Community Health Needs Assessment of St. Boniface and St. Vital

Process, Method, and Assessment Tools

by

Elaine Mordoch

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COMMUNITY HEALTH NEEDS ASSESSMENT OF ST. BONIFACE AND ST. VITAL: PROCESS, METHOD, AND ASSESSMENT TOOLS

BY

ELAINE MORDOCH

A Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

Abstract

Community health needs assessments are the venue by which community strengths, weaknesses, and health needs can be identified. In times of health care reform and fiscal restraint, the accurate identification of needs by the community and for the community, is an integral focus of meaningful change.

ACTION (Accessing Communities Together In The Identification of Needs) was a research project funded and commissioned by Youville Clinic through Manitoba Health. Youville Clinic commissioned a community health needs assessment of the St. Boniface and St. Vital communities. The ACTION Research Consortium (ARC), Faculty of Nursing, University of Manitoba, undertook a comprehensive overview of the health services already available in the two communities to identify what services would be needed in the future. The project was of 6 months duration.

The research design used by the ARC consisted of both qualitative and quantitative methods of data collection. The community health needs assessment model was based upon the Genesis III (General Ethnographic and Nursing Education Studies in the State) Model. Genesis III has been used to gather data for Oriented Primary Care Sites, a concept similar to Community Nurse Managed Resource Centers.

The Practicum Experience encouraged the writer to cast a critical eye over the process of conducting a community health needs assessment. In doing so, it is hoped future researchers will benefit from the Action Experience, and continue to refine community health needs assessment tools and the dynamic processes inherent in such projects.

Funding for this study was provided by Youville Clinic through Manitoba Health. Youville Clinic commissioned the community health needs assessment of St. Boniface and St. Vital (Volumes I & II), and the publication of the assessment and method used by the ACTION research consortium (Volume III).

Upon acknowledgment of Youville Clinic and the ACTION Research Consortium, all materials from this report, including the assessment tools, may be adapted and used by the public.

The assessment tools may require modification to be relevant to the context of individual community health needs assessments.

Acknowledgments

Appreciation and gratitude are extended to the community participants of St. Vital and St. Boniface who shared their stories and perspectives with the ACTION Research Consortium.

Appreciation and gratitude are extended to both Youville Clinic and Manitoba Health for their foresight in promoting the St. Boniface/St. Vital Community Health Needs Assessment.

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Appreciation and gratitude are extended to Ms. Verna Sylvestre, past Executive Director of Youville Clinic, a woman of courage and foresight. Thank you Verna, for the privilege of learning from your vast experience in innovative Primary Health Care.

Appreciation, gratitude and respect are extended to all the members of the ACTION team, each of whom contributed uniquely to the project.

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Heartfelt thanks to Dr. David Gregory, a mentor and a friend.

"When the student is ready, the teacher appears."

Native American Proverb

Dedication

To my Mother, a wise and strong woman,

To Isaac, whose name means "He laugheth",

To David Stacey, a steadfast friend.

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Chapter One

The Vision

The vision to conduct a community health needs assessment to plan future health services arose because of fiscal constraints impinging upon existing programs and the delivery of services. The conceptualization of the Community Nurse Resource Centers (CNRCs) developed because of these fiscal constraints and the Community Health Needs Assessment was viewed as the most logical first step. The Youville Clinic Board of Directors (the Board) and Manitoba Health responded to health care reform challenges, in part, by proactively commissioning the St. Boniface/St. Vital Community Health Needs Assessment. In collaboration with the Manitoba government, the Board determined the initial parameters and objectives of how a community health needs assessment could facilitate the expansion of Youville Clinic services under the auspices of the proposed Community Nurse Resource Center (CNRC) (Appendix A). The St. Vital CNRC, a satellite of the Youville Clinic, is slated to receive approximately $1 million in annual operating funds, redirected from institutional health care budgets. The CNRC will collaborate with a variety of agencies and community groups to ensure linkages with other programs such as housing, social services, and education; all broad determinants of health.

Quality Health for Manitobans: The Action Plan: A strategy to assure the future of Manitoba's health services system: Partners for Health (Manitoba Health, 1992) outlines a vision of health care reform to maintain and improve the health and health care services of Manitobans. Within this vision, the main principles of medicare (universality, accessibility, portability, comprehensiveness and public administration) are integrated in the proposed changes. Greater wellness, better quality of life, reduced disability and care that is closer to

home will be the measures of the health outcomes of our medical services. The focus will be on health promotion and disease prevention, community oriented care, and increased consumer participation in health decisions.

Although Canada has the second highest health services budget after the United States, countries such as Sweden and France who spend considerably less per capita, have higher life expectancies than either the United States or Canada (Manitoba Health, 1992). The "Partnership for Health" described in the government's vision of health reform is committed to the needs of individual Manitobans and communities. The "Partnership for Health" ensures a broad cross section of the health services community as well as the consumers of health care services.

Attention to consumer needs and the measurable outcomes of health care reform is an integral part of the health care vision. The vision for health care reform recognizes that hospitals and physicians are not the main factors that affect health. Determinants of health (socioeconomic status, productivity and wealth, environment, lifestyle, genetic endowment and the health services system) all impact on the health status of the population (Manitoba Health, 1992). Thus to affect the health status of the population, these determinants must be evaluated and considered in health promotion strategies.

The vision of Quality Health for Manitobans (1992) promotes a more balanced allocation of resources between prevention, community-oriented and institutional services. The Diabetes Education Resource Program is cited as an example of a partnership between patient, physician and the community which has provided an alternative to hospitalization during the initial stages of diagnosis. Youville Clinic has provided this service in the St. Boniface community since 1985. The challenge of Quality Health for Manitobans includes participation

from not only health care providers but also community members to contain health care costs and achieve better health services and better health for Manitobans (Manitoba Health 1992).

The conceptualization of the community health needs assessment was important to plan strategies to capture both the larger vision as portrayed by Manitoba Health and the Youville Steering committee's personal vision. In October, 1994, Youville Clinic and the St. Boniface/St.Vital Public Health nurses organized an inventory of services provided by Youville Clinic and the Public Health Nurses. Their main purpose was to identify gaps and overlaps in services. Both parties hoped the data would provide a clearer vision for new modes of services, increased continuity of care, and greater community accessibility.

The main findings of the report were:

1. Gaps in service occurred in health promotion, clinical services, community supports and community development.

2. Necessary overlaps in services occurred with pregnancy option counselling, prenatal nutrition and special needs classes (i.e. single and disabled women), individual counselling on parenting and child health issues, and coordination of referrals to other agencies.

3. Expanded community nursing roles were identified in the areas of a) health promotion, b) prenatal health- midwifery, information health phone line, and community resource information and data base, c) post partum support and education, d) child health- immunization programs, case management, mass media health promotion strategies, e) school age health - health promotion activities, peer support groups, self esteem and mental health issues, f) adult health - management of chronic diseases, additional counselling services, family violence and a community resource data base for referral identification, and g) seniors - develop linkages to physicians, home care and support services, develop lifestyle

management programs, expand clinical health care services and disability prevention programs.

The report identified major services provided by Public Health (St.Boniface/St.Vital) and the Youville Clinic. Services were viewed within the context of both programs, thus overlap and deficiencies were identified. Comparison with the larger project of the community health needs assessment would hopefully corroborate these findings or present a new perspective (Vielhaber & Schmalenberg, 1994). The vision of more coordinated services, greater community involvement and accessibility to services, became a driving force for future planning.

The Youville Clinic's vision for tomorrow continues to be based on a Primary Health Care model. Within this model, programs and new initiatives will be developed which complement existing services and resources for the promotion of health and the prevention of disease and illness (Youville Clinic Inc., Strategic Plan: Yesterday, Today, and Tomorrow, 1994).

The vision of enhanced services focused on two areas in which Youville Clinic was already delivering care; namely family health and diabetic education. Future initiatives in family health included the provision of more broadly based Primary Health Care services wherein nurses would serve as initial contacts in the provision of these services. Specific initiatives included the provision of services for pregnant women with addictions, midwifery/birthing centre services, and additional counselling services. These services feasibly could be delivered in the community (for example, day care, work place) and within expanded clinical hours.

Complementing the existing services of the Diabetes Education Resource program, outreach teams (nurses and dieticians) could provide ongoing education to the public. The emphasis of these initiatives would be primary and secondary prevention. A range of services could be expanded including foot care. Service would become more accessible with expanded clinic hours. Strategic directions which Youville Clinic foresaw were:

1. develop collaborative relationships with researchers at the provincial universities,
2. obtain funding for external evaluations of program outcomes, and explore areas of service,
3. obtain funding to conduct a community needs assessment to ensure that community health care needs are being addressed,
4. support initiatives in the development of community health center accreditation,
5. explore areas of service which will facilitate integration of services to avoid duplication. (Youville Clinic Inc. Strategic Plan: Yesterday, Today, and Tomorrow, 1994).

To validate the direction of new programming and initiatives and to ensure that true community needs would be met, the community health needs assessment was undertaken. Thus, Youville Clinic, with its foresight and commitment to serve the community, had the wisdom to seek the community's opinion of the true needs of St. Boniface and St. Vital.

Beginning Stages

In Manitoba, the Youville Clinic has successfully provided nurse-managed care since 1984, focusing on health promotion within a holistic health framework. Nurses at the Youville Clinic have practiced in an expanded role and in collaboration with allied health care professionals.

Youville Clinic opened its' doors on February 1, 1984 as a "store front" operation in a shopping centre located in St. Boniface. The clinic was established by the Sisters of Charity

of Montreal, the "Grey Nuns", to provide comprehensive community-based resources to mothers, children and families. The philosophy of the clinic promotes healing, compassion and an environment marked by mutual respect and sensitivity to the varied needs of others. The clinic supports healthy lifestyles by encouraging individual responsibility for health and creating clients' awareness of their own strengths. The goals of the Youville Clinic are to:

1. Provide cost effective, community based, client-centered and directed health care services to clients and families.

2. To develop and offer services within the framework of Primary Health Care.

(Youville Clinic Inc. Strategic Plan: Yesterday, Today, and Tomorrow, 1994).

Initially the first programs at Youville centred on maternal child health, healthy family living and parenting. Specific services were provided both at the clinic and in the community with the emphasis on maternal child health. In July of 1985, at the request of Manitoba Health, a Diabetes Education Resource Program was added. This program was established to meet the educational needs of people with diabetes and their families (Youville Clinic, Inc. Strategic Plan, Yesterday, Today, and Tomorrow, 1994). In October 1986, a satellite of Youville Clinic was established in the core area of Winnipeg to provide outreach health promotion services to Aboriginal people. The program closed in 1992 because of funding cuts.

Youville Clinic has been avant garde in the delivery of Primary Health Care services and in expanding the role of the nurse. The clinic is considered a model of primary health care outside of the traditional illness focused model of care. Care is client centred. The primary health care model incorporated and practiced at Youville since 1984, is now being implemented across Canada and in Manitoba. For example, the Manitoba government will

fund four CNRCs in the areas of St. Vital, (a satellite of Youville Clinic) Thompson, Norman and Parklands regions. Today, Youville Clinic is responding to health care reform challenges by creating leading community initiatives. One such initiative was the community health needs assessment of the St. Boniface and St. Vital areas. Within the financial constraints of health care, community needs assessments are vital to determine the essential health needs of a community and how best to use limited health care services to meet these needs.

Central to the Manitoban context is the current government approach to decentralizing health care. Quality Health for Manitobans (1992) recognized the need for balance between community-oriented and institution-oriented services. Previously, the majority of resources were allocated to institutional settings. The government plan aims to develop and strengthen community alternative services, enhance public education/consumer empowerment, and develop a new role for Community Health Centres.

The government is now moving from a tertiary care focus to prevention of disease and health promotion. A stronger focus on broader healthy public policy recognizes that the determinants of health; genetics, culture, socio-economic status, employment opportunities, and housing combine to effect individual health resources. The ideology underlying the current government's philosophy on health care reform is not new. Primary Health Care approaches and the concept of health's broad determinants were identified in Achieving Health for All: A Framework for Health Promotion (Epp, 1986) and in the Active Health Report—Perspectives on Canada's Health Promotion Survey (Health and Welfare Canada, 1985). Today, financial constraints in health care have necessitated a reorganization of current services and a more in depth analysis of the root determinants of health. The need for new

modes of delivering health care services and increased consumer involvement in the planning and monitoring of these services has become evident.

One of the suggested new modes of delivery of health care services are the CNRCs. The CNRCs are based on a Primary Health Care model which advocates community based health care services. Projects such as the McAdam Community Project (McAdam, New Brunswick, 1993) and the Comox Valley Nursing Clinic (Comox Valley, B.C., 1993) are examples of nurse-managed care and serve as other examples of decentralized health care services offered within a Primary Health Care model (Nursing B.C., 1993; May/June; November/December; Globe and Mail, 1994, January 28). In the Primary Health Care model, the nurse is the facilitator of individual, family and community health. The nurse assesses, provides care or refers a client to appropriate resources. Nurse managed care recognizes the community as an integral part of planning, delivery and monitoring of care. Community action and development, education and outreach, are central to nurse managed care. Within the concept of nurse managed care, services must be accessible, community based, e.g. may be incorporated into the existing community infrastructure, and determined by the identified needs of the community (Manitoba Association of Registered Nurses, 1994).

The vision of the CNRCs is that services are community based, delivered closest to the person's home, place of work, study, or play and provided at lowest financial and social costs. The underlying philosophy of the CNRCs is consistent with the current government philosophy of community care, client empowerment and initiatives addressing the broad determinants of health.

Chapter Two

Literature Review

Since the time of John Graunt (1662), measuring the health of communities has been considered necessary for the planning of public health activities (MacDonald & Howell, 1988). Although health promotion and primary health care are now important foci in the changing Canadian health care system, limited Canadian literature exists on community health needs assessment.

The majority of the literature on community health needs assessment is from the United States depicting methods and situations in harmony with the ethos and structure of the American health care system. Canadian nurses need to refine unique assessment tools to reflect the Canadian health care context. The current fiscal crisis in health care necessitates an increased emphasis on systems of care and workable health promotion programs based on accurate community health needs assessment (Barton, Smith, Brown, & Supples, 1993).

Analysis of methodological issues in community needs assessment is extremely limited. Descriptions of successful approaches which have been used are lacking. The process of conducting a community health needs assessment is not well documented. Stalker (1994) provided an overview of the Scottish community care planning in relation to the assessment of community needs. While a combination of quantitative and qualitative data approaches was used, and interviews with users and providers of services were conducted, little attention was paid to outcome measures desired by the Scottish government. Whether the community health needs assessment actually facilitated the attainment of the government's program vision is unclear.

Kosialak and Kerpelman (1987) describe a computer program standardizing community assessment and analysis. Their model is a systematic standardized approach for community assessment, analysis of current services, and monitoring of services. The model has been used extensively throughout Virginia and appears to have been effective in planning primary health care services. Computer spread sheets with formulas are used to determine the service requirements. Qualitative data is not discussed and there is no notation of how the data is gleaned prior to data entry. Gikow and Kucharski (1987) describe the use of the Functional Health Pattern Assessment tool, a tool adopting a systems approach, i.e., health perception, nutrition, elimination, etc. Although the tool is described and the framework wherein to find the pertinent data, the actual process of implementing the tool is not described.

The Genesis model has been used in several locales in the United States. The majority of the literature describes the various Genesis projects with little being written on the methodological issues used in their approach (Barton, Smith, Brown, & Supples 1993, Glittenberg, 1981; Stoner, Magilvy, & Schultz, 1991). Stoner, Magilvy, and Schultz (1991) in their systematic analysis of methodological issues, provide insight into the process involved in a community health needs assessment. The article addresses the more abstract process and highlights the potential problem areas, such as group dynamics, and inherent bias of the researchers.

Balacki (1988) critiques assessment approaches as applied to conducting a mental health community needs assessment in a rural area. Approaches such as key informant, community forum, rates-under-treatment, and social indicators are described as separate entities in conducting a community health needs assessment. Newer literature suggests a

combination of approaches to generate a rich diverse data base reflective of the whole community (Barton, Smith, Brown, & Supples, 1993; Feather, McGowan, & Moore; 1994). Basic process issues such as the amount of work involved in successfully organizing a community forum approach are discussed; however these issues are only superficially touched upon. Balacki (1988) pays credence to the scope of a community health needs assessment and the forethought and collaboration needed among a variety of professionals; somewhat indicating to the potential planner the amount of work involved.

Planning Healthy Communities

Planning Healthy Communities: A Guide to Doing Community Needs Assessment (South Australian Community Research Unit, 1991) is a comprehensive tool that meticulously outlines the intricacies of conducting a community health needs assessment. A video is also available to complement the printed material. The manual describes the "What, Why and How" of conducting a community health needs assessment in a style that is easy to read but provides an in-depth analysis of the issues associated with undertaking a project of this nature. The manual is interspersed with examples, mainly from the Australian context, and laced with humorous graphic illustrations. Key concepts are isolated within boxed inserts facilitating the absorption of the volume of material presented.

The manual addresses critical issues such as misplaced value judgements and societal inequities; concurring with the work of Epp, 1988. Ethical issues in research are discussed, namely the ethics of using limited research resources and the ethical outcomes of the research, namely who will benefit from the research. Who has access to the information, how will the information be disseminated to the public, confidentiality, and the right to privacy are

discussed. Research and ethical issues are presented in detail and brought to the forefront early in the planning of a community health needs assessment.

Methods of conducting surveys; face to face, telephone and mail-out are discussed with information supplied on sample selection, writing individual questions, and formulating a questionnaire. The guiding principles of analysis considerations such as coding data for computer input are provided. The manual is practical presenting these considerations adjacent to the creation of the questionnaire, enabling the reader to identify analysis issues early in the planning process.

Qualitative research, the pros and cons as opposed to quantitative research, and the underlying power dynamics dictating each type of research's meritorious value are presented. Examples of the use of qualitative methods are provided with sufficient detail to enable the organizer to conduct the research, identify pitfalls, and compensate for limitations.

Details depicting how the final report should look, including suggestions for the executive summary, the introduction, recommendations and strategies for presenting the results are provided. Specific detail such as how to report statistics, the use of graphs and charts, and ways to present qualitative data are well described. The authors urge that results be disseminated to as many community parties as possible for maximum beneficial use of the data.

Additional resources are listed for the reader supplementing the information presented. A complete appendix of tools used in the community health needs assessment enables the reader to visualize the process described. The manual is unique in its thoroughness in discussing both method and process.

Guide to Community Health Assessment: The Canadian Context

Canadian literature appears to have concentrated on specific aspects of needs assessments, i.e., telephone surveys, health promotion surveys; the result being little available information on how to conduct a community needs assessment within the context of the current Canadian health care reform (Catlin and Shields, 1988; Gregory, Russell, Hurd, Tyance, and Sloan, 1992; MacDonald and Howell, 1988).

The Canadian Public Health Association published a Guide to Health Needs Assessment: A Critique of Available Sources of Health and Health Care Information (Chambers, Woodward, & Dok, 1983). The guide describes the basic concepts of wants and needs demonstrating that the Health Care System is in equilibrium when Want=Need=Demand=Use=Supply and Quantity=Quality. The guide recognizes that the health care system is usually not in equilibrium and it is from these situations that community health needs assessments arise. Steps in conducting a health needs assessment are described. A series of questions focuses the reader on the feasibility of a community health needs assessment and on realistic outcomes to expect.

Existing sources of health and health care information are described with addresses of potential sources. The guide discusses national and provincial, profit and non-profit sources of data and provides examples of each. The advantages and disadvantages of using existing data sources are briefly discussed but the actual complexities of the problems that may arise are not addressed. While the guide does allude to problems that may arise within data collection, it provides only a superficial "hint" of what may occur.

At the time of writing, key informants and qualitative data gathering were relatively new phenomena. The information regarding using this strategy of data collection provides a

superficial overview of how to organize the strategy. The guide is a basic "launching pad" that provides only elementary information, i.e., "Sometimes it is better to record replies of key informants after the meeting" (p. 16). Basic research flaws are discussed with little information given on how to remedy them.

Throughout the guide, the use of case examples demonstrates the application of strategies and the reality of how these strategies affected change within the health care system; i.e.positively, negatively or not at all. The limitations of the guide are compensated for, in part, by the list of references supplied on various topics. The reference list includes topics of:

1. Needs Assessment
2. Prioritizing Needs
3. Methodological Papers on Existing Data Sources
4. Survey Research

The topics chosen are integral to a community health needs assessment. The reference list provides classic information but is dated with the years of reference ranging from 1970 to 1982. The guide is useful to outline preliminary steps in conducting a community health needs assessment but dated with little information on the complexity of the process involved.

Feather, McGowan, and Moore (1994) published a general paper on planning health needs assessments. The concepts outlined are basic building blocks for the framework of community assessments. Definitions of terms, understanding the reasons for conducting a health needs assessment, and general guidelines as outlined by the authors are provided. Their goals are to develop multi-disciplinary research skills, new conceptual models, and methods and approaches to health promotion research. An overview of community health needs assessment is provided and the authors introduce basic choices that are required when

planning and implementing a needs assessment (Feather, McGowan, & Moore, 1994). Although an overview of essential information is presented, specific analysis of the processes of communication and organization are not thoroughly addressed and are generally lacking in any of the Canadian literature.

Community Health Promotion In Action: The Action Guide is a health promotion tool designed for community use (Manitoba Health, date not available). The original intent of the booklet was to reduce harmful alcohol and tobacco use and improve healthy eating. The general principles can be applied to other projects such as housing and environment. The tool was originally developed by the Ministry of Health, Ontario and later published by Manitoba Health to encourage private and public sector organizations to adopt health promotion activities. The tool serves as a practical guide for communities and organizations to strategically plan work, identify resources and provides advice and guidelines from initiation to evaluation of the final project. The booklet is written in an easy to understand manner and can be utilized by lay people. It provides a superficial overview of "how to" conduct a health promotion project without addressing any of the rigorousness of research.

The Health Indicator Workbook

The Health Indicator Workbook: A Tool for Healthy Communities (1992) was published by the Office of Health Promotion, B.C. Ministry of Health. The intent of this workbook is to encourage local communities to identify and resolve their unique health issues. The tool uses indicators to reflect the broad range of health determinants i.e., socio-economic status, education, social support, and encourages communities to assess both their strengths and limitations. In the hopes of generating expanded models and future research in

healthy communities, the British Columbia government presents the tool as a beginning point for continued development.

The Health Indicator Workbook: A Tool for Healthy Communities (1995) has been updated by the British Columbia Ministry of Health and Ministry Responsible for Seniors. The original format of comparing communities to gardens is still used and the general information in the booklet has not changed. Newer references and possible sources of data, i.e., Data Directory for Community Health, 1993; A Report on the Health of British Columbia's Provincial Health Officer's Annual Report, 1994; are included. Both editions were based on the assistance and collaboration of eleven communities who pilot tested the health indicators. Reviewers from many organizations and disciplines and two health analysts contributed to the development of the workbook (Population Health Resource Branch, B.C. Ministry of Health and Ministry Responsible for Seniors, 1995).

The workbook is useful to mobilize community action to identify needs and generate solutions. The language used is devoid of professional jargon and demystifies the process of conducting a community health needs assessment. Throughout the booklet, possible information contacts such as Data Dissemination, B.C. Stats, Ministry of Government Services are identified.

The booklet invites communities to formulate their own definition of health within the World Health Organization (1984) holistic definition of health. The indicators of health are broad, similar to those defined in Quality Health For Manitobans: The Action Plan (Manitoba Health, 1992). The broad indicators of health are clearly delineated and concrete ways of accessing the data related to them are suggested. For example, studies in a variety of countries have shown an association between literacy and health. The studies have supported

the correlation between low literacy rates and poor health status. The degree of illiteracy in a community can be accessed by ascertaining the number of people with a grade nine level of education. This grade level is used throughout Canada as a proxy measure for literacy. Statistics Canada Survey of Literacy Skills Used in Daily Activities (no date given) and the Adult Literacy Centers in communities supply information on literacy trends.

Housing, access to food, and the number of people accessing food banks are identified as broad indicators affecting health. Basic strategies to collect this information are described. The Nutritious Food Basket is a measurement tool that has been used to monitor the cost of food in eighteen Canadian cities. The tool and instructions on how to use it are provided in the Health Indicator Booklet. As food is an absolute necessity for health, this tool provides a concrete method to obtain basic data on nutritional practices within the community.

Community preparedness emergency plans illustrate how a community would mobilize in case of emergency. Data of this nature includes assessing how people access social support. A suggested measure to determine an effective social support network is to assess whether community participants can name at least three people whom they could call in the middle of the night in the event of crisis.

Thus the Health Indicator Workbook (1995) effectively outlines basic strategies to conduct a community health needs assessment and is a useful tool for community mobilization. Appendices and references provide future resources for individual strategies within the community health needs assessment. The tool is a valuable resource to begin a community project but offers little guidance on the intricacies of the process involved.

Primary Health Care: A Nursing Model

Primary Health Care: A Nursing Model: A Danish-Newfoundland (Canada) Project (1990) published a community health needs and resources assessment package which was developed by Danish and Canadian nurses. The package arises from the Primary Health Care, A Nursing Model project initiated jointly in Denmark and Newfoundland in 1990. Funding was provided by the Newfoundland Provincial Government and the World Health Organization. Within the context of the project, the following objectives were developed:

1. Demonstrate nurses' full potential in providing primary health care in an affordable and cost effective manner.
2. To place emphasis on assisting individuals and groups to develop skills in self, family and community health care.
3. To involve the community in all aspects of program planning, implementation and evaluation.

(Association of Registered Nurses of Newfoundland and the Danish Nurses' Organization, 1992; p.1).

Within the framework of these objectives, community and individual assessment tools were developed; with general public and key informant questionnaires, community profile guides, and community health resources tools. Description of the administration process, involving the Project and Practice level activities, address some process issues of communication and responsibility. For the purpose of the project, Project level work was outlined as developmental (i.e., conceptual framework, teaching package, budget, evaluation and administrative policies). Practice level referred to areas of assessment, planning, implementation, and evaluation as well as teaching and research. A description of the

composition of committees provides insight into some of the process issues in community health needs assessment. The project planning group is made up of an international group of nurses from Denmark and Canada which is called The International Steering Committee. The project is coordinated by three directors, an international coordinator who oversees the total project, with Danish and Canadian project directors overseeing their respective programs. Advisory committees and governmental agencies interface with the project directors and practice level nursing staff (Association of Registered Nurses of Newfoundland and the Danish Nurses Organization, 1990).

The Newfoundland project is funded for a three year period and it is likely once the outcomes are published, the assessment tools and needs assessment process will be further evaluated.

Saskatchewan Health (1993) provides a basic guide for conducting a community health needs assessment. The guide presents the basic steps but does not describe the intricacies of the method. The reader is given a very general framework and is not prepared for the amount of work or the complications that can arise. Further references are cited as possible resources to assist with the details of conducting a community health needs assessment.

The Social Planning Council of Winnipeg (1987) published a brief "Community Infokit" with basic information about community needs assessment. Five steps to completing a community needs analysis are identified with an overview of how to achieve them. The steps include identifying the purpose of the needs analysis, defining the community focus of the analysis, defining the problems in the community, describing the available services, and prioritizing problems for future services. General directions and information are followed by additional resources and possible contractual fee-for-service consultants.

While the kit is informative, it presents a superficial overview of the task and little information is given on the process dynamics involved in conducting a community health needs assessment. A brief overview of the relative strengths and weaknesses of data collection methods is provided.

In 1994, The Salvation Army Grace General Hospital conducted a community health needs assessment of the hospital catchment area based on the principles outlined in Higgs and Gustafson (1985). The community health needs assessment final report describes the findings in detail and discusses the various methods used to gather data. The process of how these data collection strategies actually "worked" is not documented (Mordoch, 1994).

Prairie Region Health Promotion Research Centre published the results of a national consultation on how to make research results meaningful (1995). The results of this consultation have implications for the process of community health needs assessments in both method and process. Dominant themes that emerged were:

1. User groups need to be involved from the onset in all aspects of the research process, including design of the project, interpretation and dissemination of the results.
2. There is a need for improvement in dissemination of information. This includes how the information is packaged, how it is made accessible and clear definition of who is responsible for the dissemination of the information.
3. User groups need education, training and skill development to assist them in their involvement in the research process.
4. There is a need for improved use of technology to ensure optimal use of data bases.
5. Partnerships between users and producers of research must be strengthened to facilitate the flow of information vertically, horizontally, and interactively.

The results of Making Research Results Meaningful to Users (Prairie Region Health Promotion Research Centre, 1995) while not specifically outlining process issues in the methodology of community health needs assessments, have implications for the method and consequently the process of conducting a community health needs assessment. Further research and literature based on the new findings and recommendations is needed.

Summary

The above mentioned projects represent the key foci in the Canadian literature. Work currently being conducted will add to the sparse body of knowledge now available. The escalating costs of health care services and the challenges of delivering quality care within financial constraints will likely increase research in both the areas of primary health care and community health needs assessments. The Canadian literature on the subject of community health needs assessment tools is limited and in need of development. While various tools such as the Health Indicator Workbook (1995) and Planning Health Needs Assessment (1994) are useful for planning the framework within which to collect data, the actual intricacies and complications of the process are not well addressed within the existing literature. This gap in the literature is made more obvious by the current health care crisis accentuating a need for accurate and efficient assessment strategies. As more community health needs assessments are conceivably undertaken, understanding the process with its intricacies and complications will be both beneficial and energy saving. Tools and processes that take into account the diversity of small towns versus urban centers, and that can lend themselves to various contexts are needed. The description of methodological issues in the literature is currently lacking. The development of this literature will hasten the refinement and creation of flexible effective tools and processes.

Chapter Three

The Genesis Model

In the beginning stages of the ACTION (Assessing Communities Together in the Identification of Needs) project, the model for conducting a community health needs assessment was developed after a review of existing community health needs assessment tools. The GENESIS (General Ethnographic and Nursing Evaluation Studies in the State) model of community assessment was selected, as it had been used in several rural communities in the United States. The model makes use of both quantitative and qualitative data sources (Stoner, Maglivy, and Schultz, 1992). GENESIS assumes that the health needs of a community and its residents are inter-related with the community's environmental, economic, social, educational and cultural dimensions. This assumption is congruent with the concept of holistic health, a key component in the ACTION research project.

At the time of its development, GENESIS was innovative in that most community health needs assessments concentrated on quantitative data collection, comprised mainly of statistics related to health problems. The GENESIS model was developed by the faculty of the School of Nursing at the University of Colorado (Glittenberg, 1981), modified as Genesis II by faculty of the University of Utah College of Nursing (Boyle, 1984), and further refined as Genesis III by West Virginia's School of Nursing faculty (Counts, 1985). The title was recently changed to Project Community Analysis (PCA) to better reflect the purpose of the project (Barton, Smith, Brown, & Supples, 1993). GENESIS embraced health as an integral part of the community culture and expanded data collection tools to include qualitative data in the form of key informant interviews and participant observation (Barton, Smith, Brown, & Supples, 1993).

In GENESIS, a team of researchers would typically "descend" upon the community and become immersed in the data collection for a limited time period (Stoner, Maglivy, and Schultz, 1992). The team, composed of faculty and students, gathered data from primary key informants, through participant observation, field notes, and existing published reports. As the GENESIS model was used in various projects, the process of conducting community health needs assessments evolved. This multi faceted approach to gathering data provided a rich and meaningful data base. For these reasons, the ACTION research consortium chose GENESIS from which to develop a model to conduct a community health needs assessment of St. Boniface and St.Vital.

ACTION was a research consortium based at the University of Manitoba, Faculty of Nursing. The Youville Clinic contracted the ACTION research consortium to conduct a community health needs assessment of St. Boniface and St. Vital. The project was unique in Manitoba and Canada in that a community health needs assessment of this scale had not previously been undertaken. The Project was of six months duration with the purpose of: establishing the health needs of residents of St. Boniface and St. Vital, providing a comprehensive overview of available health services, and identifying future service needs.

The ACTION model also defined health in holistic terms and recognized that the major determinants of health include environmental, social and economic factors concurrent with lifestyle, genetics, and availability of appropriate services. This broad perspective on health was in keeping with Manitoba Health's strategic plan for quality health reform (Quality Health for Manitobans: The Action Plan, 1992). The ACTION community health needs assessment was a proactive approach to health care reform and afforded nursing a concrete opportunity to contribute to health care reform.

The Challenge

ACTION was challenged to expand the GENESIS framework to identify the health care needs of St. Boniface and St. Vital, with a population in excess of 100,000 people. The GENESIS model had not been used in a community of this size. Considerable forethought went into planning additional strategies to accommodate the urban setting and the large population.

An experienced co-chair, Dr. David Gregory, who had previously conducted a community health needs assessment, (Gregory, Russell, Hurd, Tyance, & Sloan, 1992) provided guidance in the selection of appropriate research strategies. The strategies consisted of: key informant interviews, focus group interviews; inclusion of culture, values and history of the areas captured with specific questions and photographs; surveys (telephone, mail-out and drop off); and unique organizational structures, i.e., Steering Committee, Co-Chairs, Data Collection Committees (PODS), Research Assistants and a Project Manager.

The organizational structure, located in Figure 1, p.33, was of key importance to the efficient management of the project. The project infrastructures facilitated communication between and among ACTION members. The communication channels located in Figure 2, p. 34, controlled the flow of information and consequently the pace of the work. ACTION met the challenge of expanding the GENESIS model to accommodate the more diverse and larger urban setting by investing time and effort in the organizational framework of the ACTION project. Vigilant monitoring of the efficiency and effectiveness of the organizational structure was a continuing challenge throughout the project (Appendix B).

