olivia and group members are ready to take over.

Facilitators' perceptions

Olivia describes the women who come to the group as active, and mostly younger seniors. The group is small, and hasn't grown much in the first eight months, but the people involved keep coming back. While most of the women are willing to help out in the group, none of them are willing to take ongoing leadership responsibilities. Many are involved with helping out neighbours, family or friends. Several members of this group were in the helping professions. They still help people, but don't wish to take on the responsibility of group leadership.

PORTRAIT #4

A Year Old Program where an Expert Volunteer Takes Charge

The Program Site

Roseberry Community Centre is a one story stucco building located in an old established neighbourhood a block away from quaint old shops. The centre has just completed a new addition which houses the seniors' exercise class and mom's and tots activities every day of the week. Young families and older adults can be seen coming to the centre. The centre is surrounded by trees that provide welcome shade to the adjacent playground on a hot summer's day. The neighbourhood has a village-like atmosphere with its old modest homes and stable resident population.

A Day in the Program

Entering the centre in the morning, one is greeted by the sound of children's' voices mingled with the voices of their mothers and centre staff. The mom's and tot's class has just finished and the seniors' fun and fitness class is about to begin. The room is slowly filled with active older women between the ages of 65 and 78. They arrive alone or with one other person. Several gather together to talk about their gardens, summer company, and next weeks Neighbourhood Festival.

Peggy, the fitness instructor arrives limping, with tape deck in hand. She is a large woman in her late sixties who has been leading this group since it started one year ago. A recent ankle sprain has slowed her down, but she says "these exercises are designed for older adults and people with various disabilities. By me continuing to lead classes here, I am showing them that it can be done".

Peggy welcomes a visitor who comes with a regular member. She tells the ladies to take their places and starts the music. Peggy leads the group through the 45 minute exercise class to the strains of music from the 1940's. She talks throughout the class, and by the time they get to the cool-down exercises, many of the women are singing with Peggy to the tune of a favorite war-time ballad.

The women return the chairs to their place, and move to the discussion room where they get a glass of juice for a quarter. One half of the women leave, and the remaining eight sit down to talk while waiting for the discussion group to start. The topic for today is recycling.

Kate, the discussion group facilitator, arrives with Harry, the speaker from the recycling depot. As is typical in this group, Peggy, the fitness

instructor, frequently interrupts the speaker. Group members exchange glances. Kate tried to redirect the discussion back to the topic. Harry appears frustrated by the interruptions, but is no match for Peggy. Several women in the group manage to ask questions after Peggy is called away to answer a phone call.

The group disbands after planning for next weeks speaker, a retired lady doctor. Four women leave together for their weekly lunch date. They have been friends and neighbours for twenty years. Betty, a new member who is caring for a mentally fragile husband, stays to talk to Kate about her concerns.

Participants of the Program

A new member of the program

Betty is a newly retired 65 year old who worked at the local supermarket for 25 years. Her husband's memory has been deteriorating rapidly over the last six months, requiring more of her time and attention. She enjoys the opportunity to get out for a couple of hours to the centre. Betty says her family is supportive but she enjoys getting out and forgetting her problems and being with people who don't know about her husband's changing health. Betty has volunteered to be on the phoning committee, because it is something she can do from home.

She hasn't made any new friends in the group but knows most of the women from working in the store. She finds Kate a sympathetic listener and a source of information about dealing with her husband's changing health status. Betty also enjoys the exercise class which she has attended twice a week for the last three months. Massage is another part of the program that

Betty enjoys. Peggy gives massages to interested participants before exercise class every second week, while Dorothy, a retired nurse, takes blood pressures.

An active participant volunteer

Dorothy is a retired nurse who takes pride in her volunteer activities both here in the program and at the Red Cross. She attends the exercise part of the program occasionally, and the discussion group every second week when she comes to take blood pressures. Taking blood pressures and offering participants related health counselling is an important part of the program in Dorothy's view.

Like several other women in wellness programs in this study, Dorothy takes care of her grandchildren after school. She has been a caregiver all her life and continues in this role after retirement. The program provides her with further opportunities to maintain this role which is important in maintaining her self esteem and sense of purpose.

The Fitness Instructor

Expert volunteer

Peggy, a round and jovial red-headed woman in her late sixties leads the Fun and Fitness exercise classes held in conjunction with three wellness programs. Five years ago she took an instructors' certificate program through the Red Cross, which qualified her to lead their seniors' Fun and Fitness program. Then Peggy instructed wellness programs all over the city. Peggy shares some interesting reflections on the differences in activity level, behavior and cultural norms of the various groups she had led. In the past

two years she has confined her activities to leading programs five days a week at three community centres. "By me continuing to lead classes here, I am showing them that it can be done."

Participants of Roseberry Community Centre Fun & Fitness programs are described by their instructor Peggy, as an unusually active group of women ranging in age from 64 to 97. Peggy describes effects of the program on participants as "improvement in mental and physical flexibility". She estimates that between 20% and 30% of participants have been involved in exercises before coming to the program and many others are involved in her program several times a week or do other exercises such as walking, Tai Chi, and/or swimming.

Peggy describes herself as a dedicated caregiver who continues to lead the one program here at Roseberry in spite of a recent ankle injury. Her need for involvement in the program is evident in her comments - "When they stop, I stop. I do it for myself, not them".

Program participants enjoy her cheerful banter and encouraging, yet challenging approach to exercises. Her presence dominates any room she enters. She is well known and well liked by many participants and other fitness instructors for the interest she shows in them. Peggy phones them when they are away, sends them birthday and get well cards, and crochets items for them. Peggy says "most people who come to my class stay, they know I love them." Some people find her approach overbearing.

Peggy's need to be in charge inside and outside the fitness class is evident in her tendency to try to dominate the discussion group, she frequently interrupts others including the discussion leader, and tries to make decisions for the group. This is further illustrated by her response to the question regarding program planning: "What I say goes", and "There isn't

one, probably not two people in any of my groups who would have planned something like this field trip". When talking about the program and participants, Peggy shows a sense of pride and ownership by her frequent reference to "My seniors", and "My program". She is not open to program change. and her response to this question was, "if they try to change it, I'll leave. I don't have time for any more - - I can't think of anything in this area that will go as well."

While she says "without them there wouldn't be a program", she holds strong views on the roles and duties of leaders and participants. An example of this is her view on massage, a frequent component of wellness programs. While she has professional training in this area, she is very critical of program leaders and participants who do relaxing massage for each other. No one who has experienced her shoulder and neck massages would question her skill. However, those well versed in health promotion as an enabling activity find her strong need to "do for others", to be the "expert volunteer", a hindrance to nurturing independence in participants.

Her definition of health is to "be interested and active", and health promotion is "encouraging people to get out, be involved, be interested in everything." Peggy says her view has changed on types of activities seniors should be involved in, from bridge and bingo to a more active role in current events and other people. She describes participants' roles in the program as volunteers for taking attendance, serving juice, suggesting topics, keeping track of each other and taking blood pressure twice a month. The blood pressure is taken by a retired nurse, who like Peggy, is one of the founding members of the wellness group at Roseberry.

Peggy feels that the wellness group which has grown from three to twenty in the first year of operation "is not a thing we want to grow - we only

have limited space - although everyone is welcome". The seniors in this program aren't interested in a seniors' centre or wing. She relates the story of cuts to the original building expansion which limited the space planned for seniors' programs. ". . . any money that comes in goes for young people's services. This place is not specifically for seniors." Despite the low priority for seniors wellness programs, Peggy feels the program "does have an effect on the community". That effect is "healthier seniors".

PORTRAIT #5

An Established Program in Trouble

The Program Site

Huckleberry Community Centre is a grey stucco two-storey building set in a park-like setting. It is located in a neighbourhood of quaint older homes and two storey apartments. The neighbourhood landscape is gradually changing as many single family dwellings and old apartments are demolished to make room for luxurious and expensive high-rises. The neighbourhood is becoming too expensive to live in, a concern shared by many of the old-time residents who can't afford the inflated rents.

People of all ages attend a variety of events at this community centre. There are children playing on the swings and cars are parked in the centre parking lot from early in the morning until late at night. The centre serves lunch and coffee six days a week, with the help of many seniors who volunteer. This meal service has made the centre a popular meeting place for seniors.

The Program

Conflict affects the program

The Wellness Program at Huckleberry has been in operation for more than four years. The participants of this program have the option of coming three times a week for exercises and once a week for the discussion group. Recent friction, both at the centre and in the program, has caused a strain and resulted in a number of participants leaving or finding themselves in opposing camps with other seniors at the centre or in the group. The resulting strain has caused a reduction in attendance. This drop in attendance is greater than one would expect when fine weather and holiday time arrives.

Participants in the Program

The oldest program participant

One of the oldest program participants at Huckleberry is Ada, an eighty-six year old widow with poor vision. Ada's social activities have been greatly reduced over the last few years. She enjoys coming to the centre with her neighbour and friend, Myrtle. They have been attending the program at the Centre for three years. Myrtle comes to the exercise part of the program twice a week, and often brings Ada with her. While Ada only occasionally takes part in the exercises, she does enjoy the opportunity to talk with others, and usually stays for lunch. Myrtle occasionally will stay for the discussion if the topic interests her. Then she rushes home after the discussion to make her husband's lunch, leaving Ada to find her way home across the park.

Ada says she used to enjoy the discussion group, but finds that the tension and frequency of more than one person talking at once tends to confuse and frustrate her. Myrtle finds it inconvenient that the group is late in starting and finishing the discussion. Ada and Myrtle, like most other members of the wellness program feel they haven't made new friends here, but just acquaintances. They, like most of the others, did not respond to the question that asked about their degree of satisfaction with their contact with program members. While many are dissatisfied at Huckleberry, some members have succeeded in meeting their needs through involvement in the program.

Harriet, a program success story

Harriet is a petite and well groomed lady in her early seventies who has regularly attended the exercise and discussion group since moving into the neighbourhood two years ago. While she only sees other program members occasionally outside the program, when shopping or having lunch at the centre, several members phoned her when she was ill last winter. Harriet says she often feels unable to influence situations that arise in her life and frequently seeks the help of others. Her son is the person she turns to most for financial advice.

As a result of the Wellness program involvement, Harriet heard about a group of citizens who are concerned with the problem of finding affordable housing. This gentle lady had never been a member of a group that focused in on a current community issue. She was encouraged by both the Wellness Program facilitator and several other members to express her views on this issue which was affecting her and her neighbours.

Harriet lives in one of the apartment buildings that has had large rent increases and is threatened to be sold and demolished. She, like many other seniors on incomes below the poverty line, is required to pay more than 70% of her income on rent. Staying in the neighbourhood is important to Harriet. Her son and grandchildren live near, and the community centre and both shopping and medical services are within a five-block radius from her apartment.

Involvement with the affordable housing group resulted in a number of new activities for Harriet, such as marching in a parade, carrying a placard, blocking a bulldozer at a demolition site, and appearing on national television and in newspapers.

Since becoming involved in the Concerned Citizens group, Harriet doesn't have the time or the energy to deal with the Wellness Program discussion group. However, she still attends the exercise class whenever it doesn't interfere with the Concerned Citizens Group activities.

Harriet reported that her family was supportive and delighted in her new found activism. She said, that "My grandchildren saw me for the first time as a real person". Her sense of purpose and pride in belonging to an intergenerational group of neighbours enhanced her quality of life by giving her an opportunity to talk about and take action on her fears regarding affordable housing issues. Clearly, program involvement provided her with encouragement and information which lead to involvement in the affordable housing group, and opportunities to improve her sense of influence, social support and, therefore, the quality of her life.

PORTRAIT #6

A Program that has been functioning for less than a year

The Program Site

Mayberry Community Centre is a small building located on a quiet tree-lined street a few blocks away from a busy shopping centre. The playground and playing field are full of children and young adults involved in their favorite recreation activity, baseball. The centre is well-used and in need of a coat of paint. Walking inside the centre I hear the voices of adults in the gym and children in the activity room. The noise level makes it difficult to hear the answer to the inquiry of directions to the Seniors' Wellness Program room. The staff are friendly, and seem accustomed to shouting above the noise.

A Day in the Program

The program that attracts male participants

The seniors meet in a room that is used as an office, storage room for craft supplies, a meeting room and to serve weekly dinners. There are two over stuffed old couches and matching chairs along two walls. Several mismatched dining room chairs face the couches. Martha, a woman in her early seventies, is serving tea in pottery mugs to the three other Wellness Program members gathered for the discussion. The group facilitator is running around in a frenzy setting the table for the supper that follows, and checking on the pot of stew cooking on the stove in the adjoining kitchen. The noise from the playground comes in from the open window. The smell

of the food cooking in the kitchen mingles with the fragrance of lilacs outside the window, and homemade peanut butter cookies served with the tea. The atmosphere seems homey.

The early arrivals are an elderly man and woman in their eighties, Martha, who is serving tea, and a visually impaired man about sixty. Soon several other women enter, two sisters and a woman in her late sixties called Helen. Helen announces that her husband, Stan, will be a few minutes late because he is taking a neighbour home from a doctor's appointment, and picking up Marie, the oldest member of the group. The discussion today is on humor and healing.

Program Participants

A Male Program Participant

Hector is an eighty-three year old bachelor that attends the Wellness Program weekly at Mayberry. He has been coming to the program since it started last fall. Hector is one of three males who regularly attends this program. Unlike the other men in the program he is not uncomfortable when he finds himself the only man in attendance. He is treated differently by the women in the group. While he never helps out with any activities, his gentlemanly manner, humor and willingness to listen make him a welcome group member.

Married Program Participants

Stan and Helen are a couple in their late sixties who are active members of the Wellness Program when they are not away on trips or

involved in other activities of their various interest groups. Stan enjoys the discussion and often redirects it to topics he is interested in, such as health food and computers.

Helen and Stan are natural helpers both with group members and with their neighbours. Helen is capable of taking on the leadership in the group, but doesn't want to be tied down to that responsibility. They both do things in the group and for the group, such as type letters, provide transportation and check in on members who are away and ill. If either one of them is involved in some other activity, the other one will attend the group alone. In this and any other program in this study, where couples attended, it was the wife who would come alone, never the husband.

When Stan is asked about what it is like for a man to attend a predominantly female group, he shares his insights and experience. Stan feels that women in this group tend to expect him to do things, such as set up tables and organize activities. He says "I like to decide when I'll help out and not be told or expected to always do what they want. It's the same in other groups I'm involved in, the women are always eager to volunteer my time without asking me. But I set them straight pretty quickly." Stan's experience is typical of what other men in, and former members of, these programs report about their role and women members' expectations.

The Facilitator

The Facilitator, Pam, loves waiting on the program members. She feels they have worked hard all of their lives and deserve to rest. Some members seem to enjoy the attention, especially Marie, the oldest member who says she does as little as possible for herself. Other members who would prefer to do

more for themselves say they don't want to hurt Pam's feelings, because they know she enjoys helping others. While Pam asks program participants for input for topics and believes she involves them in the program, most of the participants say they aren't involved or their offer to help is not acted on. Pam phones program participants to remind them of the discussion group. She also arranges for others to bring them if they need a ride. Pam refers to the program participants as "my seniors" and calls them "Lovey" and "Dear" more often than she uses their names.

Summary of Study Findings

This chapter has reported the findings of the case study by answering the eight questions about the wellness programs, describing approaches to these programs and reporting typical and atypical characteristics and issues by the use of portraiture writing. The following chapter will deal with the issues arising out of the study findings, implications for practise and make suggestions for future research directions and approaches to data collection.

Chapter V

CONCLUSIONS AND IMPLICATIONS

"The purpose of life, after all, is to live it, to taste it, to experience it to the utmost, to reach out eagerly and without fear for newer and richer experiences" . Eleanor Roosevelt.

This chapter will discuss the conclusions drawn from the research findings relevant to the two major purposes of this exploratory case study. The two major purposes were to: 1) investigate the effectiveness of wellness programs for older adults from the perspective of program participants, facilitators and referring professionals; 2) see if these programs reflect new approaches to health promotion that enable participants to increase control over and improve their health.

This chapter then outlines issues identified during the study. Finally, it discusses implications of these findings for practise and future research needs in the area of health promotion programs for older adults.

Conclusions

Program Effectiveness

The program participants

The profile of program participants in this study showed that 77.3% were Canadian born, 92.4% were female, 44.3% were widowed and 58.5% were living alone. The age range of these participants was 59 - 88 years with a mean of 71.2 years. The majority of program participants, 81%, had completed high school while 26.4% had completed post graduate studies. Most of the sample, 92%, described themselves as currently retired, while

86.7% said they had worked outside the home prior to retirement. A further 84.9% of participants in this study felt their income was sufficient to meet their needs.

Clearly the older adults in this study were mostly in the young - old age category, well educated and not below the poverty line. Fitch and Slivinske (1988) found those who scored above average on wellness were married, younger, had a higher income and perceived control while those who scored less were not married, older, poor and perceived lack of control. In the current study there were insufficient numbers of common characteristics to draw any conclusions about the older, poorer, and less educated program participants.

The majority of program participants who took part in this study stated they maintained good health, knew about and practised health maintenance activities to various degrees, and gave and received social support. Slightly more than half of participants (57%) believed that program benefits to them were:

- improved physical fitness;
- increased social networks and opportunities for social support;
- providing them with a sense of purpose in life;
- giving information and providing, through discussion, opportunities for deeper understanding of aging and health-related issues;

The remaining 43% felt they had always been active, had experienced no health change, just enjoyed the people contact or were unsure of benefits.

Clearly, from the perspective of the majority of participants in this study program, involvement helped them maintain or enhance their sense of well-being.

The majority of program participants (83%) felt in control of their lives and 71.7% felt able to make choices that positively influenced their well-being. Program participants did not directly say program involvement changed their sense of control. The fact that many participants were active in many activities, and often attended several programs showed that they exercised a degree of control over activities they felt helped promote their well-being. These findings concur with Houldson (1989) who found participants attended programs to enhance their well-being through exercise and social contact with others.

Less than half of the participants (43.4%) felt able to influence others and 11.3% felt unable to take charge of situations that arose in their lives. What some participants reported in questionnaires, what they said in interviews, and what the investigator observed were not, however, always congruent.

The portrait of Harriet illustrates a woman who said she did not feel able to influence people or situations. However, she demonstrated that her involvement in the secondary group on housing helped her gain some sense of influence over a situation (affordable housing) that affected her sense of well-being.

While some other participants stated they felt they could influence others, and situations, they did not apply this in relationship to control issues in programs. This was demonstrated in the portraits of programs at Roseberry Centre, Blackberry Centre, Huckleberry Centre and Mayberry Centre. Other program participants dealt with control issues and tension in

programs by leaving or going to programs at other centres. Participants left the troubled program until the tension subsided, or they felt better able to cope, or they left this type of program indefinitely.

It seems that the issue of self-efficacy may be different for individuals regarding different situations and at different points in time. This makes it difficult to establish a relationship to program involvement and change in self-efficacy. Empirical evidence of this relationship was beyond the scope of this study.

The Facilitators' Perspective

Facilitator perception of program effectiveness matched with objectives outlined in the Keep Well brochure. The facilitators said participants in these programs become: more flexible, both mentally and physically; more informed about a wide variety of health, aging and community related issues; less lonely and more open to talk; more active in other activities. They also said the general quality of life was improved for most participants.

While facilitators felt participants benefited from program involvement they were the first to admit that many program participants were highly motivated and active in health maintenance prior to program entry. This perception was shared by participants.

Older adults at risk

Facilitators all expressed concerns that the programs were reaching very few of the older adults who needed programs the most. These people were described as the frail elderly, or at risk group for serious health

problems. Many facilitators expressed concerns about the need for more time to build programs through networking and by taking some programs to apartment complexes where these frail older adults lived. Many facilitators felt they could do this if the centre administrators were prepared to pay them for the time it would take to establish the networks and start the programs.

While participants said they encouraged others who could benefit from the program they just weren't motivated to attend. Not all older adults who could benefit from program participation are interested in attending programs. Clearly, other avenues need to be explored to provide health promotion information and support to these individuals.

Administrative and space barriers

Several facilitators said centre administrators and policy makers lacked understanding regarding seniors' needs and placed program space and staff time as a low priority. Examples they gave included: limited funds for programs which resulted in paying staff only for hours of the program; little time for program preparation, and building networks with seniors and other facilitators in other centres; inadequate or inappropriate space for programs.

At some sites both facilitators and program participants complained about noise and location. Several programs were located on the second floor which is not easily reached by some older adults with limited mobility. Program members at one centre were lobbying for a seniors centre because they felt they needed a space of their own that was quiet and more frequently available.

Educational barriers

Facilitators also expressed a need to know more about working with older adults. While the Parks and Recreation Board supported this in principle, they only recently had provided workshops for staff working with seniors. Senior facilitators' attendance at these workshops was dependent on individual centre administrators' willingness to give them the time and to pay for their attendance. The need for more information about special needs of older adults was recognized by facilitators, and some programmers and administrators.

Referring professionals perspective

Referring professionals had limited knowledge about actual programs and their effectiveness on referred clients. Forty percent (40%) of referring professional respondents were unsure if their clients benefitted from wellness programs, because there is no mechanism for follow-up feedback. Five percent said no, and ten percent did not respond. Several persons in nursing professions did not choose to respond to the questionnaire because they felt their clients were "too frail for wellness". Several referring professional respondents were confused about the difference between adult daycare programs and health promotion programs. These responses support the need for information sharing with health professionals and other service professionals about wellness programs as an option for their clients or their clients caregivers. The referring professionals are an untapped resource for getting information about programs to the frail and at risk groups of older adults.

Clients who benefit

Another (45%) of referring professional respondents said their clients benefitted when there was a good social match among clients, other program participants, and facilitator, and if the client was interested and took part in the program. They noted that a small number of clients became very active in the community as a result of wellness program attendance. Referring professionals' perception of clients' involvement in other activities as a result of program attendance was shared by participants and facilitators.

Participants reported becoming involved in other activities, as a result of program attendance (48%), or becoming involved in the wellness program as a result of attending other activities (52%). All facilitators and the researcher noted that many program participants were involved in other activities as a result of attending wellness programs. This ripple effect was evident and substantiates the effectiveness of programs in expanding participants social networks, as well as providing opportunities for meaningful activities where the relationships are often inter-dependent.

When referring professionals responded to the question about the benefits of this type of health promotion program, twenty-five percent mentioned that participants would likely feel more in control of their lives. This control issue was mentioned by only two of the program facilitators. Sixty-two percent participants stated they valued their independence and many others referred to the importance of feeling free to make choices and exercise some control over their activities. Clearly independence and the ability to feel in control is recognized as important to most older adults who took part in wellness programs in this study.

Barriers to effectiveness

Referring professionals described the disadvantages of wellness programs in general as: not appropriate for people who are not well motivated; not accessible to people who have mobility and/or transportation problems; having the potential of creating dependence or at least supporting it. This dependence factor was illustrated in the portrait of the Mayberry Wellness Program. Clearly, approaches to program delivery influence programs' effectiveness in promoting independence of participants and attracting people to programs. The next section will address the relationship of approach to program delivery and effectiveness.

Approaches to Program Delivery

One of the purposes of this study was to determine if programs reflect the change in definition of health promotion from the disease-centred approach of self-responsibility for healthful lifestyles (Lalonde, 1974), to the current view expressed by the World Health Organization, as the slow "process of enabling people to increase their control over and to improve their health."

Facilitators of programs defined health promotion in terms of increasing people's awareness of health factors, including social as well as physical needs, helping people to grow and providing more information to enable them to deal with changes. When they were asked "has this definition changed?", one mentioned the change from a disease focus to a broader view and one other referred to the independence philosophy and community development approach to health promotion as one "which has people identifying their own needs and planning their own programs to deal with

issues important to them currently". The other facilitators felt the only change was in more information, awareness and different interests such as current events, instead of bingo.

The perceptions of facilitators in this study and their actual approaches to program planning and delivery reflect two views. One based on the medical model, a noted barrier approach to health promotion for older adults (Minkler & Checkaway, 1988), the second is the community development model supported in the literature by Minkler (1985), Labonte (1987), and Minkler and Checkaway (1988).

The Medical Model Approach

View I

- expert professionals facilitate programs
- facilitators role is putting programs on for seniors
- references to "my seniors", "my program", "What I say goes".

The medical model approach was supported by three facilitators in this study to varying degrees. It was supported by two facilitators in programs that had been in operation for more than five years and by a new facilitator in a program that had been in operation less than one year.

Community Development Model Approach

View II

- lets program participants define their own needs
- views facilitator's role as working with seniors.

This approach was supported by three facilitators to varying degrees. Facilitator education and openness to learning were common factors rather than length of program operations.

Larsen (1988) reported three characteristics of facilitators effectiveness were interpersonal skills, personal resources and practical traits. He also noted that the facilitators age relative to the program participants, leadership styles and co-facilitating were important factors in effectiveness. In Larsen's study, facilitators were trained in facilitating using enabling approaches. In the current study, only one facilitator was trained in the community development approach and group process. The literature reviewed supported the community development model and identified the facilitator's role as: nurturing empowerment and removing obstacles, Labonte (1987b). This training was not available to the majority of facilitators in this study.

Personality characteristics, coupled with knowledge about aging, community development and group process, are important factors in the facilitators' ability to enhance the effectiveness of these programs for older adults. Participants' perceptions of their opportunities and interest in program planning and implementation are other significant factors to consider in program outcomes.

Impinging Factors in Program Delivery

Different perceptions of participants' involvement

An interesting finding in the study was the difference between perceptions of facilitators and program participants regarding the participants opportunity for input to program planning and delivery. All six facilitators

said participants were involved in program planning and implementation to various degrees. However, one senior's comment was that they were limited to the role of kindergarten children "to show and tell", but not encouraged or allowed to take care of their own needs.

While all facilitators believed program participants were involved, 62% of participants in this study said they were not involved in planning or organizing program content or events, and only 38% said they were involved. A few program participants were seen by others and themselves as very active in all aspects of the program. Still others chose not to be active in these programs because they were already very active in many other activities or were caregivers to spouses, other family members, or friends. Some other participants stated they chose to be passive observers, because they were too new to make suggestions, had health problems or expressed attitudes on aging that supported a passive role. Clearly, programs in this study did not fully utilize community development approaches, or promote empowerment in relation to participants' involvement in program planning and delivery.

Participants' interests and beliefs in group leadership

A significant 74% of program participants in this study said they could not take on a leadership role. The reasons they gave included health, demands of their role as caregiver or other group activities, or personal choice. Approximately one quarter of program participants described themselves as workers, or doers, not leaders. Several others believed they were too shy, not knowledgeable enough, or not effective in a leadership role.