Figure 1

Organizational Structure

Action Research Consortium (ARC)

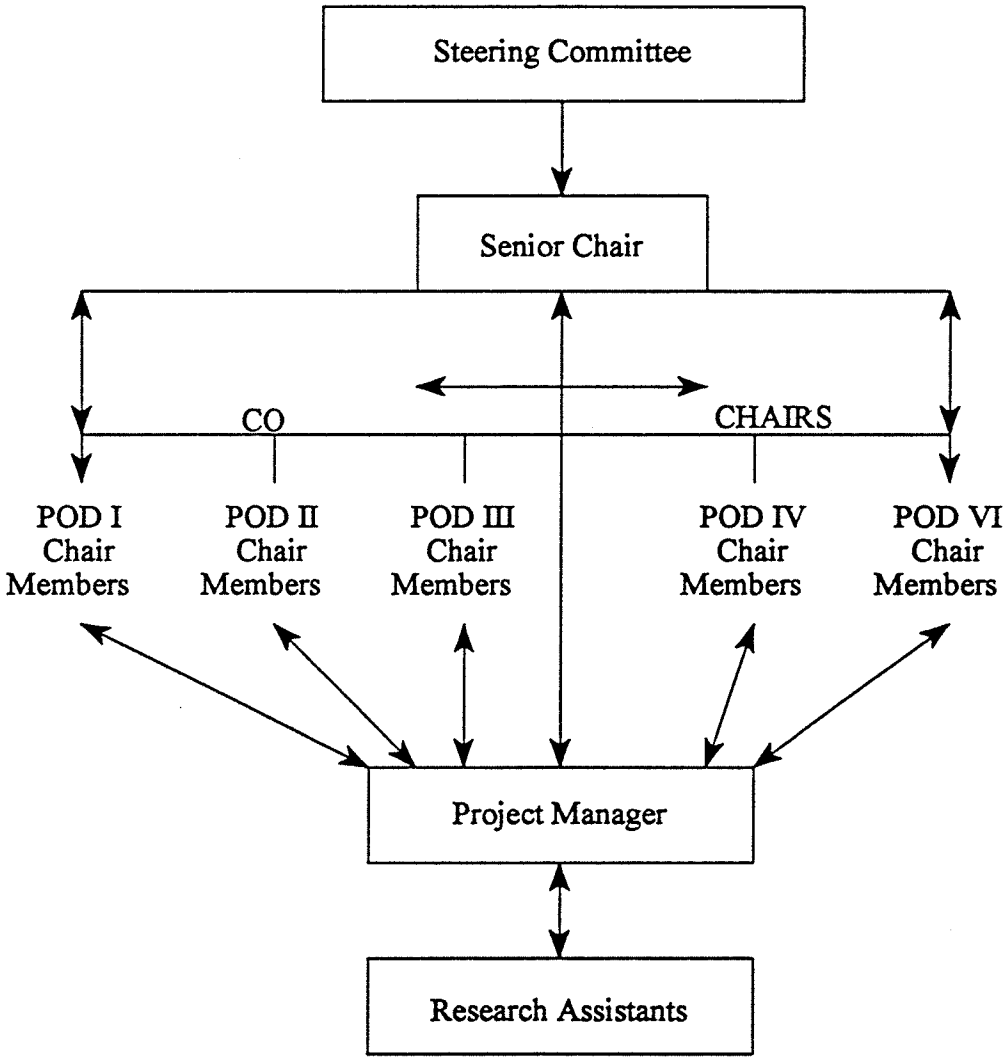
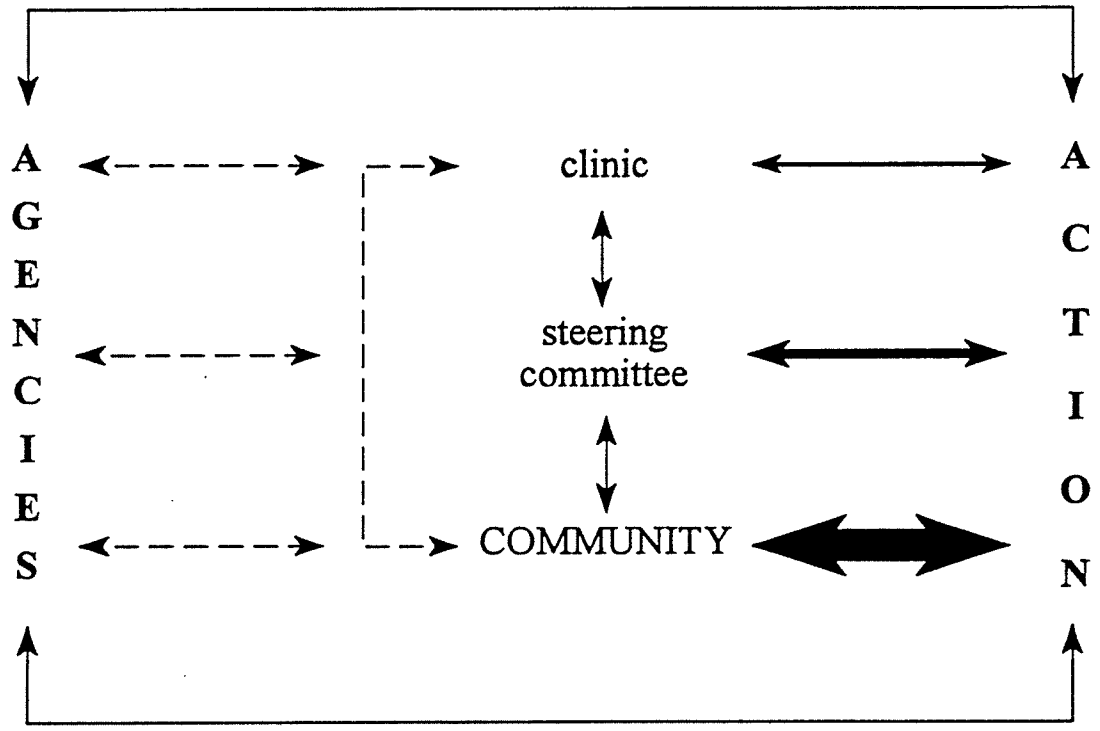


Figure 2

Communication Patterns



(Russell, Gregory, Wotton, Mordoch, & Counts, 1994)

Project Infrastructures

Organizational Structure

The Steering Committee. The Steering Committee was initially constituted to provide guidance to the ACTION Research Consortium and ensure the project was developing within the parameters of the identified vision. The members of the committee were chosen from diverse backgrounds to provide a well rounded representation of interests and expertise. The members included the following:

- Community hospital administrator (Chair)
- School Principal
- Youville Clinic Trustee
- Community Representatives
- Manitoba Health Representatives
- Faculty of Nursing, Dean's Representative
- Public Health Nursing
- Chair, Board of Directors Youville Clinic
- Executive Director, Youville Clinic

This eclectic group had a broad wealth of experiences to draw upon, was able to incorporate many perspectives, both personally and professionally, and often provided a current pulse on community events; i.e. historical presentations of St. Vital, current developments in palliative care, and practice issues presenting in the Youville clinic. The committee also reviewed monthly progress reports, critiqued instruments, assisted in problem solving and facilitated access to agencies and databases.

The Project Manager. In ACTION, the role of the Project Manager (PM) was complex given the communication lines and the magnitude of the project. The PM acted as a clearing house for all initial work, had an ongoing current overview of the various POD activities and directly oversaw the research assistants.

Research assistants were mobilized via the PM and information was disseminated to outline future work as generated by community contacts. Of key importance was the communication between the Co-Chairs, particularly the Senior Chair and the PM. Effective communication between the PM and the Senior Chair facilitated task allocation and proactive trouble shooting. The role of the PM was complex and included the following duties:

1. Research Assistants

   - Orientating the research assistants to the project
   - Assigning appropriate work and maximizing individual strengths
   - Monitoring the work to ensure progress and maintenance of the critical path
   - Administrating tasks regarding pay, hours of work
   - Facilitating communication between research assistants and ACTION members
   - Supporting and mentoring the research assistants in their research endeavours
   - Providing feedback on quality of work
   - Problem solving collaboratively
   - Ensuring commitments made to the community by the research assistants were honoured (i.e., not publishing names, informing the community of research results)

2. The POD Members

- Developing linkages with POD members and the research assistants
- Matching research talents with the task at hand
- Problem solving collaboratively regarding any communication problems, data collection problems
- Providing information on the total project
- Relaying information from POD to POD
- Relaying information from PODs to Senior Chair
- Relaying pertinent information from the community to the appropriate POD
- Communicating deadlines, meeting dates, and general information dissemination
- Incorporating POD feedback on system issues (i.e., communication, data collection methods) to improve the ACTION project
- Initiating problem solving meetings

3. The Co-Chairs

- Collaborating closely on project strategies
- Problem solving and carrying out remedial action
- Transmitting information from PODS, community, and research assistants to Co-Chairs
- Receiving information from the Co-Chairs and disseminating appropriately
- Activating ideas, suggestions with concrete follow up
- Exchanging perspectives on an ongoing basis to decrease bias in the research
- Monitoring the research process collaboratively

4. The Secretaries

- Delegating work to the secretaries from all PODS
- Delegating administrative work (i.e., thank you letters, letters soliciting access for data collection, faxes re: community requests, etc., memos to ACTION members
- Facilitating follow through with tasks (i.e., ensure that specific tasks were completed. For example, if faxes were to be received from ACTION members stating completion of work in a particular area, validating with secretaries if follow through complete.)
- Communicating frequently with the secretaries who were cognizant of the overall project work and also served as invaluable "trouble shooters" in practical matters. For example, the secretaries were aware of printing deadlines and the details to ensure deadlines could be met.
- Instigating communication strategies wherein secretaries would relay information to all ACTION members.

5. The Senior Chair

- Communicating initially on a daily basis
- Meeting weekly throughout the duration of the project for in depth discussions of project issues
- Receiving information from the Steering Committee via the Senior Chair
- Disseminating information
- Initiating actions related to the information received

- Strategizing on group process issues; i.e. ensuring attendance at group meetings and compliance with deadlines
- Monitoring collaboratively the expenditure of resources, i.e. money, time and energy
- Maintaining the critical path
- Analyzing the data (qualitative)
- Ensuring dissemination of results to the community (Community forums)
- Presenting the project to Manitoba Health
- Presenting the community health needs assessment project to community members of Sprague, Manitoba
- Collaborating on articles discussing the ACTION project; i.e., Putting Nursing into ACTION: Assessing the Needs of St. Boniface and St. Vital (Gregory, Mordoch, Wotton, McKay, & Hawranik, 1995).

The Co-Chairs. Four Co-chairs, members of the Faculty of Nursing, University of Manitoba, directed the project, with one, the Senior Chair, assuming the major leadership role. Within the capacity of this leadership role, the Senior Chair (Dr. David Gregory) maintained a forward looking perspective and always kept the total project goals foremost. This role propelled the project and kept the research process both moving and directed. When a tendency to become disproportionately immersed within the numerous details generated by a project of this magnitude, having one person with a clear vision of the critical path and the end project was invaluable. Theoretical and practical expertise coupled with external collegial affiliations strengthened the effectiveness of this role.

The Co-Chairs, Ms. Donalda Wotton, Ms. Marion McKay, and Professor Pamela Hawranik, continuously influenced the project within the planning, data collection, and analysis stages. Besides having their own research areas of responsibility, the Co-Chairs were available for intermittent "brain storming" sessions wherein the group would decide on project tactics. As much as time would allow, which depended on the workload of their own research areas at any given time throughout the project, the Co-Chairs maintained a broad overview of the project's functioning and often served as proactive "troubleshooters". In addition to these functions, the Co-Chairs were an additional resource for others involved in the project.

The PODS. Managing the large volume of data about the health and social care needs of St. Boniface and St. Vital necessitated the creation of six PODS (or information areas). The PODS gathered quantitative and qualitative data in the following areas:

1. Statistical (secondary data) information.
2. Cultural, social and historical contexts.
3. Interviews with community residents and health care providers.
4. Existing health and social services.
5. Industry, environment, and crime.

(Gregory, Mordoch, Wotton, McKay and Hawranik, 1994).

A sixth pod originally designed to formulate a portable data base was unable to proceed because of the inadequate and disparate data bases (Appendix C).

Faculty members with varied backgrounds and interests volunteered their services to organize the work of their respective PODS. Within the goals of the project, the POD members devised frameworks and strategies to ensure their particulars goals were met. For example,in POD II where the data collection was focused on the culture, history, and values

of the communities, a framework consisting of 26 questions was generated (Appendix D). Unique methods of data collection using popular art, people on the street and photography helped to capture these less tangible aspects of the communities.

The POD Co-Chairs provided guidance and ongoing direction to the research assistants and POD members, plus assisted with problem solving. Within the PODS, the role of POD members varied according to the nature of the data collected. Some of the POD members were actively involved in the "hands on" research processes while others ensured data collection was proceeding by overseeing the research assistants assigned to the PODS.

Research Assistants. A total of 17 research assistants were involved with the ACTION research project. The research assistants also came from diverse backgrounds. Some were experienced clinicians, other were new graduates and still others were currently students in university nursing programs. Their various talents were used in a multitude of ways. Several of the research assistants were bilingual which was particularly helpful in the St. Boniface community. Their bilingual assignments consisted of interviewing French community members, assisting with media releases, accessing the Franco-Manitoban community, and presenting project findings in the French language at two community forums.

Research assistants with advanced computer skills were invaluable. One of the research assistants was responsible for organization and preliminary analysis of the Statistics Canada (C91) data base which permitted ACTION to conduct a detailed analysis of the communities according to postal codes. Computers skills and knowledge were also used to organize the final compilation of the community contacts, a list of over 400 contacts.

Research assistants were key to the collection of data and the ethical integrity of the study as they had access to confidential information. Their interviewing skills and ability to develop rapport with community members had a direct impact on community involvement.

The research assistants were energizing to the project with their creative ideas, vitality, and fresh approaches. At times they would come up with "the obvious" that was sometimes overlooked. For example, when the team was strategizing on ways to increase community involvement, one of the research assistants initiated the idea of the community newspapers. Research assistants also monitored press releases and initiated corrections. As they were closely involved with the community, they were able to identify new leads and unforeseen avenues to explore, i.e., a Francophone gay/lesbian support group.

Consultants. Three consultants were available throughout the ACTION project:

1. Project Consultant with expertise in the GENESIS model of community health needs assessment: Dr. Cindy Russell, College of Nursing, University of Tennessee, Memphis.

2. Statistical consultant with expertise in data analysis and statistical procedures: Dr. Jeff Sloan, Manitoba Nursing Research Institute, Faculty of Nursing, University of Manitoba.

3. Research methods consultant with expertise in research methods: Dr. Annette Gupton, Director, Manitoba Nursing Research Institute, Faculty of Nursing, University of Manitoba.

All three consultants were called upon at various times throughout the project. Dr. C. Russell, the project consultant, offered her expertise regarding the process of community health needs assessment, presentation and analysis of the data, and was able to identify potential problems. Dr. Russell conducted two "on site" visits providing direct guidance and feedback to the Action Research Consortium (ARC) team on the methodology being used and

assisted in problem solving. Dr. J. Sloan, the statistical consultant, provided expert insight on statistical analysis of the data and advice on how to maintain statistical rigor. He also provided feedback regarding the construction of the surveys. Dr. A. Gupton provided intermittent advice on research strategies and coordinated the administration of the ACTION research grant.

Secretarial resources. The secretarial pool at the Faculty of Nursing, University of Manitoba was invaluable throughout the project. The dynamic nature of the project often necessitated prompt delivery of work within short timeframes. The workload was unpredictable depending on when community contacts were finalized, while deadlines remained generally fixed for the provision of monthly reports to the Steering Committee.

In retrospect. The organizational structure was preplanned as much as possible. Because of the dynamic nature and number of people involved within the organizational structure, however, it continuously evolved. What worked well for some parts of the project required modification at other stages of the project. For example, towards the completion of the project, some of the research assistants' work was delegated directly by the POD members, circumventing the Project Manager. This was necessitated by time constraints. Increased dialogue between the Project Manager and the POD members, was implemented at this time and seemed to avoid potential problems. Redundancies in data collection were not as frequent at this stage of the project so that allocation of work through one central source was not as crucial. Initially, all work assignments were directed to the research assistants by the Project Manager.

The GENESIS model was able to accommodate a wide range of data and served as a starting point for the ACTION project. ACTION used GENESIS as a tool which

accommodated a broad and generous quest for data. The glaring differences noted in using GENESIS to fit ACTION's specific situation were not American versus Canadian, but rural versus urban. The GENESIS model had been used almost exclusively in rural areas. Methods used by GENESIS, such as "immersion" within the community, worked well for smaller more wieldy communities, but were impractical in the larger communities of St. Boniface and St. Vital. ACTION used the GENESIS model to direct the research process while developing unique strategies to capture the more diverse communities.

The GENESIS model did not provide strong direction for community mobilization. This could have been more effectively achieved by proactively reaching out to the abundant sources of existing community groups. These groups could provide a potentially rich source of data and a means of mobilizing the community early in the research process.

Generally the GENESIS model served as a building block which was expanded to include specific strategies to capture the unique features of the St.Boniface and St. Vital communities. The strengths of the model included
the holistic conceptual framework, and its inclusion of both quantitative and qualitative data collection strategies. The limitations of the model included the
difficulty of adapting the method to an urban setting and lack of clear quidelines on how to mobilize the community more effectively. The model was flexible enough to accommodate expansion without weakening its holistic framework and specific attributes. ACTION's modifications to the GENESIS model strengthened its diversity and illustrated how the model could be accommodated to the urban setting.

Chapter Four

Setting up the Project

Orientation of the Research Assistants

Once the vision and the basic working structure (the ACTION model) was developed, time was spent planning the research project. By investing time "up front" and resisting the urge to plunge "headfirst" into the data collection, potential problems were avoided. Orientating the research assistants to the ACTION project comprised some of this up-stream effort. The goal of orientation was to ensure that the vision of the community health needs assessment was understood and shared by all. Discussion was generated on the concepts of community health needs assessment and holistic health. The research assistants needed to have a complete understanding of these concepts to ensure that all pertinent data were collected. This was particularly important when using open ended questions and probes in interviews and allowed the research assistants to explore and encourage discussion of holistic health issues.

As the research assistants had varying degrees of familiarity with the concept of a community health needs assessment, considerable discussion centered around previous community health needs assessments. The ACTION model was based on the GENESIS model; therefore all research assistants were provided with an article on the utilization of GENESIS (Stoner, Magilvy, & Schultz, 1992). The projected expansion of the GENESIS model to incorporate the multiple complexities of the urban population in the ACTION project was discussed. Time for clarification of details and questions regarding the process was scheduled, i.e., group meetings were held.

The intent of the community health needs assessment was presented as a means to identify gaps in health and social service versus generating solutions to existing problems. Thus it is crucial that the community health needs assessment findings are thoroughly and critically analyzed prior to generating quick solutions (Feather, McGowan and Moore, 1994). Understanding this concept was crucial to data collection so that the research assistants would be able to discuss realistically the intent of the assessment and to whom the results would be distributed.

Within the orientation phase, Youville Clinic and its role in the community was stressed. Literature on the concept of primary health care, the history of Youville, and an overview of services offered was distributed to the research assistants (Appendix E). Youville Clinic is a well known community resource and regarded as a role model of Primary Health Care throughout the City of Winnipeg and within the Province of Manitoba. Using the name of the clinic often facilitated the collection of data and in various community strategies printed information on Youville Clinic was distributed; ie St. Vital Mall when advertising research activities. Using the Youville Clinic "name" encouraged interest and community participation (Appendix F).

The research assistants needed a broad overview of the current political issues in order to be able to respond to comments and questions that arose during data collection. In Manitoba, health care and Community Nurse Resource Centres were political issues during the community health needs assessment data collection period. Research assistants needed to be cognizant of the emerging issues as they were often questioned in these areas. If they were questioned, they made conscious efforts to present factual statements and not allow their biases to influence the response.

Ethical Considerations

Prior to the hiring of the research assistants, ethical approval for the project was received from The Ethical Review Committee, Faculty of Nursing, University of Manitoba (Appendix G). Research assistants were informed of the ethical considerations and any concerns they had were clarified. Installation of a strong ethical framework in the early planning stages generated an awareness of the importance of ethical research and guided the research process. The research assistants often internalized the ethical considerations of the project and were diligent in the identification of any unforeseen ethical dilemmas that arose. The research assistants vigilantly monitored the ongoing ethical concerns and brought these concerns forward to the Co-Chairs for resolution. For example, the research assistants ensured that any promises, such as assurances of confidientiality, were honored. They also advocated for all voices of the community to be heard; homosexual persons, children, and ethnic minorities.

Investing the time to discuss ethical concerns early on in the data collection process was invaluable. Open discussion of the ethical issues encouraged critical thinking and quality control of the process (Appendix H).

Collaboration Among Co-Chairs and Pod Members

Initially, the Project Manager (PM) and the Senior Chair organized a meeting of all Co-chairs and POD members. As the PM was hired after the contract was awarded to the ACTION research consortium, the first meeting provided the opportunity for committee members to get to know each other and understand their prospective roles. Members shared their experiences, expectations and reservations concerning the community health needs

assessment. This allowed participants to familiarize themselves with the other committee members and generated discussion of pertinent issues.

All members stated their particular interest in the project and expressed ideas related to their specific areas of data collection. Members identified ethical considerations in data collection, such as ongoing confidentiality issues. Research techniques and their appropriateness to the identified goals of the project were rigorously examined. During the course of the ACTION project, a continuous monitoring of strategies and their effectiveness sharpened the evolving process of data collection.

The role of the PM was further operationalized by identifying various methods of communication and organization that would accommodate the diverse schedules of the group. Beginning lines of communication were developed during the initial meeting with all committee members. The ACTION telephone line, wherein messages could be left for the Project Manager, became an invaluable and effective way of communicating. All POD committee members had busy schedules and the ACTION phone line voice mail proved to be an efficient way of relaying messages to the PM. The telephone voice-mail system was time efficient and cost effective for the PM in that messages could also be left for the research assistants. Often this would be the sole means of communication for several days. Having the line available saved much time, energy and frustration. A continuing dialogue and problem solving strategy often took place on the telephone line without having to wait until both parties had an opportunity to return calls.

The PM and the secretaries developed a working rapport that greatly facilitated communication between all ACTION members. This relationship between the secretaries and the PM was informal and highly effective for information transmission. The secretaries

facilitated expedient information exchange between PM and POD members. The secretaries frequently assisted with communication to POD members not having voice mail services. As the secretary and the POD co-chairs were generally at the University, the PM would contact the secretary, often by voice mail, who would then deliver the messages either by memo or in person. This procedure expedited information sharing and was extremely helpful in urgent situations. Conversely, Co-Chairs would also leave messages with the secretaries to deliver to the PM. The secretary often played a key role in transmitting information informally. At times during the project, the secretaries and the PM would converse frequently during the day.

In retrospect. Time spent in the beginning stages of setting up the project was invaluable. However, this time could have been more effectively used. A realistic discussion of the time commitment involved in a project of this magnitude would have better prepared participants to schedule their timetables to allow sufficient blocks of time to be set aside for the ACTION project.

Over estimation of the time involved would have been less detrimental and less stressful to all committee members. The nature of the ACTION project, and community health needs assessments in general was dynamic. Using a tool such as the ACTION model, generated a rich data base that required heavy time commitments to both collect and analyze the data. The dynamic nature of the project further necessitated that spontaneous impromptu blocks of time were required to deal with emergent issues.

Progress in any community health needs assessment is uneven, the process itself may be repetitious and serendipitous, with unplanned pauses to summarize information. The process itself may require forwarding information to appropriate resources for immediate action (Feather, McGowan, & Moore, 1994). Recognizing early on in the project, the level of

time commitment required and the spontaneous nature of the task, is key to effective working relationships.

If a realistic understanding of the time commitment can be achieved by all team members early on in the project, then these issues can be addressed "up front". The issues of the dynamic nature of the process, the required spurts of sustained effort, and the energy level in general, need to be discussed openly to ensure all team members are aware of the level of commitment a community health needs assessment requires. These issues were further compounded by having a deadline imposed by the funders. Various ways of working around potential time commitment problems, e.g., having a reserve of research assistants available to take on impromptu tasks, may be helpful. Knowing what time and energy key players can realistically manage is of utmost importance. Ensuring that key experienced people have adequate time resources increases the rigor of the research and ensures that time can be spent mentoring novice researchers.

Allocation of Work to the Research Assistants

All work delegated to the research assistants was channelled through the PM. This strategy was put in place to prevent redundancies in data collection and to ensure that time, energy, and money were being used in the most efficient manner. This process required continuous monitoring and vigilance on what tasks were currently ongoing within the project. Potential community contacts generated via the data collection process were meticulously recorded to ensure follow up contact.

At times, the research assistants would contact the PM to verify if newly identified contacts from their work in the community had already been contacted by other ACTION members. To facilitate this process, all research assistants were asked to record their

community contacts diligently and submit them to the ACTION office in a timely manner. A Community Contact sheet was devised to track the contacts and the pertinent data documented, i.e., key informant interview completed, unable to contact, notation of suggested new contacts (Appendix I).

The Community Contact sheets were filed categorically, i.e., Francophone, Women, Seniors; and then alphabetically within these categories. They were stored in the ACTION office and were available to the Project Manager as a reference for completed, ongoing, and future work. The sheets were also useful to the research assistants to ensure new contacts generated from the community had not been previously approached. Often, the Community Contact sheets provided new directions for the research assistants to follow. For example, in a contact made to the police department, several other key informants were identified as valuable spokespersons for the community. Tracking the contacts became a time consuming and complicated process as the project progressed.

Considerable forethought in the planning stages enabled the ACTION team to anticipate many problems. An attempt was made throughout the project to coordinate specific research assistants' talents with appropriate projects. Assistants who were bilingual were used in the Francophone community and assisted with translation of various materials throughout the project. Sensitivity, interest in particular areas, and related past experiences of the research assistants, all guided the PM to direct various tasks towards specific research assistants. For example, senior research assistants with more advanced levels of interview skills and an expanded knowledge base conducted interviews with local politicians, government figures and influential community members.

Research assistants were responsible for submitting weekly reports depicting their activities. The original form did not delineate if the designated task was ongoing or complete (Appendix J). This form was revised to include notation on the status of the task (Appendix K). Denoting whether the task was ongoing or completed, assisted the Project Manager to decide if pursuing the task was warranted, or if, in the interest of the whole project, the task should be terminated and efforts invested elsewhere.

Tracking the weekly activities of the research assistants enabled the PM to have an overview of how the work was progressing, to proactively institute problem solving approaches, and to immediately correct any misunderstanding of instructions. The documentation also assisted the PM to have a current overview of all POD activities as the research assistants were involved in all of the various PODS. For the research assistants, the weekly report assisted them to organize their work, to visually see their progress, and communicate with the Project Manager on a weekly basis. In the initial phases of the project, weekly telephone contacts were maintained between the Project Manager and the research assistants to ensure the aims of the community health needs assessment were understood.

In retrospect. Redundancies were often distressing to the research assistants if the community contact person was annoyed. The majority of the redundancies occurred within POD II. While all ACTION members were aware of the question framework guiding the data collection, no one envisioned the redundancies that could occur. The data collection strategies developed by POD II were unique, fluid, and evolving. Unfortunately the potential for redundancies was overlooked. For instance, when one examined the questions, (Who and what are the controlling forces in the community?, What are the sources of humour in the community?), potential multiple contacts were not obvious (Appendix D). In determining the

answers to these questions, contacts such as Neighbourhood Watch or schools were previously contacted by other ACTION research assistants. Although these research assistants pursued different information than the POD II contact, this was often difficult for the community members to comprehend. Being approached twice by ACTION, caused some community residents to voice their displeasure.

At the time of the ACTION project, students in the Community Health course from the Faculty of Nursing, University of Manitoba also were situated in the St.Boniface and St.Vital communities for their community experience. This experience had been prearranged prior to the onset of the ACTION project. Changing the students' community site was not an option at the time. Considerable effort was made to share the data collection, community resources, and not to infringe on the goodwill of the community. Despite the best efforts of all involved, some repeat contacts occurred; however these were kept to a minimum. Coordinating the efforts of both ACTION and the nursing students to a greater degree may have better utilized the students' energy and input to the community health needs assessment. Having two research assistants involved with both the course and the ACTION project further helped to reduce multiple contacts. As community goodwill is crucial to a community health needs assessment, attention to these details was very important.

The research assistants could have been better prepared to deal with the inevitable multiple contacts that arose. Discussion of this possibility beforehand and how to diffuse the situation would have been helpful to the research assistants. Often they were not prepared, and were unable to initiate "damage control" for such situations.

Facilitation of Group Process

As the ACTION project was of six months duration and all members had other work commitments, it became the role of the PM to facilitate the ongoing group process. In order to ensure ongoing communication between all PODS, the Project Manager initiated regular contact with POD members for updates on their work. During these contacts, concerns with workload requiring reallocation of the research assistants, problems in obtaining data from various sources, and plans for future work were identified. All problems requiring action were recorded in the PM's task book to ensure completion and follow through by the PM. Prompt attention to requests alleviated the stress of overwhelming workloads in conjunction with other responsibilities.

In any group working together, the question of equity of workload arises. Differences arose in the amount of work carried by each project member and at times caused additional strain on those who were carrying a heavy load. As identified by Barton, Smith, Brown and Supples (1993), the issue of workload commonly arises in projects of this magnitude.

Varying levels of commitment and standards of excellence among team members was also problematic. At times this was due to unclear expectations of the role and perhaps lack of effective communication regarding ownership of responsibilities. Working within a team, on a large scale project with predetermined deadlines, is in itself stressful. Combining various levels of expertise, various levels of commitment, and various outside obligations which drained the energy level of members amounted to intense demands on all members of the ACTION project. While some of the particular stressors were unique to ACTION, many were common group process issues that required resolution (Barton, Smith, Brown, and Supples

1993). Often, due to the intensity and high paced tempo of both the project and the members' professional lives, it was difficult to resolve some issues in a timely fashion.

When misunderstandings arose about workload expectations, efforts were made to increase communication between the PM and the team member. At times, this was an effective strategy wherein the team member was unaware of the work expected and was able to deliver the same once informed. On other occasions, the matter remained largely unresolved and the team member did not assume any further workload responsibilities. For example, initially a large number of focus groups were to be organized with the expectation that all POD members conduct one group. Following discussion of this idea, there was no satisfactory resolution of the problem and the end result was the number of focus groups were decreased.

In retrospect. Generally the ACTION team was able to function at an adequate level throughout the duration of the project. Extensive commitments outside the ACTION research project were draining on both the project and its members. Hiring the Project Manager as a full time person whose energies could be solely devoted to the project, would have greatly facilitated proactive problem solving, increased levels of communication throughout the organizational structure, and timely intervention. Increasing the time the PM was available would have also maintained the rigor of the research with consistent monitoring of all details in a timely fashion. Adequate time to facilitate group meetings and nurture beginning research assistants would have added to the quality of the product produced and the efficiency of the process.

Although the PM is the ideal person to be available at all times, having any member consistently available on the ACTION project would have eased the strain and sense of

intensity often recognized within the process.The project demanded full time commitment of one central key figure, particularly since both faculty and research assistants were often already overburdened with academic commitments. Having a reserve supply of research assistants on hand would also have been helpful. Toward the end of the project, new research assistants were hired. If they had been orientated with the original research assistants, the new research assistants would have been prepared to start once needed. As noted by Barton, Smith, Brown, and Supples (1993), members are more willing to expend extra effort if they are being fairly compensated for their work. In long intense projects, it becomes crucial that one central person has the time to ensure that all members are rewarded psychologically, given the opportunity to grow, and supported in that growth.

Office Management

Tracking Financial Costs

Throughout the project, the Project Manager was responsible for the tracking of financial costs and ensuring the project remain within the proposed budget allowances. As the project was funded by Youville Clinic through Manitoba Health, the funds were public monies. Ethically, the Action research consortium felt a strong responsibility to use the funds wisely for the benefit of the communities in truly identifying needs. All monies spent were tracked by the PM. Only the Chair and the PM had signing authority on the cash flow. Large purchases were discussed within the research consortium, i.e., the C-91 data base, an electronic data base from Statistics Canada. The benefits of purchasing such a data base were deliberated with the co-chairs who would be accessing data from this base.

Research assistants were instructed to record any purchases they were required to make. In the majority of instances, these purchases were previously discussed with the PM or

Chair. Having two people sharing the financial responsibilities increased the accountability of the consortium, the immediate accessibility of an Action member, and encouraged critical thinking regarding financial purchases. At times it was necessary for the research assistants to be able to contact either the Chair or the PM quickly. A research assistant would sometimes hear of resources that could be potentially helpful and would want to purchase them while out in the field. For example, the data base from a recent Canadian community health needs assessment of key cities across Canada was available in the community. The research assistant was able to track down the preliminary details to enable the Chair to decide, based on the resources that would be spent, if this matter was to be pursued. Having two key people in this capacity expedited the decision making process.

Weekly time sheets depicting the number of hours each research assistant worked were submitted and verified by the PM (Appendix L). To track ongoing costs, the Chair would frequently obtain a running report on the finances from the Manitoba Nursing Research Institute. This double monitoring encouraged scrutiny of all expenses. For example, if the PM missed an unusual amount of time being spent on a task, the Chair served as an additional check. Thus, resources were constantly monitored and time efficiently utilized.

Organization of the Office Space

An ACTION office was "set up" at the beginning of the project. The office space was used in a variety of ways. Elaborate files were kept to store the continuous flow of paper generated by the 5 PODS. Each POD had a series of files set up to house and store the data. These working files were for general office management, and much of the current data for each POD was stored in the Co-Chairs' offices. Data would be filtered to the ACTION office when the ACTION team members were finished their individual work. The data would be

filed or directed to other ACTION members who might be interested in examining the data from a different perspective.

Each POD had a file for ongoing work, completed work, and collected data. To record the ongoing work, the Co-Chairs would submit an overview of their current progress either via a written communique or via the ACTION telephone line (Appendix M). The ACTION office also housed all incoming reports and circulated lists of these reports to all PODS. Reports of relevance to a particular POD were forwarded to the POD leaders. All reports were tracked, signed in and signed out, to ensure the data would be accessible if needed (Appendix N).

The office space was a communal space that was available to the research assistants to make calls, organize data, and work on projects. To ensure there was not a conflict in office space usage, a form was devised wherein an ACTION member could book the office for a specific time (Appendix O). The PM blocked off large timeframes to ensure the office would be available for essential tasks. This strategy was effective in organizing office utilization during the early stages of the project, when the majority of the work was accomplished by telephone.

As the project progressed, the office was not used as frequently by the research assistants as they either worked from home or were out in the community. A communal key was kept at a central location, the General Office in the Faculty of Nursing, and then signed out by the research assistants when they required the office.

During the beginning stages of the ACTION project, many questions were asked about the actual boundaries of the St. Boniface and St. Vital communities. Maps, depicting the boundaries and a written outline of the definitive boundaries, were distributed to each

ACTION member to ensure all members were cognizant of the parameters of the communities (Appendix P). As well, a large map was permanently placed in the ACTION office as a quick reference. These strategies proved invaluable in the early days of the project, as ACTION members were frequently called upon to define the parameters of the study. Although, this may seem like an elementary step, it took considerable effort to ensure the boundaries were factual. Various opinions on the St. Boniface/St. Vital boundaries were circulating. ACTION contacted City of Winnipeg Planning Department to obtain the official boundaries of both communities. The City Planning Department then forwarded to ACTION a detailed outline of the boundaries for both communities. Having the written reference to the actual streets was helpful on several occasions.

A considerable amount of administrative time was needed to organize the ongoing "paper" that was generated during the community health needs assessment. Having this organized and readily accessible assisted in the tracking of voluminous data. In addition to the voluminous data bases, files were kept on all financial transactions including the research assistants' expenses and hourly wages.

All items that were translated into French were also filed and stored. This was helpful if any questions arose regarding the accuracy of the translation and for verifying media releases. Throughout the project, media releases were used to generate interest and increase awareness of the community health needs assessment. As the media release strategy was used intermittently throughout the project, keeping a readily available file of previous releases, contact persons and fax numbers was time saving for the secretarial staff.

Administrative files were kept regarding administrative processes, i.e., ethical committee applications, arrangements with consultants, notification to POD members of any

upcoming meetings, and process changes necessitated by the project; i.e., change in deadlines for submission of reports. The "business" area of the project generated its own paper. For example, at times, considerable correspondence would ensue from the office to gain access to specific populations. ACTION had wanted to contact people living with chronic disabilities, to understand their lived experiences in the community. In order to do this in an ethical manner, there was a considerable amount of correspondence with specific associations to answer all their questions about the project. Keeping meticulous files on the administrative procedures was of utmost importance. Often files were used to verify and track details that otherwise might have become lost.

Data Storage

A system in which data could be stored for future analysis was devised early on in the project. Each community contact was filed as previously described. Once it was determined who the key informants were, the research assistants conducted key informant interviews (Appendix Q) and recorded interview data in a specific format.

By using a standardized format, the PM was able to readily determine future key contacts and the essential themes contained in the data. (Appendix R). Throughout the process of data collection, it was sometimes difficult to monitor whether this agreed upon format was being followed. For example, if new key contacts were not identified specifically, it was much more time consuming to read through the information searching for contacts. The momentum of the project was such that it was often not time efficient to have the information rewritten in the agreed upon format.

The key informant interviews were categorized and stored as Individual, Agency, and Focus Groups. The Individual category contained community members who were representing

their own viewpoints. Often they were identified by "word of mouth" as community residents who were willing to express their views. They commonly were looked upon as informal leaders.

Individuals who assumed an agency's perspective were categorized as "Agency". The viewpoints they offered and the knowledge they were privy to, arose largely from their connections within their work domain. The Action Research Consortium (ARC) was cautious in printing names of individuals without their approval. When individuals spoke from an agency's perspective, they were far more free to be candid in their remarks if they knew their names would not be published. This was an important consideration as one cannot expect informants to be completely candid for fear of being misquoted or judged as being disloyal to their agency. The ARC guaranteed anonymity for individuals who spoke on behalf of their agencies. Research assistants took an active role in ensuring that the ACTION research consortium was scrupulous in this regard. Research assistants also upheld promises of confidentiality and were vigilant in ensuring that their informants were aware that the final report would be submitted to Youville Clinic. Youville would then disseminate the information to other community members. Time invested in the early stages of the project to instill ethics and values, and time spent in the selection process of the research assistants, very much contributed to the high ethical standards evidenced. During the initial orientation sessions for the research assistants, considerable time was spent discussing the ethical responsibilities of the research assistants. The research assistants were aware, that as they were the ACTION members most in contact with the communities, they would set the tone for the quality of research conducted.

Focus Group interviews, in which specific groups of people (Moms and Toddlers, Seniors etc.) met to discuss their views on community needs, were filed in a specific binder. These collective viewpoints were then analyzed as group findings. Within the focus group session, much information was transmitted and often gaps in community services were identified. All interviews, individual, agency, and focus groups, were photocopied in preparation for data analysis and the originals were filed in the appropriate binders.

French and English versions of the community health needs assessment survey were developed with input from the Steering Committee. The surveys (N=800) were randomly mailed out to community residents. In addition to the mail out surveys, drop off surveys (n=250) were also collected and stored. The surveys were secured either within the ACTION office or the office of the Chair. Survey data were kept within a locked area and only key individuals, e.g., the Senior Chair and PM, had access to the raw data.

Other information, such as government data about tuberculosis and sexually transmitted diseases, was stored within the specific POD data base file. Data that initially came into the ACTION office was sorted and filtered by the PM. All information was saved in the event it might be useful in the future. As the project proceeded and it became clear what data would be useful, the information was once again screened by the PM.

The ACTION Telephone Line

The Action telephone line was central for communication throughout the research project. During the initial organization of the office, the line was set up and the number circulated to the public. When the ACTION Project Manager and other team members were not in the ACTION office, messages were relayed on a daily basis via this phone. The research assistants developed the habit of checking the telephone line daily for messages and

would also leave messages for the PM. This became a very easy and efficient way of connecting ARC members with each other.

The phone line also facilitated communication with the public. Once the number was circulated in the public domain, community residents regularly contacted the ACTION office. Community members called for various reasons; general information about the project, specific concerns individuals wanted to convey to the ARC, and often to inquire about employment opportunities with the research project. Nurses also called with questions concerning the proposed satellite clinic in St. Vital and the educational requirements to practice in such a setting. The questions about employment, which also came from people other than nurses, suggested that people were diligently scanning opportunities for employment. The majority of these employment calls were a result of an advertisement describing the project (Appendix S). There was no mention of employment opportunities in this advertisement. These calls served to reinforce the prevalence of unemployment and also illustrated the resourcefulness of the public.

Promotional Materials

Throughout the ACTION project, various promotional materials were developed. These included posters displayed within the community, newsflashes circulated to English and French media outlets, faxes to community bulletin boards, and contact with reporters (Appendix T). As the project was ongoing for six months, it was necessary to maintain momentum and interest in the community. In a large urban community with a population in excess of 100,000, many events compete for the public's attention. The ARC invested considerable energy contacting media personnel and promptly returning any calls from the media. Interviews were conducted with newspaper reporters, both English and French and

also on the radio (Appendix U). All opportunities to capitalize on interest in the project were readily investigated. For example, some of these activities included: an interview with Statistics Canada on the merits of the C-91 data base, information sessions in a local shopping mall, and presentations to Manitoba Health and local organizations. Throughout the six month project, intermittent faxes were sent to local radio stations with community bulletin boards, updating them of the project's current activities.

In retrospect. Generally the office management strategies worked well. Most breakdowns in the system were due to lack of communication. At various times in the project, all ACTION members were overwhelmed with their diverse responsibilities. ACTION duties often had to be postponed and consequently receiving data in the ACTION office was delayed. More frequent communication with the research assistants would have ensured that they understood the procedures for relaying information, the format for recording the data, and the timeframes for providing information to the Project Manager.

As some of the research assistants were involved in the project at a later date than when the original core of research assistants were hired, there were gaps in their understanding of the organizational process. This occurred largely because of time constraints. Usually these research assistants were hired during a crisis period when a task needed to be completed immediately and there was no available ARC staff. The research assistants were orientated quickly and with enough information to "do the job" at hand. Later, gaps would surface in their understanding of the procedures. Again, having senior research assistants and ARC staff available to nurture and mentor the "crisis" based research assistants would have decreased the stress these newly hired research assistants experienced. To overcome some of these difficulties, the PM attempted to answer all research assistants' calls promptly. Hiring

the PM as a full time employee, would have enhanced her availability and strengthened the general organization of the project.

When recording key informant data (individual, agency, and focus group), it would have been beneficial to immediately discuss with the data recorders any problems in the recording structure. Because of the bursts of activity within which the community health needs assessment was propelled, there was little (if any) time to discuss this issue with the research assistants. Though the majority of the data was still well presented, adhering to the designated format, would have facilitated analysis of the data.

A stronger focus on community awareness of the health needs assessment could have been implemented. Throughout the project, increased proactive promotion of the goals of the community health needs assessment, discussion of the actual process in the community, and direct community involvement would have been desirable. By doing so, increased meaningful mobilization of the community may have produced a richer grassroots perspective. Many existing community groups could have been accessed earlier in the project with a focused proactive recruitment of the community voice. This may have been accomplished by actively seeking out these existing groups and accommodating their schedules for promotion and mobilization strategies.

Organization of PODS

Initial Communication with POD Chairs and Co-Chairs

The basic design for the PODS had been established when the PM was hired. ACTION created six PODS to collect data on all the information areas (Gregory, Mordoch, Wotton, McKay and Hawrinik, 1995). Five data collection groups, known as PODS, would gather both quantitative and qualitative data (Appendix C). Data about the health and social

care needs of the St. Boniface and the St. Vital communities were to be collected. The PODS were to gather the following information:

1. Statistical information.
2. Cultural, social and historical contexts.
3. Interviews with community residents and health care providers.
4. Existing health and social services.
5. Industry, environment, and crime.

A sixth POD originally designed to formulate a portable data base was unable to proceed because of the inadequate and disparate data bases available.

POD I - Secondary data analysis. POD I focused on statistical information. ACTION purchased an electronic software program from Statistics Canada (C91 data). This allowed areas to be identified by postal code and generated a focused community profile. This census data base consisted of more than 400 different variables which were amenable to examination according to specific Forward Sertation Areas (FSAs). Each FSA is identified by the first three letters in the postal code system allowing for detailed analysis of specific areas within St.Boniface and St. Vital.

Other existing quantitative reports such as information on sexually transmitted diseases, post-partum delivery services, nutrition, the use of foodbanks, and community health intervention and health promotion were also reviewed.

POD II - Cultural, social and historical context. POD II explored cultural and social values within St.Boniface and St. Vital, as well as historical information. POD II members developed a unique research framework. A series of 27 questions were generated to "tap into" the essence of these communities (Appendix D). For example, "What are the religious or

spiritual practices in the community?" "How does the community use humour?" POD II attempted to capture the "pulse" of communities in verbal, visual and historical terms.

POD III - Interviews with community residents and health care providers. In POD III, the voices of community residents were captured. POD III provided a direct link to the reality of how the health care system was experienced by community residents. Five data collection techniques were used: interviews with community members, focus group interviews, telephone interviews, mail out, and drop off surveys. These information gathering strategies within POD III ensured that community members "had a say" in health care programming. The collection techniques are discussed under the section of the report headed Data Collection.

The population of St. Boniface and St. Vital numbers in excess of 100,000. In order to adequately ensure that a broad sampling of community members were accessed, a variety of data collection methods were being used. Survey, (drop off, mailed, telephone), key informant interviews, secondary analysis of existing data bases, and pertinent focus groups were the major methods of data collection. Sampling techniques included purposive, snowball, and random. A concentrated effort was made to include marginalized groups such as immigrants, the mentally ill, youth, Aboriginal, Metis, isolated elderly persons and the homeless.

POD IV - Health and social services. POD IV was a complex POD as it analyzed the services provided by formal health care agencies. Churches and agencies with other mandates, such as schools were contacted for their perspectives on the health of the community. This POD divided its analysis into eight sections: voluntary organizations, facilities, professional providers and agencies, Francophone services, infant and pre-school services, school aged services, senior services and services for the immigrant population.

POD VI - Industry, environment, and crime. The industrial sector and the environment were explored in POD VI. The focus was on infrastructure services (police, fire, ambulance, waterworks, waste disposal) and industry within St.Boniface and St.Vital. In addition to reports and existing data, interviews with key informants contributed to an understanding of this data base.

After the initial meeting between the PM and the ACTION team, an outline of future work was generated. Through regular discussions of POD activities, POD members were aware of the activities proposed for each POD. Having this knowledge was helpful. If during the course of data collection, a POD member was referred to a new community contact this information was presented to the other PODS to reduce the occurrence of redundancies. Knowing the focus of other PODS, enabled the appropriate channelling of data contacts that arose in the community. For example, when contacting the churches in the community, many leads were uncovered that were invaluable, particularly for POD IV, Existing Social Services. Although POD IV was examining formal service agencies, contacts with the churches uncovered another layer of informal service providers who were extremely vital for community well being. Services offered by churches were varied, from soup kitchens, day cares, and womens' groups offering emotional support and life skills. These informal church services were inclusive of the marginalized and evidenced caring for the whole community.

Initial communication with POD chairs and Co-Chairs attempted to build a collegial atmosphere, outline the critical path for the upcoming weeks, and foster autonomy and creativity within the holistic framework of the project. Lines of communication were established; i.e., all research assistants would receive their work from the Project Manager

and would be assigned to the various PODS by the Project Manager. When the PODS needed additional research assistants, the Project Manager was responsible for assigning them.

Determining Starting Points and Direction

Each POD had a preconceived idea of how they would begin their data collection. Some of the PODS had a very clear direction they would follow. For example, POD IV with its mandate for existing social services had no difficulty knowing where to begin. POD I, whose mandate was to collect statistics had some initial ideas of what to collect, but after "brain storming" with ARC had further directions to pursue. POD II with its more free flowing concepts of values, history and culture, had unique beginning strategies for data collection which were further developed in subsequent POD II planning meetings. POD III, which focused on accessing the voices of the community, had initial key informant contacts identified by the Steering Committee and also by faculty members who had previously worked within the communities of St. Boniface and St. Vital. Meeting with the POD members enriched this list of contacts. POD VI, which initially was designed to focus on industry and infrastructure services, perceived its initial focus as collecting existing information. As this information was collected, key informants were identified from contacts made when obtaining the existing reports. POD V, whose main aim was to develop a portable data base from the findings of the ACTION research project, was not actively involved at this point. Involvement was projected to occur at a later date when some of the existing data bases were compiled. Unfortunately, because of the poor state of data in the public domain, this POD ceased to be viable. Meeting as a group with all POD members was productive in determining the direction of data collection. The broad range of perspectives, assorted talents and experiences greatly expanded the potential richness of the data base.

Faculty members with knowledge of the existing community services and established contacts, expedited the initial process of data collection. Having initial contacts was advantageous and time saving. Other talents of the POD members included knowledge in research techniques, previous experiences in large projects and group work, varied experiences in community work and primary health care, and previous involvement with community health needs assessments. The varied interests of the ACTION team included mental health, community health, and public health, values clarification work, system analysis, emergency nursing, geriatrics, marginalized groups (i.e.immigrants, gay and lesbian, aboriginal) and Primary Health Care. The ACTION research consortium was fortunate to have this array of talents to draw upon from within the team.

Refinement of the Evolving Process of Data Collection

Initial strategies were effective to instigate data collection and generally remained consistent for the majority of the project. Communication links evolved as specific situations arose. Although the lines of communication were established from POD members to PM, this was not always convenient.

The PM worked "off campus", while the majority of the POD members and Co-Chairs were located "on campus" within the Faculty of Nursing, University of Manitoba. Therefore it sometimes became easier to contact the Senior Chair whose office was "on campus". Confusion arose if the Senior Chair and the PM were unable to communicate prior to the PM meeting the POD members. In the majority of incidents, the POD members and Senior Chair attempted to leave messages on the ACTION telephone line to inform the PM of any decisions made in her absence.

As the data collection strategies expanded with all five PODS in operation, maintaining an overview of the POD operations became critical and daunting. To ensure this overview perspective, the PM spent considerable time on the telephone contacting research assistants, POD members, and the Chair. The project was so large that this needed to be done on a consistent basis. Any time lapses that occurred necessitated an intense expenditure of energy to clarify any problems and ensure the project was proceeding as planned.

To maintain an overview of POD activities, meticulous recording of requests, problems, and leads by the PM was essential. The dynamic nature of a community health needs assessment generates "everything happening at once" many times throughout a project.

To ensure appropriate follow up to problems and concerns in a timely manner, notation of minute details; i.e., name of caller, time, request, to whom task was delegated, and all pertinent detail were recorded in one book. This book was maintained by the PM throughout the ACTION project and often served as a handy reference as to what had been done and by whom. Issues sometimes resurfaced at a much later date, because of the ongoing data flow, it became difficult to recall all the details of the incident. In these times, the details recorded in the Project Manager's book validated perceptions, highlighted omissions and served as a reminder for unfinished activities.

An overview of the POD activities was also sustained with brief reports from the POD chairs (Appendix M). This strategy served a dual purpose of encouraging the POD chairs to intermittently "take stock" of their activities and to ensure the PM was aware of all undertakings. The research assistants often had reports and correspondence mailed directly to the PM. The PM would then screen the written material to determine future follow up leads that could pertain to any of the PODS. From this initial screening, data were then delegated to

whom the PM determined to be the appropriate referral. Being familiar with the community data facilitated the recognition of themes that arose between the PODS and assisted in the realignment of data collection efforts.

Communication Between Research Assistants and POD Members

Once the PODS determined their tasks, research assistants were assigned to the POD. Sometimes a research assistant would be delegated to work solely within a particular POD. At other times, research assistants would be taken away from their core tasks within one POD to accommodate an immediate short term request of another POD. For example, one of the research assistants responsible for the initial analysis of the C-91 data base, an enormous job in itself, was taken from this ongoing task several times to assist with short term immediate tasks. When these were completed, she would return to her ongoing task, analysis of the C-91 data . At these times, the PM would play a key role explaining the task to the research assistant who was "parachuted" in without having ready access to the complete picture. The PM provided the broader perspective to the research assistant. This was helpful to the research assistants as often they were completing the task under time pressure. Having as much information as possible increased their comfort level.

Relaying information from the research assistants to the POD members was important, particularly when a research assistant working in one POD would discover data useful to another POD. As the research assistants were involved in completion of their immediate tasks, they would not necessarily be aware of the significance of their data for other PODs. Information transfer was coordinated via the central role of the PM.

In retrospect. The large group meetings with POD chairs and the four co-chairs were very helpful. In the beginning stages of the project, these meetings were held at fairly

frequent intervals, i.e., every second week. As the project became busier and required more energy of the POD members, it became difficult to meet on a regular basis. Being unable to devote sole attention to the ACTION project restricted the availability of some of the POD members. While not every community health needs assessment will have the luxury of all time and resources being solely devoted to the project, participants need to be forewarned of the heavy time commitment involved. The cross fertilization of ideas throughout the project is difficult to maintain if all members do not meet on a regular basis.

ACTION strategized to meet with individual PODS which proved to be beneficial and time efficient. POD members did not have to "sit through" the discussion of details that did not specifically concern them. The infrequency of full attendance ACTION team meetings in the later stages of the project increased the workload of the PM who had to relay and seek out information from each POD. While this was inconvenient, the more serious disadvantage was the loss of "group think" and valued input to the ongoing project.

Cross fertilization of ideas was definitely productive in the initial setting of directions for each POD's data collection strategies. One can not assume that everyone understands the time commitment, or places the same value on attending meetings. Perhaps if the concept of cross fertilization could have been discussed more fully within the group, this may have encouraged more regular attendance at meetings. Understanding the fluid nature of the community health needs assessment, and the need to be flexible also could have been discussed in more depth at the onset of the project. If this had been done, the possibility of developing alternate strategies to deal with sudden onslaughts of heavy time commitments may have occurred earlier on in the project and better prepared POD members for this reality.

The key issue within the organization of the PODS was the limited time PODS members had to devote to the ongoing process. While deadlines were generally met by all ACTION members, a more equitable sharing of the workload and time commitments would have contributed to a more fluid group process. Feminist strategies, i.e. member checks, wherein each member "checks in" and "checks out" at each meeting may have addressed these issues early on in the process. The process of "checking in" encourages all members to share issues and concerns that may affect their participation in the project. The strategy encourages reflection and open communication on group process (Barton, Smith, Brown, & Supples, 1993). These techniques have been used in other community health needs assessments wherein equity of workload became problematic (Barton, Smith, Brown, & Supples, 1993).

The simplistic strategy of recording all the small day-to-day details requiring attention in one book was remarkably effective. This strategy arose out of necessity and simplified tracking and remembering details. At a glance, one could refer to details that would certainly have become lost in the mass of information generated. At meetings, the book was an organizational tool for identifying tasks to be undertaken, ongoing and completed. One could accomplish the same goals with a laptop computer. This strategy of recording day-to-day details was most simplistic and yet effective.

Facilitation of communication between the research assistants and POD members via the Project Manager was also effective. Anytime this strategy was neglected, ensuing complications often resulted. During the latter part of the project, negating this original communication strategy was necessary and given the stage of the project, was less crucial. The role of the Project Manager as a central figure must be maintained throughout the project

as much as possible. As time pressures became intense, it became crucial that one key member remain in "the eye of the hurricane." Being able to do so, decreased the stress of the other team members who were tired at the end stages of an exhausting project. The quality of the research work would consequently be maintained with less physical and mental stress to all.

Because of the dynamic nature and number of people involved within the organizational structure, however, it continuously evolved. What worked well for some parts of the project required modification at other stages of the project. For example, towards the completion of the project, some of the research assistants' work was delegated directly by the POD members, circumventing the PM. This was necessitated by time constraints. Redundancies in data collection were not as frequent at this stage of the project so that allocation of work through one central source was not as crucial. Initially, all work assignments were directed to the research assistants by the PM. Increased dialogue between the PM and the POD members, was implemented at this time and seemed to avoid potential problems.

As identified by Barton, Smith, Brown, and Supples (1993), coordinating and monitoring data is extremely time consuming for a PM. At times, not all areas of the project can be monitored and it becomes necessary to trust that members of the project are completing their tasks both competently and ethically. In the ACTION project, times of intense workload and pressing deadlines necessitated this approach.

Data Collection

Filing System

Data accumulated quickly and having a preliminary organizational system in place was prudent. Being able to refer to the data quickly was of key importance in keeping abreast of all the details. Some discussion ensued as to what would be the most logical system to store the data; i.e., alphabetical or by growth and developmental stages. Data were stored in broad categories as described under office management.

This system allowed all aspects of a category to be viewed simultaneously. For example, data under the category of women, stored information on single parents, mental health, day care, and counselling services. Specific POD information was kept in the appropriate POD file; for example, Manitoba Health data on Sexually Transmitted Diseases and the number of available day care spots in the community were filed directly into PODs I and IV respectively. When general information, was obtained and it was not initially clear which POD should receive this information, it was stored in the community contact book. For example, some information related to the services provided by Parks and Recreation initially appeared to "fit" with POD IV—Social Services but eventually, the data were filed under POD VI—Environmental Context.

Community Contact Book

The community contact book was periodically reviewed by the Project Manager and information in the book was discussed at team meetings. Dialogue about these community contacts at the group meetings, facilitated the tracking of detail and ensured that follow-through was implemented. From these discussions, the research assistants were able to add

valuable information which helped the ACTION team decide if the contact was complete or ongoing.

Reports

Reports from various organizations were also stored with respect to language—French and English. French reports were translated by a bilingual research assistant so that the information could be passed on to an ACTION member for analysis. Periodically, lists of the accumulated reports were distributed to the POD members (Appendix V). The reports were available in the ACTION office and were also sent to appropriate POD members upon request. A variety of reports were available. For example, the Utilization of Medical Services for Mental Health Disorders Manitoba: 1991-1992 (Manitoba Centre for Health Policy and Evaluation) and the First Annual Report of the Children's Advocate of the Department of Family Services (1993/94) (Office of the Children's Advocate). Information in these reports often validated the major themes which were identified in other data bases within the ACTION project.

Secondary Data

The data collection process did not always proceed smoothly. POD I data, which entailed the secondary analysis of existing reports, were extremely difficult to obtain. The Senior Chair, POD I Chair, the research assistants, and the PM spent considerable time attempting to secure data from government sources. This process was frustrating as it necessitated perseverance, repeated calls, and assertiveness often to no avail. Initially, it appeared that data would be obtained without difficulty. However, the data often remained unavailable despite the assistance of "influential persons." Securing morbidity and mortality data for St. Boniface and St. Vital took from January 1995 to June 1995 despite continued

efforts on the part of the ACTION team to obtain the data. Numerous phone calls were needed to finally track the appropriate person with access to the data. Once this was accomplished, the same amount of time was needed to ensure that the department sanctioned release of the data. This occurred despite ACTION's previous attempts to obtain permission for release of the data. Additionally, data were often not available for the specific communities, but were city-based or province-wide.

In the ACTION progress report of February 22, 1995, POD I had already initiated attempts to obtain information from the Department of Health Statistics regarding physician use, personal care home use, morbidity, and cause of death. Several Health Department program representatives were contacted for information about workload, staffing, types of services provided and characteristics of users. Attempts to secure this data were still ongoing in June, 1995.

In retrospect. The problematic nature of procuring epidemiological and government data was unforseen. As depicted by the graph (Appendix W), collecting this data consumed an enormous amount of time. In the initial planning stages of data collection, ACTION erroneously estimated that secondary analysis of the existing data bases would be completed within two months. This assumption was based on the understanding that existing data would be readily available and accessible.

While the secondary analysis of existing data was itself a massive task, it proved to be less of a problem when compared to the frustrating, at times overwhelming task, of obtaining statistical data. Gaining access to data was, in the majority of cases, extremely difficult. Finding the person who actually was able to deliver the data was also time consuming. In

several instances, obtained data bases were incomplete or lacking in relevance to the ACTION project.

Of note is the fact that the ACTION project had the support of "influential people" with respect to accessing data. However, the inability to obtain data plagued the ACTION project well until the end of the project. Difficulties accessing data bases and obtaining disparate data bases have been identified in other community health needs assessments as problematic (Barton, Smith, Brown, & Supples, 1993; Community Health Research Unit, 1991). From the experiences of the ACTION team, a generous allowance for extended time frames in obtaining data of this nature should be built into the data collection strategies. Funds to hire a programmer to assist with collecting specific data from large data bases would also be helpful.

Information contained in the various reports collected, could have been utilized concurrently throughout the project. Initially, reports were intended for the PODs where the information would best be incorporated. Lists were generated and distributed to all POD chairs identifying the available reports. The reports were not used to any great extent by the individual PODs. Towards the end of the project, research assistants compiled a synopsis of the reports, pulling out the major community implications. Data contained in these reports were then used to corroborate themes identified in the community-based data. In retrospect, having the reports complied early on in the process would have been helpful in establishing themes or highlighting discrepancies. Data from the reports were used by the Senior Chair and the PM during the writing of the report. Ideally, data could have been used by the PODs during the data collection period to ensure the information would be used to its fullest potential.

Surveys

Various surveys were implemented during the course of the research project. These included 116 telephone surveys, 836 mail-out, and 84 drop-off. The surveys were printed in both English and French and were colour coded ie. blue = English; yellow = French (Appendix X and Y). The colour coding facilitated easy storage and retrieval for data analysis. The surveys were stored in a safe and confidential manner throughout the research project. Confidentiality was ensured with the mail out surveys as participants were identified only by postal codes. The anonymity of surveys offers participants a safe vehicle for voicing their perspective on sensitive subjects.

Telephone surveys. The telephone survey was conducted by two research assistants in an attempt to ensure consistency of questioning. Telephone surveys are inexpensive and "fast" with decreased distracters such as dress and body language which might influence the subjective researcher. However, the participant may be distracted if the household is busy. Generally, the researchers are more able to control standardization of the interview and the time factor with a telephone interview as opposed to a face-to-face interview (South Australian Community Health Research Unit, 1991).

The research assistants met periodically with the Senior Chair during the implementation of the survey. These meetings were helpful to discuss what data were being collected and to confirm various interview techniques that were effective. Each research assistant had their unique style of conducting the interviews and both were able to learn from each other.

A random proportionate sample (N=116) was conducted based on the Forward Sertation Areas (FSAs). A data base which offered a random proportionate sample of

households within the St. Boniface/St. Vital areas, was purchased from the Manitoba Telephone System (MTS). This data base included names, addresses, and telephone numbers. The sampling frame was proportionately established according to postal codes. For example R2H represented 19 percent of the St. Boniface population, therefore 19 percent of the telephone survey sample was from the R2H postal code area. Random selection determined which households were contacted. Community residents without telephones were excluded by this method of sampling. However, it is estimated that 95 percent of Winnipeg residents have a telephone within their homes.

While implementing the telephone survey, the researchers tracked the responses to their calls. They recorded the completed interviews, the "call backs", and those community residents who chose not to participate. Mail-out surveys were not sent to households who chose not to participate in the telephone surveys. Each researcher developed their style of introducing themselves by name, organization and revealing the purpose of the call. Rapport was established by using a friendly and inviting but purposeful tone with a simple factual explanation.

The telephone interview questionnaire consisted of seven questions related to health plus ten questions about demographic information (Appendix Y). The questionnaire was carefully constructed by ARC members and informally pilot tested among family members of ARC.

Mail out surveys. The mail-out survey underwent a stringent process of multiple drafts. Survey questions were (a) developed by members of ARC, (b) modified from the Canada Health Promotion Survey (1985), (c) modified from other smaller-scale assessment projects, e.g., Newfoundland-Denmark Project, etc. In addition to Dr. Jeff Sloan of the

University of Manitoba—an expert in statistical survey construction, and Mr. Paul Fieldhouse of Manitoba Health—an expert in health promotion research and nutrition, the Youville Steering Committee added valuable input to the design. The members of the Steering Committee had diverse backgrounds which contributed a wide variety of perspectives.

The original questionnaire was based on a modified version of the Health Promotion Survey (1985) distributed nationally across Canada. Some of the questions were reworded, clarified, and "fine tuned" to elicit the appropriate data. Draft procedures were time consuming. Contacting reviewers for their initial agreement to participate, waiting for their feedback, processing the feedback, redrafting and returning the drafted version for revision comments, all required time and energy. While one may initially believe, organizing a survey is relatively straightforward and non-time consuming, the ACTION experience found quite the opposite to be true. Adequate time to build a quality tool is of utmost importance for appropriate data collection. Referring to someone with expertise in survey design eliminated the more obvious pitfalls. Although a well constructed survey will look simple and easy to design, considerable forethought is needed to ensure the data that is wanted will be elicited. The wording, the formatting, and sequencing of the questions all effect the type of data that will be collected.

Consideration must be given as to whether open or closed ended questions will be used. Open ended questions may generate information which is not relevant and may be difficult to analyze. Generally a mix of open and closed ended questions works well. Questions must be extremely clear when the survey is being self-administered as the research assistant will not be available for clarification. Pilot testing and retesting assists the researchers to clarify their tool. A pilot test of between 20 -50 participants is suggested

(South Australian Community Health Research Unit, 1991). The pilot test clarifies the design of the survey as misinterpretations, ambiguous areas, i.e., unclear instructions, hidden assumptions, and lack of appropriate space to answer will be identified. Short, simple instructions with concrete wording will work best.

Questions 1-9

In ACTION, the questions were based, in part, on The National Health Promotion Survey (1985) and, as in the telephone survey, modified for ACTION's specific needs. The questions were chosen to reflect the broad definition of holistic health. The first nine questions were related to specific concerns regarding the participant's health and the health of their household. Questions on lifestyle factors, for example smoking, obesity and stress, plus chronic illnesses and environmental concerns were addressed. A list of conditions that could feasibly affect health were provided. These ranged from poverty, gambling, young family members in trouble with the law, to caring for an elderly family member. Forty-two separate conditions reflecting known holistic health concerns were presented wherein participants could identify which concerns affected their household. They were then asked to identify the number one concern in their household. Participants were also afforded the opportunity to add their own concerns, not listed among the 42 items.

The listing of multiple concerns encouraged participants to identify items they might not otherwise associate with health. The researchers could not assume that the concept of holistic health was familiar to the general public. Health may be narrowly viewed as the absence of disease, thus the multiple listing acted as a stimulus to generate holistic health concerns. Listing holistic health concerns was particularly important with the mail-out survey as compared to the telephone survey. With the telephone survey, the research assistant was

able to directly clarify any concerns as the survey was being conducted. The drop-off and mail-out surveys needed to be extremely clear and well developed to ensure optimal understanding of the participants.

Questions 10-18

The next set of questions gathered data on broad determinants of health such as affordable housing, crime, and recreational opportunities for all ages. The participants' perceptions of the availability of health care services in their neighbourhood and if they viewed their neighbourhood as a healthy place to live were also solicited. The response options to these questions were either "yes" or "no". Additional space was provided for a brief comment. The "yes" or "no" response encouraged participants to readily formulate an opinion of their neighbourhood.

Question 17 attempted to have participants identify programs or services which were needed in their community. A graphic chart was devised listing 36 possible health promotion and health maintenance services. Opportunity was provided for participants to identify other services not listed. Participants were asked to comment on whether they saw each service as a"low", "medium", or "high" need and then to prioritize their first three choices. Simple clear instructions preceded the graphic chart. Considerable time and thought were needed to compile the list, design the graphic layout for ease of completion, and format the wording of the question. A simple system where the participant could easily denote their opinion was needed.

Question 18 asked the participant to identify from the possible services and programs listed in question #17, three which would be most important to them or their household. The question attempted to determine the most desired services across the sample.

Questions 19-27

Questions 19-27 attempted to obtain data on household patterns of health care services usage. These services included traditional healthcare such as physicians, hospital emergency rooms, and public health nurses along with newer services such as walk-in clinics. Use of alternative health care services such as therapeutic touch, chiropractic, and acupuncture plus less formalized self-help groups such as Alcoholics Anonymous was also surveyed. Mental health services were addressed in the questions on counselling services and the availability of these services.

Questions 28-38

The remainder of the survey collected demographic data on ethnicity, spoken language, gender, education, household size and the ages of household residents. The only identifying variable was the participant's postal code. Demographic data were collected to enable the researchers to describe the sample and understand the findings in light of this sample. Demographic data also provided insight into the specific neighbourhoods identified by the postal codes.

Survey design was geared towards making the survey attractive, appealing, easy to read and easy to complete. ACTION worded the introductory notation in such a manner as to convince the potential participant of the importance of their participation. The introductory notation was brief, to the point, easy to understand and provided necessary general information. A letter briefly explained the project, ethical approval, purpose of the survey plus where and when the results would be available. The anonymity of the participants was ensured and voluntary participation emphasized. Names of the ACTION members having access to the data were provided, and the ACTION telephone number was included for further

information. The front cover of the survey identified Youville Clinic and the Faculty of Nursing, University of Manitoba as the sponsors of the survey. Community residents generally accepted Youville Clinic as an integral part of the community, and the inclusion of the clinic name undoubtedly encouraged community participation.

Sampling for the mail out surveys was based on the number of households in each of the five Forward Sertation Areas (FSAs) within the St. Boniface and St. Vital areas. A random proportionate sampling strategy was used to select the participating households. ACTION purchased a list of these randomly generated households based on the FSAs within St.Boniface and St. Vital from Manitoba Telephone Systems (MTS). For ease of return, surveys were mailed with a pre-stamped and addressed return envelope. The ACTION team held a "envelope stuffing bee" prior to mailing. This project served to functionally achieve the mundane task of getting the surveys ready for mailing, and also improved team morale and sense of purpose by providing an opportunity for the team to work together on a non stressful relaxed task.

Initially ACTION considered sending out a reminder letter to participants who had not responded within two weeks (Appendix Z). This strategy has been reported to be effective in increasing response rates (South Australian Community Health Research Unit, 1991). When the cost factors were weighed against the estimated benefits to the research, the strategy was abandoned. ACTION recorded the returned surveys, i.e., not at this address, deceased etc., and dispatched a supplementary survey within the postal jurisdiction to another randomly selected household. ACTION then decided to pursue the drop off surveys as a more cost effective means of supplementing the community voice.

Drop-off surveys. Drop-off surveys (N=84) were distributed in both communities in locales such as libraries, medical clinics, the St. Boniface General Hospital, a community pool and a community club. Each location was prearranged via telephone contact during which the purpose of the survey was explained. Occasionally, potential sites requested further information which was faxed or sites requested to meet with the ARC.

Arranging the sites was time consuming. In an effort to plan ahead, sites were contacted and a tentative date arranged for drop-off. The survey was in the final stages of completion, and feedback had been requested from various consultants, formal and informal. Deadlines were difficult to maintain and constantly changed because of delays in obtaining feedback from various consultants. Consequently, the survey drop off dates changed. This in turn necessitated communicating with the sites to explain the delay in delivering the surveys to the sites (Appendix Z). Details such as these were time consuming but were important in maintaining positive community responses. The drop-off strategy was instigated to complement the mail-out survey and further access the community voice.

Posters advertising the surveys were displayed at all drop-off sites (Appendix A-1). A research assistant delivered the surveys and provided containers to store the completed surveys at each site. The completed surveys were then collected by the research assistant after a one week period. In one of the library settings, members from the community volunteered to conduct the survey for several evenings. Community participants were able to complete the surveys on location and clarify any uncertainties with the volunteers. The community residents had called ACTION and volunteered their time to conduct the survey. The residents were versed in the general concepts of the Community Health Needs Assessment and able to answer basic questions. Surveys were also mailed out to residents who had requested them at

the St. Vital Mall information day. During the information day, members of the ARC distributed literature and answered questions about the community health needs assessment. While surveys could not be distributed in accordance with the St. Vital Mall's policy, ARC collected the names of residents who wished to have a survey mailed to their homes (Appendix B-1).

In retrospect. In all the surveys used by ACTION—mail-out, drop-off, and telephone—the design of the final version of the tool was the result of an exacting process. The process required time, energy, and group feedback which is essential in survey design. While ACTION used the Health Promotion Survey as a framework, a tool to meet the specific needs of the St. Boniface/St. Vital community health needs assessment was required. Increased planning and development time could have been allocated to this effort. More intense pilot testing of the survey tools would have teased out subtle inconsistencies and ambiguities. The mail-out survey solicited information from both participant and the household. At times it was unclear to whom the answers applied. Rewording and redesigning the tool after pilot testing could have prevented this occurrence. The ambiguity relating to the source of the data made analysis more complicated. ACTION struggled with the issue of whose "voice" was captured, e.g., individual versus household. The data collected on the individual was in depth and straight forward. The household data was more limited and the findings more general as ACTION was speaking to households and not individuals.

Strategies for distributing surveys were generally effective. The media, however, could have been used more effectively to promote community participation. The response rate for the mail-out survey was approximately 30 percent, a respectable return in keeping with other survey response rates and ensuring an appropriate confidence interval. ACTION initially

hoped for at least a 40 percent return rate. A more organized and intense use of media resources prior to and during the time the surveys were out in the community may have increased the return rate.

In several Australian community health needs assessments, response rates of 70 percent have been reported (South Australian Community Health Research Unit, 1991). To obtain this rate, a structured reminder system was devised. The first reminder was sent out within 10-14 days. The reminder was the same colour as the survey. Within two weeks, another questionnaire and letter were sent to the respondents. Postcards and innovative bulletins using cartoons, graphics, and bright colours reminded potential participants to complete the survey. These strategies may be time consuming and expensive. Their relative merit needs to be balanced with the available resources and viewed in context with other research strategies. ARC decided that the expenditure and effort to accomplish a second mail-out was not an efficient process for the purposes of the ACTION project.

Data triangulation was built into the ACTION research project with the implementation of three kinds of surveys, the secondary analysis of existing data bases, and the key informants/focus groups data sources. Data triangulation maintained the rigor of the research method and enhanced the richness of the data base.

Extra efforts to reach the community via special promotion, i.e., radio announcements, guest appearances at community affairs, presentations at various community groups, may have also increased community participation. Efforts such as the St. Vital Mall initiative, where ACTION maintained a booth distributing information on the community health needs assessment and collected names of those interested in obtaining a survey, could have been

increased. If a survey strategy is used, efforts to advertise and promote it, are advised to maximize the benefits related to the costs.