Clearly, participants' beliefs about their ability and other interests and responsibilities strongly influence their perceived and actual roles in wellness

programs. While enabling approaches may increase participants' ability to influence their own sense of well-being, it may not bring many more into group leadership roles. Also, leadership styles which fail to empower participants do not nurture leadership skills or confidence in participants who may be potential leaders or co-facilitators of programs. More discriminating questions need to be asked regarding the role of participants in these programs.

In this study several participants' at three sites felt the group cooperatively made decisions, but often named several participants or a facilitator as persons taking leadership roles. Participants who were involved in phoning others and arranging for speakers, or taking responsibility for various activities did not see this as leadership activities. There was no clear pattern between participants responses to questions on leadership and program planning or facilitator approach.

Further studies need to ask more discriminating questions, and clarify definitions before the relationship of participants involved in program activities as workers and/or leaders can be clarified.

ISSUES

Several issues became evident during this study. The key issues were:

1. The educational needs of policy makers and centre administrators regarding the needs of older adults and appropriate ways to meet those needs.

2. Educational needs and training of facilitators.

3. Facilitators' leadership styles and the degree of participant involvement in the program planning and delivery.

4. A commonly held belief is that programs are not reaching the older adults who need them the most.

5. Older men's needs for health promotion have not been fully assessed or addressed.

6. Needs of older adults to accept the value of their experience and the value of sharing this with others.

7. Needs of referring professionals for information about wellness programs and their possible benefits to clients and client caregivers.

IMPLICATIONS

Implications For Practice

The influence of policy makers and program administrators impacts on program effectiveness through funding and space allocation. An example of this relationship is the best location for programs. Many program participants stated they enjoyed meeting in community centres, where there was an intergenerational mix of people. Community Centres where there was low priority given for seniors' programs, and/or space for seniors activities, that were crowded and noisy, were sites where seniors lobbied for more space or a separate seniors centre.

Clearly, policy makers and administrators need to consider the needs of their community of older adults, and consult with them regarding their needs and program environment. Policy makers and centre administrators also need education about older adults' needs, understanding of trends in the aging population and awareness of enabling strategies that could guide their

allocation of funds and improve their selection and support of staff to implement these programs.

Leadership styles and philosophy played a key role in program delivery and participants interest in attending. Where participants felt they were having fun, and believed their contribution was valued, they were more likely to come back. Several participants and former program participants expressed their frustration when individuals monopolized discussion, or talked at the same time. Facilitators with knowledge and experience in facilitating group process were more able to effectively deal with these problems. Where effective facilitators were able to see their own role as that of enabling, rather than doing for seniors, fewer participants felt excluded. There is a need for education of program facilitators about aging, teaching and facilitating groups of older adults, understanding group process and enabling strategies of community development, the model in health promotion that promotes empowerment of individuals. A training program needs to be developed for facilitators that also prepares willing older adults as co-facilitators.

Program participants need to have more opportunities to be involved in designing the framework, as well as the content, and in participating in the delivery of these programs. As supported in the community development model by nurturing empowerment, the program participants need to be able to define their own roles and the role of the facilitator, in order to truly take ownership of their programs. It is the challenge of administrators and facilitators to take the time to provide patience and support for this process.

Clearly programs in this study provided opportunities for improving or maintaining physical fitness, and expanding social networks with possible increased social support. While the predominantly female program

population enjoyed programs and the social interactions, the majority were already considered active. Program planners and facilitators need to look for and implement ways of reaching men, the frail elderly, and other at risk groups.

While the frail and at risk groups may not be able to change of their conditions, programs can offer information and social support that could add quality to their lives. These programs need to be easily accessible and not too physically demanding. They would provide opportunities for the sharing of concerns and respecting the value of individual contributions.

Similarly, program planners and facilitators need to consult with potential male program participants, as well as those who presently attend, to determine how their needs for health promotion could best be addressed. Possibly having the option of male facilitators or co-facilitators in programs for men, or even in women's or mixed groups, could enhance group dynamics.

Programmers need to look for ways they can reach out to the more frail and isolated older adults. They also need to explore ways to involve inter-generational and multicultural groups, with older adult participants if they choose. This could provide opportunities to share their experiences, and explore the issues which promote quality of life for all groups. Certainly the future group of seniors from the "baby boom" generation will demand nothing less.

There is a need for referring professionals to have more information about wellness programs and what they offer clients and client caregivers. Mechanisms need to be developed to see how these program affect the referred clients and their caregivers. The majority of referring professionals

have been indoctrinated in the medical model approach, they could benefit from developing skills that promote empowerment of individuals.

FUTURE RESEARCH

As is common, this exploratory case study raised many questions while answering several others. Future research needs to address some of these unanswered questions. The study showed that programs which had been in operation longer were more prone to have problems because of cliques and power issues in leadership styles. Many factors influence this however, the sample was not large enough to generalize these findings to other programs.

The literature reviewed for this study supported the community development model as the approach that promotes participants empowerment W.H.O. (1984); Epp (1986); Health Communities (1988). Several studies reviewed in the literature demonstrated support for the community development approach, Minkler (1985); Labonte (1987); Wallterstein & Bernstein (1988) and Larsen (1988a). This study demonstrates that the community development model has not been fully utilized and that many program facilitators have not been trained to facilitate community development strategies that promote empowerment.

Further studies are needed to assess strategies to promote independence and changes in levels of independence as a result of program involvement. Another area for future research is assessing participants' involvement in program activities, leadership and changes in their self-efficacy as a result of program involvement.

A further area of study is identifying how beliefs and practices of policy makers and administrators affect program delivery and effectiveness.

A fourth area for future research would be exploring ways of reaching and motivating the 'hard-to-reach clients' to be involved in some type of health promotion program to meet their needs, and respect their choices.

Finally, while this study has briefly explored men's perceptions of health promotion programs, further research is needed regarding men's interests and issues regarding health and appropriate strategies for program planning and delivery.

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Appendix A.01

Letter to Program Participants

Simon Fraser University
Burnaby, British Columbia
June 1989

Dear

As a student with the Faculty of Education at Simon Fraser University under the direction of Dr. Michael Manley-Casimir, Dr. Marvin Wideen, and Dr. Jack Altman, I am doing a study of health promotion programs for older adults.

I am particularly interested in the effects of health promotion programs to older adults from the perspective of participants and program facilitators. I hope to be able to compile useful information on what happens in programs and how these programs function for participants like you and as a community resource.

In this study I intend to ask participants like you to fill out an information questionnaire about yourself. This activity will take about one half hour and I will be present to give guided instruction on how to fill out the questionnaire. Then I will interview a sample of participants from this program at a time and place that is convenient for each person. This interview about your involvement in the program will take approximately one half hour. Your opinions, experience, and suggestions are a valuable source of information. Your individual responses are held in strict confidence.

I will also be interviewing the program facilitator about program content and her view of its effects on participants. All comments will be held in strict confidence.

I would be very grateful if you would take part in this study.

Patricia E. Campbell
Master of Arts in Education Candidate
464-4831

A.02

Participants' Consent Form for Questionnaire

I am willing to fill out a questionnaire. I understand that the information I give will be kept strictly confidential, that I do not have to answer any questions I choose to leave out and that I am free to discontinue filling out the questionnaire at any time. I understand that I may register any complaint I might have about this study with the chief investigator Patricia E. Campbell or with Associate Dean of Education Stan Shapson -- 291-4517.

Signature _____

Date _____

A.03

Participant's Consent for the Facilitator

I am willing to have the facilitator of the health promotion program I am attending discuss with the interviewer the effects of the program on participants such as myself. I am aware that these general comments of the facilitator's perceptions will be held in strict confidence and that in no way will I be identified in the report. I am aware that this study will be available for me to read if I so choose. I understand that I may register any complaint I might have about this study with the chief investigator Patricia E. Campbell or with Associate Dean of Education Stan Shapson -- 291-4517.

Signature _____

Date _____

A.04

Participant's Consent Form for Individual Interview

I am willing to take part in an audio tape recorded interview about the health promotion program I currently attend. I understand that the information I give will be kept strictly confidential, that I do not have to answer any questions I do not wish to answer, and that I am free to end the interview at any time. I understand that I may register any complaint I might have about this study with the chief investigator Patricia E. Campbell or with Associate Dean of Education Stan Shapson -- 291-4517.

Signature _____

Date _____

A.05

Participants' Questionnaire

To be filled out by individual program participants in a group setting with investigator guidance.

1. What does the word "health" mean to you?

_____

_____

_____

PLACE A CHECK MARK BESIDE THE ANSWER THAT IS MOST LIKE YOU IN THE FOLLOWING QUESTIONS.

2. How would you rate your health?

   1) Excellent _____
   2) Very good _____
   3) Good _____
   4) Fair _____
   5) Poor _____

3. Compared to others of your age, how would you rate your health?

   1) Much better than others _____
   2) Better than most _____
   3) About the same as others _____
   4) Worse than others _____
   5) Much worse than others _____

4. What are the most important things you do to improve or maintain good health? _____

_____

_____

5. Are you satisfied with your life these days?

   1) Completely satisfied _____
   2) Usually satisfied _____
   3) Don't know _____
   4) Seldom satisfied _____
   5) Completely dissatisfied _____

6. Do you ever worry about being dependent on someone else?

   Circle the number that is most appropriate for you.

Never		Sometimes		Always
1	2	3	4	5

7. Do you know people who would help you on an ongoing basis if it were necessary?

   1) Yes _____
   2) Unsure _____
   3) No _____

8. Do you help out your:

	always	sometimes	never
1) neighbours	_____	_____	_____
2) friends	_____	_____	_____
3) family	_____	_____	_____

If you help out your neighbours, friends and/or family please give an example of the things you do for them. _____

_____

_____

9. Do others help you in any way?

	Yes	No
1) neighbours	_____	_____
2) friends	_____	_____
3) family	_____	_____

If yes, please give an example of what others do for you.

_____

_____

10. Place a checkmark beside the following statement(s) that are most like the way you feel.

    1) I feel in control of my life _____

    2) I am able to influence others _____

    3) I am usually unable to influence others _____

    4) I feel unable to take charge of situations that arise in my life _____

    5) I feel able to make choices that positively influence my wellbeing _____

11. The things I value most about my independence are _____

    _____

12. The things I need most assistance with are _____

    _____

13. The things I wish I could do are _____

    _____

14. On the following diagram place the initials of the persons you feel are important to you. For example, a family that you feel is close to you would go just above the word "Me".

FAMILY

4

3

2

1

Neighbours Friends

4 3 2 1 ME 1 2 3 4

1

2

3

4

OTHER SIGNIFICANT INDIVIDUALS

15. Frequency of Social Contacts.

Place an "O" for Personal Contact and a "T" for Telephone Contact in the appropriate square.

	DAILY	WEEKLY	MONTHLY	SELDOM	NEVER
1. Neighbour(s)					
2. Friend(s)					
3. Family					
4. Program Participant					
5. Physician					
6. Other Professional					

16. Please place a checkmark in the appropriate box to identify your degree of satisfaction with the frequency of contact with the following persons.

	USUALLY SATISFIED	OCCASIONALLY SATISFIED	USUALLY DISSATISFIED
1. Neighbour(s)			
2. Friend(s)			
3. Family			
4. Program Participant			
5. Physician			
6. Other Professional(s)			

A .06

Participant Information Sheet

To be filled out by individual program participants in a group setting with investigator guidance.

Please fill in the information below. Fill in the blanks or place a checkmark in the appropriate place.

1. Place of birth _____

2. First language spoken

   1) English _____

   2) French _____

   3) German _____

   4) Italian _____

   5) Russian _____

   6) Chinese _____

   7) Other, please specify _____

3. Area of the city in which you are currently living.

   _____

4. How long have you been living in this area?

   1) Years _____

   2) If less than a year state in months _____

5. Are you currently living in an:

   apartment _____

   house _____

   other _____ Please specify: _____

6. Do you live:

   alone _____

   with a spouse _____

   with a relative _____

   other _____ Please specify: _____

7. Do you have a pet?

   No _____

   Yes _____

   If yes, please specify _____

8. Are you currently:

   Retired _____

   Semi-retired _____

   Working _____

9. What is or was your occupation? _____

10. What do you work at now? _____

11. Are you involved in any:

Clubs _____ or Volunteer Activity _____

If yes, please specify _____

12. Are you involved in any recreation programs:

No _____

Yes _____ If yes, please name _____

Name of Program	Year	Month

EDUCATION INFORMATION

13. Education:

1) Grade 8 or less _____
2) High school incomplete _____
3) High school complete _____
4) College _____
5) Trade School _____
6) Post Graduate Studies _____

If you checked #4, 5 or 6 please specify _____

_____

14. Recent experience with the education system.

Name of Program	Program Dates	Year	Month

15. Age _____

16. Sex:

    Male _____

    Female _____

17. Marital Status:

    Single _____

    Married _____

    Divorced _____

    Widowed _____

18. Is your current income sufficient to meet your needs?

    No _____

    Yes _____

19. To what degree do you find your financial resources cause you stress?

    1) Very stressful _____

    2) Occasionally stressful _____

    3) Seldom stressful _____

    4) Never stressful _____

A.07

Focused Interview Guide for Individual Participants

This interview will be conducted with individual participants using audiotapes to record responses.

Program Related Questions

1. How did you hear about the program?

2. How long have you been attending this program?

3. How often do you attend this program?

4. What do you do there?

5. 1) Has your life changed since you started coming to the program?

   No _____ Yes _____

   2) If yes, please comment.

   3) If no, please comment.