The table used in question number 17, posed problems for the participants (Appendix X). The table of options may have been overwhelming, unclear to the participants, or perhaps redundant from the participants' perspective. This table was not well answered and did not generate the detailed data ACTION had hoped to obtain. Perhaps this question, a very important one could have been collected separately via door to door or as separate mail-out.

The delivery of the drop-off surveys to their respective sites could have been better organized. Realizing that survey design and revision can be a lengthy process, the process should be started early to ensure completion prior to implementation dates. Allowing extra time and setting the drop-off dates later versus earlier would have decreased some of the confusion experienced by several drop-off sites. ARC was operating under intense time pressures which did not always allow for optimal planning time.

The telephone surveys were conducted with minimal disruption and few identified problems. Developing interpersonal skills in the interviewer and dialoguing on various communication strategies were proactive strategies which were effective.

Key Informants

Key informant interviews provided the qualitative stream of the research strategies. Combining qualitative and quantitative approaches is generally thought to strengthen the research design (Barton, Smith, Brown, & Supples, 1993; Office of Health Promotion, B.C. Ministry of Health, 1992; South Australian Community Health Research Unit, 1991). Qualitative research broadens the perspective of the research and assumes that not all relevant

data can be quantified. ACTION included qualitative strategies in the key informant and focus group interviews using semi-structured questionnaires.

The questionnaire provided a framework within which to conduct the interviews. The questions were discussed at length by the ARC members prior to the final drafting of the interview form available in both French and English (Appendix Q). The majority of the key informant interviews were conducted over the telephone. This strategy was used to save both time and money. Key informants were often highly involved community people with busy schedules. Telephone interviews frequently accommodated their schedules.

Any participants who requested additional information about the purpose of the study or requested to review the questions prior to their interview were relayed printed information often by FAX. The information included an introductory letter explaining the project and a disclaimer clearly outlining the details of the interview. The information was available both in French and English (Appendix C-1). On occasion, influential key informants were interviewed in person; for example, politicians and city officials. On these occasions, senior experienced members of the ARC would conduct the interview. In the face-to-face interviews, the interviewers were aware of the effects of non-verbal communication and used this knowledge to maximize rapport. In all interviews, whether on the telephone or face-to-face, interviewers were aware of their tone of voice, rate of speech, choice of words, and the potential to make assumptions and influence responses.

The purpose of the questions was simplified at the top of the form to remind research assistants what data the ARC was soliciting. ACTION was interested in the participant's perspective on current health care services, "gaps" and "overlaps" within these services, "strengths and weaknesses" of the current system, and how a community based health centre

might complement the existing services. Some community members found the difference between "gaps and overlaps" and "strengths and weaknesses" difficult to determine. At these times, the research assistants would explain the differences in an attempt to clarify the questions. The research assistants needed to understand the intent of the questions, have active listening skills and be able to direct the interview to obtain the data. The semi-structured interviews provided a framework, but encouraged the respondent to freely pursue particular issues. The research assistants were aware that while the questions were designed to guide the interviews, flexibility to follow participants' emerging themes was to be encouraged.

Key informants were originally identified by the Youville Steering Committee, who were cognizant of influential knowing community members. Lists of names with areas of expertise and interest were generated originally from the committee members. Once these contacts were made by the research assistants, the lists would "multiply" with other key informants identified by the community itself. In the beginning stages of interviewing key informants, new contacts would always be identified. Eventually a saturation point was reached and the names generated were duplicated.

Posters were distributed at various locations that could potentially access clients who otherwise might not be represented, i.e., Miriam Center. The poster invited community members to voice their perspective in a confidential interview. This strategy was only partially effective, perhaps because of the blandness of the poster. Some target populations were already stressed with limited resources, and may not have had the time or energy to participate. Bulletins in community papers such as "Coffee News" informed the public of the community health needs assessment and invited their participation. Several important contacts were made as a result of this strategy.

Focus groups. Focus groups, wherein a group of community members came together to discuss the health care needs of the community, were an additional means of collecting data. Initially, ACTION planned to facilitate focus groups with the majority of the major stakeholders, i.e., multi denominational clergy, elementary, junior high and senior schools, parents, teachers, and students, physicians, firefighters, seniors, etc. For several reasons which will be discussed, the number of groups that were held was much smaller than originally conceptualized.

Early in April 1995, a list was distributed to all POD members identifying key groups and each member was asked to facilitate a group interview. There was limited positive response to this request on behalf of the POD members. As the project had been underway for an intense three months, with all POD members having other responsibilities, energy resources had diminished.

Organizing the focus groups, recruiting members, and accommodating schedules was a time consuming task involving numerous telephone calls and flexibility to make all the calls. Obvious leads would be followed to recruit a group, i.e., physicians. Often "word of mouth" from the community would identify groups and individuals for potential focus group interviews. ACTION would then decide if this perspective had already been included or if the group would add another dimension to the data.

At times, a research assistant was available to coordinate the group facilitator's schedule with the focus group's schedule. This strategy worked well in the organization of two groups. Often, however, POD members felt they did not have the time to participate in the groups.

ACTION was challenged to organize the groups which could be managed with the available resources and the short time frame. The original list was then prioritized and the groups were delegated. For example, some of the groups represented were: low income mothers, public health nurses, seniors, apartment dwellers, school representatives, immigrant people, Muslim women, women living in poverty, and representatives of the Franco-Manitoban community. Whenever possible, two representatives from ACTION would attend the group interviews. A senior experienced member of the ARC facilitated the group and the assistant recorded the major themes. Both members later validated the accuracy of the documentation. Less experienced research assistants were given the opportunity to participate in group work after viewing the senior member facilitate the group. At other times, only one ACTION member facilitated a group depending on the experience of the member, the size of the group, and the availability of an assistant. On these occasions the facilitators used whatever method was comfortable for them to record the data. Some used flip charts and noted themes as the group progressed, others took notes seated at a table.

Attention to group dynamics was necessary to draw out the maximum information from the group. Being able to explore, encourage, probe, and validate the group's responses were key skills involved in extracting maximum data from the group. The facilitator needed to be skilled in establishing an inviting friendly atmosphere wherein all participants were able to express their concerns.

Differences were noted in the recording of data within the focus groups. Some recorders were very thorough noting all detail which later was very helpful in recalling, not only the details of the group, but the context within which the statements were made. Other recorders took brief notes, which indicated they may not have been aware of the depth of

detail expected or the significance of the data. ACTION did not audio-record the group discussions as has been done in other situations. The decision was made not to record the group discussion in the hopes of encouraging more open uninhibited dialogue. Also the cost of transcribing the tapes could have been prohibitive.

The framework for focus group questions was the identical framework used for the key informant interviews. A brief explanation of the project and the terms "holistic health" and "community health needs assessment", preceded the structured questions. Similar to the key informant interviews, the focus groups were also semi-structured with the questions serving as a guide. The facilitator needed to have enough skill and flexibility to follow and probe for emergent issues.

All key informant interviews, individual, agency, and focus groups were stored in binders and immediately photocopied for analysis purposes. Thus, the originals of the interviews were protected. A coding system was developed where the interviews that had been copied were marked with "C" and then filed. Any that had not been photocopied, were placed in the front of the binders indicating they were not to be filed prior to photocopying. The copied interviews were analyzed for themes and highlighted with many written notations. The original interview without any analysis comments was thus available for future reference. A periodic review of the binders also served as a reminder for the work that had been completed and alerted the PM to any unforeseen data gaps.

If during the course of data collection, one of the POD members was referred to a new community contact, this information was relayed to the PM. The PM then alerted other PODS (as appropriate) to this new contact. By channelling all contacts through the PM, redundancies were avoided, i.e., ACTION members avoided calling on community contacts more than once.

For example, when contacting religious organizations in the community, many leads were uncovered that were invaluable, particularly for POD IV - Existing Social Services. Although POD IV was investigating formal service agencies, contacts with the religious organizations uncovered another layer of informal service providers who were extremely vital for community well-being. Services offered by these organizations were varied, and included soup kitchens, day cares, and women's groups. Many religious organizations offered emotional support and life skills. Informal services were inclusive of the marginalized and evidenced caring for the whole community.

Data Templates

Religious organization/school templates. Within various categories of data collection specific templates were developed to collect data that were needed. Sometimes the initial data forwarded to ACTION were not relevant. Research assistants were not always able to determine if the data were pertinent to the ACTION project as a whole. In order to ensure that all possible venues were included, ACTION welcomed any data that agencies were willing to share. The PM would peruse the data and forward it to the POD Chair for feedback as to its usefulness. Often the data presented would not be complete for the purposes of the ACTION research project. The POD chair determined what was missing and at times drafted a data collection tool to assist both the agencies and the research assistants in obtaining the needed data. This approach worked well with information gathered from schools, religious organizations and several POD I government sources (Appendix D-1).

The templates facilitated thorough pertinent data collection and honed the data to a workable format early in the process of data collection. The templates also encouraged consistent information gathering. This decreased "backtracking" strategies when data from one

facility was compared to another. Within large data collection categories, such as religious organizations and schools, this strategy proved very effective. For instance, information on each religious organization was categorized initially on the template. When data analysis was commenced, information on religious organizations was organized in a similar format and comparisons and identification of themes were then easily made.

With regard to government data bases, data were often unavailable or were much too general to be of assistance. The templates provided government representatives with an outline of specific information needed by the ACTION research team. The POD I chair spent considerable time clearly outlining what data were needed plus considerable time tracking who would be responsible for delivering the information. Even after this was determined, the process of actually obtaining the data was arduous.

In retrospect. The key informant strategies generally worked well, often the community itself identified influential members, as well as formal and informal leaders. Using a more thorough "grassroots" approach, might have identified more key informants with a wide variety of experiences within the community. Women from a "Moms and Toddlers" group could have "bridged" other community perspectives; for example those of their extended families, the men of their families and the youth. Youth problems were identified by the mothers, and perhaps this would have been an avenue to initiate contact with adolescents. Increasing contact with established community groups, i.e., church groups, and more determinedly tracking "fringe" groups, i.e., alienated youth, the chronically mentally ill, may have strengthened the "grassroots" perspective. Efforts to use a more thorough "grassroots" approach also decreases the inherent bias of classism.

Within the "ACTION Round Table Discussions" inclusive of the research assistants, performing interval checks on the community contacts proved invaluable. Going over the contact sheets as a group effectively directed data collection strategies and conserved the collective energy of the group. These meetings were very active with a dynamic exchange of ideas which was productive and efficient in tracking and following through with established contacts as well as generating new contacts. Often when going through the community contact sheets, different perspectives were shared which resulted in the identification of new key informants.

Having a semi-structured interview tool provided the flexibility to glean a rich data base. The questions ensured that the main concerns of the community health needs assessment were addressed, while the interviewer's techniques facilitated the participant's open expression. The research assistants quickly became skilled at directing interviews, following cues and facilitating communication. As the research assistants were all nursing students or nurses, they had knowledge of basic communications skills. A brief review of these skills and ongoing discussion of interview techniques was helpful to maintain clear direction and problem solve.

The key informant process worked smoothly and evolved from within the community once the initial contacts were made. ACTION continued to make a concentrated effort to include all groups. Researchers need to be aware that leads from the community may identify only one perspective and ensure the research design reduces inequity (South Australian Community Health Research Unit, 1991; Epp, 1988).

Unfortunately, the focus groups effort began at a time where the majority of the ACTION team was busy with other responsibilities. Early April was an extremely busy month

for faculty who were preparing for the end of term and for students who had to write exams. These activities impeded the full development of the focus group strategy. The earlier months of the ACTION project were spent in necessary preliminary data gathering and therefore organizing the focus groups earlier would not have been appropriate. A "full time" PM could have organized the details of the focus groups and established the contacts.

Group dynamics and group facilitation techniques could have been emphasized more thoroughly to all research assistants participating in the focus groups. While they had superficial knowledge of beginning group skills, the majority had limited experience in facilitating groups. A more thorough preparation would have been beneficial.

Media

Throughout the ACTION project, the media was monitored by community volunteers. Each week, these volunteer scanned city and community papers for any health related articles that could potentially influence public opinion. Articles covered a wide range of topics, such as government health care policies, hospital bed closures, housing issues, child prostitution, and reports on crime (Appendix E-1). The PM met with the volunteers weekly to discuss their findings. Articles were reviewed for major themes that ostensibly could have influenced the study participants. The media watch assisted ACTION in tracking community events that were of importance to the project and also highlighted biases that might arise due to media coverage. All media information was compiled into a report which highlighted the major themes that had arisen during the course of the ACTION project.

Community Leads

At times, community members contacted ACTION to ensure that various aspects of their health were being considered in the research project. The PM ensured that all contacts

were followed up. The ACTION project valued all input from the community and encouraged community participation. Calls from community members were recorded on the ACTION line. Residents were concerned about palliative care services, Myalgic Encephalomyelitis, (Chronic Fatigue Syndrome), weight reduction programs, and smoke free environments. The PM called these community residents and offered to interview them about their concerns.

From among these telephone contacts and interviews, incredible stories were heard. Two were particularly poignant. A woman spoke from her palliative care bed about her situation and the nature of health care services available to the dying. Another woman spoke from the perspective of a mother caring for a mentally challenged child. These stories were inspiring and moreover, identified strengths and weaknesses within the existing health care system. Both women had activated and mobilized their communities regarding their diverse situations. The stories illustrated that even in communities of 100,000 people, individual experiences can have an impact, both on a personal level and within the community context. ACTION members, who were privileged to the information shared within these stories, processed them individually, but all came away with a different understanding of human experiences within the health care system.

These contacts and the voices of these community residents shaped the direction of data collection within the community health needs assessment. Both stories illustrated community mobilization as each evidenced a "gathering around of community forces" to ease their suffering and pain. One mother effectively mobilized the community to assist her in the rehabilitation of her daughter. The mother herself was inspiring and resilient; the community was equally inspiring in its response to the mother's request. These stories exemplified the meaning of community as suggested by Feather, McGowan and Moore (1994), "A

psychological bond or relationship that unites individuals in a common goal or experience" (p.16).

In retrospect. While ACTION did follow up on all telephone calls to the ACTION line, more proactive strategies could have been incorporated in a concentrated effort to reach out to the community. For example, there were many ongoing groups which met in the community, i.e., organized baseball, senior's groups, church groups, which ACTION may have attended to informally publicize the community health needs assessment and understand the groups' views on health concerns.

Marginalized Groups

The ACTION Research Consortium (ARC) was aware from the onset of the project of the need to include the voices of marginalized groups. POD III attempted to access both the vulnerable and the strong voices of the community. Data collection strategies within a community health needs assessment, must consider how to privilege as many voices as possible. Often, many community residents are silenced by their marginality. Accessing and hearing their voices can be challenging.

Voices of service providers, many of whom have not experienced the struggles of those who make use of the service, may reflect a much different perspective. For example, the First Annual Report of the Children's Advocate of the Department of Family Services (1993/94) presented the reality of the lived experiences of children while in the care of Child and Family Services. During the course of data collection, several concerns identified in the Child Advocate's report were voiced within the community. Controversial reports critiquing services, such as The Child Advocate's report, assisted the ARC to gain an overview of problems, broadened the scope of the data collection and sharpened the listening acuity of the

researchers. The inclusion of the Child Advocate's report is an example of how, if one listened only to the voice of the service providers, the interpretation of the effectiveness of services would be vastly different.

The vulnerable often have few resources to make their voices heard as all their energy is consumed in daily living and, for some, in surviving. Populations such as the mentally ill, immigrant people, and poor women have varying abilities and degrees of comfort in voicing their concerns (Feather, McGowan, & Moore, 1994). ARC attempted to reach marginalized groups and assist them to express their needs. For example, lower income women over the age of 55 and young parents, were actively consulted for their perspective via community identified key informants, both individuals and groups.

The voice of the mentally ill was accessed through various self help groups, representing the major mental illnesses; schizophrenia, anxiety, depression and bipolar disorder. Unfortunately attempts to meet with the chronically mentally ill at a local restaurant were not successful. ACTION did however, meet with the Mental Health Advocate of the Canadian Mental Health Association. The Advocate arranged for a consumer of mental health services from the St. Boniface/St. Vital to speak with the PM. Formal and informal services provided care to the mentally ill. Community mental health workers from each community were contacted for their perspective of how the mental health services they provided, met the needs of their clients. As ACTION was gathering data, the churches were identified as an important informal support system for the chronically mentally ill and other marginalized groups. Churches were offering food banks, soup kitchens, clothing banks, and social support to many marginalized groups. Some of the chronically mentally ill frequented the churches on

a regular basis. Contacts made with the churches allowed ARC to "tap into" marginalized groups.

Attempts to reach alienated youth were also largely unsuccessful, but again the churches did provide a window on this population. ARC contacted the facilitators of Ron's Drop In Centre, a youth program organized by one of the community churches. Managers of Seven-Eleven stores provided their perspective on youth problems. Teachers, principles, home economists, and outreach workers from the schools were interviewed by ARC for their perspective on youth's health concerns. Organizations dealing with adolescents, such as Child and Family Services, Child Guidance Clinic, and Addictions Foundation of Manitoba provided data on the presenting problems of youth. Representatives from parents groups voiced their opinions on adolescent health concerns.

Research assistants were able to meet with immigrant people and the gay community enabling their perspectives to be heard. The immigrant population was contacted through formal agencies delivering Immigrant services, community schools, and Immigrant women's groups. The gay community was contacted through the Winnipeg Gay and Lesbian Resource Centre. Additional contacts were then obtained and the ARC research assistant was able to met with representatives from the Gay/Lesbian and Immigrant communities.

Several attempts were made to gather data on the Métis and Aboriginal health care concerns in the St. Boniface/St. Vital areas. ARC contacted organizations such as the Assembly of Manitoba Chiefs, Aboriginal Students Association at the University of Manitoba, and Pemmican Publishing but was unable to gather data specific to the needs of the Aboriginal and Métis people in the communities.

ACTION was proactive in reaching out to these groups. While attempting to listen to the voices of the vulnerable, it was imperative to recognize the strength of other voices and to keep their concerns in perspective. For example, the Franco-Manitoban community was particularly well organized and able to articulate its concerns eloquently. The research team needed to be aware that this very strong voice could potentially, "out volume" the voices of the less articulate, the less organized and the less politically active. A key component of the ACTION team's philosophy was the inclusion of marginalized voices and the belief that all opinions were of value. The research team attempted to be cognizant of value judgements that they themselves might project on voices with whom they did not agree.

In retrospect. Marginalized groups (Immigrants, the mentally ill, and the poor) were actively sought out for their perspectives on community health needs. This approach could have been strengthened by devoting more time to these efforts, tapping into the existing community resources more assertively, and by repeated contacts with the groups to ensure all key issues were addressed. For example, in the case of the chronically mentally ill, ACTION was unable to connect with a community member who had established rapport with this population. Because of time constraints, the strategy was then abandoned, perhaps prematurely. To prevent superficial representation of marginalized groups, ongoing contact and a variety of interventions to reach these populations are needed. Broader use of community leads would have facilitated a richer "grassroots" perspective.

Community Mobilization

Community mobilization was undertaken in various ways throughout the project. Key informant "leads" often led ACTION to identify community members who would otherwise not have been contacted. On one occasion, an individual was identified as representing a

specific population and having a "pulse" on this group. ACTION facilitated a focus group by offering babysitting and transportation services to the group. Several other focus groups were also organized from community suggestions. In an attempt to increase community participation, the ACTION telephone number was published in local news bulletins and on French and English radio and television stations. An "Information Day" was held at a local mall. While the mall policy restricted conducting surveys on the premises, community members were extended the opportunity to participate via the mail.

Bilingual interviews in local papers, The Lance and La Liberte, informed the community of the purpose, process and progress of the community health needs assessment (Appendix U). Bilingual posters were distributed to various community locales throughout the duration of the project. Some of the locales were libraries, medical clinics, book stores, grocery stores, and community clubs.

Several people volunteered during the course of the community health needs assessment. Members of the community oversaw the implementation of the drop-off survey in the St. Vital library in an effort to encourage community participation and also to ensure that community voices were heard. People volunteered to share their knowledge of the history of the community and donated their time to do so. Several of the research assistants were hired after they had generously volunteered their time. Some of their reasons for volunteering included: a strong belief in the philosophy of community health needs assessments, namely accessing the community voice; to gain experience in conducting a community health needs assessment, and a keen interest in the diverse populace of the communities. Faculty members, some of whom were also community members of St. Boniface and St. Vital, also volunteered their time and talents to the project.

ACTION hosted public forums in both St. Vital and St. Boniface to disseminate preliminary findings of the report. The purpose of these forums was to inform the community of preliminary findings, and to solicit feedback from community members. Community members were invited to present their impressions of the findings, whether they agreed or not, and to identify any obvious data gaps. These community forums were sparsely attended with a larger turnout at the St. Boniface meeting, with mainly Francophone community members in attendance. At the St. Vital forum, health care providers comprised the majority of the audience.

Sparse attendance at community forums has been documented in other community health needs project. The ACTION research consortium was aware of the possibility of poor attendance associated with other public forums. With the current political interest and government initiatives in health care, ACTION was hopeful that community residents would have responded positively. The forums were advertised in the local coffee news papers, via the media bilingually, and via posters distributed around the communities (Appendix F-1).

During the forum sessions, members of ARC presented the preliminary findings. The origin of the project highlighting Youville Clinic's involvement, the method of data collection and analysis, and the opportunity to give feedback to ARC were discussed. Photographs of the community and overheads with key points served as visual aids in the presentation. The audience was provided with a printed bulletin with basic information on the community health needs assessment (Appendix G-1).

After the presentation, refreshments were provided and the audience had the opportunity to ask questions or comment on the findings. ACTION also placed high value on ensuring the communities had access to the findings and an opportunity to voice any concerns

associated with the process or findings of the community health needs assessment. The preliminary findings were presented as the beginning stage of community programming and mobilization. The challenge would now be for Youville Clinic to use the findings to implement services best suited to the communities' needs.

In retrospect. A community development approach to community health needs assessments assumes that the community becomes empowered by assuming responsibility and control for their health. In this approach, one of the key goals of the community health needs assessment is that partnerships develop between community members, organizations, groups and service providers to sustain initiatives (Feather, Mc Gowan, & Moore, 1994). Labonte (1989 and 1986) articulates that all community projects should assume a critical stance with the intent of seeking a more just and equitable society. To do so, community participation at all stages of the project from planning to evaluating is fundamental. Community members need to be involved in setting goals and objectives, to ensure these goals and objectives will accurately reflect what the community hopes to achieve.

People who live in well documented risk conditions, i.e., poverty, low socioeconomic status, and who experience inequities in power due to racism, ageism and sexism, are often prone to poor social support, low self esteem, isolation, and high self blame (Labonte, 1990, 1987 & 1986). To enable them to begin to develop the skills for self direction, people must be allowed to participate in the decisions that affect them (Dveirin & Adams, 1993). To ensure success, time is needed to help people develop skills and self esteem. To ensure people are equipped to succeed, demands a considerable investment of time and resources.

The strategy of including community members from all socioeconomical backgrounds within the ACTION research team, may have provided a consistent strong link to the

grassroots of the communities of St. Boniface and St. Vital. Groups identified in the community health needs assessment, poor women +55 years of age, isolated elderly, chronically mentally ill and disadvantaged parents need encouragement to participate in planning. These groups could have been involved more effectively throughout the community health needs assessment project. In the Community Health Needs Assessment of St. Boniface and St. Vital, Volume II, Final Report, the section entitled Community Perspectives: Advice to Youville Clinic, presented the viewpoints of the residents, agencies and health care providers. Of key importance, was the need to "reach out" to the community, to have an active presence "in the community" and not "just in the clinic". Adopting an "out reach" philosophy encourages the continuation and prioritizing of community development and mobilization. Through mobilization of the community, community members become empowered to define new values or reconfirm old values. This process may become the catalyst for change (Tebbitt, 1993). Hopefully, this philosophy will be a strong component in the utilization of the community health needs assessment findings.

A stronger proactive drive to link with the community by contacting and nurturing relationships with existing groups, would have ensured a solid connection between the community and the research team. Being able to prioritize and allot time to these endeavours is crucial. The act of prioritizing this approach conveys the true spirit of community valuing all perspectives and committing to community involvement. While community health needs assessments and the government superficially agree with this concept, often health care providers have difficulty operationalizing these ideas as they dictate a relinquishing of power. Reflecting on the process of the community health needs assessment, senior ACTION members agreed that a broader inclusion of all community members would have made the

findings more comprehensive. The large size of the community and the limited time frame within which to conduct the community health needs assessment, necessitated more conservative methods.

True community mobilization is illustrated with the following example. Women in a Toronto housing complex were told by the Public Health Department, that they needed an awareness program about nutrition. The women rejected this advice and instead asked for a community garden. Their success with this project both improved their nutrition and increased nutritional knowledge. More importantly, their self esteem and sense of control over their lives was improved (Labonte, 1986).

Youville Clinic will now have the opportunity to implement strategies to meet the needs of the community.

As Youville Clinic and its St. Vital satellite will not be able to meet all the identified needs, sharing and disseminating the information generated by the community health needs assessment is key to community mobilization and empowerment. The Clinics, however, will have the opportunity to creatively engage the community in their new programming. The tradition of Youville has always been that of a leader and once again the Clinic has seized the opportunity for innovative health care delivery.

The data collection strategies used by ACTION were broad and varied. The strategies were generally effective as ACTION had spent considerable time planning data collection. A major strength of the ACTION project was its diverse methods of obtaining data and its ongoing commitment to accessing the community voice.

Chapter Five

Data Analysis

C-91 Data

The analysis of the data was ongoing throughout the project. POD I data were analyzed by the POD Chair as various sources of data were compiled. Preliminary analysis of the secondary data base began as early as February. Once the C-91 data base was installed, a research assistant was assigned to work with this data. Information such as population numbers, marital status, lone-parent families, religion, immigration, education, unemployment, and ethnic origin was extracted from the data and compiled into reports. The POD Chair would then analyze these reports. The data were analyzed according to the specific FSAs within St. Boniface and St. Vital. The POD Chair was then able to situate the data within the whole context of the POD data collection and note any discrepancies or similarities in other information being gathered.

Emergency Data - St. Boniface General Hospital

POD I data analysis included information from the St. Boniface General Hospital (SBGH). The POD attempted to gather information on the users of emergency services. Data were not readily available as the emergency data had not been computerized. With the help of the SBGH administration specifically, Mr. Riel Cloutier, the majority of the data became available.

The POD Chair was able to provide tables on emergency utilization by age, triage category, i.e., emergent, urgent, non-urgent, and scheduled; entrance times, entrance complaint, and frequency of use. SBGH Emergency Room services had been undergoing a review as of January, 1995, to address issues of overcrowding and long waiting periods. The

Barer/Shepps report (1994) identified that SBGH handled 20 percent of all visits made by seniors in the City of Winnipeg.

Analysis of the data included blending previous findings such as the Emergency Room Use in Winnipeg Hospitals, 1991/1992 report (Barer/Schepps, 1994) and current data from the SBGH. The POD Chair had an enormous amount of detail to consider in all the POD I areas of data analysis. Data were organized into tables for ease of understanding with a preceding short text describing any pertinent analysis factors. For example, when presenting the data from the C-91 data base, several points were clarified. Two populations were circumscribed; population A which included people in institutions, and population B which was collected from a 20 percent sample of households in the same geographical areas. Random rounding, a confidentiality procedure, was used in the presentation of the C-91 data. This strategy did not add significant error to the data but accounted for some minor discrepancies in the totals at the end of each column. Attention to details such as this was pertinent to the analysis of quantitative data and for a valid interpretation of these facts.

Morbidity and Mortality Data

Obtaining the mortality and morbidity data was energy draining as previously described. Data were finally obtained from Vital Statistics and Manitoba Vital Statistics. Qualifiers were put under tables wherein the totals differed between the two data sources. The POD Chair constantly analyzed and compared the data from varying sources to determine why differences occurred. Secondary analysis of the existing data required a scrutinizing eye to screen for possible alternative interpretations of the data. POD I produced approximately 100 tables and figures which aptly illustrated the volume of secondary data available, but

minimized the effort expended to obtain the data. The disparate data bases were daunting, tedious, and time consuming to analyze and obtain.

The mortality data was analyzed by deaths per quarter of the year; the latest year available was 1993. Death statistics were categorized by cause of death, accidents and violence, and age at time of death.

The morbidity data was obtained from the 1993/1994 Hospital Abstracts which outlined the number of residents who were diagnosed with an illness at the time of hospitalization. The incidence of accidents, falls, poisonings, and other unintentional incidents was obtained. Upon analysis of the data, it was noted that both communities had a higher percentage of falls in the elderly population admitted to hospital than the statistics for Manitoba. The data was presented from both communities, St. Boniface and St. Vital, and subsequently compared to the Manitoba figures. In presenting this data, the POD Chair noted that the hospital abstracts do not represent the true number of accidents. An exhaustive review of physicians' records would have more accurately reflected the accident rates, as a proportionate number of accidents do not require hospitalization.

Information on continuing care, Manitoba Immunizations Monitoring System (MIMS), adult special services, vocational rehabilitation, sexually transmitted diseases (STDs), communicable diseases, and Public Health nursing activities was obtained from Department of Health programs and the Department of Health Statistics. Raw data pertaining to communicable diseases were available only for the province or smaller geographically areas such as Winnipeg South which included St. Boniface, St. Vital, Fort Garry, and Charleswood. The 1994 data were available for the combined municipalities of St. Boniface/St. Vital. Analysis of data always took into account the varying parameters, i.e., citing trends of all

communicable diseases in St. Boniface/St. Vital was not possible due to the nature of the previous data collection.

With the STD data, which was computerized as of 1994, errors in the recording of the data became evident. These errors were noted with the presentation of the data. The Winnipeg data was compared with the Manitoba data for consistency of trends.

Throughout the data analysis attention to the strengths and limitations of the individual sources was crucial. Addressing the limitations of the data analysis dictated by the disparate nature of the data bases was essential in the final report. The difficulty with secondary data bases is noted elsewhere in the literature (Barton, Smith, Brown, & Supples, 1993; South Australian Community Health Research Unit, 1991).

The majority of the analysis of the POD I data was completed by the POD chair who had expertise in analyzing secondary and quantitative data bases. The research assistant working on the preliminary analysis of the C-91 data base would alert the POD chair to questionable areas in the data which the POD chair would investigate.

Socio-Cultural Historical Data

Within POD II, socio-cultural-historical data, ongoing analysis identified gaps and strategies to ensure complete data collection. During data collection, preliminary analysis of what information was collected to date, determined the future direction of data collection. Research assistants were given 26 questions and a binder in which they were to store the collected data. The information was periodically sorted by the POD Chair and Co-Chairs and analyzed for themes, gaps, and future strategies. A final report with a compilation of the data was forwarded to the Senior Chair. The findings represented aggregate findings based on

inductive reasoning. Data analysis was built into the data collection strategy and ongoing dialogue with the research assistants who were in the field.

Key Informant Data

POD III data concentrated on the key informant interviews and the survey data. The key informant interviews were collected from all of the PODS, therefore a wide variety of information was included. The initial step of the data analysis consisted of collecting the current key informant interviews and subdividing them into categories; i.e., mental health, children, seniors, community, family, religion, women's issues etc. Once the categories were established, the interviews were read by the PM and the Senior Chair and patterns (categories and themes) extracted. Information that was useful to other PODs was marked with highlighter and the POD's name. General data was highlighted with another colour which was then input to a computer data base. After the general data from the individual interviews were categorized and entered into the computer, the key informant interviews were forwarded to the appropriate POD chair. The POD chairs would refer only to the colour coded information that was deemed to be of relevance to their POD, maximizing efficient use of time and energy. This process worked well, particularly for the POD IV Chairs who generally had relevant information on each key informant interview.

The questions in the key informant interviews delineated the major framework of the data collection, i.e., the services needed, the overlaps in service, and how a CNRC could address gaps in services. Each interview was meticulously examined for emergent themes. During the process of data analysis, saturation of the data occurred when themes began to be redundant and there was no new information forthcoming. The researchers were constantly comparing findings with various sources, such as; published reports—the First Annual Report

of the Children's Advocate, Manitoba Family Services, 1993/94, key informants with focus group findings, and secondary analysis of existing data bases. The analysis process was ongoing and required an intense scrutiny of preconceived assumptions and biases that could have influenced data interpretation. Open discussion with challenges as to how conclusions were derived attempted to ensure the rigor of the research process. This process required constant monitoring to ensure that preconceived ideas were not erroneously represented.

The mail out (N=250) and drop off (N=84) surveys were analyzed separately and then combined (N=334). Statistically significant differences in sample demographics were acknowledged:

1. gender
2. education
3. self-reported health status and health conditions
4. stress in life

With these differences acknowledged, the two samples were pooled to create a total sample size of N=334. The data were analyzed according to gender, age-cohorts, geography, (St. Boniface compared to St. Vital) and French language speakers. The findings were interpreted in light of the differences inherent in the drop off cohort. The impact of these differences on health needs and program needs, however appeared to be mitigated by the sample size of the randomly distributed surveys. Within the pooled sample, for example, there were no significant differences regarding the gender of subjects, their educational achievements, presence of stress, or self reported health status.

The statistical consultant, Dr. Jeff Sloan, analyzed the data with the appropriate statistical tests. As ACTION had consulted closely with Dr. Sloan in designing the survey, the survey provided the data that ACTION was attempting to collect. Initial energy and time

spent in designing the survey was beneficial for smooth analysis of the data eliminating any "surprise" errors in the survey instrument which would affect the survey results.

Data in both PODS IV and VI were analyzed with qualitative and quantitative methods. The PODS used existing reports, key informant interviews, and focus group interviews to derive their results.

ACTION consistently monitored the sources of all the data scrutinizing it to avoid unwarranted generalizations. With the disparate nature of the POD I data, this strategy was extremely important. Logical implications as to whom the data could be generalized guided the analysis process.

In retrospect. The analysis facet of the community health needs assessment was an enormous task. While the POD Chairs provided their individual reports, the Senior Chair had the onerous task of integrating all of the data in a synthesized format. During the analysis, the PODS were "collapsed" and the data reviewed outside of POD parameters. ACTION was fortunate to have an experienced Senior Chair who had worked extensively with qualitative data analysis and was well able to ensure the rigor of the research. Having experience with large projects was itself valuable and communicating that the "task was finite" motivated and encouraged the team.

Even with this background, the task was challenging and required much time and energy to complete. Having an experienced colleague is invaluable as energy then can be channelled where it will yield maximum results. The volume of data can be overwhelming to the uninitiated, therefore a clear vision of the ongoing research steps provides much needed direction at this point in the community health needs assessment.

While ACTION was fortunate to have the talents of the Senior Chair, the time factors and never ending deadlines decreased the time available for processing the team members' personal biases. The research assistants were given some direction as to detecting bias and encouraged to be vigilant while interpreting and recording their data. What could have further strengthened this process would have been ongoing dialogue and challenges to thinking within a large group context. Building this strategy into the community health needs assessment framework and prioritizing time to implement it, would have enhanced the research process and controlled for unintentional bias. The need for ongoing direction and nurturing to the research assistants was demonstrated with the focus groups. Differences in the recording strategies of the research assistants exemplified this need. If more time could have been allocated to the development of the research assistants, the research rigor of the data collection may have been improved. Each team member had varying levels of comfort and experience with data collection, and further investment with those who were less experienced would have benefited the research process. How the data is collected and interpreted affects the data analysis.

The community forums, which were held once the preliminary findings were complied, gave the community the opportunity to comment on the accuracy of the findings and provide feedback to ARC. The Youville Steering Committee was also a resource to validate whether the preliminary findings had any serious omissions or concerns based on the committee's knowledge of diverse areas of the community.

The preliminary findings were scrutinized by the Steering Committee and their feedback was integrated into the Final Report. Presenting the preliminary findings to both the community and the Steering Committee was an integral part of the analysis process. To

involve the community more fully, the findings might have been presented at intermittent points of the community health needs assessment to the general community. Idealistically, this strategy would have mobilized the community and involved them in the ongoing process of the community health needs assessment.

ACTION was able to accomplish a phenomenal amount of work in the final analysis stages due to the expertise of several key players on the ACTION team. Anyone undertaking a project of this size, must plan for adequate time and skills to successfully analyze the data. The task consumed hundreds of hours in spite of the experience of the ARC.

The Preliminary Report

Reporting the findings back to the community, not only ensures the rigor of the research, but provides the community the opportunity to add information that may have been overlooked or misinterpreted. ACTION conducted the public forums in both communities and advocated that both the preliminary and final results of the community health needs assessment be made easily accessible to the public.

During the ACTION project, distributing the preliminary findings in an easy to read, colourful one page "news sheet" may have helped disseminate the results to the "grassroots community". The use of a graphic or cartoon and the brightly coloured paper may have attracted interest. These techniques have been used successfully in the dissemination of other research findings (South Australian Community Health Research Unit, 1991). The results can be used informally to reach populations that otherwise may not have access to the findings or motivation to read a more professional report. Information should be set out clearly in an easy to read style on both the "news sheets" and the formal report.

ACTION printed the text in a columnar format for ease of reading. Photographs and graphic charts were dispersed throughout the formal report to maintain the reader's interest. On occasion, quotes were interspersed from community residents. This helped "ground" the research and added interest to the text. The report made use of headings, subheadings, short paragraphs, and a spacious layout versus crowding the pages. These strategies made the report more aesthetically pleasing and aided reader comprehension.

The Final Report, which was delivered to the Youville Clinic Steering Committee after changes were made to the Preliminary Findings Report, will be launched with a press conference organized by the Steering Committee. The findings of projects funded by public monies, should be made public and readily available to the community. By doing so, the community health needs assessment can establish priorities which may lead to action by the community and the health care system (South Australian Community Health Research Unit, 1991; Prairie Region Health Promotion Research Centre, 1994).

Throughout the project, ARC advocated that the findings be used in this manner. The Final Report contained recommendations to Youville from the community. These recommendations were derived from the key informant interviews and focus groups. The listing of the recommendations was a direct bridge from the community to the Steering Committee wherein the community perspective was clearly articulated.

In Retrospect

During the process of the community health needs assessment, both strengths and issues arose from within the process underlying the project. Reflection of both aspects of the process will assist future researchers in their endeavours.

Strengths

The strengths inherent within the ARC were many. ARC members had diverse areas of expertise. The areas of expertise included gerontology, community health, mental health, Public Health, values clarification, research, and statistics. The vast amount of experience represented within the ACTION working group facilitated the research project. Previous experience with community health needs assessments, minority groups, and large research projects, enhanced the research process. Both the diverse expertise and the diverse experience of ARC members fortified the project.

All ARC members were committed to the concepts of community health and health promotion. Identifying with the underlying philosophy and having a belief system congruent with the ACTION project, motivated and buoyed the effects of the intense workload. ACTION members were generally enthused with the project, its timeliness with health care reform and implications for nursing practice.

The project allowed for creativity. Although the data collection PODS were structured, creativity in collecting data and following leads was encouraged. Community health needs assessments are on "the cutting edge" of health care reform, being the first logical step in the planning process. Realizing this and striving to expand the existing models of community health needs assessment, encouraged creative thinking within the ACTION process. The leadership of the project attempted to decrease power differences among ARC members, welcomed creativity and celebrated differences. Differences in thought processes, human strengths and "ways of knowing" were honoured as the research design allowed.

ACTION was astute in allowing ample time for planning and identifying a critical path. Time was built into the planning process to determine if the ARC was on course with

the critical path. Planning time to incorporate unforeseen developments, critically examine the process to date, and evaluate that process within project goals was invaluable. The Senior Chair was instrumental in ensuring adequate planning time throughout the duration of the project.

Issues

In reviewing the process of the ACTION project, several issues arise that constitute areas of growth. Workload equity, community mobilization, monitoring of the research process, lack of a full time central figure, and problems in securing existing data were key issues within the community health needs assessment process.

The community health needs assessment generated an enormous amount of work and consequently data to be analyzed. At times during the process, the equity of the workload was not fairly distributed among team members. Various levels of commitment to the project and other responsibilities outside of the project occasionally interfered with the amount of work undertaken by each member. Workload equity is commonly an issue in large projects, with several members often assuming the majority of the work. Addressing workload expectations openly at the beginning of any project could be advantageous. The spontaneous nature of data collection created intense workloads often under pressure of imposed deadlines. These times were difficult to predict, increasing the stress levels of the team.

Community mobilization requires concentrated effort and energy. Having a specific task team assigned to accomplish this, may have increased community interest. A more concentrated approach to "courting" the community, utilizing community members in planning the community health needs assessment, plus instituting a broader "grass roots" approach throughout the process of the community health needs assessment, would have facilitated

community mobilization. A focused "out-reach" effort to existing groups in the community could have been incorporated in the strategies used to gather data. Efforts to mobilize the community reduce the chance of bias and elitism.

A more rigorous monitoring of the research process could have occurred if time constraints were not pressing. Less experienced researchers could be mentored as the project progresses and learn from more experienced researchers. Cross fertilization of ideas, with an ongoing critique of the research process and monitoring of inherent bias are important concepts for the rigor of the research. These concepts, while addressed adequately within the ACTION project, may have been strengthened adding to the purity of the research process.

Having one key central person available on a full time basis, would greatly improve the process of conducting a community health needs assessment. Ideally this person should be the Project Manager whose main task is to oversee the project from initiation to termination. Having the Project Manager available on a full time basis, would facilitate the tracking of details, the planning process, and timely attention to emergent issues. Not having one key figure readily available during the ACTION project, increased the workload and stress levels of the ARC. A full time central figure would have facilitated the process of data collection, reduced redundancies, and strengthened community mobilization and mentoring of research assistants.

Collecting existing reports and data bases proved to be an onerous task that was not well understood as the beginning of the project. Accessing the information was extremely difficult and even when obtained was frequently not in the desired format. Problems with existing data bases are common as detailed in other community health needs assessments and much time needs to be allotted to this endeavour. ACTION was not prepared for the

inordinate amount of time needed, not only for the collection, but also the analysis of the data.

Strengths and issues of the ACTION project provide insight into the process of conducting a community health needs assessment. The above mentioned overview of the obvious strengths and issues associated with the project is not inclusive of all the strengths and issues within the project. However, an understanding of those discussed will enable future researchers to plan more effectively to avoid identified pitfalls.

Conclusion

The vision of conducting a community health needs assessment was the initial step in a long and rewarding project. The foresight of the Youville Clinic and its Board of Directors responded to the challenging fiscal restraints and reforms of health care proactively. The community health needs assessment attempted to accurately discern the community's perception of service gaps, overlaps, and needs. In the tradition of Youville Clinic, the community health needs assessment was conducted to enable clients to acquire a greater understanding of, and responsibility for their health and the health of their families.

The mission of Youville Clinic articulates the values of creating an atmosphere of concern and respect, fostering hope in individuals and families seeking help, providing help in a caring nonjudgemental environment, promoting help by assisting people to be aware of their own resources; offering education and direction; support and encouragement (Celebrating the Year of the Family, 1994).

ARC attempted to conduct the community health needs assessment in accordance with the values outlined in the mission statement of Youville Clinic. In the spirit of feminist research, the ARC supported a nonjudgmental egalitarian approach between researcher and

participant, emphasizing unconditional positive regard towards all participants. From the onset of the project, ARC was concerned that the findings of the research be made available to the community and that the community be encouraged to question, supplement, and validate the accuracy of the findings. The ethics of community research decree that the information collected during the research process belongs not only to the researchers but also to the participants (South Australian Community Health Research Unit, 1991; Feather, McGowan & Moore, 1994). The ARC fulfilled its obligation to the community by conducting community forums, ensuring that the community was aware of the forums, and informing the community where the final report could be obtained.

The process wherein the community health needs assessment was accomplished was complex and arduous. The ARC team, though prepared for a large project, was not totally cognizant of the volume of data that would be generated nor the energy required to adequately collect, store, and interpret the data. While various models and methods of conducting a community health needs assessment were described in the literature, little information on the complexity of the actual process was to be found. Having Dr. Cindy Russell as a clinical consultant was of immense value to the ARC in this regard. While her contact with the ARC was mainly via telephone, Dr. Russell's personal visit to ACTION afforded the team an opportunity to learn from her experience with other community health needs assessments. Though the communities Dr. Russell assessed were vastly different than the urban communities of St. Boniface and St. Vital, many of the process issues were similar. Because of the lack of literature on process, the researchers were in "uncharted" waters and would have been totally unprepared for challenges of the research process. Having Dr. Russell as a consultant, enabled the ARC to proactively prepare for known potential trouble areas.

ACTION's experience demonstrates the need for documentation of the processes wherein community health needs assessments are conducted.

In the pamphlet Celebrating Year of the Family Year, 1994, (Youville Clinic, 1994) (Appendix E) the meaning of the International Year of the Family Symbol is discussed. The symbol is explained as such:

> A heart sheltered by a roof, linked to another heart, to symbolize life and love in a home where one finds warmth, caring, security, togetherness, tolerance and acceptance—that is the symbolism conveyed by the emblem of the International Year of the Family 1994. The open design is meant to indicate continuity with a hint of uncertainty. The brushstroke, with its open line roof, completes an abstract symbol representing the complexity of the family (World Health Organization, Celebrating Year of the Family Year, 1994).

The concept of community blends well with the symbol of the family. The community is a social unit, with characteristics similar to a family. The community exists within a larger social environment; interaction takes place among its members; and the community is organized in order to meet the needs of the members. The community has common interests and needs and a sense of togetherness (Higgs & Gustafson, 1985).

In a healthy community, the members will find warmth, security, caring, togetherness, tolerance and acceptance. At the same time, the community may also have a sense of uncertainty as it is a part of the larger social structure. The community, like the family, is also complex with many layers and interconnections.

Similarities exist between family and community. Individuals constitute families as both constitute community. The community health needs assessment undertook to consider the

needs of the community composed of individuals and families, with the hope that the findings will lead to the further development of a healthy community wherein all members may find security, tolerance and acceptance within the concept of togetherness.

ACTION attempted to bridge the gap between theory, research and practice by using research strategies that incorporated both humanistic and scientific method, a strategy employed in Action research (Holter & Schwartz-Barcott, 1993). The results of this research hopefully will assist in the identification of practical meaningful solutions to strengthen the community and achieve health for all.

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Appendix A

St. Vital to get first community nurse centre

The first of four Community Nurse Resource Centres will begin operating in the St. Vital area of Winnipeg in April.

The Winnipeg centre will operate as a satellite of the Youville Clinic and will receive approximately $1 million in annual operating funds, redirected from institutional health care budgets. The new centre will create 16 new positions, consisting of 12 new nursing positions and four support staff.

"The establishment of Community Nurse Resource Centres will give Manitobans direct access to primary health care delivered by nurses," Premier Gary Filmon said.

Health Minister Jim McCrae said final arrangements are being made for the establishment of a Community Resource Centre in Thompson, while site selection is proceeding for centres in Norman and Parklands health regions.

"The Resource Centres complement the existing system," said McCrae. "They provide increased opportunities to work with families and the community to prevent disease, promote health and postpone disabilities, in addition to streamlining the entry process to primary care for those who are ill."

Community Nurse Resource Centre staff will work with a wide range of agencies and community groups in many sectors. Together they will build supportive environments for health by providing links with other programs and services such as housing, social services and education and training which are all essential components of good health.

The development of the four centres is a result of recommendations made by the Working Group on Nurse Managed Care and the work of the advisory committee, chaired by Dr. Helen Glass of the University of Manitoba's faculty of nursing.

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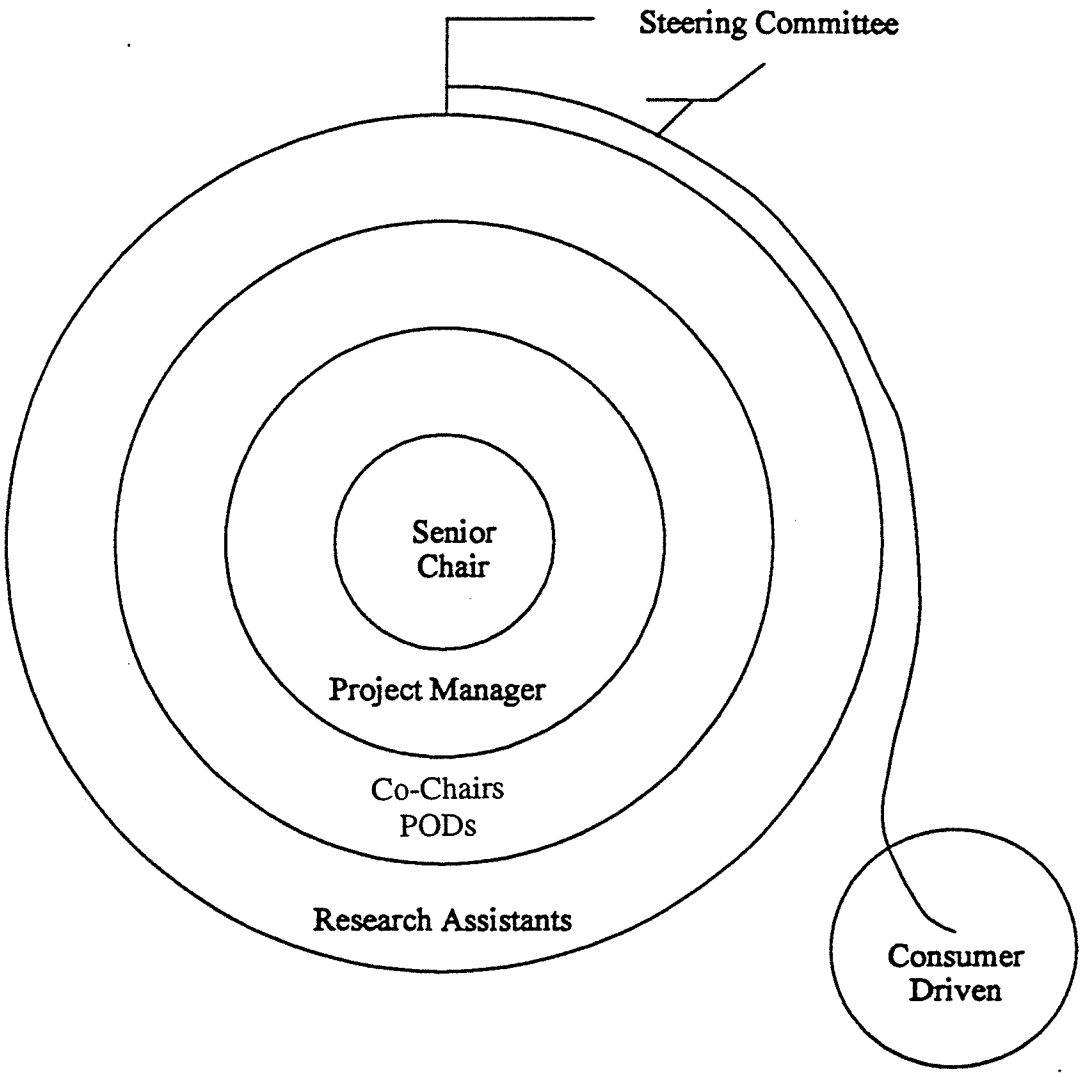
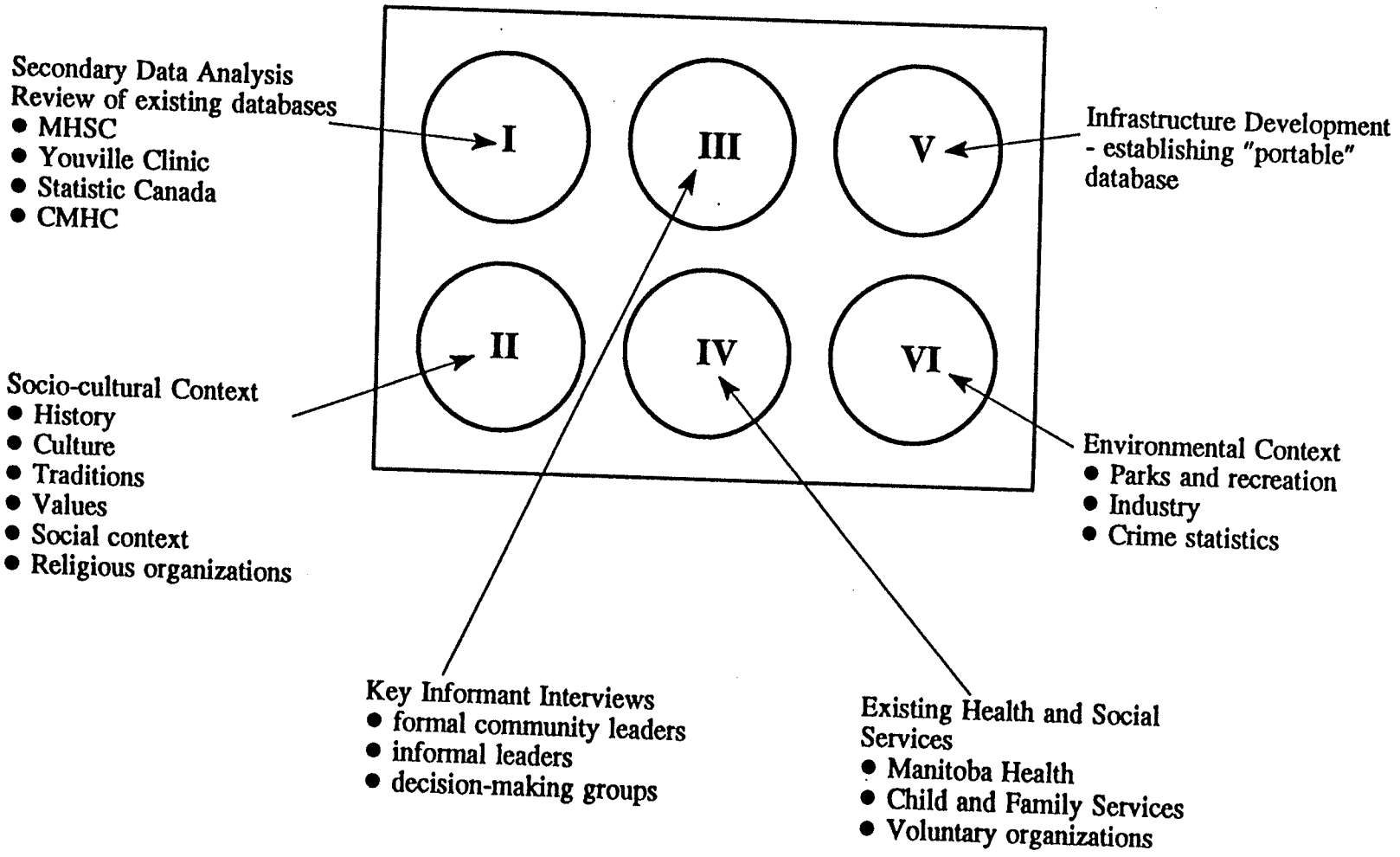
Appendix B

Organizational Structure



Adapted from: Bruce, G. (1993). Improved university campus wellness plan. American Association of Occupational Health Nurses, 4(3), 120-123.

Overview of Community Assessment Project*



Examples - not an exhaustive list

Appendix D

Framework of Questions for POD II - Socio-Cultural

These questions are intended to capture the concepts of Pod II.

This framework will guide the data collection process of the RA's and serve to organize the formal writing of Pod II for the final document.

The RA's will record the data with respect to each question in a binder. Each question is indexed. (To date 27 questions make up the framework.)

1. How did the community come to exist?

2. What historical customs/traditions are evident today?

3. Who is included and who is left out in the community? i.e., What are the caring practices? Are the "left-out" neglected or left out and cared for?

4. What are the social/socialability customs and practices? What are the local gathering places?

5. What are the religious/spiritual practices in the community?

6. How does the community nourish itself? i.e., food buying practices.

7. How does the community express itself artistically? Music, dance, festivals, etc?

8. What is the geographic movement of the community? Transport, movement in and out?

9. What is the adherence to ethnic roots in the community?

10. What languages are spoken and what colloquialisms are operating?

11. What have been the major changes in the community? What has driven major changes, over the years, in the community?

12. Who and what are the controlling forces in the community? (power)

13. Does the community feel empowered? (town hall meetings, voting records)

14. Does the community have a newspaper(s) and who contributes?

15. Does the community have local authors? (editors of little papers too)

16. Does the community have pride (ownership) and of what, i.e., roads, people, dress, etc.?

17. How does the community clothe itself?

18. Does the community feel safe? (i.e., lock doors, cars, etc.) What is the trust quotient?

19. How physically active is the community? (jogging, swimming, walking)

20. How does the community "get away from it all"?

21. What does the built space look like? (houses, gardens, parks) i.e., amount of new growth (balconies, front porches, back yards).

22. What are the sources of humour in the community?

23. What are the formal and informal communication structures and practices?

24. What are the characteristics of the local signage (signs) and do names repeat? Can patterns be identified in the community?

25. What are the traditions/practices surrounding death in the community?

26. What are the traditions and practices surrounding rights of passage, i.e., births, marriages, divorces?

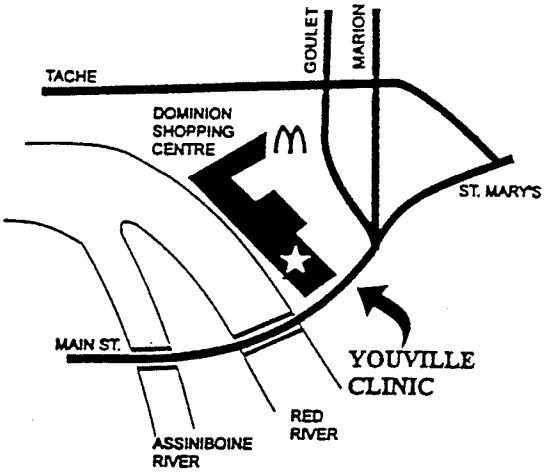
27. Other.

Appendix E

YOUVILLE CLINIC INC.

33 Marion Street

233-0262



Youville Clinic, a health promotion centre, was established by the sisters of Charity of Montreal "Grey Nuns" in 1984. This nurse managed clinic is located in the community of St. Boniface. It has two main components, Family Health and Diabetes Education.

Hours
Monday to Thursday 9:00 a.m. to 9:00 p.m.
Friday 9:00 a.m. to 5:00 p.m.

Free parking available

The Clinic welcomes everyone and offers its services in a caring, non-judgemental, respectful, and confidential manner.

Services which include education, direction, support and encouragement are offered to enable clients to acquire a greater understanding of, and responsibility for, their health and the health of their families.

International Year of the Family Symbol

A heart sheltered by a roof, linked by another heart, to symbolize life and love in a home where one finds warmth, caring, security, togetherness, tolerance and acceptance – that is the symbolism conveyed by the emblem of the International Year of the Family 1994. The open design is meant to indicate continuity with a hint of uncertainty. The brushstroke, with its open line roof, completes an abstract symbol representing the complexity of the family.

C E L E B R A T I N G

Year of the Family Year

1994

Promoting Family Health

YOUVILLE CLINIC'S MISSION

- to create an atmosphere of acceptance, concern and respect.
- to foster hope in individuals and families seeking help in a caring, non-judgemental environment.
- to promote healthy lifestyles by assisting people to assume responsibility for their well-being, and to create an awareness of their own resources, by offering education and direction, support and encouragement.

FAMILY HEALTH PROGRAMS

Prenatal
Are you pregnant and wanting helpful information about what to expect?
We offer an informative class in a group setting which looks at nutrition, labour and delivery, infant care and other related topics.

Refresher Prenatal
Are you expecting a second child and want to brush up on information about birth?
If the answer is yes, Youville offers a group refresher course which covers topics such as labour and delivery, sibling rivalry and infant care. Classes meet weekly for 4 weeks.

Natural Family Planning
Do you want to have a greater awareness of your fertility?
Natural Family Planning offers information on natural methods to achieve or prevent a pregnancy. Individual or group classes are available.

Parent Building
Are you a new parent or pregnant and want more information on caring for an infant?
"Parent Building" offers a child care course for new parents who want practical information. Groups meet weekly, for three weeks.

Parent Support Group
Do you have young children and want to meet with other moms?
If so, we provide a supportive, educational group for parents who want to share parenting information with other parents. Groups meet every second Tuesday morning, Sept - June. Topics discussed range from child care to women's health.

How to Talk
Do you want to speak to your children and have them co-operate?
Then this is ideal for you. 'How to Talk' is a communication skills course for parents of children 2 years of age and over, in a supportive setting. Groups meet once a week during this 6 week program.

Call 233-0262 to register or obtain more information.

There is no charge for our services but we do accept donations !

DIABETES EDUCATION RESOURCE

Do you have diabetes
- **and want to learn about healthy living?**
- **during pregnancy and want to learn about taking care of yourself and your baby?**

Diabetes Education is offered to all persons with diabetes and their families, to enable them to assume a greater responsibility for the management and control of their diabetes and lifestyles, helping them live healthier lives. Individual appointments and group classes are offered on a variety of topics related to diabetes.

The Diabetes Education resource at Youville Clinic operates in conjunction with the Manitoba Diabetes Education Program.

Listen to favorite family music.

STAFF

Executive Director
Verna Sylvestre

Support Staff
Paulette Abraham
Administrative Assistant
Joëlle Poirier
Secretary/Receptionist
Sylvie Roman
Secretary/receptionist

Family Health
Donna Vielhaber
Nurse Coordinator
Jackie Lawson
Counsellor
Maria Mackay
Nurse
Barbara Wasilewski
Nurse
Suzanne Zonneveld
Nurse

Diabetes Education Resource
Carole Ash
Nurse Coordinator
Jacqueline Grégoire
Nurse
Diane Labossière
Nurse
Agnès Mao-Tougas
Dietitian
Debbie Marcynuk
Nurse
Janie Peterson Watt
Dietitian

Plant a family tree.

C
E
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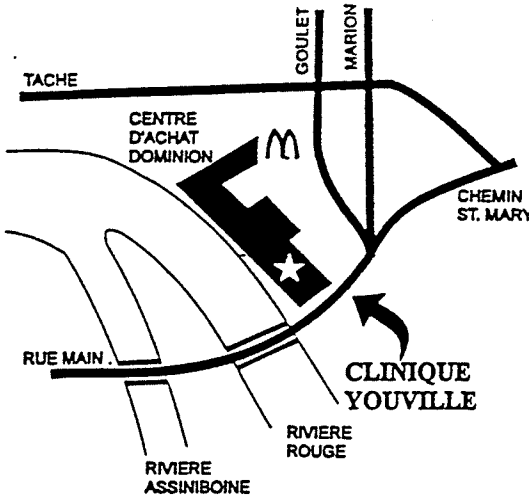
L'anneé
de la
Famille

1994

CLINIQUE YOUVILLE INC.

33, rue Marion

233-0262



La Clinique Youville, un centre de promotion de la santé, à été établi pas les Soeurs Grises du Manitoba en 1984. Ce centre, dirigé par un personnel infirmier est situé dans la communauté de Saint Boniface, et se compose de: la *Santé familiale* et le *Centre d'éducation et de ressources en diabète.*

Heures de bureau
du lundi au jeudi de 9h à 21h
le vendredi de 9h à 17h

Stationnement gratuit.

Année
Internationale
de la famille

Deux coeurs unis sous un même toit, symbolisant la vie et l'amour dans un foyer plein d'amour, de sécurité, de convivialité et d'indulgence, c'est ce que représente le logo de l'Année internationale de la famille 1994. Le fait que le toit ne se referme pas sur le coeur évoque tout à la fois une continuité et une certaine vulnérabilité. Le coup de pinceau à droite du logo met la dernière touche à ce symbole abstrait de la complexité de la famille.

La Clinique est au service de tous et offre ses services aux personnes et familles en recherche d'aide et d'accueil inconditionnel, dans un climat respectueux et confidentiel.

Les services offerts comprennent l'éducation, la direction, l'appui et l'encouragement. Ils permettent aux client(e)s d'acquérir une meilleure connaissance, (de prendre en main la responsabilité) de leur santé et de celle de leur famille.

Promouvoir la santé familiale

Enoncé de mission de la Clinique Youville

- créer un climat chaleureux plein de sollicitude et de respect des personnes
- développer l'espérance chez les personnes et les familles en recherche d'aide et d'acceuil inconditionnel
- promouvoir des habitudes de vie saines et des moyens concrets d'éducation, de soutien et d'encouragement qui favorisent chez les personnes le sens des responsabilités et une prise de conscience de leurs propres ressources intérieures.

SANTE FAMILIALE

Préparation à l'accouchement
Etres-vous enceintes et désirez-vous de l'information utile au sujet de la grosesse, la naissance, le noveau né?
Si oui, la Clinique Youville offre des classes pour les parents qui attendent leur premier enfant. Les sujets de discussion: la nutrition, le traivaille et l'accouchement; les soins d'un nouveau né.

Cours de recyclage - préparation à l'accouchement
Attendez-vous un deuxième enfant et désirez-vous réviser l'information sur la naissance?
Si oui, la Clinique Youville offre des classes de ressourcement. Les sujets de discussion: le traivail et l'accouchement; la rivalité fraternelle; le soins d'un nouveau né. Les classes sont offertes une fois par semaine pour quatre semaines .

Planification naturelle de la famille
Voulez-vous acquérir une meilleure connaissance de votre fécondité ?
Nous offrons des reseignements sur les méthodes naturelles pour empêcher ou pour planifier une grossesse. Des rencontres individuelles ou par groupe sont offertes.

"Parent Building"
Etres-vous de nouveaux parents ou attendez-vous un bébé et désirez-vous de l'information au suject du nouveau né ?
La Clinique Youville offre un cours d'apprentissage au rôle de parent. Il s'agit d'un cours de soins à l'enfant pour les nouveaux parents qui veulent de l'information pratique.

Groupe de soutien pour parents
Avez-vous de jeunes enfants et désirez-vous rencontrer d'autres parents?
Si oui, nous offrons un groupe de soutien éducatif pour les parents qui veulent partager de l'information au sujet de leur rôle avec d'autres parents. Les groupes se rassemblent à tous les deux mardis matins de Septembre à Juin. Les sujets de discussions sont divers.

"How to Talk"
Voulez-vous améliorer votre communication avec vos enfants?
L'idéal c'est un cours de "How to Talk"; un cours en techniques de communication pour les parents qui ont des enfants de deux ans et plus. Les groupes se rassemble une fois par semaine pour six semaines.

Pour plus de renseignements, composez le 233-0262

PERSONNEL

Directrice générale
Verna Sylvestre

Personnel de soutien
Paulette Abraham
Assistante administrative
Joëlle Poirier
Secrétaire/réceptioniste
Sylvie Roman
Secrétaire/réceptioniste

Santé familiale
Donna Vielhaber
Infirmière coordinatrice
Jackie Lawson
Conseillère
Maria Mackay
Infirmière
Barbara Wasilewski
Infirmière
Suzanne Zonneveld
Infirmière

Centre d'éducation et de ressources en diabète
Carole Ash
Infirmière coordinatrice
Jacqueline Grégoire
Infirmière
Diane Labossière
Infirmière
Agnès Mao-Tougas
Diététiste
Debbie Marcynuk
Infirmière
Janie Peterson Watt
Diététiste

Tous les services sont gratuits nous acceptons gracieusement les dons!

Programme d'éducation en matière de diabète

Vous souffrez de diabète
et vous désirez apprendre à vivre de manière plus saine ?
enceinte et vous désirez apprendre à prendre soin de vous-même et de votre bébé ?

La Clinique Youville offre de l'éducation à toutes les personnes atteinte de diabète et aux membres de leur famille pour leur permettre de mieux gérer la maladie et les aider à adopter des habitudes de vie plus saines. Des séances d'information idividuelles et de groupes sont offertes sur diverses questions liées à la maladie.

Le programme d'éducation de matière en diabète de la Clinique Youville est offert conjointement avec le Programme manitobain d'éducation en matière de diabète.

CNA
NOVEMBER 1994 VOLUM
Today
THE NATIONAL NEWS IN NURSING

Community nurse resource centres spreading throughout Manitoba

A decade after it opened, Manitoba's nurse initiated, nurse run Youville Clinic is being held up as a model of health care services to be emulated throughout the province.

Premier Gary Filmon announced that Community Nurse Resource Centres will be integrated into the health care system. "Nurse resource centres will provide Manitobans with another point of access to the health care system," said Filmon. "They will focus on health promotion and disease prevention while also providing primary health care."

Youville Clinic was set up in a Winnipeg shopping centre in 1984 by the Grey Nuns to provide maternal/child and family life services. The clinic now focuses on promoting family health with services including pre and post natal care, parenting programs, counselling, health promotion and prevention. The service is obviously needed and accepted with more than 18,000 client contacts each year. Youville rapidly came to exemplify nurse managed care in a primary health care service. Like the new nurse resource centres, it:

- is client centred
- is wellness oriented
- offers a point of access into the health care system
- offers continuity of care in program delivery.

Manitoba's Community Nurse Resource Centres will be introduced through a planning committee. That committee, chaired by Dr. Helen Glass, professor emeritus in the University of Manitoba's faculty of nursing, has been meeting since May.

Glass says they are now working with four communities that want to establish Community Nurse Resource Centres. One group is ready to apply for Treasury Board financing.

"The enthusiasm of Manitoba nurses is incredible," says Glass. "Nurses want to work in these centres." ❑

A pre-natal client gets counselling from a nurse at the Youville Clinic in Winnipeg, Manitoba.
(Photo courtesy of the Manitoba Association of Registered Nurses)

Appendix E
CNA (1994) The National News in Nursing.

CNA. (1994). The National News in Nursing

Promoting
Family
Health

YOUVILLE CLINIC

Fostering hope in those seeking help.

YOUVILLE CLINIC INC.
GROWING TO MEET THE NEEDS

Youville Clinic Inc., a nurse-managed, health promotion centre, was established by the Grey Nuns of Manitoba in 1984 to promote individual and family health, healthy family life, responsible parenting, and the respect for life. The Diabetes Education Resource was added in 1985.

The Clinic welcomes everyone and offers its services in a caring, non-judgemental, respectful, and confidential manner.

Family Health

Services which include education, direction, support and encouragement are offered to enable clients to acquire a greater understanding of, and responsibility for, their health and the health of their families.

Both individual and group programs are offered by nurses and/or counsellors in the following areas:

* *natural family planning*
  - information on natural methods to achieve or prevent a pregnancy
  - individual appointments or group classes
  - "Let's Talk" (an opportunity for mothers and daughters to talk about womanhood)
* *preparation for childbirth programs*
  - classes for first time expectant parents
  - refresher classes
  - programs for those with special needs
* *parenting programs*
  - parent support group (a supportive educational group for parents who want to share parenting information with other parents).
  - parent building (a child care course for new parents who want practical information)
  - single parent support group (a coming together for those who are parenting without a partner)
  - "How To Talk" (a communication skills course for parents of children ages 2 years and older)
* *counseling*
  - health/wellness/parenting
  - individual and/or family
  - marriage
  - personal growth workshops

Diabetes Education Resource

Diabetes Education is offered by nurses and dietitians to persons with diabetes and their families to enable them to assume a greater responsibility for the management and control of their diabetes and lifestyles helping them live healthier lives.

Individual appointments and group classes are offered on the following topics:

- types of diabetes
- nutritional/meal planning
- exercise
- medication
- insulin administration (if necessary)
- management of stress
- care of feet, eyes, teeth
- illness and diabetes
- complications of diabetes
- self blood glucose monitoring

Education is directed toward persons with newly diagnosed diabetes as well as those in whom it has been previously diagnosed.

The Diabetes Education Resource operates in conjunction with the Manitoba Diabetes Education Program.

THERE IS NO CHARGE FOR OUR SERVICES
DONATIONS ARE GRATEFULLY ACCEPTED

For more information please call or write:

Youville Clinic Inc.
33 Marion Street
Winnipeg, Manitoba
R2H 0S8
(204) 233-0262

Hours:

Monday to Thursday	9:00 a.m. - 9:00 p.m.
Friday	9:00 a.m. - 5:00 p.m.