6. 1) Are you involved in any other activities as a result of participating in this program?

   No _____ Yes _____

   If yes, please name: _____

7. With whom do you come to the program?

   By myself _____ With friend _____ With Neighbour _____

   Relative _____ Other _____

8. 1) Have you made new friends in the program?

   2) If yes, name them.

   3) Do you see them outside the program?

9. 1) Are you involved in the planning or organizing of program content and events?

   No _____ Yes _____

   2) If yes, name the activities and role you play or give examples.

10. 1) Do you feel suggestions that you have about the program are implemented? No _____ Yes _____

   2) Please give examples.

11. 1) Who takes the leadership for your group?

   2) Name some of the leaders.

   3) Has any of this changed since you became involved in the group?

   If so how has it changed?

Appendix B.01

Letter to Facilitators of Health Promotion Programs

and Consent Form

Simon Fraser University
Burnaby, British Columbia
June 1989

Dear

I am a student with the Faculty of Education at Simon Fraser University and am doing a study of health promotion programs for older adults under the direction of Dr. Michael Manley-Casimir, Dr. Marvin Wideen and Dr. Jack Altman.

I am particularly interested in the effects of health promotion of older adults delivered on a drop-in basis from the perspective of program participants and facilitators. I hope to be able to compile useful information on what happens in programs and how these programs function for older adult participants and as a community resource.

In this study I intend to ask participants information about themselves in a questionnaire and then interview some of them individually about their involvement in the program. This should take about one half hour for each activity. I would also like to sit in on several program sessions and interview you, at your convenience, about the program, using the attached questionnaire guide. This interview will take approximately one hour.

I would be very grateful if you would take part in this study.

Patricia E. Campbell
Master of Arts in Education Candidate
464-4831

Appendix B.02

Facilitators' Consent Form

I am willing to be part in an audio-taped interview about the health promotion program I facilitate. I understand that the information I give will be kept strictly confidential, that I do not have to answer any questions I do not wish to answer, and that I am free to end the interview at any time. I am aware that a summary of this study will be available for me to read if I so choose. I understand that I may register any complaint I might have about this study with the chief investigator Patricia E. Campbell or with Associate Dean of Education Stan Shapson -- 291-4517.

Signature _____

Date _____

Appendix B.03

Facilitators Interview Guide

Please read over the following questions and answer the ones you recall. I will arrange a time convenient for you to conduct an audiotaped interview to discuss the questions.

History

1. How did this neighbourhood health program come into being?

_____

_____

_____

_____

2. How many people were involved at first? _____

_____

3. Who was responsible for the program:

   1) planning? _____

   2) implementation? _____

4. What were the program goals and objectives in the beginning?

_____

_____

_____

_____

5. What activities were carried out then?

_____

_____

_____

_____

The Present

1. If you were asked to define health, how would you define it given your current knowledge?

_____

_____

_____

_____

2. 1) If you were asked to give a complete and current definition of health promotion, what would you need to include?

_____

_____

_____

_____

2) Has this definition changed? No _____ Yes _____

If yes, how has it changed?

_____

_____

_____

3) Is this the operational definition you use in this program?

No _____ Yes _____

4) Please explain the reason for your answer in question #2, part 3).

_____

_____

_____

3. 1) How many attend the drop in program? _____

2) Do you attract new members? No _____ Yes _____

If yes, please explain how.

_____

_____

_____

_____

3) Why do participants leave the program? (Please explain and quote examples).

_____

_____

_____

_____

4. 1) How would you describe the participants of this program?

a) Average age _____ Age range _____

b) Activity level _____

c) Health deficits _____

d) Other _____

2) Do you see changes in participants since the program started?

No _____ Yes _____

If yes please describe the changes.

_____

_____

_____

_____

5. 1) What are the needs of participants in relation to what the program offers?

_____

_____

_____

_____

2) How do you adjust the program to meet the changing knowledge of older adults' needs in your community?

_____

_____

_____

_____

6. 1) What is your role in the program?

_____

_____

_____

_____

2) What are the participants' roles in the program?

_____

_____

_____

_____

3) Do you see changes in these roles since the program started?

No _____ Yes _____

If yes, please explain.

_____

_____

_____

_____

4) In what way do you involve seniors in the overall design and implementation of the program?

_____

_____

_____

_____

_____

_____

7. What sort of community outreach does the program foster?

_____

_____

_____

_____

_____

_____

8. 1) Does the program have an effect on the community?

No _____ Unsure _____ Yes _____

2) How do you know?

_____

_____

Please give an example.

_____

9. How often do you meet with other community agencies to exchange ideas?

10. How do you measure the program's effectiveness?

The Future

1. What, if any, are your current plans for change in program content, delivery, and organization?

2. Who would you consult and involve in those changes?

Appendix C.01

Letter to Professionals

Simon Fraser University
Burnaby, British Columbia
June 1989

Dear

As a student with the Faculty of Education at Simon Fraser University under the direction of Dr. Michael Manley-Casimir, Dr. Marvin Wideen, and Dr. Jack Altman, I am doing a study of health promotion programs for older adults.

Your perception is sought as to the value to your clients of health promotion programs delivered in drop-in centers. This study is specifically concerned with perceptions of older adult participants, facilitators, and referring professionals on the programs' effect on participants' well-being, independence, and supporting social networks as it relates to program goals, and objectives.

The results of this study will help to provide information on what happens in these programs and how these programs function for older adult participants and as a community resource.

I would welcome any comments that you may have concerning any aspects of health promotion programs' effects on clients not covered in this instrument. Your individual responses will be held in strict confidence.

Thank you for your cooperation.

Patricia E. Campbell
Master of Arts in Education Candidate
464-4831

Appendix C.02

Professional's Consent Form

I am willing to fill out the attached questionnaire and/or be interviewed by telephone. I understand that I do not have to answer any questions I do not wish to answer and that I am free to discontinue answering questions at any time. I understand that my comments will be held in strict confidence and that in no way will I be identified in the report. I am aware that a summary of this study will be available for me to read if I so choose. I understand that I may register any complaint I might have about this study with the chief investigator Patricia E. Campbell or with Associate Dean of Education Stan Shapson -- 291-4517.

Signature _____

Date _____

Appendix C.03

Questionnaire to Referring Professionals

You will be contacted by telephone in the next week to arrange a convenient time for a telephone interview to answer these questions, or if you prefer, to fill out this questionnaire and return in the stamped and self-addressed envelope enclosed with this questionnaire.

1. What is your role in working with older adults? _____

   _____

2. Are you aware of neighbourhood health promotion programs for older adults?

   1) No _____

   2) Yes _____

   3) If yes, please name the ones with which you are familiar.

      _____

      _____

3. Have you referred older adult clients to these programs?

   1) No _____

   2) I don't recall _____

   3) Yes _____

   If the answer to #2 was no, go to question #8.

4. If the answer to question # was yes, please identify the approximate number of referrals in the last year _____

5. Have you found these programs accessible to your clients?

   1) No _____

   2) Unsure _____

   3) Yes _____

6. What criteria do you use to refer clients to these programs? For example: program philosophy, location, personality of facilitator, activities, etc.

   _____

   _____

   _____

7. Have your clients benefitted from the program?

   1) No _____

   2) Unsure _____

   3) Yes _____

   Please give reasons for your answer _____

   _____

8. In your opinion what are the benefits to older adults and the community of this type of health promotion program? _____

   _____

   _____

9. In your opinion what are the disadvantages of this type of program?

_____

_____

10. If you were asked to give a complete and current definition of health promotion, what would you include? _____

_____

_____

_____

11. If you were asked to define health, how would you define it given your current level of knowledge? _____

_____

12. Has your view of health, well-being, and health promotion changed over the years?

    1) No _____

    2) Yes _____

    3) If yes, please explain _____

_____

_____

13. Are you aware of any changes in these neighbourhood health promotion programs' content or approach?

    1) No _____

    2) Yes _____

    3) a) If yes, please state what they are _____

    _____

    _____

    b) In your opinion how do you view these changes?

    _____

    _____

14. If the answer to question #13 was no, how do you view the absence of change? _____

    _____

Appendix D.01

Participants Questionnaire Responses

Table D-1. What does the word "health" mean to you?

(summary of responses from all sites)

- a sense of well-being including: mental, physical, financial/or mind, body and soul; being at peace with oneself. (15 respondents)
- feeling well enough to enjoy life, work, hobbies and social activities, coping with the stress of life (11 respondents)
- balancing eating, rest, exercise and being happy with self and others (5 respondents)
- having a well functioning body (5 respondents)
- no major problems, pain free, free of illness, out of hospital (4 respondents)
- self care (5 respondents)
- being able to do things you would like, sleep well, look well, breeze through the day like the wind (3 respondents)
- happiness (2 respondents)
- living longer actively (1 respondent)
- being active with positive thinking people (1 respondent)

Table D-2. Self Rated Health and Life Satisfaction

Self rated health

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Excellent	1	0	0	1	1	1	4	8%
Very good	5	4	1	6	3	4	23	46%
Good	1	2	2	7	4	1	17	34%
Fair	1	0	1	1	3	0	6	12%
Poor	0	0	0	0	0	0	0	0
Total Responses	8	6	4	15	11	6	50	100%

Table D-3. View of Personal Health Compared to others of same age:

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Much better than others	1	2	0	2	0	1	6	12.5%
Better than most	5	4	3	9	7	4	32	66.7%
About the same as others	1	1	2	1	4	1	10	20.8%
Worse than others	0	0	0	0	0	0	0	0
Total Responses	7	7	5	12	11	6	48	100%

Table D-4. What are the most important things you do to maintain good health? (Participants may have responded to more than one category)

- maintain a diet low in calories, with lots of vegetables and fruit (40 respondents)
- exercise (29 respondents), walking (10 respondents), gardening (2 respondents), bowling (1 respondent)
- rest (7 respondents)
- maintain interests (5 respondents)
- drink water (3 respondents)
- maintain mental interests (1 respondent), think positively (2 respondents) use common sense (1 respondent)
- maintain good friendships (1 respondent), take social trips (1 respondent)

Table D- 5. Current Life Satisfaction:

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Completely satisfied	2	2	0	2	2	4	12	24.5%
Usually satisfied	5	4	4	11	6	2	32	65.3%
Don't Know	0	0	0	1	2	0	3	6.1%
Seldom Satisfied	0	0	0	1	1	0	2	4.1%
Total Responses	7	6	4	15	11	6	49	100%

Table D-6. Do you ever worry about being dependent on someone else?

	Site #	1	2	3	4	5	6	Total	%
		N-8	N-7	N-5	N-15	N-12	N-6	53	
Never	1.	1	0	2	3	1	2	9	17%
	2.	4	4	0	4	2	2	16	30%
Sometimes	3.	2	3	2	7	6	2	22	41.5%
	4.	0	0	0	1	1	0	2	4%
Always	5.	0	0	0	0	1	0	1	2%
Total Responses		7	7	4	15	11	6	50	
No response		1	0	1	0	1	0	3	5.5%
									100%

Table D-7. Do you know people who would help you on an ongoing basis if it were necessary?

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Yes	4	5	4	15	7	4	39	73.6%
Unsure	0	2	0	0	2	2	6	11.4%
No	3	0	0	0	2	0	5	9.4%
Total Responses	7	7	4	0	11	6	50	
No response	1	0	1	0	1	0	3	5.6%
								100%

Table D-8. Do you help out your:

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Neighbours:								
Always	2	3	0	4	2	2	13	24.5%
Sometimes	6	3	3	9	7	4	32	60.5
Never	0	0	1	1	2	0	4	7.5%
Total Responses	8	6	4	14	11	6	49	
No response	0	1	1	1	1	0	4	7.5%
								100%
Friends:								
Always	3	5	1	7	3	3	22	41.5%
Sometimes	5	1	2	6	6	3	23	43.4%
Never	0	0	1	0	2	0	3	5.7%
Total Responses	8	6	4	13	11	6	48	
No response	0	1	1	2	1	0	5	9.4%
								100%

Table D-8. (continued) Do you help out your:

	Site #	1	2	3	4	5	6	Total	%
		N-8	N-7	N-5	N-15	N-12	N-6	53	
Family:									
	Always	4	6	1	11	7	3	32	60.4%
	Sometimes	3	0	2	1	2	1	9	17%
	Never	1	0	0	2	2	0	5	9.4%
	Total Response	8	6	3	14	11	4	46	
	No response	0	1	2	1	1	2	7	13.2%
									100%

Table D-9. Examples of what program participants say they do for neighbours, family and friends are: (*see Table D-8 for the number of participants who help neighbours, family and friends)

1. childcare (16 respondents - 10 with grandchildren)
2. shopping (1 respondent)
3. providing transportation (9 respondents)
4. being there to support them (8 respondents)
5. help plan social functions (7 respondents)
6. household chores and maintenance (5 respondents)
7. visiting the sick (5 respondents)
8. checking on them (2 respondents)

Table D-10. Do others help you in any way?

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Neighbours:								
Yes	5	5	2	10	9	2	33	62.2%
No	0	1	1	3	2	2	9	17%
Total Responses	5	6	3	13	11	4	42	
No responses	3	1	2	2	1	2	11	20.8%
								100%
Friends:								
Yes	6	7	4	14	8	4	43	81.1%
No	0	0	0	1	0	0	1	1.9%
Total Responses	6	7	4	15	8	4	44	
No Responses	2	0	1	0	4	2	9	17%
								100%

Table D-10. (continued) Do others help you in any way?

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
Family:								
Yes	6	6	3	14	11	4	44	83%
No	0	0	0	0	0	1	1	2%
Total Response	6	6	3	14	11	5		
No responses	2	1	2	1	1	1	8	15%
								100%

Table D-11. Examples of what participants say others do for them are:
(see table #7 for the number of participants who are helped by neighbours, family and friends)

- providing support (7 respondents) "always being there for me"
- sharing entertainment (5 respondents)
- providing transportation (5 respondents)
- caring for home, transportation and pets (5 respondents)
- household repairs and maintenance (6 respondents)
- shopping (4 respondents)
- sharing meals (2 respondents), clothes (2 respondents), garden produce (2 respondents)
- giving advice (2 respondents)
- writing letters (1 respondent)

Table D-12. Self Efficacy:

Site #	1	2	3	4	5	6	Total	%
	N-8	N-7	N-5	N-15	N-12	N-6	53	
*I feel in control of my life	7	3	4	15	9	6	44	83.0%
*I am able to influence others	4	3	2	8	3	3	23	43.4%
*I feel able to make choices that positively influence my well-being	8	5	4	10	7	4	38	71.7%
*I am usually unable to influence others	0	0	1	0	2	1	4	7.5%
*I am unable to take charge of situations that arise in my life	1	0	1	3	1	0	6	11.3%
No response	0	0	1	0	0	0	1	1.8%

*= Able to respond to more than one statement

N=Number of Participants

Table D-13. The things participants value about their independence are:

- choosing to follow their own interests (7 respondents)
- making their own decisions (5 respondents)
- good health & peace of mind (5 respondents)
- freedom of the clock and not having to account to anyone (4 respondents)
- do what they never had time for when caring for others (3 respondents)
- flexible lifestyle (3 respondents)
- financial (3 respondents)
- privacy (2 respondents)
- the ability to handle my own problems

Table D-14. The things participants said they needed more assistance with:

- have maintenance (7 respondents) and yard care (4 respondents)
- transportation (5 respondents)
- household cleaning (4 respondents)
- emotional support (3 respondents)
- shopping (3 respondents)
- companionship (3 respondents)
- encouragement to get out (2)
- financial advice (1 respondent)
- hearing what people say (1 respondent)
- writing letters (1 respondent), threading needles (1 respondent)
- raising grandchildren (1 respondent)

Table D-15. The things participants wished they could do are:

- travel more (8)
- walk more (2 respondents), dance (2 respondents), ski (1 respondent), swimming (1 respondent)
- ongoing activities outdoors (1 respondent)
- do things faster (2 respondents)
- do more with friends and grandchildren (2 respondents)
- further their education (2 respondents)
- do what they like (1 respondent)
- not to take things so seriously, accept things as they are (2 respondents)
- keep self the same as they are now (1 respondent)
- not to get feeling down (1 respondent)
- read (1 respondent), rest (1 respondent), garden (2 respondents), play the piano (1 respondent), drive a car (1 respondent)

Table D-16. Range of relationships of persons program participants say they feel close to:

	1(close to me)	2	3	4	Total Range	Relationship FA	FR	N	O	Total Participants
Site 1	1-2	0-26	0-20	1-10+	2-82	8	5	5	4	8
Site 2	2-156	1-5	1-8	1-4	6-159	6	6	4	5	7
Site 3	0-13	1-33	0-6	0-6	2-50	4	4	4	2	5
Site 4	0-13	0-16	0-15	0-6	1-42	14	13	9	7	15
Site 5	0-6	0-5	0-6	0-4	0-11	10	10	9	6	12
Site 6	1-5	1-5	1-6	0-6	6-20	6	6	6	3	6
						48	44	37	28	53
					Percentage	90.5	83	70	53	

Code: FA = Family

FR = Friends

N = Neighbours

O = Others

Table D-17. Frequency of Social Contact:

Neighour(s)		Daily P	Daily T	Weekly P	Weekly T	Monthly P	Monthly T	Seldom P	Seldom T	Never P	Never T	Total
N-8	Site 1	4	0	3	1	1	0	0	0	0	0	9
N-7	Site 2	1	1	1	0	0	1	0	0	0	0	4
N-5	Site 3	2	0	0	0	2	0	0	0	0	0	4
N-15	Site 4	5	2	3	1	1	0	0	0	0	0	12
N-12	Site 5	6	1	1	0	0	0	1	0	0	0	9
N-6	Site 6	3	0	1	1	0	0	0	0	0	0	5
Percentage all sites		40%	7.5%	16.9%	5.6%	7.5%	1.8%	1.8%	0	0	0	43 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-18. Frequency of Social Contact:

Friend(s)		Daily		Weekly		Monthly		Seldom		Never		Total
		P	T	P	T	P	T	P	T	P	T	
N-8	Site 1	1	1	5	2	1	0	0	0	0	0	10
N-7	Site 2	2	0	2	0	1	0	0	0	0	0	5
N-5	Site 3	3	0	1	0	0	0	0	0	0	0	4
N-15	Site 4	3	3	3	2	0	0	0	0	0	0	10
N-12	Site 5	4	1	2	3	1	1	0	0	0	0	12
N-6	Site 6	1	1	2	1	1	0	0	0	0	0	6
Percentage all sites		26.6%	11.3%	28.3%	15%	7.5%	1.8%	0	0	0	0	47 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-19. Frequency of Social Contact:

Family		Daily		Weekly		Monthly		Seldom		Never		Total
		P	T	P	T	P	T	P	T	P	T	
N-8	Site 1	3	5	5	0	0	0	0	0	0	0	13
N-7	Site 2	4	2	1	2	0	1	0	0	0	0	10
N-5	Site 3	0	0	1	1	2	0	0	0	0	0	4
N-15	Site 4	5	4	2	2	0	0	0	0	0	0	13
N-12	Site 5	4	0	5	2	1	0	0	0	0	0	12
N-6	Site 6	3	0	0	0	1	1	0	0	0	0	5
Percentage all sites		35%	20.7%	26.4%	13.2%	7.5%	3.7%	0	0	0	0	57 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-20. Frequency of Social Contact:

	Daily		Weekly		Monthly		Seldom		Never		Total
	P	T	P	T	P	T	P	T	P	T	
Program Participants											
Site 1 N-8	0	0	6	1	1	0	0	0	0	0	8
Site 2 N-7	2	0	2	1	0	0	1	0	0	0	6
Site 3 N-5	0	0	3	0	0	0	0	0	0	0	3
Site 4 N-15	1	1	8	0	0	0	0	0	0	0	10
Site 5 N-12	3	0	3	1	1	0	0	0	0	0	8
Site 6 N-6	0	0	3	1	1	0	0	0	0	0	5
Percentage all sites	11%	1.8%	47.1%	7.5%	5.6%	0	1%	0	0	0	40 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-21. Frequency of Social Contact:

		Daily		Weekly		Monthly		Seldom		Never		Total
		P	T	P	T	P	T	P	T	P	T	
Physicians												
	Site 1	0	0	0	0	4	0	4	0	0	0	8
N-8												
	Site 2	0	1	0	0	1	1	3	0	0	0	6
N-7												
	Site 3	0	0	0	0	0	0	4	0	0	0	4
N-5												
	Site 4	0	0	0	0	2	0	6	2	0	0	8
N-15												
	Site 5	0	0	0	0	5	2	3	0	0	0	10
N-12												
	Site 6	0	0	0	0	1	1	2	0	0	0	4
N-6												
Percentage all sites		0	1.8%	0	0	24.5%	7.5%	41.5%	3.7%	0	0	40 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-22. Frequency of Social Contact:

	Daily		Weekly		Monthly		Seldom		Never		Total
	P	T	P	T	P	T	P	T	P	T	
Other Professionals											
Site 1 N-8	0	0	0	0	0	0	3	0	0	0	3
Site 2 N-7	0	1	0	1	1	0	1	0	0	0	4
Site 3 N-5	0	0	0	0	1	0	2	0	0	0	3
Site 4 N-15	0	0	0	0	3	0	0	0	0	0	3
Site 5 N-12	0	0	0	0	4	1	2	1	0	0	8
Site 6 N-6	0	0	0	0	0	0	0	0	3	0	3
Percentage all sites	0	1.8%	0	1.8%	16.9%	1.8%	15%	1.8%	5.6%	0	24 total respondents

Code: P= Personal contact
T= Telephone contact
Participants could respond to both P and T
*% based on sample of 53 even though they all didn't answer each section of this questionnaire.

Table D-23. Participants degree of satisfaction with frequency of contact with:

	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Response	Total Responses	N
Neighbours:						
Site 1	8	0	0	0	8	8
Site 2	4	1	0	2	5	7
Site 3	4	0	0	1	4	5
Site 4	11	0	0	4	11	15
Site 5	12	0	0	0	12	12
Site 6	6	0	0	0	6	06
Total	45	1	0	7	46	53
Percentage all sites	84.9%	1.8%	0	13.3%	100%	

Table D-24. - Participants degree of satisfaction with frequency of contact with:

	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Responses	Total Responses	N
Friends:						
Site 1	8	0	0	0	8	8
Site 2	7	0	0	0	7	7
Site 3	4	0	0	1	4	5
Site 4	12	0	0	3	12	15
Site 5	11	1	0	0	12	12
Site 6	6	0	0	0	6	6
Total	48	1	0	4	49	53
Percentage all sites	91%	1.8%	0	7.3%	100%	

Table D-25. Participants degree of satisfaction with frequency of contact with:

Family:	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Response	Total Response	N
Site 1	8	0	0	0	8	8
Site 2	7	0	0	0	7	7
Site 3	2	2	0	1	4	5
Site 4	12	1	0	2	13	15
Site 5	10	2	0	0	12	12
Site 6	4	1	0	1	5	06
Total	43	6	0	4	49	53
Percentage all sites	81%	11.5%	0	7.5%	100%	

Table D-26. Participants degree of satisfaction with frequency of contact with:

	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Response	Total Responses	N
Program Participants:						
Site 1	7	0	0	1	7	8
Site 2	6	0	0	1	6	7
Site 3	4	0	0	1	4	5
Site 4	7	1	0	7	8	15
Site 5	8	0	1	3	9	12
Site 6	4	0	0	2	4	6
Total	36	1	1	5	38	53
Percentage all sites	68%	1.8%	1.8%	28.4%	100%	

Table D-27. Participants degree of satisfaction with frequency of contact with:

	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Response	Total Responses	N
Physicians:						
Site 1	7	0	0	5	7	8
Site 2	7	0	0	2	7	7
Site 3	2	1	0	2	3	5
Site 4	11	1	0	7	12	15
Site 5	8	2	1	5	11	12
Site 6	5	0	0	3	5	6
Total	40	4	1	24	34	53
Percentage all sites	75.4%	7.5%	1.8%	15.3%	100%	

Table D-28. Participants degree of satisfaction with frequency of contact with:

	Usually Satisfied	Occassionally Satisfied	Usually Dissatisfied	No Responses	Total Responses	N
Other Professionals:						
Site 1	3	0	0	5	3	8
Site 2	5	0	0	2	5	7
Site 3	1	2	0	2	3	5
Site 4	8	0	0	7	8	15
Site 5	7	0	0	5	7	12
Site 6	3	0	0	3	3	6
Total	17	2	0	24	29	53
Percentage all sites	50.9%	3.8%	0	45.3%	100%	

Appendix E.01

Participant Information Sheet
N-53

Table E-1. Place of birth

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
Place of Birth								
B.C.	1	3	2	6	2	-	14	26.4%
Prairie Province	5	2	1	5	6	2	21	39.6%
Ontario	2	-	-	1	-	2	5	9.4%
Maritimes	-	-	-	-	-	1	1	1.8%
Total Canada	8	5	3	12	8	5	41	77.3%
Britain	-	1	2	3	2	1	9	17.%
Poland	-	1	-	-	-	-	1	
Germany	-	-	-	-	2	-	2	
Total Europe	-	1	-	-	2		3	5.7%
Total all countries:								100%

Table E-2. First language

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
English	8	5	4	14	8	6	45	84.9%
French	-	-	-	- 1	-	-	1	1.9%
Welsh	-	-	1	-	-	-	1	1.9%
German	-	1	-	-	2	-	3	5.6%
Polish	-	1	-	-	-	-	1	1.9%
Romanian	-	-	-	-	1	-	1	1.9%
Norwegian	-	-	-	-	1	-	1	1.9%
Total responses	8	7	5	15	12	6	53	100%

Table E-3. Area of city in which participant is currently living:

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
Neighbourhood in which program offered	6	4	4	12	6	6	38	71.7%
adjacent neighbourhood	2	2	1	2	6	-	13	24.5%
distance community	-	1	-	1	-	-	2	3.8%
							53	100%

Table E-4. Length of time participant has been living in the area:

Site 1	Range	1.5 years to 40 years
	Average	19.8 years
Site 2	Range	6 months - 45 years
	Average	17.9 years
Site 3	Range	25 - 62 years
	Average	39.4 years
Site 4	Range	2 years - 50 years
	Average	18.9 years
Site 5	Range	3 years - 67 years
	Average	36.3 years
Site 6	Range	11 - 45 years
	Average	26.6 years
Total:	Range, all sites	6 months - 67 years
	Average, all sites	27.8 years

Table E-5. Currently living:

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
a) in an apartment	4	2	1	12	1	3	23	43.3%
in a house	4	4	3	3	11	3	28	52.9%
other	-	1 t.h.	-	-	-	-	1	1.9%
no response	-	-	1	-	-	-	1	1.9%
							53	100%
b) alone	6	3	1	11	7	3	31	58.5%
with spouse	2	2	1	4	4	3	16	30.2%
other relative	-	2	1	-	1	-	4	7.5%
other	-	-	1 friend	-	-	-	1	1.9%
no response	-	-	1	-	-	-	1	1.9%
							53	100%

Table E-5. (continued) Currently living:

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
c) with pet								
No	4	2	2	14	4	4	30	56.7%
Yes	3	5	2	1	7	2	20	37.7%
No response	1	-	1	-	1	-	3	5.6%
							53	100%

Type:

Site 1	dog, rabbit
Site 2	dog, cats, budgie, squirrels
Site 3	dog, cats
Site 4	cat
Site 5	cats, dog, bird, fish
Site 6	dog

Table E-6. Current status:

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
Retired	8	5	4	15	12	5	49	92.4%
Semi-retired	-	-	1	-	-	-	1	2.%
Working	-	2	-	-	-	1	3	5.6%
							53	100%

Table E-7. Currently working at:

Site #	1 N8	2 N7	3 N5	4 N15	5 N12	6 N6	Total 53	Percentage 100%
Housewife	2	1	-	1	-	-	4	7.5%
Volunteer	2	3	2	7	4	3	21	39.6%
Hobbies	2	1	1	-	1	3	8	15.1%
enjoying life	2	1	1	1	1	-	6	11.3%
care of grandchildren	-	1	-	1	1	-	3	5.7%
as little as possible	-	-	1	-	-	-	1	1.9%
no response	-	-	-	5	5	-	10	18.9%
							53	100%

Table E-8. What is or was your occupation?