Yes! I want to support Youville Clinic's work. I understand that community support is necessary for the ongoing work at Youville Clinic.
I would like (please check the appropriate boxes):

☐ To make a tax-deductible donation to Youville Clinic in the amount of: ___$10 ___$25 ___$50 ___$100
I prefer to donate $ _____

☐ To volunteer my services as _____

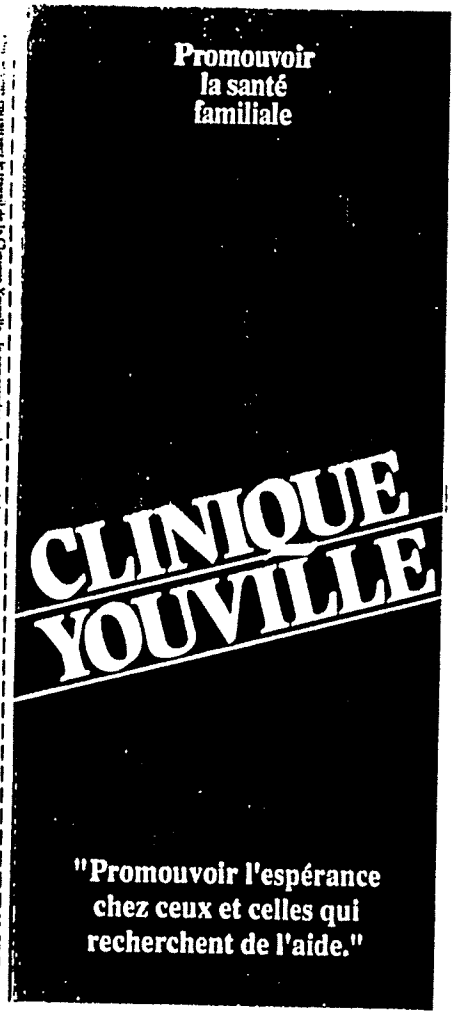
☐ More information on Youville Clinic's programs and services, especially: _____

☐ To comment on the services available at Youville Clinic: _____

Please PRINT your name, address and telephone number below so we may respond to you without delay, and mail to Youville Clinic Inc., 33 Marion Street, Wpg., Mb., R2H 0S8.

Name: _____ Telephone: _____
Address: _____ Postal Code: _____

THANK YOU FOR YOUR INTEREST AND SUPPORT! Youville Clinic Inc. Charitable Registration #0653 4747 11 21



LA CLINIQUE YOUVILLE INC.
NOUS GRANDISSONS POUR RENCONTRER LES BESOINS

La Clinique Youville Inc, est un centre de promotion de la santé, dirigé par un personnel infirmier, qui a été établi par les Soeurs Grises du Manitoba en 1980 en vue de promouvoir la santé individuelle et familiale, un style de vie familiale de santé et la parentalité responsable. Le Centre d'éducation et de ressources en diabète a été inauguré en 1985.

Santé familiale

Les services offerts comprennent l'éducation, la direction, l'appui et l'encouragement. Ils permettent aux client(e)s d'acquérir une meilleure connaissance, (de prendre en main la responsabilité) de leur santé et de celle de leur famille.

Les programmes individuels et de groupes sont offerts par un personnel infirmier autorisé et/ou des conseiller(e)s dans les domaines suivants :

* *la planification naturelle de la famille*
  - renseignements sur les méthodes naturelles pour empêcher ou pour planifier une grossesse
  - rencontres individuelles ou par groupe
  - "Let's Talk" (une occasion permettant aux mères et leurs filles d'échanger leurs idées sur la féminité)
* *programmes de préparation à l'accouchement*
  - classes pour les parents qui attendent leur premier enfant
  - classes de ressourcement
  - programmes pour les gens ayant des besoins spéciaux
* *programmes offerts aux parents*
  - groupe de soutien pour parents (un groupe d'éducation et de soutien pour les parents qui veulent partager de l'information au sujet de leur rôle avec d'autres parents)
  - apprentissage au rôle de parent (un cours de soins à l'enfant pour des nouveaux parents qui veulent de l'information pratique)
  - groupe de soutien pour parents sans conjoint (un groupe qui rassemble les parents sans conjoint)
  - "How To Talk" (un cours en techniques de communication pour les parents qui ont de enfants de deux ans et plus)
* *counselling*
  - santé/bien-être/rôle parental
  - individuel et/ou en famille
  - mariage/de couple
  - sessions de croissance personnelle

Centre d'éducation et de ressources en diabète

L'éducation sur le diabète est offerte par des infirmier(e)s et des diététicien(ne)s spécialisé(e)s à des personnes assument une plus grande part de responsabilité dans la gérance et le contrôle de leur diabète et afin de les aider à vivre une vie plus saine.

Des rendez-vous individuels et des rencontres de groupes sont offerts sur les sujets suivants :

- le type de diabète
- planification de la nutrition/repas
- l'exercice
- la médication
- l'administration de l'insuline (si nécessaire)
- gérance du stress
- soin des pieds, yeu et dents
- la maladie et le diabète
- les complications dues au diabète
- surveillance personnelle de la glucose dans le sang

L'éducation est au service des personnes qui viennent tout juste de se faire diagnostiquer avec le diabète tout comme celles qui sont diabétiques depuis longtemps.

Le Centre d'éducation et de ressources en diabète oeuvre avec le Programme d'education sur le diabète du Manitoba.

TOUS LES SERVICES SONT GRATUITS NOUS ACCEPTONS GRACIEUSEMENT LES DONS

Pour plus de renseignements, communiquez avec :

La Clinique Youville Inc.
33, rue Marion
Saint-Boniface, Manitoba
R2H 0S8
(204) 233-0262

Heures d'ouverture :
- du lundi au jeudi de 9 h à 21 h
- le vendredi de 9 h à 17 h

Appendix G

HE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

January 2, 1995

Dr. David Gregory
Assistant Professor
Faculty of Nursing
University of Manitoba
Winnipeg, MB R3T 2N2

Dear Dr. Gregory:

RE: Research proposal #94/42, "Community assessment: St. Boniface/St. Vital"

The Ethical Review Committee of the Faculty of Nursing reviewed your research proposal at its meeting this evening. No concerns of an ethical nature were identified.

The issue of mental competence of subjects was discussed by the committee and a concern was expressed that the perspective of the mentally ill (many of whom may be homeless) not be omitted from the study. Without a formal test of mental competence this criterion will be difficult to meet. Therefore, it is recommended that the criteria include a willingness on the part of subjects to participate in the interview and an ability to respond to questions posed. If it becomes apparent that the subject does not understand the question, then the interview may be politely terminated and the data not used.

A concern for the safety of interviewers was also discussed. Given the community based nature of this project, the researcher cannot be as certain about the situations that research assistants (interviewers) will encounter. Therefore, careful attention to training of research assistants regarding safety precautions should be given (e.g., day time interviewing, interviewing in pairs, use of public interview spaces, notification of interview addresses and timing, etc.). As a faculty member hiring undergraduate and graduate nursing students for this research, attention to the safety issue is an important responsibility which we expect you will take seriously.

The Ethical Review Committee enjoyed reviewing this proposal and is supportive of the project. Please find enclosed a copy of the final ethical approval form for the project.

Good luck with your research.

Yours sincerely,

Linda J. Kristjanson, RN, PhD
Chair, Ethical Review Committee

Appendix H

RESEARCH ASSISTANTS **ACTION** **January 16, 1995**

Welcome to Action! I hope this will be a positive experience for all of you that you will both learn from and enjoy.

As research assistants you will be working both independently and with the team. During the times you are independent, it will be important to communicate data clearly, and to troubleshoot problems promptly. Please call with any problems so that we can brainstorm effectively.

The community goodwill toward the project will be largely determined via your communication skills, attitudes and ethics. The project's philosophy supports a nonjudgemental egalitarian approach between researcher and participant. Unconditional positive regard, genuineness, and active listening are crucial to all your interactions.

The first part of the project will entail secondary analysis of existing databases followed by interviews and focus groups. For now, a review of basic communication skills will assist you to best represent the project. We will discuss interview techniques as that part of the project begins.

TIPS FOR RESEARCH ASSISTANTS

1. Hours will vary from week to week; maximum of 20 hours.

2. Record your activities on a log sheet (see attached). Record your time as hours and minutes. Hand the log sheet in to Sachi Eales once a month.

3. Initially, most of your work will take place in the university. Once out in the community, you may have mileage expense. A special mileage form must be submitted. Discuss with me prior to submitting please.

4. Basic safety precautions should be observed in the community.

    a) When going door to door, work in pairs, i.e. on the same street.
    b) Always let your partner know your whereabouts.
    c) Carry ethical approval slips with you.
    d) Be aware of potential crisis situations and trust your instincts. If in doubt, remove yourself from the situation and forfeit data collection.
    e) Communication skills can be used to heighten rapport and to deescalate situations. Be aware of your verbal and nonverbal communication.

5. Remember, the elderly may resent personal questions; be respectful and sensitive.

6. It is your responsibility to communicate with myself re your work. This is very important to ensure the project remains focused and I look forward to working closely with you.

7. Research is enjoyable and rewarding -- so enjoy!

Any reports to be mailed out, please have sent to:

Action
c/o David Gregory / Elaine Mordoch
246 Bison Building
Faculty of Nursing
University of Manitoba
Winnipeg, MB R3T 2N2

Keep names of all contact persons, title and telephone number, please.

Appendix I

COMMUNITY CONTACTS

ORGANIZATION:

ADDRESS:

TELEPHONE:

CONTACT PERSON: **TITLE:**

DATE:

MATTERS DISCUSSED OR REPORTS REQUESTED:

Appendix J

ACTION GROUP
Research Assistants

Name_____ **Month** _____

Date	Description of Work	Hours
Total Hours Worked		

Appendix K

ACTION GROUP
Research Assistants

Name_____ **Month** _____

Date	DESCRIPTION OF WORK			Hours
	Completed	Ongoing	Follow-Up	
Total Hours Worked				

Appendix L

FILE COPY

TO: Dr. David Gregory
Co-Chair ACTION
Associate Dean, Graduate Studies, Faculty of Nursing
University of Manitoba

FROM:

For services rendered off campus:

Title of Research Project: "ACTION Research Consortium: Community Health Needs Survey"

Principal Investigator: Dr. David Gregory

Nature of Duty: Contacting community members by phone for data gathering purposes (Personal Care Homes, Women's Shelters, Formal Health Agencies, and various others). Data retrieval from Statistics Canada's C91 Census Data Base. Contacting various community sites re: Survey interviews with members of general public.

Amount Requested: 43 hours and 45 minutes of labour x $12.00/hour = $525.00

GST #: N/A projected total income for 1995 will be less than $30,000.

March 1, 1995
Date

ACTION GROUP
Research Assistants

Name ____________________ Month FEBRUARY /95

Date	DESCRIPTION OF WORK			Hours
	Completed	Ongoing	Follow-Up	
Feb 1 /95		calls to POD I Agencies.	call to Soc. Planning Council City Planning Dept	4 hours
Feb 2 /95	call [illegible] Action Meeting	call [illegible]	calls to POD I Agencies.	4 h 15 mins.
Feb 5 /95	fill in Community Contact Sheets			1 h 30 mins.
Feb 6 /95	- Dennis MacIntyre Inter. - [illegible] - [illegible]	messages to remaining POD I agencies.	[illegible] - Home. [illegible] City Planning	3 h 45 mins.
Feb 7 /95	- [illegible] - call to	C91 training / practice. - track down Mall contacts	visit to [illegible]	3 h.
Feb 9 /95	- Anti Poverty org.	- contacted malls / legions - contacted IGA	- Osborne House / crisis line.	1 h
Feb 10 /95	- [illegible].	- St. Vital mall - Public health stats. - legions C91 data	-	3 h.
Feb 11 /95	- C91 data retrieval			~~[illegible]~~ 4h
Feb 16 /95	- STD info. - Millie Birk Interview.	- interview Millie Birk - C91 data retrieval. - f/u calls to [illegible]	- [illegible].	3h 30 mins.
Feb 17 /95	- meeting - C91 [illegible] request - [illegible]	- Women's Shelters	-	4 h
Feb 22 /95		- facilities template		1 h.
Feb 23 /95	- C91 - ethnic grps.			15 min
Feb 24 /95	- medical clinics.	- International Centre. - Women's Shelters	- Main St. Project	4 h 30
Feb 27 /95	faxes to clinics			1 h.
Feb 28 /95	- Main St. Project.	- Public Health Stats. - Facility Templates. - St. Vital Centre.	- Alpha / [illegible]. - Med Clinics.	5 h
\				

8.15

16.15

7.30

5.45

~~47h~~ 45 min

43h 45 min

$525

total: 43 h 45 min
$525

Appendix M

STEERING COMMITTEE UPDATE
FEBRUARY 22, 1995

POD IV - EXISTING HEALTH AND SOCIAL SERVICES

CURRENT ACTIVITIES:
This listing is just a brief summary of the work-in-progress.

- Compilation of voluntary agencies, reports, and identification of potential services (ongoing).

- Sampling of religious organizations are being contacted for information about health services provided and potential interviewees.

- Interviews are being arranged with physicians, service providers from Manitoba Health, other community workers.

- Listing of licensed daycare centres and family daycares has been generated. A sampling of providers will be interviewed.

- Key facilities being contacted for information about their community outreach programs (for example, St. Boniface, St. Amant).

- Contact with Child & Family Services and Social Services.

- Each school has (or will be) contacted for information about community outreach activities. Interviews are being arranged with school personnel. Pending ethical approval, interviews will begin with students, parents, and teachers.

- Listing of subsidized housing projects, interview with M.H.A. and identification of community representatives from various groups.

- Contact with local women's shelters and identification of interviewees.

- Contact with the International Centre & Literacy Centre about available services.

- Concurrently, a listing of francophone health services and identification of key informants are being generated.

For further information about Pod IV activities, please contact:

Donalda Wotton (787-2514) or
Marion McKay (474-9095)

POD #1

Secondary Data Analysis: Existing Data Bases

1. Statistics Canada--C91 Data
   Purchase data in electronic form
2. St. Boniface General Hospital
   Emergency Room Data
   Discuss with
   Community Outreach/Out-Pt Dept
3. MHSC Database
   Annual Reports
   Morbidity/mortality statistics for St.B/St.V.
   Discuss with re: access
   Discuss with the
4. MIMS (Manitoba Immunization Monitoring System)
5. College of Physicians and Surgeons
   Discuss with as to what may exist
6. Youville Clinic
   Discuss with Professor
   Discuss with
7. Postpartum Service Delivery Project (PPSD)
8. Continuing Care/Home Care Branch
   Discuss with
9. Communicable Disease
   Discuss with
10. Tuberculosis
    Discuss with
11. Social Planning Council
    Check to "see" what databases are available
12. Canada Mortgage and Housing Corporation
    Check housing stock
    Discuss with
13. Institute of Urban Studies, University of Winnipeg
    Check to "see" what databases are available
14. City Counsellors for St. Boniface/St. Vital
    Check to "see" what databases are available
    Discuss with (St. V)
    Discuss with (St. B)
15. MLAs
    Check to "see" what databases are available
    Discuss with (St. V)
    Discuss with (Niakwa)
    Discuss with (Riel)

16. MPs
    Check to "see" what databases are available
    Discuss with
17. Provincial Nurses
    Check to "see" what databases are available
    Discuss with
    Discuss with
18. Manitoba Health
    Discuss with
    Discuss with
19. Brighter Futures Initiatives
    Check to "see" what databases are available
    Discuss with
20. Day Care Centres
21. City Welfare/Provincial Welfare
22. School Health Data
    Check to "see" what databases are available
    Discuss
23. Occupational Health and Safety

NB: ACTION members--what other relevant databases can be added to this list?

Appendix N

REPORTS

REPORT	DATE RECEIVED

Appendix O

RESERVING ROOM 209H - ACTION OFFICE
(to avoid double bookings)

Room is reserved by filling in the date and time you need the room, and your initials.

DATE	TIME	INITIALS OF USER
SATS Always (↑ = SATURDAY)	12-1700	EM
Feb 3/95	13:00-16:00	
Tues. Feb. 7/95	9-4 p.m.	UL
Fri. Feb. 10/95	9-12:45 pm	QT.
Thurs Feb 16/95	1400-1800	EM
Tues Feb 21	3:30-4:30	QT
Thurs	1500-	EM
Mar 2	11 — 1700	EM
Mar 3	FRI 12-1700	EM
Mar 6	11:00 — 4:30	[illegible]
March 7	11:30 - 1:30	TK.
March 8	11:30 - 1:30	TK
[illegible] 9	11:00 1:30	TK
[illegible] 6	[illegible]	[illegible]
M- & 10	10:00 - 16:00	[illegible]

Appendix P

Elmwood

Commence at Leighton Ave. & Henderson Hwy.
E. on Leighton Ave. to Roch St.
N. on Roch St. to S. limit Rossmere Golf Course
E. on S. limit Rossmere Golf Course to Watt St.
S. on Watt St. to S. limit Rossmere Golf Course
E. on S. limit Rossmere Golf Course to C.P.R. lac du Bonnet
S. on C.P.R. Lac du bonnet to Concordia Ave.
E. on Concordia Ave. to Lagimodiere Blvd.
S. on Lagimodiere Blvd. to C.N.R. Main Line
W. on C.N.R. Main Line to Rue Archibald
N. on Rue Archibald to C.P.R. Main Line
W. on C.P.R. Main Line to Red River
N. on Red River to N. limit Elmwood Park
E. on N. limit Elmwood Park to Henderson Hwy.
N. on Henderson Hwy. to Leighton Ave.

St. Boniface

Commence at C.P.R. Main Line & Red River
E. on C.P.R. Main Line to Rue Archibald
S. on Rue Archibald to C.N.R. Main Line
E. on C.N.R. Main Line to Public Rd. R.O.W. E. of DeBaets St.
S. on Public Rd. R.O.W. E. of De Baets St. to Plessis Rd.
S. on Plessis Rd. to Perimeter Hwy.
W. on Perimeter Hwy. to Seine River
N. on Seine River to N. limit The Glen
W. on N. Limit The Glen to Rue Youville
N. on Rue Youville to Carriere Ave.
W. on Carriere Ave. to Red River
N. on Red River to C.P.R. Main Line

St. Norbert

Commence at S. limit Water Control Works & Brady Rd.
E. on S. limit Water Control Works to Waverley St.
S. on Waverley St. to Bishop Grandin Blvd.
E. on Bishop Grandin Blvd to Red River
S. on Red River to W. limit Public Reserve, Pl. 14, 862
N. on W. limit Public Reserve, Pl. 14, 862 to River Rd.
E. on River Rd. to Novavista Dr.
E. on Novavista Dr. to Dakota St.
S. on Dakota St. to Perimeter Hwy.
E. on Perimeter Hwy. to Plessis Rd.
S. on Plessis Rd. to N. limit Township 9
W. on N. limit Township 9 to N. limit Red River Floodway
W. on N. limit Red River Floodway to W. limit Range 4 East
S. on W. limit Range 4 East to Four Mile Rd.

E. & S. on Four Mile Rd. to S. limit Lot 180
W. on S. limit Lot 180 to Two Mile Rd.
S. & E. on Two Mile Rd. to S. limit Lot 188
W. on S. limit Lot 188 to Red River
N. on Red River to S. limit Lot 70
W. on S. limit Lot 70 to Brady Rd.
N. on Brady Rd. to S. limit Water Control Works

St. Vital

Commence at Carriere Ave. & Red River
E. on Carriere Ave. to Rue Youville
S. on Rue Youville to N. limit The Glen
E. on N. limit The Glen to Seine River
S. on Seine River to Perimeter Hwy.
W. on Perimeter Hwy. to Dakota St.
N. on Dakota St. to Novavista Dr.
W. on Novavista Dr. to River Rd.
W. on River Rd. to W. limit Public Reserve Pl. 14, 862
S. on W. limit Public Reserve Pl. 14, 862 to Red River
N. on Red River to Carriere Ave.

***Note** Within communities, electoral wards conform to the Community Committee limits.

Appendix Q

KEY INFORMANT INTERVIEWS
FOR HEALTH AND SOCIAL CARE PROVIDERS

The purpose of the key informant interviews (face-to-face or focus group format) is to:

1. identify the major health care and social concerns as viewed by health care providers and social care providers;
2. identify any "gaps" or "overlap" in the existing system;
3. examine the strengths and weaknesses in the present system;
4. recommendations for community-based health care/social care services.

---

1. From your perspective, what are the major health and social problems in St. Boniface/St. Vital?

2. What strengths are present in the available health care/social care services within your community? Examples? How can we capitalize on these strengths?

3. Are there currently "gaps" in the health care/social care services available to residents of St. Boniface and St. Vital? Examples? What should be done? What community-based health care/social services are needed in St. Boniface/St. Vital? Examples?

4. What weaknesses are present in the available health care/social care services within your community? Examples? How can we address these weaknesses?

5. Is there any "overlap" in the existing health care/social care services available to residents of St. Boniface/St. Vital? Examples? What should be done?

6. What advice would you offer to the Youville Clinic regarding the establishment of community-based health care/social care services? Probe: Information available to the community.

ENTREVUES AVEC DES FOURNISSEURS DE SERVICES DE SANTÉ ET DE SERVICES SOCIAUX

Ces entrevuew (individuelles ou en groupe) ont pour objectif :

1. d'indentifier les prindipaux problèmes que perçoivent les fournisseurs de services de santé et de services sociaux;
2. d'identifier les « lacunes » ou les « chevauchements » dans le système actuel;
3. d'examiner les points forts et les points faibles du système actuel;
4. de formuler des recommandaations quant aux services de santé et aux services sociaux communautaires.

---

1. Selon vous, quels sont les principaux problèmes sur le plan des services de santé et des services sociaux à Saint-Boniface/Saint-Vital>

2. Quels sont les points forts des services de santé et des services sociaux offerts actuellement dans votre communauté? Des exemples? Comment peut-on tirer profit de ces points forts?

3. Y a-t-il des « lacunes » dans les services de santé et les services sociaux offerts acutellement aux résidents des quartiers Saint-Boniface et Saint-Vital? Des exemples? Comment peut-on améliorer la situation? Quels sont les services de santé et les services sociaux communautaires qui doivent être établis à Saint-Boniface/Saint-vital? Des exemples?

4. Quels sont les points faibles des services de santé et des services sociaux dans votre communauté? Des exemples? Comment peut-on éliminer ces faiblesses?

5. Existe-t-il des « chevauchements » dans les services de santé et les services sociaux offerts acutellement aux résidents des quartiers Saint-Boniface et Saint-Vital? Comment peut-on améliorer la situation?

6. Quels conseils fourniriez-vou à la Clinique Youville en ce qui concerne l'établissement de services de santé et de services sociaux communautaires? Cherchez à connaître l'information transmisse à la population.

Appendix R

Key Informant Interview

February 16, 1995

Interviewer: Gregory
Length of interview: 2 hours

Community Police Officers

Major health care concern: **mental health patients**. The officers have noticed an increase in the number of mentally ill persons, particularly in St. Boniface. While most of the people are "harmless", they do generate considerable work for these police officers.

When a mental patient calls 911 frequently (called: frequent callers), the 911 people pass these names on to these two constables. The officers will then initiate a visit to these frequent callers to try and resolve the problem.

The **answering machine** in their officer is a VITAL LINK to the communities of St.B/St.V. The line is available 24 hours a day. They get calls at 3 am from people--and the officers will call them back the next day (7am to 5 pm). Instead of calling 911 these people will call the community police office--knowing that the officers will call them back--or that the officers will visit them the next day.

The officers identified several agencies who are of assistance to these persons and the constables:

1. Sarah Riel, 110 St. Mary's Road and 210 Kenny. This agency is providing much care to mentally ill patients in the community setting.
2. Mobile Crisis Unit. This agency conducts ?mental health assessments on people and offer services 24 hours a day.

3. Home Care

4. Continuing Care

The second major health care concern was **isolated elderly living alone**, particularly those elderly who exhibit **dementia**. When the officers contact these elderly persons, they spend a great deal of time trying to establish which agencies are "looking after them." For example, the officers will contact the VON, etc.

The officers mentioned that ACTION should interview _____ at "Elderly Abuse" agency on Portage Avenue.

The other agency that the officers have contact with is the Regional Housing Office. This agency looks after housing needs for the poor.

According to the officers, homelessness is not a problem in St. Vital and St. Boniface. They can only recall a handful of people over the past several years who were truly homeless.

The officers identified that the _____, are feeding people.
The officers are involved in follow-up and deal with individuals as opposed to groups. The work with people who have chronic problems. They often provide advice to community residents regarding their problems; the officers provide reassurance to many people.

The officers suggested that ACTION should interview _____ at 185 Smith Street regarding mental health services in St. Boniface and St. Vital.

The officers suggested that ACTION should speak with _____ at St. Boniface General Hospital.

The officers also noted that sometimes clients from the methadone clinic at the St. Boniface General Hospital are "a problem". (panhandling, prescription forgery, double doctoring).

The officers felt that OVERALL, there are adequate services available to residents of St. Boniface and St. Vital. They described St. B. and St. V. as composed of mostly blue collar workers who work during the day. Things are quite (for the police) during the day--most people are at work. They stated that St.B/St.V. are quiet areas and have the **second lowest** crime rate in the City of Winnipeg (NOTE: MARLENE PLEASE CHECK THIS WITH CRIME STATS).

The was identified as a problem in St. Vital. The hotel offers cheap alcohol (eg., 99cent beer) which encourages **heavy drinking** and **underage alcohol consumption.** The police had >400 contacts with this hotel last year. The other hotels/bars in St. Boniface/St. Vital were not identified as problematic.

Traffic: The officers noted that **Archibald/Marion intersection** is one of the three worst intersections in Winnipeg (NOTE: MARLENE PLEASE CHECK THIS). Apparently there are statistics kept on accidents and they are call ADAMS. Also, the **TransCanada Highway** runs through St.B/St.Vital--**heavy traffic, trucks, etc.**

Cultural Groups: The officers identified two major cultural groups:

The French, Franco-Manitoba Societe
Belgians, The Belgium Club

The officers indicated that there are **12 bilingual** officers on staff.

They noted that there are few aboriginals in the two communities. They noted that some Band Councils have purchased homes in Windsor Park and people from these northern communities stay at these homes.

The officers also noted that they are involved in **safety issues**, and the prevention of safety-related issues. For example, they were part of the incident. Kids were playing at (dangerous situation). These constables worked with the City of Winnipeg and the community to "fix up" the abandoned site. eg., filled holes with gravel, welded openings shut, etc.

The officers noted the following services for abused women

--service for abused French women
, women's shelter

According to the officers **gangs** are not a problem. They advised ACTION to contact

, Youth Services Division, 986-6245. This officer knows about the **YOUTH** in the community.

. (986-6322) is the Community Relations Officer. is the person to talk about safety audits, the school liaison program, etc.

Major Health/Social Problems

1. mental health patients
2. the elderly with dementia
3. elderly who live alone and in isolation
4. heavy traffic because of the TransCanada Highway
5. safety issues
6. answering machine as a vital link to the community

Follow-up Contacts **(CHECK WITH ELAINE MORDOCH)**

1. Sarah Riel, 110 St. Mary's Road
2. Mobile Crisis Unit
3. Home Care
4. Continuing Care
5. " " at "Elderly Abuse Agency" on Portage Avenue

6. Regional Housing Office
7. Holy Cross Convent
8. 195 Smith Street, Mental Health Services
9. at St. Boniface General Hospital
10. Methadone Clinic, St. Boniface General Hospital
11. ADAMS data base, City of Winnipeg, Police Department re: accidents, traffic
12. Franco-Manitoban Society
13. The Belgium (Belgian?) Club
14. Entre-Temps (womens' shelter)
15. Alpha House (womens' shelter)
16. Youth Services, City of Winnipeg Police, 986-6245
17. Officer (986-6322)

What's Happening

Arthur Day School Craft Sale: Sat., Apr 8 from 10 am - 4 pm, 43 Whitehall Blvd. For table rentals call 222-3065. Net proceeds to the Arthur Day Band.

Spring Craft Sale: Sunday, March 26 from 10 am - 4 pm at My Place Pie Place, 103-912 Portage Ave. Net proceeds to charity.

Computerized Monitoring Service: is available through CompTel Communications for those who need to be monitored on a regular basis, such as seniors, people homebound, children & the handicapped. The system calls the homebound daily at pre-designated time(s) to make sure everything is O.K. If a problem arises, or help is needed, the proper assistance is implemented immediately. For more inf[illegible]

Volunteers Needed: St. James Industries is seeking volunteers who can work one-on-one with mentally disabled adults at [illegible] sites in the community. Training will be provided. Interested parties should contact Kim Michaels at 888-5422.

Community Health Needs Assessment: of the St. Vital and St. Boniface areas is being conducted by the Youville Clinic and the University of Manitoba Faculty of Nursing. A variety of methods such as individual interviews and surveys will be used to gather information. To participate or to find out more please call **ACTION** at 474-7420 for further information.

Coffee News, 7(13), Mar 27-Apr 30, 95

Appendix T

ACTION NEWS FLASH

Youville Clinic and the ACTION Research Consortium, University of Manitoba, Faculty of Nursing, are conducting a community health needs assessment of the St. Vital and St. Boniface areas. The project is designed so that community members will identify existing strengths and "gaps" in health care services. A variety of methods such as individual and group interviews, telephone interviews, and surveys will be used to gather information.

The assessment continues until June 1995 at which time the results will be shared with the general public and other health services organizations. ACTION welcomes your input and invites you to share your opinions. Call ACTION at 474-7420.

FLASH ACTION

La Clinique Youville et l'ACTION Research Consortium de l'Université du Manitoba (Faculté des sciences infirmières) procèdent à une évaluation des besoins en santé communautaire dans les quartiers Saint-Vital et Saint-Boniface. Le projet est conçu de manière à ce que les membres de la collectivité identifient les points forts et les « lacunes » acutels des services de santé. Les responsables auront recours à diverses méthodes, telles que des entrevues individuelles et collectives, des entrevues téléphoniques et des enquêtes, pour recueillir l'information nécessaire.

L'évaluation se poursuivra jusqu'en juin 1995, date à laquelle les résultats seront communiqués au grand public et à d'autres organisations de santé. ACTION vous invite à lui faire part de vos commentaires et de votre point de vue. Vous pouvez joindre ACTION au 474-7420.

Appendix U

Canadian Publishers

the Lance

Vol. 63 No. 9 Tuesday, February 28, 1995 CIRC. 51,373

Health care subject of needs study

ACTION study targets health and social services needs in St. Boniface and St. Vital.

By Dawn Jackson
Lance Writer

A research team from the University of Manitoba is currently assessing the health and social services needs of residents in St. Boniface and St. Vital.

ACTION, or Assessing Communities Together in the Identification of Needs, is made up of staff and students from the Faculty of Nursing at the U of M. The six-month study is being funded by the Youville Clinic, a nurse-managed community resource centre in St Boniface.

The purpose of the study, according to co-chair Dr. David Gregory, is to provide a comprehensive overview of health services already available in the two communities and anticipate what services will be needed in the future.

"Not too many studies have been done before on such a large scale," Gregory said. "Our number one goal is to make sure we give a voice to as many people in the community as we can."

The study began in early January and is expected to wrap up in June. Research topics include the social and cultural history of the target areas, the contribution local businesses make to the health of the communities, as well as the health and social services provided by institutions such as schools and churches.

"We want to take into account as many different aspects of health as we can," Gregory said. "Often people think health is just about physical well-being. But something like adequate housing for example can affect the health of an individual."

In addition to collecting data, researchers will also be asking residents what services they would like to see in their communities. Gregory said ACTION expects to target about 1,000 households through surveys and random telephone interviews. Surveys will be available at walk-in clinics as well as libraries and community clubs, he said.

"We will also be speaking to key people in the community like MPs, MLAs, community police officers and people involved with the Chamber of Commerce to see what they see as the major health concerns in St. Boniface and St. Vital," Gregory said.

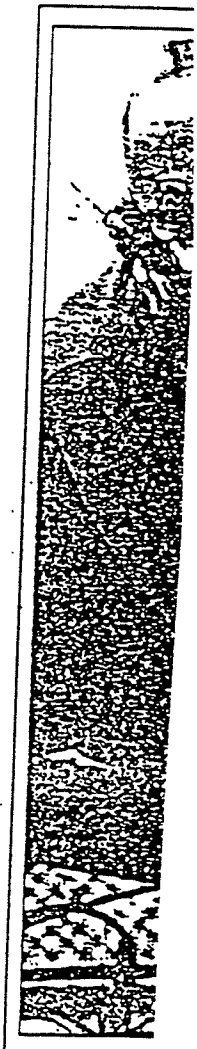
The study coincides with last week's announcement that the Filmon government will establish four nurse-run community clinics. The first, an off-shoot of Youville Clinic, is expected to open in St. Vital sometime in May.

Verna Sylvestre, executive director of Youville Clinic, says the needs assessment is part of the province-wide proactive approach to health care.

"(The province) is looking at broadening the health care services available to the public through nurses. The needs assessment is an ideal way to know exactly what the needs are in the community," she said.

Sylvestre said the results of the assessment will be used to develop an information data base which will be shared with other health care agencies. The research team will also make the results public at a town hall meeting in the fall, she said.

Call 474-7420 for more information.



Welding
Steel fabricat
tion on Main
Ltd., lives in S

St. Vital clinic to open in May

The first of four community nurse resource centres is expected to open in the St. Vital area sometime in May.

The Winnipeg centre will operate as a satellite of the Youville nurses," Premier Gary Filmon said.

"The resource centres complement the existing system," said Health Minister Jim McCrae. "They provide increased opportu- haven't been met before. They will play a key role in educating and empowering communities and individual consumers so that they know how to stay healthy," McCrae said.

FACES AND PLACES

LAURIE MUSTARD

GOOD MORNING!!

As I write this, Friday morning, I look out my office window and see SNOW ... big, fat, white flakes of the rotten stuff ... falling between the mosquitoes (oh yes, they're out, too) to land with an audible THUMP on the tender heads of the new shoots of grass below.

ENOUGH!! Begone ye white plague!!! Leave us be till next winter! We want, nay we demand ... SUMMER!!

And, in fact, it's here. YES, this is May 1, and within mere minutes cats will be gobbling up baby birds, bikers will be ruining the Cleaver's weekend in campgrounds all over the province and clouds will begin showing up EVERY FRIDAY MORNING now through the end of September!

Beauuuutiful ... SUMMER HAS ARRIVED!

Kidding aside (or was I kidding)... I promise you ... we've seen the LAST of the snow for this year.

So get out the shorts and T-shirts, polish up your shades and keep an ear tuned for the sound of a soft, gentle, breeze blowing through your leaves ... SOON. Enjoooooy.

■ MAIL MILESTONE

Congrats to today's Canada Post Silver Postmark Award winner (the highest mark of recognition bestowed by Canada Post) **Susan Robbie** (right).

Susan's award was presented in recognition of "the effective and professional wav she deals with customers.

■ BAY BIRTHDAY BASH

HAAAAPPY ANNIVERSARY to everyone at The Bay, celebrating "325 years of continuous commercial enterprise in Canada" ... TOMORROW!!

However, if you "get on down to The Bay Downtown," by 10 a.m. this morning, you can join them for all kinds of interesting displays and activities lasting throughout the day — the highlight being a noon ceremony (Grand March) with many special guests including Premier **Gary Filmon**, Mayor **Susan Thompson**, Lt. Gov. **Yvon Dumont** and Grand Chief **Phil Fontaine**.

Great day at The Bay ... don't miss it!

■ TO YOUR HEALTH

Health care watchdogs ... take note! Youville Clinic and the ACTION Research consortium, U of M faculty of nursing, are curently conducting a community health needs assessment of the St. Vital and St. Boniface areas.

The project is designed so that community members will identify existing strengths and "gaps" in health care services. The project will continue until next month.

At that time, results will be shared with the general public and other health organizations.

ACTION welcomes your input and invites you to share your opinions, by calling 474-7420.

■ WINNER'S CIRCLE

... CONTEST ... how

Yo... DE... S... OF T...

Preeeesentin... Manager, Media ... Prairie Division, ... Saskatchewan a... tario.

Originally fro... spent 32 years i... nd joined Cana... arried, to Gerr... a... three grand... an... Kiera.