Site #	1 N8	2 N7	3 N5	4 N15	5 N12	6 N6	Total 53	Percentage 100%
teacher	3	-	1	1	2	1	8	15.0%
health careworker	-	2	1	1	2	1	7	13.2%
social worker	-	-	-	1	-	1	2	3.8%
psychologist	-	1	-	-	-	-	1	1.9%
missionary	-	-	-	1	-	-	1	1.9%
secretary	2	-	-	5	2		9	17.0%
office worker	-	-	1	1	2		4	7.5%
telephone operator	-	1	1	-	1	-	3	5.7%
manager	1	1	-	-	-	1	3	5.7%
housewife	2	-	-	2	1	2	7	13.2%
sales person	-	2	-	3	2	-	7	13.2%
mechanic	-	-	1	-	-	-	1	1.9%
							53	100%

Table E-9. Education:

Site #	1 N8	2 N7	3 N5	4 N15	5 N12	6 N6	Total 53	Percentage 100%
•Grade 8 or less -	-	1	1	-	1	-	3	
•high school incomplete	1	-	1	1	4	-	7	
•high school complete	5	3	2	9	4	3	26	
•college	2	1	-	2	1	1	7	
•trade school	1	1	1	1	2	-	6	
•post graduate studies	2	2	1	4	2	3	14	

• could respond to more than one item.

Table E-10. Recent education experience:

Site #	1	2	3	4	5	6	Total	Percentage
•health	1	-	-	-	-	-	1	1.9%
•completed high school	-	-	-	1	-	1	2	3.8%
•fine arts	2	-	-	2	-	-	4	7.5%
•elder hostel	-	-	1	-	-	1	2	3.8%
•photography	-	-	1	-	-	-	1	1.9%
•computers	-	-	1	-	-	-	1	1.9%
no response	5	7	2	12	12	4	42	79.2%
							53	100%

• could respond to more than one activity

Table E-11. Current interests:

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
•clubs	8	2	4	5	2	2	23	43.4%
•volunteer activity	5	4	2	7	7	3	28	52.8%
•church	2	1	-	3	2	1	9	17.0%
•recreation	7	7	4	14	7	3	42	79.2%

• could respond to more than one activity

Table E-12. Age and Sex

Site #	1	2	3	4	5	6	Total
	N8	N7	N5	N15	N12	N6	53
Age range	59-86	65-78	65-88	62-86	64-79	64-78	59-88
mean age	71	69.5	75.2	71.5	66.5	68.3	71.2
Sex:							
Male	1	0	2	0	1	0	4
Female	7	7	3	15	11	6	49
							53

Table E-13. Marital Status

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
Marital status								
single	2	0	1	4	1	1	9	17.3%
married	3	2	1	4	5	3	18	34.6%
seperated	1	0	0	0	0	0	1	1.9%
divorced	1	0	0	0	0	0	1	1.9%
widowed	1	5	2	7	6	2	23	44.3%
Total response	8	7	4	15	12	6	52	
No response	-	-	1	-	-	-	1	
							53	100%

Table E-14. Is your current income sufficient to meet your needs?

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
No	-	1	1	1	-	-	3	5.7%
Yes	8	5	2	14	10	6	45	84.9%
No response	-	1	2	-	2	-	5	9.4%
							53	100%
Degree that particpants find financial resources causes them stress:								
very stressful	-	-	-	-	-	-	0	0
occassionally stressful	-	1	1	4	4	1	11	20.6%
seldom stressful	3	1	1	8	4	2	19	36%
never stressful	5	4	2	2	1	2	16	30.3%
no response	-	1	1	1	3	1	7	13.3%
							53	100%

Table E-15. Current sources of income.

Site #	1	2	3	4	5	6	Total	Percentage
	N8	N7	N5	N15	N12	N6	53	100%
Participants current source of income:								
•Pension	5	5	5	9	12	6	42	79.2%
•money from assets	5	1	1	10	4	3	24	45.2%
•spouses	1	-	-	1	-	1	3	5.7%
•money from current employment	-	-	-	-	-	-	-	-
•no response	-	2	-	1	-	-	3	5.7%

• could respond to more than one category

Table E - 16 Total household income from all sources before taxes & deductions in 1988:

10,000 & under	1	1	-	1	-	-	3	5.7%
Between 10,001-12,999	1	-	-	3	3	1	8	15.1%
Between 13,000-25,000	2	2	2	5	4	4	19	35.8%
Between 25,100-39,999	2	1	-	-	-	-	3	5.7%
More than 40,000	-	1	-	2	2	-	5	9.4%
no response	2	2	3	4	3	1	15	28.3%
							53	100%

Appendix F.01

Summary of Focused Interview with Participants
N - 42

Table F-1. How did you hear about the program?

Site #	1	2	3	4	5	6		Total	Percentage
Newsletter	1	-	2	1	1	2		7	Advertising 19%
Advertising	-	1	-	-	-	-		1	
								8	
Community Centre	-	2	-	5	3	-		10	Centers
Senior Center	2	-	-	-	-	-		2	29%
								12	
Personal contact	-	2	2	4	4	1	13		Personal contact
(Neighbour, family & friends)									32%
Fitness Activities	4	2	-	-	-	-		6	Fitness Activities 15%
Referring Professionals	-	-	-	-	2	-		2	Referring Professionals 5%
TOTAL RESPONSES	7	7	4	10	10	3		41	100%

Table F-2. How long have you attended this program?

Site #	1	2	3	4	5	6	Total	Percentage
Length of program operation	4 mo.	14 mo.	6 mo.	6 yr	8 yr	10 mo.		
3 months or less	5	1	3	1	-	1	11	26%
4 - 7 months	2	-	1	-	-	-	3	7%
8 - 11 months	-	1	-	3	-	2	6	14%
1 - 2 years	-	5	-	4	3	-	12	29%
3 - 6 years	-	-	-	2	3	-	5	12%
7 - 8 years	-	-	-	1	4	-	5	12%
NUMBER OF RESPONSES	7	7	4	11	10	3	42	100%

Table F-3. Frequency of attendance:

Site #	1	2	3	4	5	6	Total Exercises		Percentage Total Discussion	
More than once per week	4*E	-	-	5E	2E	-			11E	31%
Weekly	-	7D	4D	6D	8D	3D	28D	67%		
	-	6E	-	6E	7E	3E			22E	63%
Bimonthly	6D	-	-	-	-	-	6D	14%		
	-	-	-	-	-	-	-E			
Occasionally	1D	-	-	4D	2D	-	7D	17%		
	-	1E	-	-	-	-			1E	3%
Never	-	-	-	1D	-	-	1D	2%		
	-	-	-	-	1E				1E	3%
TOTAL RESPONDENTS	7	7	4	11	10	3	35E	100%	42D	100%

D = Discussion
E = Exercise
*= Walking Club

Table F-4. What do you do there?

Site #	1	2	3	4	5	6	Total	Percentage
Exercise	5	7	-	11	9	3	32	76%
Discussion	7	7	4	10	8	3	39	93%
Exercise & Discussion	5	7	-	10	9	3	34	81%
Massage	-	3	-	2	-	-	5	12%
Blood Pressure *weight check	-	3	-	4	*1	-	7	17%
No response	0	0	0	0	0	0		

Table F-5. Has your life changed since you started the program?

Site #	1	2	3	4	5	6	Total	Percentage
No	2	4	3	5	2	2	18	43%
Comments								
Very active before	•							
Not sure		•						
Just enjoy people		•						
No change in health	•							
Yes	5	3	1	6	8	1	24	57%
Comments								
Improved energy	•				•			
Less breathless	•							
Reduced inches	•							
Improved mobility				•	•			
Feel great	•	•		•				
Keep active	•	•						
Stay healthy		•	•					
Interesting things to discuss		•	•			•		
New information					•	•		
Share information with others		•			•	•		
Feel close to others			•					
Enjoy people				•				
Increase social network reinforces action						•		
TOTAL RESPONDENTS:	7	7	4	11	10	3	42	100%

Table F-6. Are you involved in any activities as a result of participation in this program?

Site #	*Yes*	*Explain*	*No*	*Explain*
1.	2	Volunteer at centre Phone committee Fashion show for seniors Walking tour	5	Walking Club first then Wellness discussion
2.	4	Volunteer for Red Cross Arthritis Society Nutrition Neighbours Seniors Groups	3	
3.	1	Nutrition neighbours Response to healthy aging Weekly suppers	3	
4.	4	Concerned citizens for Affordable Housing Phone committee Friendly visiting Announce Speakers	7	Involved with exercise first Involved in other centers Involved with family Involved in other activities not related to this program
5.	6	Live Wires Seniors in Action Senior Strut Neighbourhood helpers Nutrition neighbours Health Unit Volunteer Recreation of Seniors Center Volunteer	4	Live Wires first
6.	3	Seniors Strut Nutirition neighbours Seniors in Action	0	
TOTAL RESPONSES:	20		22	
PERCENTAGE:	48%		52%	

Table F-7. With whom do you come to the program?

Site #	1	2	3	4	5	6	Total	Percentage		
Alone	3	7	2	6	7	1	25	60%	Alone	60%
With relative	-	-	2	-	1	-	3	7%		
With friend	1	-	1	3	1	1	7	16.5%		
With neighbour	3	-	-	2	1	1	7	16.5%	With Other	40%
Other	-	-	-	-	-	-				
TOTAL RESPONSES:	7	7	4	11	10	3	42	100%		100%

Table F-8. Have you made new friends in the program?

Site #	1	2	3	4	5	6	Total	Percentage
No	-	1	-	-	1	-	2	5%
Yes	7	5	3	11	9	3	38	90%
Friends	6	1	-	5	4	2	18	
Acquaintences	1	2	3	6	3	1	16	
No response	-	1	1	-	-	-	2	5%
								100%

Table F-9. Do you see them ouside the program?

Site #	1	2	3	4	5	6	Total	Percentage
No	2	2	1	5	5	0	15	36%
Yes	4	5	3	6	6	3	27	64%
							42	100%
Involved outside program								
•only by chance	3	2	3	-	1	1	10	
•lunch	-	2	-	1 *	3	-	6	
•neighbour	1	-	-			1 *	2	
•friend	-	-	-	1	2	1 *	4	
•volunteer	-	1	-	1	-	-	2	
•other groups	-	-	-	3 *	1 *	-	4	
•share garden produce	-	-	1	-	-	-	1	
•trips	-	-	-	-	1 *	-	1	

*may respond to more than one of the above

Table F-10. Are you involved in the planning or organization of program content or events?

Site #	1	2	3	4	5	6	Total	Percentage
No	5	4	2	7	6	2	26	62%
Comments:								
Willing to help		1						
Yes	2	3	2	4	4	1	16	38%
							42	100%

Explain:

Site 1
- *topic & content
- *only once

Site 2
- *planning
- *phoning
- *chairperson

Site 3
- *arrange speakers
- *volunteer

Site 4
- *arrange speaker
- *thank speaker
- *suggest topic
- *state views

Site 5
- *planning
- *serve refreshments

Site 6
- *suggest topics

Table F-11. Do you feel suggestions you have about the program are implemented?

Site #	1	2	3	4	5	6	Total	Percentage
Yes	2	4	2	8	7	0	25	60%

Examples:

Site 1
- day trips
- topics

Site 2
- topics
- speakers

Site 3
- speakers

Site 4
- topic
- speakers
- number of times for exercise

Site 5
- planning trips
- speakers

Site 6
- speakers

No	5	3	2	2	2	1	15	36%

Explain

Site 1
- not involved enough

Site 2
- don't make suggestions

Site 6
- not here long enough

Don't recall, unsure:	-	-	-	-	1	1	2	4%
							42	100%

Table F-12. Who takes the leadership for your group? and name leaders?

Site #	1	2	3	4	5	6	Total
Name:							
Fitness instructor	-	3 *	-	10*	-	3 *	16
Coordinator	5	3 *	3 *	9 *	8 *	3 *	30
Programmer	2	-	3 *	-	-	-	5
Cooperative effort	-	3 *	-	-	1	-	4
Members	-	-	-	-	3 *	-	3
Nutritionist	-	-	1 *	-	-	-	1
Don't know	-	-	-	1	-	-	1
							60

*Responded to more than one name.

NO RESPONSE	0	0	0	0	0	0	

Table F-13. Has any of this changed since you became involved in this group? If yes, how has it changed?

Site #	1	2	3	4	5	6	Total	Percentage
Yes	1	2	-	1	4	1	9	21.4%

Comments:

Site 1
- attendance dropped in summer

Site 2
- change of leader
- fewer people in summer

Site 4
- change in attendance, smaller
- people running it are older

Site 5
- not taking more responsibility
- number changes
- people change but leader is the same
- improved

Site 6
- leader

Table F-13 (continued). Has any of this changed since you became involved in this group? If yes, how has it changed?

Site #	1	2	3	4	5	6	Total	Percentage
No	5	5	4	10	4	2	30	71.4%

Comments:

Site 1
- topics change & group changes
- coordinator leads but involves everyone

Site 2
- cooperative effort (2)
- no comment (3)

Site 3
- no comment

Site 4
- no comment

Site 5
- same

Site 6
- not really

Don't Know	1	-	-	-	2	-	3	7.2%

Comments:

Site 1
- first time attending

Site 5
- not aware
- not sure

TOTAL RESPONSES	7	7	4	11	10	3	42	100%

Table F-14. Do you think your group could take on more of the leadership responsibility? If yes, how would you see it happen?

Site #	1	2	3	4	5	6	Total	Percentage
Yes	2	2	1	7	6	3	21	50%

Comments:

Site 1
- may not choose to
- could

Site 3
- should

Site 5
- should

No	4	5	3	1	2	-	15	36%

Comments:

Site 1
- involved in their own activites (2)
- not necessary, leader does well
- nothing that requires much leadership in discussion group

Site 3
- up to them
- very elderly

Unsure	1	-	-	3	2	-	6	14%
								100%

Table F-14 (continued). Do you think your group could take on more of the leadership responsibility? If yes, how would you see it happen?

How would it happen?

Site 1	•already do •may not choose to
Site 2	•increased number in program •reduce illness
Site 3	•should
Site 4	•don't know others well enough •could train to lead exercises •informal •small discussion group
Site 5	•requires younger person •we try •need a leader volunteer •not committed •group members teach different language group
Site 6	•we could •need a central person or it would fall apart •with some that are more familiar

TOTAL NUMBER OF RESPONSES	7	7	4	11	10	3	42	100%

Table F-15. Are there people in the group who could take on more or some leadership responsibility?

Site #	1	2	3	4	5	6	Total	Percentage
Yes	5	7	2	4	6	3	29	69%

Comments:

Site 1
- need experience & know where to look for speaker
- capable (3)
- questions having time & motivation
- some volunteer & some dont

Site 2
- doing this already (3)
- if they choose (2)
- if they have time (1)
- could with direction (1)

Site 3
- 20% could
- could

Site 4
- one's that could involved in other activities
- some could but don't know well enough
- 2 or 3 could lead exercise (2)
- already does
- capable but may work better with outsider to avoid resentment
- several like to take charge

Site 5
- if we could get them to
- 1 active and capable
- others could (2)
- some could but we will stick with one member

Site 6
- everyone has potential
- we could (2)

Table F-15 (continued). Are there people in the group who could take on more or some leadership responsibility?

Site #	1	2	3	4	5	6	Total	Percentage
No	1	-	2	2	1	-	6	14%

Comments:

Site 3
- very elderly

Site 4
- uneasy about accepting too much responsibility
- can't think of anyone, leader does involve more people during discussion

Site 5
- don't know anyone who could

Unsure	1	-	-	2	4	-	7	17%

Comments:

Site 1
- not here long enough to know

Site 4
- don't know (2)

Site 5
- don't know (1)
- some are doers
- dont know well enough (2)
- unsure

TOTAL RESPONSES	7	7	4	11	10	3	42	100%

Table F-16. Could you take on more or some of the leadership responsibility?

Site #	1	2	3	4	5	6	Total	Percentage
Yes	-	2	2	4	3	1	11	26%

Comments:

Site 2
- do already

Site 3
- too busy

Site 4
- but not right now (2)
- if asked
- could introduce speakers

Site 5
- could (1)
- does (1)
- offered but it wasn't followed up on

Site 6
- doesn't want to at this stage of life - would have to push self

No	7	5	2	8	7	2	31	74%
								100%

Comments:

Site 1
- doesn't choose to (4)
- health reason (1)
- helper not a leader (2)
- already very active in many groups
- I'm dropping things, not adding

Table F-16. (continued) Could you take on more or some of the leadership responsibility?

Site 2	•doesn't choose to (1) •carrying for ill spouse (1) •not knowledgeable enough (1) •moved to another community (1) •role is shared							
Site 3	•too lazy (78 years old) •health (poor vision)							
Site 4	•too busy (2) •health (2) •shy (1) •not good at it (1) •listen, don't take part (1)							
Site 5	•worker, not leader (3) •not interested (3) •too busy (1)							
Site 6	•not a leader •could share responsibility							
TOTAL RESPONSES	7	7	4	11	10	3	42	100%

Appendix G.01

Summary of Facilitators Response to Guided Interview

Table G-1. Who are facilitators:? N-6.

- Coordinator of Seniors Health Promotion programs in the community served by the West-Main Health Unit.
- Coordinator and Programmer of a privately run Seniors Centre.
- Instructor in two community centres fun and fitness programs.
- Facilitator of Seniors programs and fitness and yoga instructor for adults, in a community centre.
- Facilitator of seniors programs and Red Cross Fun & Fitness at a community centre.
- Facilitator of Seniors program & fitness instructor at a community centre.

Table G-2. Programs length of operation and number that attended:

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Length of Operation	6 mo	14 mo.	4 mo.	6 years	8 years	10 mo.
Average # that attended	10-15	9-15	10-12	10-30	20-30	6-8

Table G-3. Program Activities:

	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6
Exercise	*walking club *(biweekly)	*fun & fitness	- -	fun & fitness	*fun & fitness (3 x week)	exercises
Discussion	(bimonthly)	weekly	bimonthly	weekly/D/C	weekly	weekly
Blood Pressure Reading	- -	bimonthly	- -	weekly	weekly	- -
Massage	- -	Fitness instructor	- -	fitness instructor	- -	participants

*Activity occurs weekly unless otherwise stated.

Table G-4. Define Health:

•A resource for every day living. Physical/mental/social and spiritual well-being. People having hope that they can affect their personal circumstances.

•Being interested and active.

•Fresh air, food, exercise, aware of your body and what it says.

•Freedom from illness and infirmity. The ability to live a full life without pain or restriction.

•overall well-being not just lack of disease, meet friends, improve outlook on life, spiritual and environmental awareness.

Table G-5. Define Health Promotion:

•Helps people continue to grow

•Realizing what could happen, change. Discuss how you feel. Education - need more information to deal with changes.

•Encouraging people to get out and be involved, interested in current events

•awareness of health factors. Talk about what the information means - otherwise it doesn't register.

•making people aware. Not just physically, but socially needing to be aware of the importance of sharing and caring.

•physical exercise, social contacts, comfortable environment.

Table G-6. Has this definition changed?

•approach to H.P. called community development. Fits with an independence philosophy which has people identifying their own needs and planning their own programs to deal with issues important to them currently.

•its like graduating from high school just need more information for the next stage of life.

•changed from interests in Bingo, Bridge and tea, to interest in current events and more night time activities

•people more aware

•changed from disease focus to broader overview

Table G-7. Is this the operational definition you use in the program?

Explain reason for this answer

Coordinator:

Site 1, 2, 3 & 6.	•***Yes***	People grow and mature in skills, ability, wisdom and insight. Programs help people continue to grow.
Site 1	•***Yes***	The thing I learned is that seniors do for themselves. I step back. that's how I plan all programs now. If they're not interested, there's no point.
Site 2 & 4	•***Yes***	No one in my group would have planned my boat trip. They came up with the ideas - like speakers.
Site 3	•***Yes***	Share information with others as a fitness and yoga instructor as well as wellness program.
Site 5	•***Yes***	Many lonely people (die of loneliness) need to change from medical term to holistic.
Site 6	•***Yes***	Emphasizes social contact. Discussion groups. Participants views shared.

Table G-8. Do you attract new members to the Program? If yes, explain how.

Site 1.	•***Yes***	Walking club brings in new members. Word of mouth, a tea social
Site 2	•***Yes***	Brochures, word of mouth mostly
Site 3	•***Yes***	Phones and reminds participants, word of mouth more effective than advertising in newsletter
Site 4	•***No***	Program has continued exercise component by word of mouth and newsletter, discussion component closed down because of power struggle in the centre and resistance to change on the part of some individuals and monopolizing of conversation by some members.
Site 5	•***No***	Group is static, try to get seniors to carry copies of newsletters and share with others. Encourage people to come to special events.
Site 6	•***Yes***	By informing other seniors groups in the centre. Program participants hand out pamphlets at various events, by word of mouth.

Table G-9. Why do participants leave the program?

Site 1	•leave because of holiday, illness or forgetting.
Site 2	•moved, found another activity, interest
Site 3	•leave for new seniors centre, moving, illness, don't want to know any more
Site 4	•don't feel welcome by some members, cliques in groups, illness, move away, lose interest
Site 5	•move, illness, die, get bored and find other interests
Site 6	•illness, holidays, other interests or commitments

Table G-10. Do you see changes in participants since the program started?

Comments:

Site 1	•***Yes***	More open to talk about things, group is growing slowly
Site 2.	•***Yes***	More flexible, mentally and physically
Site 3	•***Yes***	One man lonely, now more active, chatting
Site 4	•***Yes***	More flexible for exercises. In discussion group some have improved and found friends. The people that attend the group and the centre are not seen as friendly by a number of people who try to feel comfortable here and make friends, some have been successful in making friends and extended their networks and interests. i.e. joining concerned citizens for affordable housing. Others have not or have been ostracized by group members for expressing an opinion counter to the central clique and centre staff volunteers.
Site 5	•***Yes***	Better range of motion, more social friendships and increase in knowledge
Site 6	•***Yes***	Improved coordination, more involved in other events

Table G-11. How would you describe the participants of this program?

Site 1	Average age	70
	Age range	60-70
	Activity level	mostly active
	Health deficits	fairly healthy
	Other	easy going, positive outlook, mostly women, occasionally men come to walking club or to hear speakers
Site 2	Average age	71.5
	Age range	64-97
	Activity level	unusually active
	Health deficits	few
	Other	many women and old friends come themselves. Help themselves and each other. No males come here
Site 3	Average age	68
	Age range	55-98
	Activity level	some very active, some not.
	Health deficits	vision, heart disease, Alzheimers.
	Other	many only come to the program , others come 2 or 3 times per week. Men, who are lonely come on a regular basis, not as insular as other groups interested in environmental issues
Site 4	Average age	70
	Age range	55-90
	Activity level	mostly active, mixed group for exercise.
	Health deficits	vision, hearing, arthritis
	Other	comes and leaves with friends Don't reach out to newcomers. Have volunteers to greet people. Few males exercise and come to occasionally to hear a speaker.

Table G-11. (continued) How would you describe the participants of this program?

Site 5	Average age	70
	Age range	60-85
	Activity level	moderately active
	Health deficits	arthritis, hypertensive
	Other	optimistic, upbeat, busy in the way they choose to be
Site 6	Average age	65
	Age range	55-78
	Activity level	very active
	Health deficits	arthritis, foot problems
	Other	-

Table G-12. What are the needs of the participants in relation to what the program offers?

Site 1 •need to know how to handle housing moves and changes. Lonely people are hard to reach and motivate. Phoning and personal contact take a lot of work.

Site 2 •need formal education and exercise. It's easier to exercise in a group than by yourself. Keep track of each other. Help them understand their own physical limitations so they see other people in the same position. This explodes the myth of being older.

Site 3 •need more people to join in. It's hard getting them out of their homes, more space, different activities.

Site 4 •exercise needs met. They're city people, they don't know their next door neighbour. They go out for entertainment. They expect to be waited on. Needs of lonely or newcomers not met because of clique and power struggle going on there. Most of the group are passive recipients. They don't reach out to others except their long time friends. Needs of newcomers, and anyone who holds a different opinion from the 'old guard' are given the cold shoulder. Some feel they can't handle the stress so ignore or leave.

Site 5 •social, fun, contributing, sharing, counselling, empathy

Site 6 •we are filling their needs regarding exercise and discussion. They like exercises the most. We want more participation of seniors in program planning and topics.

Coordinator of Seniors Health Programs.

•need a place to explore what quality of life means to them. Groups need to go more through various stages if they are healthy and growing. Stage 1 of groups development is passive. Stage 2 - interest in one another. Stage 3 - interest in community, receptive and starting to reach out. Stage 4 - interested in issues that affect themselves community and province, nation or internationally. Programs like site 3, 4, 5 are not growing. Site 4 is backsliding in this process.

Table G-13. What is your role in the program?