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Ni... seeing yo... grat... n the prom...

s...p, check it out! First prize is a ... tificate, second ... third a $50 certi... and remember ...

Winnipeg Sun, May 1, 1995, p. 17

Le premier centre de santé communautaire ouvrira dans quelques mois

Saint-Boniface et Saint-Vital servent de laboratoire

Depuis le mois de janvier, une équipe de chercheurs de l'Université du Manitoba tente d'identifier les lacunes et les besoins en matière de services sociaux et de santé dans les quartiers de Saint-Boniface et Saint-Vital.

Les responsables du Action Research Consortium ont mis en oeuvre tous les moyens pour obtenir le portait le plus complet possible: entrevues téléphoniques et en personne avec les responsables d'organismes et le public, visites d'hôpitaux, d'églises, d'écoles, de poste de police, de centres d'accueil pour les sans-logis, questionnaires bilingues distribués dans les boîtes à lettres, etc.

Au total, environ 1 000 personnes seront consultées directement dans une région qui compte plus de 300 000 résidents (1). Les chercheurs comptent terminer leur travail dès la fin du mois de juin et organiser des forums publics à l'automne.

But de l'opération: établir la liste et la nature des services qui seront offerts par un nouveau centre de soins infirmiers qui doit ouvrir ses portes d'ici l'été à Saint-Vital. Il s'agira d'un centre unique en son genre, pour lequel le gouvernement provincial déboursera un million $ par an. 16 personnes seront employées à temps plein, dont 12 infirmières diplômées (2).

Cette nouvelle institution sera chapeautée par la Clinique Youville, un centre de promotion de la santé créé par les Soeurs Grises en 1984. Sa mission: mettre en oeuvre le fameux système de santé communautaire qui doit prendre la relève des hôpitaux fortement mis à mal par les coupures budgétaires.

Photo: Laurent Gimenez

Nicole Kirouac et Patrick Talbot sont les deux membres bilingues de l'équipe de l'Université du Manitoba qui effectue une recherche sur les services de santé à Saint-Boniface et Saint-Vital.

«Je n'aime pas tellement le terme de centre parce que cela fait penser à un simple édifice, explique la directrice de la Clinique Youville, Verna Sylvestre. Notre rôle sera d'être un catalyseur au sein de la communauté.»

Concrètement, cela signifie que le centre devra identifier, activer et coordonner les ressources existantes, et orienter le public vers elles. Exemple: si un couple a un problème de communication, on lui suggérerait de consulter un conseiller matrimonial plutôt que de prendre rendez-vous chez son médecin.

Partant du principe que la meilleure façon de ne pas être malade consiste à rester en bonne santé, le centre compte également faire beaucoup de promotion, notamment auprès des futurs parents et des personnes âgées.

Il faut donc s'attendre à ce que les infirmières se déplacent souvent, non seulement auprès des associations mais également au domicile des particuliers. «Il s'agit d'élargir le rôle de l'infirmière», résume Verna Sylvestre.

Le centre accueillera quand même des patients sur place. Verna Sylvestre promet qu'il sera ouvert une quinzaine d'heures par jour, sept jours sur sept. «Il y aura quelqu'un de disponible en permanence», précise-t-elle.

Peut-on aussi espérer un service français égal au service anglais? «Je l'espère, répond la directrice. C'est ce qui est prévu.» La question est d'autant plus pertinente que les chercheurs de l'Université du Manitoba ont constaté d'importantes lacunes dans ce domaine.

«Il n'y a pas assez de services en français pour les personnes âgées à Saint-Boniface et Saint-Vital, souligne Patrick Talbot, étudiant en quatrième année de sciences infirmières à l'Université du Manitoba. La liste d'attente pour les deux seuls hospices francophones, Taché et Valade, est de deux ans. Pour attendre moins longtemps, il faut aller dans un foyer anglophone.»

Photo: Laurent Gimenez

Verna Sylvestre: élargir le rôle de l'infirmière.

Sa collègue Nicole Kirouac constate que le manque de spécialistes bilingues embarrasse également les jeunes familles dont les plus petits enfants ne parlent pas toujours l'anglais. Même la santé mentale, dont on parle rarement, souffre du manque de ressources en français. «Il n'y a absolument aucun service en français au Manitoba Mental Health Centre», affirme Patrick Talbot.

Laurent GIMENEZ

(1) Un kiosque du Action Research Consortium sera installé ce samedi 18 mars au centre commercial Saint-Vital. Les personnes qui souhaitent donner leur opinion au sujet des services de santé peuvent aussi appeler le 474-7420.

(2) Le gouvernement compte ouvrir trois autres centres du même genre dans l'avenir: à Thompson, dans la région des Parcs et dans le Nord.

Laliberte, Mars 17 au 23, 1995.

Appendix V

LIST OF ENGLISH REPORTS RECEIVED - ACTION May 1/95

1. Focus on Families (YM/YWCA)
2. St. Vital History
3. Canadian Paraplegic Association
4. MARN Immunization
5. Today National news Nursing
6. Youville Clinic Data
7. Emergency - SBGH
8. Emergency - B-Shepps
9. Planning Teams Workbook
10. Family Info. Center
11. Key Informant List - PHN
12. Salvation Army Mission Statement: Proposal Single Moms
13. Growing Together - Moms and Tots
14. St. Boniface Norwood Resource Center - Young Parents Group Newsletter
15. For Sanity's Sake - Mom's Support Group
16. VON Report of Executive Director - June 8/94
17. MIMS Annual Report 1990
18. STD Info
19. List of all RN Employers
20. Child Day Care Directory
21. All Pod I Extra Data
22. Social Planning Council
    - Community Action Brighter Future
    - Vision PHN
    - Conceptual Model PHN '93, '94
    - Sub to Child Health Survey
    - Youville and St. B/St. V PHN Service Comparison
23. The City of Winnipeg Civic Profile - 1993 and Temp.
24. Fire Stats.
25. Paper Circulation
26. TB Data
27. Shelter Affordability & Housing
28. Victor Mager - Managing the Diff.
29. Kidney Foundation of Canada
30. Canadian Cancer Stats
31. MS Society
32. Muslim Services
33. Adult Literacy Services
34. Al-Anon News Blurb
35. Association of Physiotherapists - Practice Areas
36. Child & Family Annual Report 93/94

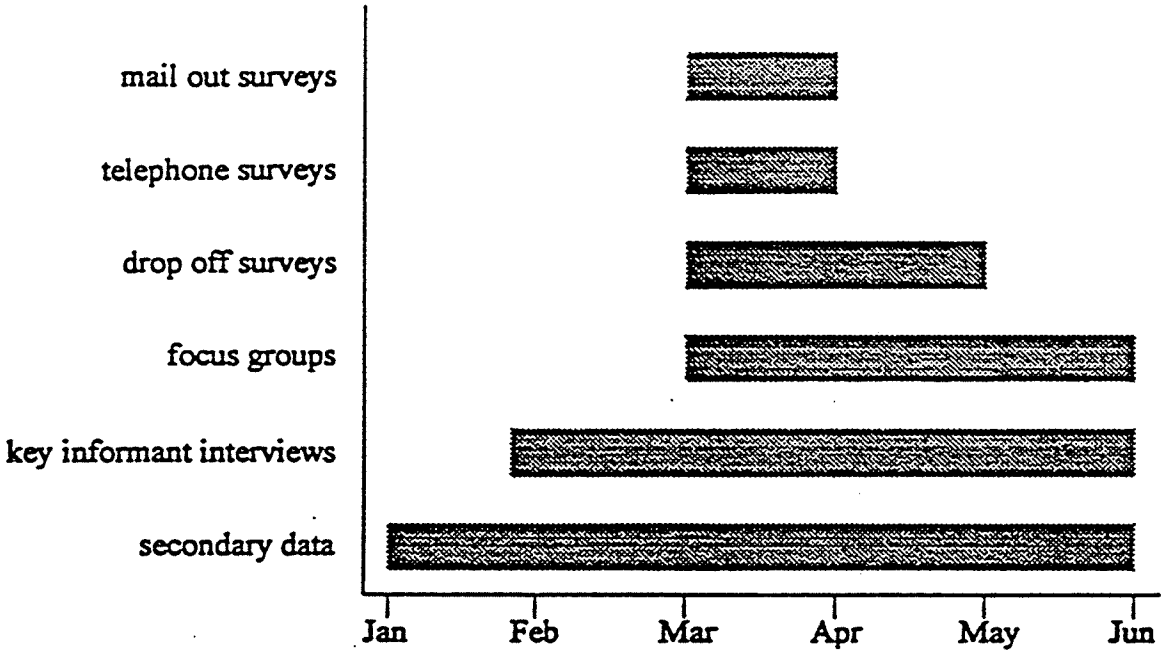
37. Cerebral Palsy Association
38. Arthritis Society
39. Dr. Henri Marcoux, Chiropractor; Brief on Alternative Health Care
40. French Language Services Manitoba
41. Crohn's Society
42. M.E. (Chronic Fatigue Syndrome)
43. Citizens for Crime Awareness
44. Age & Opportunity Pamphlets, Elder Abuse
45. Nutrition Services in Manitoba - Dr. Fieldhouse
46. AFM Literature (Addictions)
47. Utilization of Medical Services in Manitoba, 1991-92, for Mental Health Disorders (Utilization of)
48. Physicians Resources, Vol. 1 & 2, Utilization of
49. Hospital Resources, Vol. 1 & 2, Utilization of
50. Socio Economic Characteristics
51. An Assessment of How Efficiently Man. Hospital D/C Their Patients
52. Maternal Demographic Risk Factors and Low Birth Weight
53. Alternative Therapies (Independent Studies)
54. Multiple Sclerosis Info.
55. Norwood Family Resource Centre Pamphlet

LIST OF FRENCH REPORTS RECEIVED - ACTION

May 1/95

1. Proces Verbale - Scoute & Guides
2. Rapport du President - Scoutes
3. Recensement - Guides
4. Rapport des Verifications - Scouts
5. Rapport Annuel - District Guide
6. Rapport des Verifications - Guide
7. Service de Conseiller
8. Handicapped Francophones
9. Francofonds
10. Pluri Elles (Manitoba) Inc. - Centra Alpha
11. Le Entre Temps
12. Dossier Sante
13. French Services Societe Franco Manitobain
14. Welcome Info Package - to new Francophone community members
15. Parenting Association
16. French Wellness Center

Appendix W



Action Progress Report, Feb 1995.

Appendix X

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING
Office of the Associate Dean
Graduate Program

Room 245 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2
Tel: (204) 474-9317
Fax: (204) 275-5464
E-Mail: David_Gregory@umanitoba.ca

David M. Gregory, R.N., Ph.D.
Associate Dean
Graduate Program

March 27, 1995

Le 27 mars 1995

TO: Residents of St. Boniface/St. Vital
À : Résidents de Saint-Boniface et de Saint-Vital

FROM: Dr. David Gregory, Assistant Professor
DE : Dr David Gregory, professeur adjoint

RE: **Community Health Needs Survey**
OBJET : **Enquête sur les besoins en santé dans la communauté**

Dear Resident:

The Faculty of Nursing is interested in your opinions about the health care needs of your community.

Enclosed you will find two surveys---one in English and one in French. Would you please complete one survey in the language of your choice and place it in the self-addressed, stamped envelope provided.

Your participation in this survey is sincerely appreciated and valued.

Cher résident,

La Faculté des sciences infirmières désire connaître votre opinion concernant les besoins en santé de votre communauté.

Vous trouverez ci-joint les versions anglaise en française d'un questionnaire. Veuillez remplir l'une des deux versions et la retourner dans l'enveloppe pré-affranchie qui porte notre adresse.

Nous vous remercions de votre participation à cette enquête.

COMMUNITY HEALTH NEEDS SURVEY

Youville Clinic
&
The Faculty of Nursing

Room 246 Bison Building
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

COMMUNITY HEALTH NEEDS SURVEY

5 April 1995

Dear Resident:

Youville Clinic and researchers in the Faculty of Nursing, University of Manitoba (known as ACTION) are seeking your views about health and the need for health care services in the St. Boniface/St. Vital areas. By completing this survey, you will assist the Youville Clinic in planning for future health care programming in your community. Your name and address were randomly chosen from a list provided by the Manitoba Telephone System.

Professor David Gregory, Elaine Mordoch (Project Manager), and a research assistant will have access to this survey. Your identity will not be known to anyone--and only group information will be presented from the survey. You are completely free to decide whether or not you would like to complete this survey. This study has been approved by the Ethical Review Committee, Faculty of Nursing, University of Manitoba. In keeping with ethical standards, all completed surveys will be kept in a locked filing cabinet for a period of at least 7 years.

The findings of this survey will be presented at a public meeting in the fall of 1995. An exact date and time will be announced in community newspapers, on the radio, and the community TV billboard.

NOTE: This survey is only intended for residents of St. Boniface and St. Vital. We would ask that only one survey be completed for each household. A household consists of those people living in a residence.

Should you decide to complete this survey, please place it in the stamped, self-addressed envelope which is provided for your convenience. ACTION would appreciate receiving your survey as soon as possible.

Please feel free to contact Dr. David Gregory (474-9317) or Ms. Elaine Mordoch, Project Manager (474-7420), if you have any questions or concerns about this survey.

Sincerely,

David Gregory, R.N., Ph.D.
Assistant Professor
Faculty of Nursing

COMMUNITY HEALTH NEEDS SURVEY

The first 9 questions are about your health and the health of your household.

1. In general, compared to other people your age, would you say your health is:

   ____ excellent
   ____ very good
   ____ good
   ____ fair
   ____ poor

2. Would you describe your life as:

   ____ very stressful
   ____ quite stressful
   ____ moderately stressful
   ____ not very stressful

3. At the present time, do you smoke cigarettes?

   ____ yes
   ____ no (if "no", proceed to question #4)

   If you answered "yes", how many per day?

   ____ cigarettes per day

   Are you trying to quit smoking?
   ____ yes
   ____ no

4. Do you consider yourself:

   ____ overweight
   ____ underweight
   ____ just about right

5. Are you at present (please check all that apply)

   ____ employed
   ____ unemployed
   ____ looking for work
   ____ retired
   ____ maintaining a household

If you are employed, what is your job/occupation?

_____

6. Are your activities restricted because of a long term illness, physical condition or health problem? By long term, we mean a condition which has lasted or is expected to last more than 6 months.

____ yes
____ no (if "no", proceed to question #7)

If you answered "yes", how well do you feel you are coping with this restriction in your activities?

____ very successful
____ successful
____ less than successful
____ not at all successful

7. During the past 6 months, how much do you think that environmental pollution (for example, air, water, noise) has affected your health or the health of members in your household? Would you say that environmental pollution has affected your health:

____ very much
____ a fair amount
____ not very much
____ not at all

If pollution has affected your health or the health of household members, can you tell us about the pollution present in your community?

_____

_____

8. Do you feel that you get as much exercise as you need, or less than you need.

____ as much as needed
____ less than needed

9. The following is a list of conditions or issues that may affect you or members of your household. Check as <u>many of the following which are a problem</u> for you or members of your household.

____ lack of exercise

____ alcohol abuse
____ drug abuse
____ gambling addiction
____ Alzheimer's disease
____ tuberculosis
____ AIDS
____ vision problems
____ hearing problems
____ mobility/walking problems
____ psychiatric problems
____ anxiety
____ depression
____ high blood pressure
____ high cholesterol
____ high blood sugar (diabetes)
____ arthritis
____ cancer
____ heart disease/stroke
____ smoking
____ stress
____ difficulty with family relationships
____ asthma
____ gastrointestinal problems such as irritable bowel, Crohn's Disease, ulcerative colitis
____ chronic lung diseases (e.g., emphysema, chronic bronchitis)
____ caring for an elderly family member
____ need for day care (child)
____ need for day care (adult)
____ teen pregnancy
____ teen health issues (peer pressure, body image, sexuality)
____ infertility
____ loneliness
____ marital problems
____ unemployment
____ poverty
____ financial problems
____ dental health
____ young family members in trouble with the law
____ children with learning difficulties
____ other: specify _____
_____
_____

10. What would you say is the single most important health concern in your household? Please describe.

_____

The next set of questions are about the health and social needs of people in your neighbourhood.

11. Is reasonable/affordable housing available for people in your neighbourhood?

____ yes ___ no Comment:_____

12. Are the houses in good repair in your neighbourhood?

____ yes ___ no Comment:_____

13. Are there adequate opportunities for recreation for people of all ages?

____ yes ___ no Comment:_____

14. Is your neighbourhood reasonably safe from violence?

____ yes ___ no Comment:_____

15. Would you say you can get the health care services you need in your neighbourhood?

____ yes ___ no Comment:_____

16. Do you consider your neighbourhood a healthy place to live?

____ yes ___ no Comment:_____

17. Please identify which of the following programs or services are needed <u>in your community</u>. **If you don't know which programs are needed, please leave the line blank**. Otherwise, provide a check mark for each program or service listed.

Programs/Services	Low Need	Medium Need	High Need
Arthritis Self-Care Program			
Cancer Prevention			
Diabetes Education			

Programs/Services	Low Need	Medium Need	High Need
Heart Disease Prevention			
High Blood Pressure Clinics			
Marital Counselling			
Personal or Family Counselling			
Parenting Classes			
Family Planning			
Midwifery			
Postpartum Program			
Teen Pregnancy Prevention			
AIDS			
Stress Management			
Stop Smoking Program			
Suicide Prevention Programs			
Crime Prevention/Safe Community			
Preschool Daycare			
School Age Daycare			
Adult Daycare			
Mental Health Services			
Safety in the Workplace			
Health Promotion In The Elderly (e.g., medication information, safety in the home)			
Services for the Disabled			
Gambling Addiction Counselling			

Programs/Services	Low Need	Medium Need	High Need
Drug, Alcohol Abuse Services			
Services for Victims of Abuse			
Health Information and Education Services (e.g. AIDS, menopause, nutrition)			
School Nurse			
Respite Care Services (e.g. sitter service for adults or children)			
Dental Health			
Child Health Clinics (e.g., normal growth and development, immunizations)			
Child Abuse Services			
Care of the Dying at Home			
Food Banks/Soup Kitchens			
Other, please specify _____ _____			

18. From the list of possible programs and services in question #17, please list 3 which would be most important to you or your household.

    1. _____
    2. _____
    3. _____

19. Self-help groups: Some self-help groups are informal such as fitness classes, or programs based in schools/churches. Others are more formal (for example, Cancer Support Groups, Alcoholics Anonymous). Do you or members of your household make use of self-help groups?

    ____ yes
    ____ no

If "yes", please list the name of the support group you attend (for example, Al-Anon, Y-Neighbours)

1. _____
2. _____
3. _____

20. Do you or members of your household have a family doctor?

____ yes
____ no

If "yes", where is the location of your family doctor's practice?

____ St. Boniface
____ St. Vital
____ Fort Garry
____ Fort Richmond
____ Transcona
____ Downtown
____ Other: please specify _____

21. How many times have you and members of your household used the services of your family doctor in the last 6 months?

____ times

22. How many times have you and members of your household used the services of a hospital/emergency department in the past 6 months?

____ times

23. How many times have you and members of your household used the services of a medical walk-in clinic?

____ times

24. How many times have you and members of your household used the services of a public health nurse in the past 6 months?

____ times

25. Have you or a member of your household used other healing or treatment services (eg., therapeutic touch, massage, acupuncture, hypnosis, chiropractic, etc.) during the past year?

____ yes
____ no (If you answered "no," please go to question 26).

If you have made use of other treatments or ways of healing, please list the type of therapy/therapist.

1. _____
2. _____
3. _____

26. Do you or members of your household make use of counselling services (e.g., family counselling, marital counselling, or personal counselling)?

____ yes
____ no

27. Are counselling services readily available to you?

____ yes
____ no

Comments: _____

28. What language do you speak most often at home?

____ English
____ French
____ German
____ Italian
____ Japanese
____ Filipino
____ Polish
____ Ukrainian
____ Spanish
____ Aboriginal, please specify _____
____ Chinese, please specify _____
____ Other _____

29. Canadians belong to many ethnic or cultural groups such as Inuit, Irish, Scottish, French, or Chinese. To which ethnic or cultural group do you belong?

_____

30. How strongly do you identify with this ethnic/cultural, group?

____ very strongly
____ quite strongly
____ strongly
____ slightly strongly
____ not strongly at all

31. How many years have you lived in St. Boniface/St. Vital.

____ Years

32. What is your postal code area?

____ R2M
____ R2N
____ R2J
___ R3X
___ R2H
___ don't know

33. Please indicate your gender:

____ female
____ male

34. What is your highest grade or level of education completed?

____ no schooling
____ elementary (Grades 1 to 8)
____ high school (Grades 9 to 12)
____ community college
____ university
____ other _____

35. Do you own or rent your residence?

____ own
____ rent

36. What is your age?

___ 18 - 25	___ 56 - 65
___ 26 - 35	___ 66 - 75
___ 36 - 45	___ 76-85
___ 46 - 55	___ 86 +
___ no answer	

37. Including yourself, how many people are living in your household at the present time.

___ persons

38. Including yourself, please indicate the number of people in your household who are in the following age categories.

Age	Female	Male
Less than 1 year		
1 - 4 years		
5 - 9 years		
10 - 14 years		
15 - 19 years		
20 - 24 years		
25 - 34 years		
35 - 44 years		
45 - 54 years		
55 - 64 years		
65 - 74 years		
75 - 84 years		
Over 85 years		

Youville Clinic and researchers in the Faculty of Nursing, University of Manitoba, would like to thank you for your participation in this survey.

Please place the completed survey in the stamped, self-addressed envelope and mail to the Faculty of Nursing, University of Manitoba.

Thank you!

ENQUÊTE SUR LES BESOINS EN SANTÉ DANS LA COMMUNAUTÉ

La Clinique Youville
et
la Faculté des sciences infirmières
de l'Université du Manitoba

Room 246 Bison Building
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

ENQUÊTE SUR LES BESOINS EN SANTÉ DANS LA COMMUNAUTÉ

Le 27 mars 1995

Madame, Monsieur,

La Clinique Youville et les chercheurs de la Faculté des sciences infirmières de l'Université du Manitoba désirent connaître votre opinion sur les problèmes de santé et les besoins en services de santé dans les quartiers de Saint-Boniface et de Saint-Vital. En remplissant ce questionnaire, vous aiderez la Clinique Youville à planifier les futurs programmes de soins de santé offerts dans votre communauté. Votre nom et adresse ont été choisis au hasard à partir d'une liste fournie par la Manitoba Telephone System.

Une fois remplis, les questionnaires pourront être consultés par le professeur David Gregory, M^me^ Elaine Mordoch (chargée de projet) et un adjoint de recherche. Vous conserverez l'anonymat et seules des données collectives seront diffusées. La participation à ce projet est entièrement volontaire; vous n'êtes donc nullement obligé(e) d'y prendre part. Le Comité d'examen de l'éthique de la Faculté des sciences infirmières a approuvé la tenue de cette recherche. Conformément aux normes en matière d'éthique, tous les questionnaires remplis seront conservés dans un classeur verrouillé pendant au moins sept ans.

Les résultats de l'enquête seront présentés au cours d'une réunion publique à l'automne de 1995. La date et l'heure de cette réunion seront annoncées dans les journaux communautaires, à la radio et sur un babillard télévisé communautaire.

REMARQUE : Cette enquête vise uniquement les résidents de Saint-Boniface et de Saint-Vital. Nous vous prions de remplir un seul questionnaire par ménage. Par ménage, on entend les personnes vivant dans la même résidence.

Si vous décidez de remplir le questionnaire, veuillez utiliser l'enveloppe-réponse pré-affranchie qui vous a été remise. Le groupe ACTION aimerait recevoir votre questionnaire dès que possible.

Si vous avez des questions ou des préoccupations, n'hésitez pas à communiquer avec le D^r^ David Gregory (474-9317) ou avec la chargée de projet, M^me^ Elaine Mordoch (474-7420).

Veuillez agréer, Madame, Monsieur, l'expression de mes sentiments les plus sincères.

David Gregory, inf., Ph.D.
Professeur adjoint
Faculté des sciences infirmières

ENQUÊTE SUR LES BESOINS EN SANTÉ DANS LA COMMUNAUTÉ

Les 9 premières questions portent sur votre santé ainsi que sur la santé des membres de votre ménage.

1. En général, si vous vous comparez aux personnes de votre âge, comment qualifiez-vous votre état de santé?

   _____ excellent
   _____ très bon
   _____ bon
   _____ passable
   _____ mauvais

2. Votre style de vie est :

   _____ très stressant
   _____ assez stressant
   _____ quelque peu stressant
   _____ pas très stressant

3. Fumez-vous?

   _____ oui
   _____ non (passez à la question n° 4)

   Si vous avez répondu «oui», combien de cigarettes fumez-vous par jour?

   _____ cigarettes par jour

   Essayez-vous d'arrêter?

   _____ oui
   _____ non

4. À votre avis, votre poids est :

   _____ supérieur à la normale
   _____ inférieur à la normale
   _____ à peu près normal

5. À l'heure actuelle, (cochez toutes les réponses s'appliquant à votre situation) :

_____ j'occupe un emploi
_____ je suis chômeur
_____ je cherche du travail
_____ je suis retraité(e)
_____ je suis femme (homme) au foyer

Si vous travaillez, quel est votre emploi ou votre occupation?

_____

6. Vos activités sont-elles restreintes par une maladie, un problème physique ou un problème de santé prolongé (c.-à-d. qui dure depuis plus de six mois ou qui devrait durer plus de six mois)?

_____ oui
_____ non (passez à la question n° 7)

Si vous avez répondu «oui», comment parvenez-vous à composer avec cette situation?

_____ très bien
_____ bien
_____ pas très bien
_____ pas du tout

7. Au cours des six derniers mois, dans quelle mesure croyez-vous que la pollution (par exemple, la pollution de l'air, de l'eau, par le bruit) a nui à votre santé ou à la santé des membres de votre ménage?

_____ beaucoup
_____ assez
_____ peu
_____ pas du tout

Si la pollution nuit à votre santé ou à la santé des membres de votre ménage, veuillez décrire comment elle est présente dans votre communauté :

_____

_____

8. À votre avis, faites-vous assez d'exercice?

_____ oui
_____ non

9. Dans la liste de situations ci-dessous, veuillez cocher toutes celles qui présentent un problème pour vous ou pour les membres de votre ménage.

_____ manque d'exercice
_____ abus d'alcool
_____ abus de drogue
_____ dépendance aux jeux d'argent
_____ maladie d'Alzheimer
_____ tuberculose
_____ sida
_____ problèmes de vision
_____ problèmes d'ouïe
_____ problèmes de mobilité (difficulté à marcher)
_____ problèmes psychiatriques
_____ anxiété
_____ dépression
_____ hypertension
_____ taux de cholestérol élevé
_____ hyperglycémie (diabète)
_____ arthrite
_____ cancer
_____ maladie du coeur/accident cérébrovasculaire
_____ tabagisme
_____ stress
_____ relations familiales difficiles
_____ asthme
_____ troubles gastro-intestinaux (p ex. : côlon irritable, maladie de Crohn, colite ulcéreuse)
_____ maladie pulmonaire chronique (p. ex., emphysème, bronchite chronique)
_____ soins à un membre de la famille âgé
_____ garderie (enfants)
_____ centre de jour (adultes)
_____ grossesse chez les adolescentes
_____ problèmes de santé chez les adolescents (pression des pairs, image du corps, sexualité)
_____ infertilité
_____ solitude
_____ problèmes conjugaux
_____ chômage
_____ pauvreté

_____ problèmes financiers
_____ santé dentaire
_____ jeune membre de la famille ayant des démêlés avec la justice
_____ enfants ayant des difficultés d'apprentissage
_____ autres : précisez _____
_____
_____

10. À votre avis, quel est le problème de santé le plus important dans votre ménage? Veuillez expliquer :

_____

La prochaine série de questions porte sur la santé et les besoins sociaux des résidents de votre quartier.

11. Dans votre quartier, le logement est-il adéquat et abordable?

_____ oui _____ non Commentaires : _____

12. Dans votre quartier, les maisons sont-elles en bon état?

_____ oui _____ non Commentaires : _____

13. Les résidents de tout âge peuvent-ils profiter d'activités récréatives appropriées?

_____ oui _____ non Commentaires : _____

14. Votre quartier est-il raisonnablement à l'abri de la violence?

_____ oui _____ non Commentaires : _____

15. Dans votre quartier, pouvez-vous obtenir les services de santé dont vous avez besoin?

_____ oui _____ non Commentaires : _____

16. Fait-il bon vivre dans votre quartier?

_____ oui _____ non Commentaires : _____

17. Parmi les programmes et les services ci-dessous, lesquels sont nécessaires dans votre communauté? **N'inscrivez rien vis-à-vis des programmes ou services pour lesquels vous ignorez s'il existe un besoin**; sinon, veuillez cocher la case appropriée.

Programmes/services	Besoin faible	Besoin moyen	Besoin élevé
Programme de soins auto-administrés pour arthritiques			
Prévention du cancer			
Sensibilisation au diabète			
Prévention des maladies du coeur			
Cliniques d'hypertension			
Counseling matrimonial			
Counseling individuel ou familial			
Acquisition de compétences parentales			
Planning familial			
Sages-femmes			
Aide postnatale aux parents			
Prévention de la grossesse chez les adolescentes			
Sida			
Gestion du stress			
Programme de renoncement au tabac			
Programme de prévention du suicide			
Prévention du crime et promotion de la sécurité communautaire			
Garderie pour enfants d'âge préscolaire			
Garderie pour enfants d'âge scolaire			
Centre de jour pour adultes			
Services de santé mentale			
Sécurité au travail			
Promotion de la santé auprès des personnes âgées (p. ex., renseignements sur les médicaments, sécurité à la maison)			

Programmes/services	Besoin faible	Besoin moyen	Besoin élevé
Services pour les personnes handicapées			
Services de counseling pour personnes dépendantes des jeux d'argent			
Services pour personnes alcooliques et toxicomanes			
Services pour les victimes de violence			
Services d'information et d'éducation sanitaires (p. ex., sida, ménopause, nutrition)			
Infirmières en milieu scolaire			
Soins de répit (p. ex., services de garde d'adultes ou d'enfants)			
Santé dentaire			
Cliniques de santé infantile (p. ex., croissance et développement normaux, immunisation)			
Services pour enfants battus			
Soins aux mourants à domicile			
Banques alimentaires et soupes populaires			
Autres - veuillez préciser : _____ _____ _____			

18. Parmi les services et programmes possibles énumérés à la question n° 17, veuillez préciser les trois qui, à votre avis, seraient les plus importants pour vous ou pour votre ménage.

    1. _____
    2. _____
    3. _____

19. Groupes d'entraide : certains groupes d'entraide revêtent un caractère informel, comme les cours de conditionnement physique ou les programmes offerts dans les écoles et les églises; d'autres sont plus officiels (p. ex., les groupes d'entraide pour cancéreux, les Alcooliques anonymes). Est-ce que vous ou des membres de votre ménage avez recours aux services de groupes d'entraide?

    _____ oui
    _____ non

Si vous avez répondu «oui», veuillez préciser le nom du ou des groupes d'entraide auxquels vous appartenez (p. ex., Alcooliques anonymes, Y-Neighbours) :

1. _____
2. _____
3. _____

20. Est-ce que vous ou les membres de votre ménage avez un médecin de famille?

_____ oui
_____ non

Si vous avez répondu «oui», où se trouve son cabinet?

_____ Saint-Boniface
_____ Saint-Vital
_____ Fort Garry
_____ Fort Richmond
_____ Transcona
_____ Centre-ville
_____ Autre - veuillez préciser : ___

21. Combien de fois vous et les membres de votre ménage avez-vous consulté votre médecin de famille au cours des six derniers mois?

_____ fois

22. Combien de fois vous et les membres de votre ménage êtes-vous allés à l'urgence d'un hôpital au cours des six derniers mois?

_____ fois

23. Combien de fois vous et les membres de votre ménage êtes-vous allés dans une clinique médicale sans rendez-vous au cours des six derniers mois?

_____ fois

24. Combien de fois vous et les membres de votre ménage avez-vous eu recours aux services d'une infirmière-hygiéniste au cours des six derniers mois?

_____ fois

25. Est-ce que vous ou un membre de votre ménage avez eu recours à d'autres thérapies ou services de traitement (p. ex., toucher thérapeutique, massage, acupuncture, hypnose, chiropratique) au cours de la dernière année?

_____ oui
_____ non (veuillez passer à la question n° 26)

Si vous avez répondu «oui», veuillez préciser le ou les types de thérapies en question :

1. _____
2. _____
3. _____

26. Est-ce que vous ou les membres de votre ménage avez recours à des services de counseling (p. ex., counseling familial, matrimonial et personnel)?

_____ oui
_____ non

27. Les services de counseling sont-ils facilement accessibles?

_____ oui Commentaires : _____
_____ non _____

28. Quelle est la langue la plus parlée à la maison?

_____ anglais
_____ français
_____ italien
_____ allemand
_____ ukrainien
_____ japonais
_____ tagalog
_____ polonais
_____ espagnol
_____ autochtone, précisez : _____
_____ chinois, précisez : _____
_____ autre : _____

29. L'origine ethnique et culturelle des Canadiens et des Canadiennes est très variée (p. ex., Inuit, Irlandais, Écossais, Français, Chinois). À quel groupe ethnique ou culturel appartenez-vous?

_____

30. Votre sentiment d'appartenance à ce groupe ethnique ou culturel est :

_____ très fort
_____ assez fort
_____ fort
_____ faible
_____ aucun sentiment d'appartenance

31. Depuis combien d'années habitez-vous à Saint-Boniface ou à Saint-Vital?

_____ années

32. Quels sont les trois premiers caractères de votre code postal?

_____ R2M
_____ R2N
_____ R2J
_____ R3X
_____ R2H
_____ je ne sais pas

33. Quel est votre sexe?

_____ féminin
_____ masculin

34. Quel est votre niveau d'instruction?

_____ aucune instruction
_____ école élémentaire (de la 1re à la 8e année)
_____ école secondaire (de la 9e à la 12e année)
_____ collège communautaire
_____ université
_____ autre : _____

35. Êtes-vous propriétaire ou locataire?

_____ propriétaire
_____ locataire

36. À quel groupe d'âge appartenez-vous?

_____ 18-25
_____ 26-35
_____ 36-45
_____ 46-55
_____ 56-65
_____ 66-75
_____ 76-85
_____ 86 ans ou plus
_____ refuse de répondre

37. Votre ménage compte combien de personnes (y compris vous-même)?

_____ personnes

38. Y compris vous-même, veuillez indiquer le nombre de personnes dans votre ménage qui appartiennent aux catégories d'âge suivantes :

Âge	**femme**	**homme**
Moins d'un an		
1 - 4 ans		
5 - 9 ans		
10 - 14 ans		
15 - 19 ans		
20 - 24 ans		
25 - 34 ans		
35 - 44 ans		
45 - 54 ans		
55 - 64 ans		
65 - 74 ans		
75 - 84 ans		
85 ans ou plus		

La Clinique Youville et les chercheurs de la Faculté des sciences infirmières de l'Université du Manitoba vous remercient de votre participation à cette enquête.

Veillez placer le questionnaire dûment rempli dans l'enveloppe-réponse et l'envoyer à la Faculté des sciences infirmières, Université du Manitoba.

Merci!

Appendix Y

Telephone Survey

1. Do you perceive yourself as health? Why? Why not?

2. What things do you do to keep healthy?

   Probes: Explore: physical/mental health
   spiritual/social health
   other?

3. What would help you to be healthier?

   Probes: environment specific--housing, finances, social activities and opportunities
   prevention of illness and disease--diet, exercise, health teaching
   health promotion--programming, counselling services, monitoring chronic diseases
   services--specific?--clinical/educational specific
   other?

4. From your perspective, what do you think are the major health problems in St. Vital/St. Boniface?

   Probes: health problems for children, youth, adults, the elderly
   diet, nutrition// crime and safety//finances
   housing//exercises
   counselling/stress/coping
   addiction problems (smoking, drugs, alcohol, gambling)
   abuse/family violence
   other?

   nature of these problems

5. Do you currently make use of any health care services in St. Boniface/St. Vital? What kind?

   Probes: use of physician services (family doctor, specialists)
   use of emergency departments/walk-in clinics)
   use of nursing services (public health nurses, VON)
   use of other allied health care services (social workers, dieticians, chiropractors)
   prevention programs and services//occupational health
   other?