Site 1 Coordinator
- programming, arranging time, dates
- advertising, fund raising

Site 2 Volunteer Fitness Instructor
- arrange room
- check up on people that are missing
- send cards
- lead exercises
- give massages
- arrange special events

Site 3 Facilitator - Centre Seniors Programs
- send out newsletter
- plan activities
- lead exercises and yoga
- talk with them, and listen
- make tea and goodies for them
- encourage their involvement in fund raising

Site 4 Volunteer Fitness Instructor (*same as Site 2)
- arrange room
- check up on people that are missing
- send cards
- lead exercises
- give massages
- arrange special events

Site 5 Facilitator of Discussion & Fitness Instructor
- facilitate seniors learning about their responsibility for their health
- to give them hands on experience

Table G-13. (continued) What is your role in the program?

Site 6 Facilitator and Fitness Instructor
•guide, assist with exercises and discussions
•share information regarding other programs and events in centre and larger community

Coordinator of Seniors Health Promotion programs

•health educator
•facilitator
•ideas generator
•resource person
•to be aware of the growing edge of a group of people and of individuals within the group and to make sure it is moving.

Table G-14. What is the participant's role?

Site 1	•make phone list, contact members to remind; suggest topics, contact speakers •prepare and hand out name tags
Site 2	•suggest program content •attendance records •serve juice •Blood pressure cards and take blood pressure (retired nurse)
Site 3	•help serve refreshments •set up dinner •involved in association •suggest activities but NOT planning program
Site 4	•suggest program content •keep attendance records •serve juice •blood pressure cards and take blood pressure (retired nurse) •introduce and thank speakers
Site 5	•learn wellness concept •share their knowledge •to volunteer in different capacities •serve juice •take attendance and blood pressure •to be a friend

Table G-14. (continued) What is the participant's role?

Site 6
- buying and serving juice
- some capable of leading exercises
- suggest and select discussion topics
- arrange speakers
- massage each others neck and shoulders

Coordinator of Seniors Health Promotion Programs

- take as much responsibility for planning and carry out program as possible to promote independence and deal with issues that are important to them

Table G-15. Do you see changes in these roles since the program started? Explain.

	Change	Explain
Site 1	unsure	hard to say, program is too new
Site 2	yes	more familiar with names of individuals, more self-confident and outgoing
Site 3	yes	more outgoing, talk about things they wouldn't talk about before
Site 4	yes	none regarding exercise. Discussion a struggle because of old guard trying to maintain the old way and their control in positions. (volunteer and paid at centre). This has affected discussions group - some people are more interested in doing more but power plays scare some away. Group doesn't own their program.
Site 5	yes	from a fragmented group to a well rounded group, skilled in knowledge, advocacy, committee work, volunteering and fundraising
Site 6	yes	didn't expect them to be so active. Added more physical exercising because they were able. Several are capable of leading exercise, do this if I'm called away.

Table G-16. In what way do you involve seniors in the overall design and implementation of the health promotion program?

Site 1	•volunteer, program planning and fund raising for centre
Site 2	•planning time
Site 3	program, being active, phone and remind
Site 4	•suggesting speakers, planning activities
Site 5	•by an annual questionnaire, brainstorming, getting them to bring in articles and suggest speakers
Site 6	•buy juice, phone speakers, suggest and arrange speakers

Table G-17. What sort of community outreach does the program foster?

Site 1 •program is too new, it will in time

Site 2 •advertise by attending community events, do exercises for groups

Site 3 •involved in other organizations such as Red Cross and hospital volunteers, writing to city hall re bus stop being moved, and other environmental issues affecting their neighbourhood

Site 4 •some individuals involved in other activities but not as a group

Site 5 •encourage participants to hand out newsletters and program information to other seniors. Do fitness, demonstration in community and have a group table at wellness and health fairs

Site 6 •not yet. Would like to start a wellness program in a seniors high-rise or other place like church. Have a person that speaks Chinese. Volunteer willing to interpret if some Chinese ever come to this program

Coordinator of Seniors Health Promotion Programs

1. Sit on Advisory Committee to City Hall, West side advisory to health unit. Community Centre Operational Committee.

2. Seniors in Action - a one day event planned by seniors from all over Vancouver - committees, community centre operations.

3. Concerned citizens for affordable housing and any other group that program participants find they want to create or join to deal with the issues that are important to them.

Table G-18. Does the program have an effect on the community?

	Response	How do you know?
Site 1	***not yet***	it will take time to happen but the seniors centre does by providing a place for wellness programs and recreation, a place to volunteer, support group, support the attitude of doing things when retired. People have more friends and it is a nice place to come.
Site 2	***yes***	healthier seniors
Site 3	***yes***	people aware of programs for seniors
Site 4	***yes & no***	some members of program are involved in senior centre, planning and other activities such as Concerned Citizens, Seniors in Action and Neighbourhood Helpers.
Site 5	***yes***	our group fundraises for local community centre and serve on various committees and a seniors group. Some members involved in lobbying for a seniors centre.
Site 6	***yes, indirectly***	healthier person makes a better contribution. Create an awareness in self and others. Seniors in Action, and Seniors Strut.

Table G-18 (continued) Does the program have an effect on the community?

Coordinator of Seniors Health Promotion Programs

1. Raises awareness of seniors, and others of what seniors can do and explodes the myths on aging.

Table G-19. How often do you meet with other community agencies to exchange ideas?

Site 1 •once per month with the Parks Board, Marpole network, Senior Centres Advisory, and a fund raising group for city

Site 2. •work with many centres exchanging ideas and information

Site 3 •doesn't meet but talks on phone with other coordinators of seniors programs at community centres. Has access to health department staff such as Coordinator of Seniors Health Promotion and nutritionist, and also Vancouver General Hospital speakers bureau

Site 4 •(discussion facilitator) - monthly with senior operational committee at centre and other health promotion coordinators

Site 5 •monthly with Parks and Recreation

Site 6 •monthly or on the phone

Coordinator of Seniors Health Promotion Programs

1. Monthly with a number of advisory and operation committees and networks re program.

Table G-20. How do you measure the program's effectiveness?

Site 1	•that people remain interested and enthusiastic. They are telling people about it
Site 2	•meet standard. People learn exercise can be fun. They get out and get active. It is a success
Site 3	•People give feedback. Objectives of centre are social and recreational activities, the program does that
Site 4	•Discussion facilitators (coordinator of seniors wellness programs) goal of wellness programs is for people to meet one another and establish what quality of life means to them
Site 5	•when seniors are able to change the concept of themselves. By their activity in the community
Site 6	•feedback from participants and observation. What they are doing outside i.e. walking more, nutrition changes, involved. If you have a healthy balanced person, they will benefit the community. We have created an awareness

FUTURE

Table G-21. What, if any, are your current plans for change in program content, delivery and organization?.

Site 1	•Health Department Seniors Coordinator has a big part in that. Once a group is involved she backs off - helps them apply for grants to do what they want to do
Site 2	•leave as it is - content, limited space - if they try to change it I quit
Site 3	•limited change because of time allotment and other duties. Paid for 8 hours by Parks Board and 4 hours by City and another 4 hours once a month. Really works 20-22 hours per week. I would like to see more music, travel, health resource people such as C.N.I.B., neighbourhood helpers to visit and write letters
Site 4	•exercise, unchanged. Discussion programs are continually evolving, more involvement of seniors in program planning. Some enjoy discussion which allows them to raise quality of life issues but others and old guard, who control want it to stay the same as before. This resistance to change and the interference of some individuals who report that discussion group has disbanded. Discussion group discontinued. Another senior member of the centre has started a small group another day. This group supports the community development concept. The seniors coordinator is not actively involved in facilitating it but does consult on request
Site 5	•more one on one outreach to shut-ins and lonely seniors, more newsletters around the area, more publicity in local newsletters, new topics and lectures for debate

Table G-21 (continued) What, if any, are your current plans for change in program content, delivery and organization?,

Site 6 •get seniors running the program themselves because this promotes independence

Coordinator of Seniors Programs

•seniors design and running their own programs and staff provide information, more intergenerational mix, with parent groups, adolescent. Seniors have real perspective. Prepare staff to work with seniors.

Table G-22. Who would you involve in these changes?

Site 1	•health department, seniors coordinator, and seniors centre executive not necessary, only if they feel its the kind of program the centre should have
Site 2	•I wouldn't. I would leave. Younger seniors coming up are already active
Site 3	•involve more people from different agencies on personal basis, speakers, etc
Site 4	•same as #2. Discussion facilitator, seniors themselves and operational committee of centre, depending on the change
Site 5	•centre programmer, seniors group and health department
Site 6	•seniors, community centre, programmer of Public Health.

Coordinator of Seniors Health Promotion Programs

•seniors in programs, health department and community centres staff and seniors advisory groups

Appendix H.01

Summary of Referring Professional Responses
to Questionnaire & Interview
N-20

Table H-1. Role of referring professional working with older adults.

Social workers	5
RN or Assessment Unit	1
Home support Administrators	4
Home support Supervisors	1
Activity coordinator	1
Director of Volunteers	1
Home care nurse	1
Nutritionist	1
Long Term Care Case Manage	5
Total	20

Table H-2. Aware of programs -

Yes	90%
Not aware	10%
Total	100%

Table H-3. Refer clients to programs:

Yes	80%
No	15%
No response	5%
Total	100%

Table H-4. Number of clients referred to Wellness programs in the last 12 months:

14 respondents referred 134 clients in the past 12 months
- 5 - s.w., 1 Nurse in assessment unit
- 5 - L.T.C. Assessors
- 0 - Home care nurses
- 1 - home support
- 2 - coordinators
- 1 - nutritionist

Total: 14

2 said no referrals
2 did not respond
1 referred to special H.P. program for adults with specific disease

Table H-5. Accessibility of program to clients.

Yes	50%
Unsure	35%
No	5%
No response	10%
Total	100%

Table H-6. Criteria used to refer clients to these programs?

No response - 2
Responses -18

Total 20

	Number
Location -	11
Program philiosphy -	5
type of activity -	5
client needs	
client ability	
client interests & motivation	
warmth of atmosphere	
group openness	
flexibility of coordinator	2
low cost compared to adult day care	1

Table H-7. Have your clients benefitted from the program?

No response	10%	
No	5%	
Unsure	40% -	because of no follow-up (6), too soon to tell (2)
Yes	45% -	good social match, if client interested, good feedback, for those that get there, small number because very active in the community at large as a result of program
Total	100%	

Table H-8. In your opinion what are the benefits to older adults and the community of this type of health promotion program?

Benefits to older adults

	# of references
Socialization	13
network	3
feeling in control over their life	5
looking forward to activity	3
information	4
awareness of healthy life style	1
health benefits such as fitness and mental stimulation	2
contact with health professional	1

Benefits to community

	# of references
active in community life	1
reduce acute care admissions	2
reduce cost of health care for older adults	1

Response to this questionnaire	95%
Not aware of program	5%
Total	100%

Table H-9. In your opinion what are the disadvantages of this type of program?

No response	10%
Don't know	10%
Responded	80%
Total	100%

	# of references
•transportation	4
•not accessible to disabled seniors	2
•not for frail elderly	1
•not for those that are poorly motivated	2
•not for those that don't function well in large groups	2
•may promote dependency (depending on care giver approach)	1
•create problems for participants with unrealistic expectations of their optimal level of health	1
•cliques in groups may exclude new members	1
•sometimes there is a gap between expectations of participants and staff	1

Table H-10. If you were asked to give a complete and current definition of health promotion, what would you include?

No response	10%
Don't know	10%
Responded	80%
Total	100%

	# of references
•incorporated a definition that included information on a number of health promoting topics ranging from nutrition, exercise, stress reduction to specific management of disease	6
•incorporate definition related to promoting physical, mental and social wellbeing	5
•made reference to responsibility for own health	3
•referred to independence and control over health	2
•increase in quality of life	2
•described health promotions in relation to living free of disease	1

Table H-11. Asked to define health given current level of knowledge.

No response	5%
Responded	95%
Total	100%

	# of references
•mental and physical wellbeing	6
•mental, physical, and spiritual wellbeing	3
•physical and emotional wellbeing	1
•physical and social wellbeing	1
•flexibility to endure change in ones life	1
•best function	2
•anything that encourages	1
•a resource for individuals	1
•health education that deals with all aspects of a person	2
•awareness	1
•free of deficits	1

Table H-12. Has your view of health, wellbeing and health promotion changed over the years?

No change	10%
Yes	90%
Total	100%

Yes explained:	# of references
•more holistic view	3
•increased emphasis on disease prevention	3
•more information availability for all ages	4
•more aware of responsibility and consequences of caring	2
•more responsibility and choices	1
•more emphasis on mental health	1
•use to think lifestyle education was health promotion - now related to the environment where individual lives	1
•more respect for clients definition of health	2
•appreciate more interrelatedness of different aspects of a person in maintaining health and causes of illness	1

Table H-13. Are you aware of any changes in the neighbourhood health promotion programs content or approach?

No response	5%
No	55%
Unaware	10%
Yes	30%
Total	100%

a) If yes, state what they are -	# of references
•more advertising in brochures & programs	2
•increase in number of programs	1
•more emphasis on prevention of illness	1
•more emphais in program in contacts & staff involvement	1
•more support of seniors re networking	1

b) view of changes -	# of references
•very good	2
•positive	3
•more realistic approach	1

Table H-14. View of absense of change N11.

No response of those who said No to Q13	18%
Didn't know well enough to comment (5% referred most to adult day care)	36%
Expressed their view	46%
	100%

Views expressed:	# of references
•need to be more responsive to isolated elderly	2
•B/P gets people in but not a good idea	1
•need to keep abreast of changes but contradictory information too much for elderly to take in	1
•personally has changed approach but sees little change when speaking to these groups	1