6. Please tell me about any community-based services in St. Boniface/St. Vital that you or your family members use.

   Probes: school-based programs//church/synagogue based programs
   recreational centres (The "Y")/community club activities/senior activity centres
   community based agencies (Youville Clinic, Child and Family Services)
   employment centres
   self-help groups/resource centres
   other?

7. Do you think that there are "gaps" in the health care services available to residents of St. Boniface/St. Vital? If "yes"--what kinds of services would you like to see established in St. Boniface/St. Vital?

   Probes: what perceived gaps or limitations exist
   what health care or social services need to be established in the community
   Are you receiving well publicized information about available services?
   What's "good" about the existing health care services?
   other?

DEMOGRAPHIC INFORMATION

1. Postal Code Interviewer: Record street name _____
2. How long have you lived in St. Boniface/St. Vital
3. Gender: M F
4. Marital Status: M S W D C or relationship status _____
5. Age:

   _____ 18-25
   _____ 26-35
   _____ 36-45
   _____ 46-55
   _____ 56-65
   _____ 66-75
   _____ 76-85
   _____ 85+

6. Level of education achieved
7. Number of people living in your household?
8. Relationship to you? (spouse, children, etc.)
9. Do you have other family members living in St.V/St.B?
10. Language spoken at home _____

Appendix Z

February 20, 1995

Dr. David Gregory
Faculty of Nursing
Room 245 Bison Building
The University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Resident
St. Boniface/St. Vital
Winnipeg, Manitoba

Dear Resident:

Approximately one week ago a **"Community Health Needs Survey"** was mailed to your home. If you completed the survey and mailed it back to the Faculty of Nursing, University of Manitoba, please accept my sincere thanks and appreciation. Your opinions about the health care needs in your community are important. If you did not receive this survey, please call Elaine Mordoch (Project Manager) at the Faculty of Nursing (474-7420).

If you have not yet completed the survey, perhaps you would consider doing so, and mailing your survey to the Faculty of Nursing as soon as possible. Please do not hesitate to call me if you have any questions or concerns about the survey or this research project.

Sincerely,

David Gregory, R.N., Ph.D.
Assistant Professor
Faculty of Nursing

Le 10 avril 1995

D[r] David Gregory
Faculté des sciences infirmières
Immeuble Bison, pièce 245
Université du Manitoba
Winnipeg (Manitoba)
R3T 2N2

Résidents de Saint-Vital et de Saint-Boniface
Winnipeg (Manitoba)

Monsieur, Madame,

Il y a environ une semaine, nous vous avons envoyé un questionnaire intitulé «**Enquête sur les besoins en santé dans la communauté**». Si vous avez rempli le questionnaire et l'avez retourné à la Faculté des sciences infirmières de l'Université du Manitoba, veuillez accepter mes plus sincères remerciements. Nous tenons à connaître votre opinion concernant les besoins en santé dans la communauté. Si vous n'avez pas reçu le questionnaire, veuillez communiquer avec M[me] Elaine Mordoch (chargée de projet) à la Faculté des sciences infirmières (474-7420).

Si vous n'avez pas encore rempli le questionnaire, nous vous prions de le faire et de le retourner à la Faculté des sciences infirmières dès que possible. N'hésitez pas à communiquer avec moi si vous avez des questions ou des préoccupations au sujet du questionnaire ou de ce projet de recherche.

Veuillez agréer, Monsieur, Madame, l'expression de mes sentiments les meilleurs.

D[r] David Gregory
Professeur adjoint
Faculté des sciences infirmières

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

(204) 474-8202
FAX (204) 275-5464

April 10, 1995

Dear Survey Drop-off Site:

As a research assistant has already discussed with your, researchers at the Faculty of Nursing (ACTION Research Consortium) at the University of Manitoba are conducting a community health needs survey in St. Vital and St. Boniface. The purpose of this study is to explore the major health concerns in these communities and what health care services might be needed. This study is sponsored by The Youville Clinic and has been approved by the Ethical Review Committee of the Faculty of Nursing as have the surveys that have been placed in your agency.

Thank you very much for agreeing to make these surveys available in your agency. We are seeking the opinions of anyone living in the St. Boniface or St. Vital communities. If any staff in your office live in these communities and are interested in participating, they are invited to do so. We would prefer that no more than one third of the surveys be filled out by staff. Surveys are available in French and English.

A box has been provided to collect completed surveys and will be picked up on Monday, April 17 or Tuesday, April 18. I realize this may be a change from what you were initially told and apologize for any inconvenience this may cause you. If you or anyone filling out the surveys have any questions or concerns, please call 474-7420 and leave a message.

Thank you again for your assistance.

Sincerely,

Liz Loewen
Research Assistant

Appendix A-1

THE YOUVILLE CLINIC

and

The Action Research Group
(Faculty of Nursing,
University of Manitoba)

are conducting a

COMMUNITY HEALTH NEEDS ASSESSMENT

of

St. Boniface and St. Vital

Your OPINION matters!

Please complete the survey form

LA CLINIQUE YOUVILLE

et

le Action Research Group
(Faculté des sciences infirmières,
Université du Manitoba)

effectuent une

évaluation des besoins
en matière de santé communautaire
des résidents

de Saint-Boniface et de Saint-Vital

Nous tenons à connaître votre opinion!

Veuillez remplir le questionnaire

Appendix B-1

ACTION - COMMUNITY HEALTH NEEDS ASSESSMENT

If you would like to receive a survey, please **print** yoru name and address below:

NAME	**ADDRESS (include postal code)**

Appendix C-1

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

January 24, 1995

Dear Sir or Madam:

Researchers in the Faculty of Nursing (ACTION Research Consortium) at the University of Manitoba are conducting a community health needs survey in St. Vital and St. Boniface. The purpose of this study is to explore the major health concerns in these communities and what health care services might be needed. A variety of data sources (secondary data, annual reports from community agencies, and interviews with community residents) will be analyzed. Interviews will also be conducted with community residents of St. Boniface and St. Vital.

This study is sponsored by The Youville Clinic and has been approved by the Ethical Review Committee of the Faculty of Nursing, University of Manitoba.

You may direct any questions to the project manager, Ms. Elaine Mordoch (474-7420) or to Dr. David Gregory (Assistant Professor, Faculty of Nursing, 474-9317).

Sincerely,

David Gregory

David Gregory, R.N., Ph.D.
Co-Chair
ACTION

THE UNIVERSITY OF MANITOBA

FACULTY OF NURSING

Room 246 Bison Building
Winnipeg, Manitoba
Canada R3T 2N2

Tel: (204) 474-8202
Fax: (204) 275-5464

Le 22 fevrier 1995

Madame/Monsieur,

Des chercheurs de la Faculté des sciences infirmières (ACTION Research Consortium) de l'Université du Manitoba mènent actuellement une enquête sur les besoins en santé communautaire à Saint-Vital et à Saint-Boniface. Cette étude a pour objectif d'examiner les principaux problèmes de santé dans ces communautés ainsi que les besoins dans le domaine des services de santé. Les chercheurs analyseront toute une variété de sources de données (données secondaires, rapports annuels d'organismes communautaires et entrevues avec des membres de la collectivité). Des entrevues seront également menées avec des résidents des quartiers de Saint-Boniface et de Saint-Vital.

Cette étude est parrainée par la Clinique Youville et a été approuvée par le Comité d'examen de l'éthique de la Faculté des sciences infirmières, de l'Université du Manitoba.

Si vous avez des questions, vous pouvez communiquer avec la chargée de projet, M^{me} Elaine Mordoch (474-7420), ou avec le D^{r} David Gregory (professeur adjoint, Faculté des sciences infirmières, 474-9317).

Veuillez agréer, Madame/Monsieur, l'expression de mes sentiments les plus sincères.

David Gregory

David Gregory, inf., Ph.D.
Coprésident
ACTION

Disclaimer: Community Health Needs Assessment

You are invited to participate in an interview for the research project **"Community Health Needs Assessment: St. Boniface and St. Vital"** conducted by Dr. David Gregory (474-9317), Professor Donalda Wotton, Professor Pam Hawranik, Professor Marion McKay , and other researchers from the Faculty of Nursing at the University of Manitoba. The purpose of the project is to explore what you think are the major health concerns in your community. The researchers are also interested in your perspectives about your own health, what you think about the existing health care services, and what health care services might be needed in your community. Participation in this project is entirely voluntary. You are under no obligation to do so. By participating in the interview, you will be agreeing to take part in the study. The study has been approved by the Ethical Review Committee of the Faculty of Nursing. The study is being funded by Manitoba Health and is sponsored by The Youville Clinic.

The interview will be carried out by full-time undergraduate and graduate students in the Faculty of Nursing. The interview involves general questions about health and health care services currently offered in your community. For example, "What do you see as the major health problems in St. Boniface [St. Vital]?" There are also a few specific background questions about you. For example, "How long you have lived in your community?" and "When were you born?" Your comments will be recorded on the interview form and will last about 30 minutes. After the interview is over, the interview will be analyzed by researchers in the Faculty of Nursing, including the "Project Manager"--a master of nursing student who is assisting to coordinate this study. All the information you give will be kept confidential. Your name will not be used on any reports about the study or in any future publications. Any specific details which might identify you or your family will not be included. There are no benefits to you personally, but findings from this study may be used in future studies looking at community health assessment. Additionally, the information collected in this study may be further analyzed at a later date. During and after the research, the interview form with you answers on it will be securely locked, and kept from 7 to 10 years and then destroyed.

You have had an opportunity to have all your questions answered. Any additional questions you may have can be asked at any time. You may refuse to answer any question in the interview. You may withdraw from the study at any time.

Date _____

Interviewer _____

Presentations will be held in St. Vital and St. Boniface during which time an overview of the findings of this study will be shared with those who participated in this study. Announcements of the dates and times will be made in the local papers (The Sun and The Free Press), and through notices at community agencies. The presentations will occur in the fall of 1995. You are invited to attend one of these presentations.

Identifier les besoins communautaires

Vous êtes invité(e) à participer à une entrevue dans le cadre d'une recherche intitulée « Évaluation des besoins en santé communautaire à Saint-Boniface et à Saint-Vital ». Cette étude est menée par le D[r] David Gregory, M[me] Donalda Wotton, le professeur Pamela Hawranik et plusieurs chercheurs qui sont membres de la Faculté des sciences infirmières de l'Université du Manitoba. Le projet a pour objectif de recueillir vos vues concernant les besoins en services de santé dans votre communauté. Les chercheurs souhaitent comprendre vos attentes à l'égard des soins de santé ainsi que votre opinion au sujet des services de santé existants et des services de santé qui s'imposent dans votre communauté. La participation à ce projet est entièrement volontaire; vous n'êtes donc nullement obligé(e) d'y prendre part. En participant à l'entrevue, vous acceptez de contribuer à la bonne marche de l'étude. Le Comité d'examen de l'éthique de la Faculté des sciences infirmières a approuvé la tenue de cette recherche, qui est financée par Santé Manitoba et parrainée par la Clinique Youville.

Des étudiants de la Faculté des sciences infirmières seront responsables des entrevues, lesquelles comporteront des questions générales à propos des services de santé actuellement offerts dans votre communauté, par exemple : « Selon vous, quels sont les principaux problèmes de santé dans le quartier Saint-Boniface (ou Saint-Vital)? ». On vous posera également des questions personnelles, par exemple : « Depuis combien d'années habitez-vous dans le quartier? » ou « En quelle année êtes-vous né(e)? ». L'enquêteur prendra note de vos commentaires pendant l'entrevue qui durera environ 45 minutes. Ces commentaires seront analysés par des chercheurs de la Faculté des sciences infirmières, y compris la chargée de projet. Toutes vos réponses resteront strictement confidentielles. Votre nom ne sera pas révélé dans les rapports ou les publications. De plus, aucune information pouvant divulguer votre identité ne sera précisée dans l'étude. Vous n'en retirerez aucun avantage personnel, mais l'information fournie pourrait orienter d'autres études destinées à identifier et à évaluer les besoins en santé communautaire. Tous les renseignements recueillis au cours de l'étude seront conservés en lieu sûr jusqu'en l'an 2005, puis seront détruits.

Nous espérons avoir répondu à toutes vos questions. Vous pourrez en poser d'autres pendant l'entrevue et vous aurez le choix d'accepter ou de refuser de répondre aux questions qui vous seront posées. Enfin, si vous le souhaitez, vous pourrez vous retirer de la recherche à tout moment. Pour obtenir plus de détails sur cette étude, n'hésitez pas à communiquer avec le D[r] Gregory, au **474-9317**, ou avec Elaine Mordoch, au **632-2260**.

Date _____

Enquêteur _____

Tous les participants seront invités à assister aux exposés présentés à Saint-Vital et à Saint-Boniface à l'automne 1995 pour prendre connaissance des résultats de l'enquête. Les dates de ces exposés seront annoncées dans les journaux locaux (*Sun, Free Press, La Liberté*).

Appendix D-1

TEMPLATE FOR SCHOOLS

Name of School:

Address:

Telephone Number:

Elementary Jr. High High Private

Size of School:

Community Based Services Provided by the School:

Community Groups Who May Use School Space:

What are the Health and Social Needs of the School Population?

TEMPLATE FOR RELIGIOUS ORGANIZATIONS

Religious Organization:

Address/Postal Code:

Telephone Number:

Pastor/Priest/Rabbi:

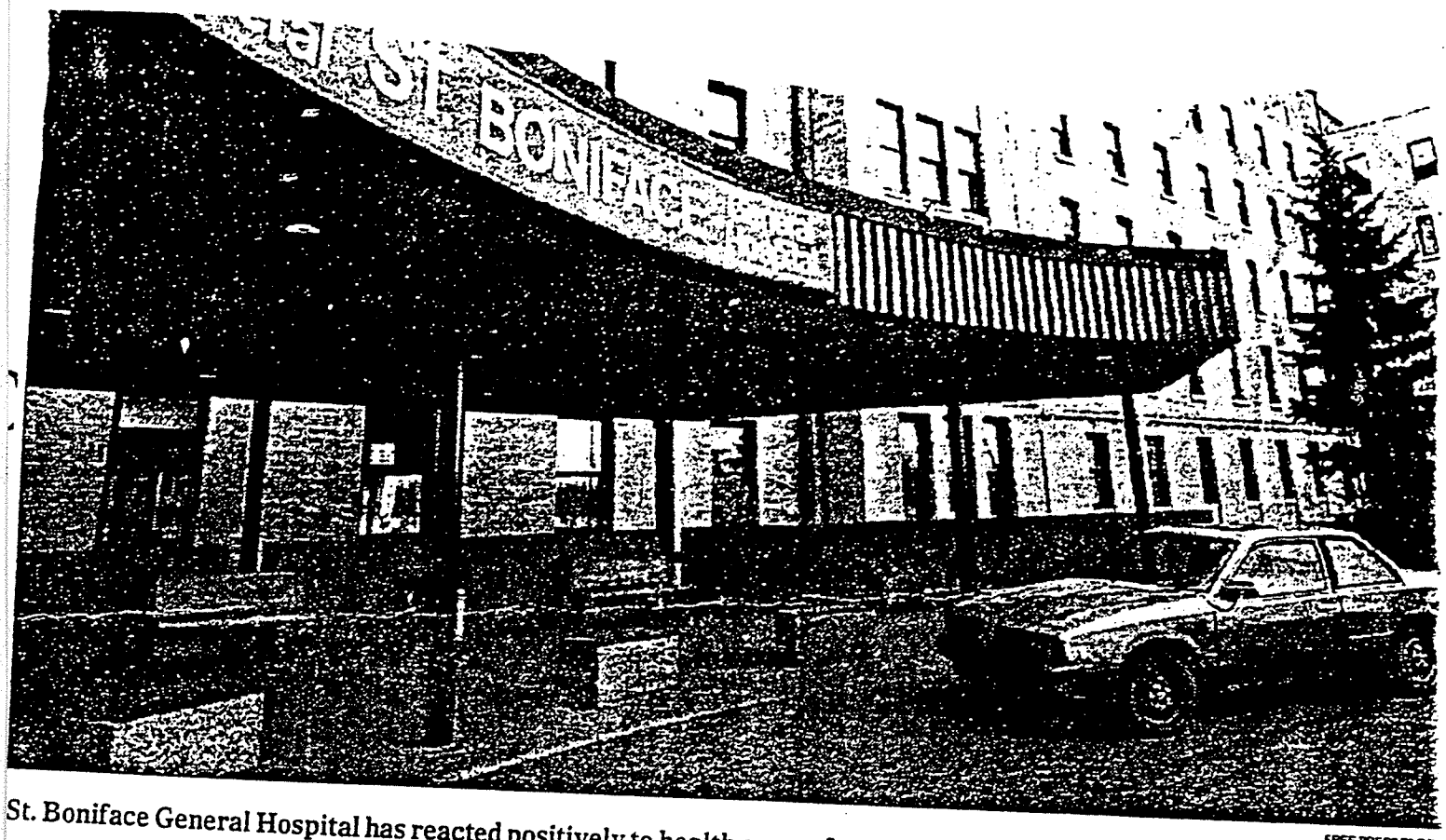
Size of Parish:

Community Based Services Provided by the Church:

Community Groups Who Use Their Space:

What are the Health and Social Needs of the People in the Parish?

Appendix E-1



St. Boniface General Hospital has reacted positively to health care reform and the funding cuts that go with it.

FREE PRESS FILE P-

Hospitals can do as much with fewer resources

Jan 17 95

Medicare safeguards

Jack T. Litvack
ecial to the Free Press

WHEN QUALITY Health for Manitobans — The Action Plan, Manitoba's lth reform document, was oduced in May 1992, health professionals, hospital agers and the public at large n to wonder what lay ahead. ld Manitoba's health system een to change and scrutiny? d hospital and health care nditures be capped and even ced? Was this an attack upon ational and provincial deletion-of-position notices were issued to St. Boniface General Hospital staff.

St. Boniface General Hospital and Health Sciences Centre agreed to participate in a comprehensive work restructuring program which soon became a political football, complicating an already complex and serious exercise involving the input and active participation of some 500 members of the hospital and medical staff, an approach which was never adequately explained to the citizens of Manitoba.

In-patient surgery has been replaced by an increasing quantity of same-day surgery and as a result of recommendations made by the hospital surgeons, anesthetists and surgical nurses, 39 surgical beds were closed and replaced by same-day surgery and a strengthening of preanesthetic clinics. We are developing a comprehensive out-patient and community services program in concert with other health providers and agencies designed to maximize efficiency of inpatient services and at the same time to develop appropriate linkages with other health care professionals and will improve opportunities for patient care, education and research within our province.

Despite the many challenges which we have faced during the past two years, the Manitoba model for reform and change is now evolving as a preferred model across Canada's ten provinces.

We have been on a gigantic roller-coaster ride during the past two years. We continue to learn and to adapt. We, in collaboration with other urban facilities, government and other health care providers, are beginning to

these proposed fundamental changes warranted?

After some 32 years of government-sponsored hospital insurance and 22 years of medicare, St. Boniface General Hospital was an active participant in the provision of quality tertiary, secondary and primary care to the people of Manitoba. Manitoba had witnessed substantial improvements in the treatment and cure of many disease entities. We have been pioneers in coronary bypass surgery. We have co-operated with the Manitoba Cancer Treatment and Research Foundation in the provision of state-of-the-art chemotherapy and radiotherapy service to Manitobans with cancer.

We have developed a broad-based network for care and caring for the elderly, and provide the largest obstetrical program in the province.

Replaced

These are just a few examples of our role and responsibility in health care service, education and research within Manitoba. Suddenly, growth had been replaced by downsizing, development by restructuring and building and enhancement by potential bed reduction.

The implementation of the health reform agenda came quickly and decisively. One hundred and twenty-seven beds were mandated to be closed at St. Boniface General Hospital alone. The closing of in-patient pediatrics was a particularly difficult pill to swallow. Simultaneously, 40 geriatric beds, 24 psychiatric beds and 15 medical and family practice beds were shut down. Between Nov. 1, 1992, and Nov. 1, 1993, 571

These were difficult times. An overall corporate culture of pride, growth and development was being subjected to pressure on many fronts. But slowly and surely, the hospital and its staff began to understand that health reform and restraint were not a unique punishment inflicted upon St. Boniface General Hospital alone.

Reviews of the literature and discussion with colleagues from coast to coast in Canada and beyond revealed that these changes and more were taking place throughout the country. We began to realize that change was inevitable, and that we should preferably become masters of our own destiny and develop proactive approaches that would be more consistent with the mission, values and corporate culture of St. Boniface General Hospital and our owners, the Grey Nuns.

This of course, was an arduous task, but slowly we began to grasp the reins of change. Dialogue with government and other health facilities and providers in Winnipeg and Manitoba began to reveal that there was room for partnerships, for the sharing of services and for the rationalization of programs and services.

Changes also began to manifest themselves in the articulation and implementation of Manitoba health policy. We could discuss and present alternatives; directives became more malleable and there was room for discussion and negotiation. Although change continued to be a necessity, the process for effecting change was now open to review and dialogue.

Our hospital's length of stay has decreased by about 18 per cent during the past two years.

other community based programs and services. We are, after all, only one integral component of a provincial health care network.

Initiatives

One of the most interesting and challenging initiatives in which we have been involved, has been the Tertiary Care Consolidation Task Force to rationalize the provision of tertiary care services in Manitoba. The results of this analytic study recommended that tertiary care services, the most complex care provided within the province, should be developed on the basis of one program, one leader, two sites. Although the approach provides a model for partnership and joint program development between St. Boniface General Hospital and the Health Sciences Centre and the University of Manitoba, it safeguards the principles of autonomous hospital governance, ownership and board trusteeship.

THIS IS a unique approach, very different from the models which have evolved in Saskatchewan, Alberta and New Brunswick where regional boards have replaced individual trusteeship and the uniqueness, culture, mission and values of individual facilities have been replaced by massive bureaucratic hierarchies. This made-in-Manitoba approach offers an opportunity for our two teaching hospitals to work together with government and the university in the best interests of the people of Manitoba in a true partnership, assuring cost effective, quality tertiary care without the vestiges of unnecessary duplication or empire building. It will also enhance our ability to recruit physicians and

understand that the forces of change will produce better re if we work together, rather th functioning separately at cross-purposes. If the action p was the blueprint for reform a change in Manitoba's health system, the implementation strategies are the cornerstone upon which the foundations of health care delivery are being built to lead us into the next century.

Do as much

Being obstructive and yearn back to "the good old days" wil achieve nothing. All of us have realize that the delivery of qu care is not necessarily a consi but a relativity. Outcome evaluation and objective assessments demonstrate that can do as much with fewer resources, but that the formul success requires time, commitment by all levels of hospital and medical staff and health care unions, and a continuing dialogue which encompasses all the players including government, patient and the community at large.

As the federal government initiates the health forum to examine the future of health ca in the country, the federal government and the provinces continue to grapple with the fu of medicare, the effects of continued revenue reduction a other health related agendas.

We must all work together t preserve and safeguard Canad precious legacy of comprehen and universal medicare. With i its inherent shortcomings, Can still offers the best health care system in the world.

(Jack T. Litvack is president St. Boniface General Hospital.

Winnipeg Free Press, January 17, 1995.

The long road back

Turned first trick at 13, now she wants to help others get off the streets

"To this day, I find it hard to trust people with my heart. I'll trust them with everything else. But my heart – it's the only thing I

Pretty BABIES

cuts, to individual triggers, like an exploitive boyfriend. "Kids are very vulnerable right now," Runner said.

A teenager who is lonely and naive can easily fall under the spell of an older man, she said. "These guys are very good at manipulating her," she said. "This guy says he loves her. Then, when she doesn't make enough money, he beats her up. Then she's afraid."

Other factors

Studies in recent years have also pointed to a host of other factors that push kids into prostitution. A 1991 study by Susan Nadon, a University of Manitoba graduate psychology student, compared adolescent prostitutes with other troubled teenagers.

She found that 68 per cent of teenage prostitutes had suffered childhood sexual abuse and 48 per cent had been physically abused at

into h
help.
Sh

ELECTION

Crapping out o

When luck turns sour, more than money is lost

By Gerald Flood
Staff Reporter

YOU HEAR it said all the time. Addicted gamblers are the architects of their own misfortune.

What you hear less often is they are also the architects of others' misfortune.

About two dozen people, most hurt by the actions of addicted gamblers, responded to a Free Press ad asking that they share their stories in confidence. The following are some of those stories.

❑ ❑ ❑

She was enjoying the freedom, her daughter having recently been married.

Then her son-in-law discovered VLTs.

Suddenly, bills weren't being paid and his employer and creditors were hounding her daughter.

He would disappear for 16 or 20 hours.

He always needed money for "car repairs."

When the fights became physically abusive, she said her daughter packed up and moved back home.

Today she's a full-time mom — again.

She cares for her grandchild during the day, and cooks meals and does laundry for her daughter, who has a full-time job.

Her freedom is gone.

"It makes me bitter against all those government gambling policies," she said. "I feel so betrayed."

❑ ❑ ❑

He said when he came back from a $70,000-a-year job at Limestone, the

Manitoba Election
ISSUES
The Hidden Cost of GAMBLING

The introduction of widespread gambling in Manitoba was one of the most significant public policy decisions of the Filmon administration, and perhaps the most significant revenue initiative since the sales tax. The Tories argue the move has helped fund hospitals, create jobs and balance the budget. But they've never answered the big question: At what cost? A team of Free Press reporters and an economist from the University of Winnipeg have spent 11 months probing for answers.

SATURDAY
The hidden cost

YESTERDAY
Business bruised

TODAY
The human face

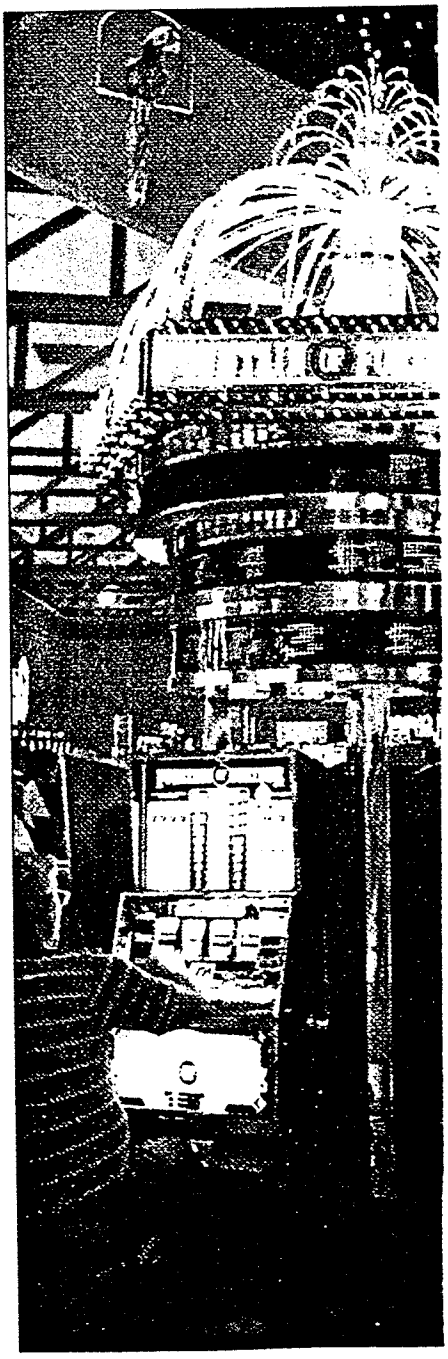
TOMORROW
The veil of secrecy

care for her daughter," he said.

❑ ❑ ❑

She quit her job at the Manitoba Lotteries Corp. when she realized it was "morally bankrupt."

She said everyone at head office was aware of studies that found gambling was addictive for some people and would ruin their lives.



Casinos offer bright lights, big fu

When the transaction is complete,

FREE PRESS

r. But she was too angry to accept his

also phoned her mother. But those calls

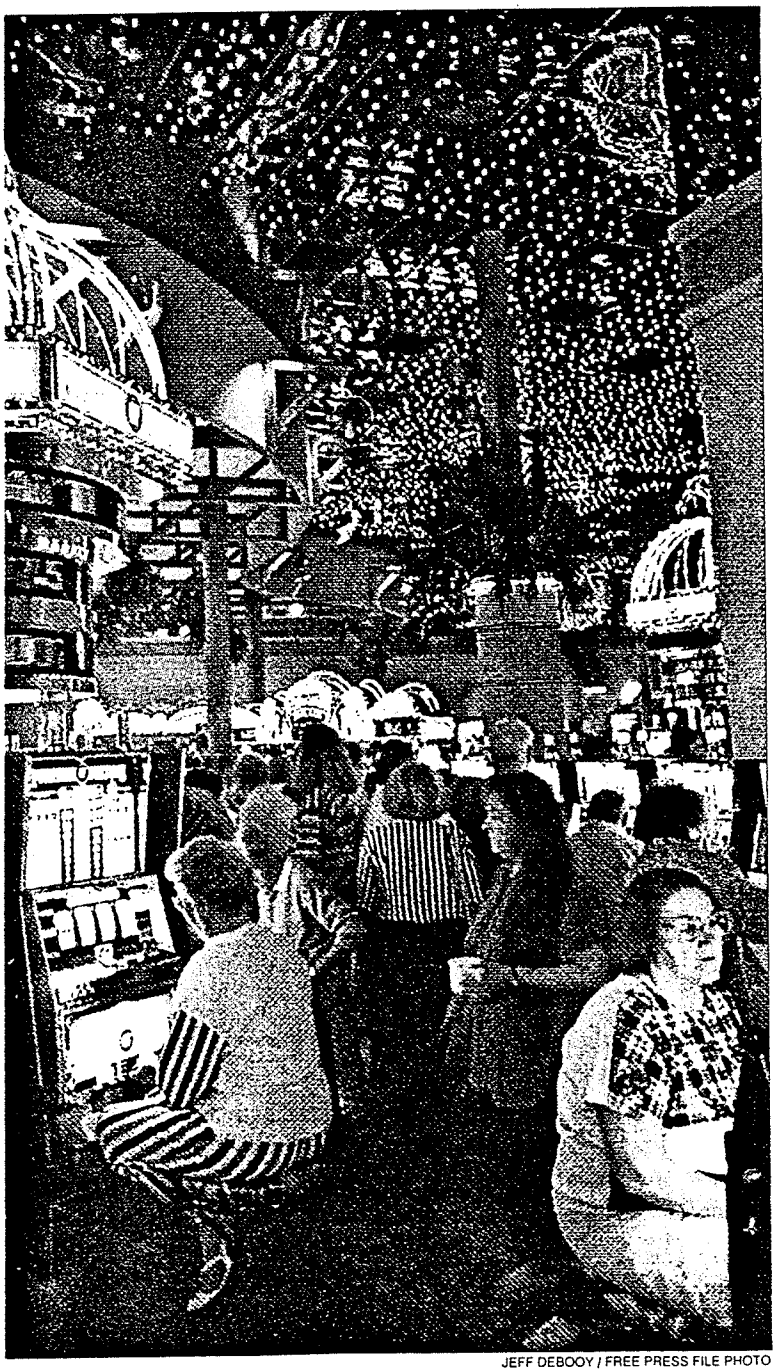
couver where she happened to be living.

One day, Leah looked in the mirror and actu ally liked the person who she saw. Her dreams came back.

Leah can now ...ive support ...ond.

MANITOBA

n life, love



JEFF DEBOOY / FREE PRESS FILE PHOTO

. . . and misery for addicted gamblers' innocent victims.

Lotteries swell treasury

VLTs take funds from needy

By Gerald Flood
Staff Reporter

THE BINGO pulled in about $40,000 a year, like clockwork, said a spokesman for the Canadian Mental Health Association's Manitoba division.

Then the province opened two gambling palaces in the summer of 1993, and the take dropped to $20,000.

Bill Martin, the association's executive director, said the group decided to move the bingo to a smaller hall in hopes that reduced costs would bolster the profit margin.

But it didn't help.

Six months later, the bingo went bust.

"We knew that if we tried to go on any longer we would slip into the red. We just closed it. There was no point.

"We were simply blown out of the water by government."

Similar stories are told at church halls, in community centres and by helping societ-

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St. Vital Issue

228-0763

Vol. 7: 25V June 17-23/95

Everybody's Talking!

Spider survivor: A maintenance man in Chino Valley, Arizona was bitten four times by black widow spiders and lived to tell the tale. "I was reaching behind my workbench to plug in a drill when I felt the bites," said Gary Boyles. "It was really painful." Boyles was given morphine to kill the pain and had to spend a week in the hospital. "He's lucky to be alive," said his doctor.

A public forum presenting the preliminary findings of ***St. Boniface/St. Vital Community Needs Assessment*** *sponsored by* ***Youville Clinic*** *and* ***Manitoba Health,*** *will be held on* ***Wednesday, June 21,*** *1995 from 7:30-8:30 p.m. in the upstairs area of the Dakota Community Club, 1188 Dakota. Refreshments and dialogue will follow the presentation. If you would like further information about this Needs Assessment, please call 474-7420.*

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228-0763

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A drink a day: Drinking booze may be damaging to an alcoholic, but studies show that a couple of drinks a day may improve the minds of non-alcoholic elderly people. Dr. Joe Christian, an Indiana University geneticist, studied the effects of one or two drinks per day on 4,000 World War II veterans over a long term. "The drinks seemed to improve mental abilities, such as reasoning and problem solving," said the doctor.

forum public

- Un forum destiné à présenter les résultats des recherches préliminaires des besoins en santé communautaire dans les quartiers de Saint-Boniface et Saint-Vital aura lieu:
- mercredi le 21 juin de 19h30 à 20h30 en haut au Dakota Community Club,1188 rue Dakota
- Un deuxième forum aura lieu à la Salle Antoine Gaborieau au Centre Culturel Franco-Manitobain jeudi le 22 juin de 19h30 à 20h30
- À la suite de les présentions, il y aura du temps réservé aux questions et des rafraîchissements
- Pour de plus amples renseignements au sujet de l'évaluation des besoins, adressez-vous à Action au 474-7420
- Le forum est parrainé par la Clinique Youville et Santé Manitoba

PUBLIC FORUMS

COMMUNITY HEALTH NEEDS ASSESSMENT

A public forum presenting the preliminary findings of the St. Boniface/St. Vital Community Needs Assessment, sponsored by Youville Clinic and Manitoba Health, will be held on Wednesday, June 21, 1995 from 7:30 - 8:30 p.m. in the upstairs area of the Dakota Community Club, 1188 Dakota. Another public forum will be held Thursday, June 22 from 7:30 - 8:30 p.m. at the Centre Culturel Franco-Manitobain, in the Salle Antoine-Gaborieau. Refreshments and dialogue will follow the presentations. If you would like further information about this Needs Assessment, please call 474-7420.

Appendix G-1

COMMUNITY HEALTH NEEDS ASSESSMENT OF ST.BONIFACE & ST.VITAL

Welcome to a community forum about the findings of the community health needs assessment in St.Boniface and St.Vital. Here is some background information about the assessment.

Who is conducting the community health needs assessment in these communities?

Youville Clinic is conducting this community health needs assessment and commissioned the ACTION research consortium in the Faculty of Nursing to complete this task.

Why is this assessment being completed?

The assessment is being completed to assist Youville Clinic and Manitoba Health to plan for programming at the proposed Community Nurse Resource Centre.

How did this assessment occur?

ACTION has used a number of strategies to gather information about the communities. Statistical data from sources such as the census & Manitoba Health is included as well as interviews with community health agencies, institutions, and health care professionals. Community residents responded to a telephone interview and mail out survey. These are just a few examples of the many data sources collected.

What will be presented tonight?

Tonight ACTION representatives will present an overview of some of the findings. The purpose of the evening is to receive feedback and perspectives from community members. There will be a discussion period after the presentation when you can ask questions and offer your opinions in a large group or if you prefer, you may speak individually to an ACTION member during the break.

Remember, tonight we want to hear from community members.