COMMUNITY PERCEPTIONS OF A HOSPITAL'S ROLE IN HEALTH PROMOTION

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ABSTRACT

The shift in emphasis in the health care field to address health promotion challenges the hospital to determine its role. To determine community perceptions of a hospital's role in health promotion, a telephone survey was conducted involving 542 adults of households in the North Area of Winnipeg. The sample was selected by random selection of household telephone numbers. A telephone questionnaire was administered by selected interviewers. A concern for health was noted. About two-thirds of the respondents were not participating in health promotion activities. Those who did participate most often identified exercise and eating habits as the behaviours practiced. These activities were most often practiced independently or at a private organization. Age was the only significant factor related to participation. Adults did view the hospital as being involved in health promotion. This view, however, varied significantly only with age and education level ($p < 0.05$). The preference of location for these programs was significant. The preferred location was outside the hospital. The sources of health information were not significant for any of the demographic factors. The task that now remains is to develop a plan of action which includes educating both the hospital staff and the public, collaborating with other health and community organizations, developing programs and developing a public relations program related to health promotion.

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CHAPTER I

INTRODUCTION

BACKGROUND INFORMATION

The rising cost of health care continues to be a concern to governments and organizations providing such services. This concern is being translated into a growing emphasis on reallocation of funds to community-based health programs. As a result, hospitals, as one such service, are faced with a need to re-examine their roles and their services. The hospital has long been the center of the health care system oriented toward the treatment and cure of illness/disease.

Hospitals have played a role in prevention. The provision of services such as immunization clinics and specialized laboratory services have contributed to the prevention of disease and illness. Rehabilitation and remedial clinics also provided an added dimension. In the 1980's, the expressed concern about the need for reorientation to meet the health needs of communities and not just their illness needs presents a challenge to the institutions (Health & Welfare Canada, 1986). The strained resources of a struggling, institutionalized health care system together with the demands of an educated public have brought about

the concept of health promotion to the fore. As well, scientific evidence increasingly points to lifestyle and behaviour as being directly related to the principal causes of morbidity and mortality (Health and Welfare Canada, 1974; U.S. Department of Health, 1979). Sixty percent of the morbidity and mortality of these new health problems are related primarily to lifestyle and environment (Yoder et al, 1985).

As the members of modern society become more knowledgeable about health matters and more aware of their health needs, they expect and demand more health care services, wider availability, and greatly improved protective measures to diminish the incidence of disease and injury. How these services are to be provided and by whom is not clear. The consensus appears to be that hospitals should be playing a major role in meeting community health care needs. The American Hospital Association asserts that each individual shares the responsibility for protecting his own health and that the proper discharge of that responsibility can reduce the incidence of injury, illness, and death (American Hospital Association, 1979). But individuals must be made aware of the importance of their role as a partner in their own care, and they must be taught how to assume that role. Hospitals and other health care institutions may be able to help.

The Hastings Report of 1972 emphasized the development of a network of independent community health care centers in an attempt to meet public need. However, this has been replaced by a preference for having the community hospital reach further into the community to provide a wide variety of services.

The Canadian Hospital Association (Canadian Hospital Association, 1972), in its comments on the Hastings Report, stated that to establish a network of independent community centers would be wasteful and would create duplication of existing facilities. The Association believes that hospitals, as a focal point of community health care, have an obligation to promote a variety of services.

Perhaps the best known and most frequently quoted document on the provision of health care services is "A New Perspective on the Health of Canadians" (Health and Welfare Canada, 1974). The main emphasis of this document is on health promotion and the need for health care professionals and institutions to devote more effort to the prevention of illness and injury. The primary message of that report was that potential improvement in the health status of people in industrialized nations was more likely to result from changes in lifestyles, social and physical

environments, and biology, rather than in allocating more resources to the existing health care delivery systems. "A New Perspective on the Health of Canadians" proposed a framework for examining the health problems and for suggesting courses of actions. This framework addressed the need for unifying all participants including the health care institutions.

The American Hospital Association (American Hospital Association, 1977) expressed a similar philosophy in its policy statement on the provision of health services when it stated:

> "This system [for the delivery of health services] must be oriented to the maintenance of personal good health and to the prevention of illness rather than being primarily oriented to the treatment of illness after it becomes acute....health education is the key to health protection and hospitals should assume a leadership role in this field" (p.1)

In 1979, the American Hospital Association published "Policy and Statement on the Hospital's Responsibility for Health Promotion" in which it confirmed its commitment to health promotion -- "...hospitals have a responsibility to take a leadership role in helping ensure the good health of their communities." (p. 1)

From a more global perspective, the World Health Organization established a new program in 'Health Promotion' in 1984. The document on "Concepts and Principles in Health Promotion" served as a focus for discussion on which to base the development of health promotion activities in Europe (Working Group on Concept and Principles of Health Promotion, 1984). This document recognized that priorities and practices for health promotion depend on prevailing economic and cultural conditions. It emphasized that health promotion should involve the participation of the people in the development of the health programs. Any agency or group would do well to establish this concept in their own future planning for health promotion.

The document "Achieving Health for All" (Health and Welfare Canada, 1986) addresses the need to seek new approaches for dealing effectively with the health concerns in a changing society. The document proposes the health promotion approach which involves the integration and expansion of the more traditional approaches. "Achieving Health for All" emphasized the need to incorporate health promotion to "compliment and strengthen the existing health care system" (p. 2).

As more evidence linking physical and social factors to disease was accumulated, there began a movement away from

hospitals and an illness orientation. Programs such as physical fitness and nutrition awareness gained popularity. Holism became a concern of health care. "Wellness" became a catchword for many agencies involved in promoting health. Criticism was directed at hospitals for focusing only on disease and excluding many other concerns of the community. The hospitals in the United States were the first to initiate a focus on health promotion. Therefore, most of the ideas relating to hospital-based health promotion programs emanate from the United States. However, consideration of their motivational basis must be considered.

The competitiveness of the United States institutions has led the way in a change of attitude toward health promotion as a role for hospitals. The use of innovative marketing strategies was seen by hospitals as a way of improving their position in the health care system. In 1978, the Centre for Health Promotion began collecting information regarding hospital-based community health promotion programs. Prior to 1978, the information suggests that few hospitals had any well-defined community health promotion efforts. Most hospitals were simply providing first aid training, and conducting health fairs and some individual activities such as seminars on health topics (Longe & Wolf, 1984). It is possible that hospitals in Canada, more specifically in

Manitoba, can similarly become ideal locations for health promotion programs. The reasons why Canadian hospitals can be ideal locations for health promotion may not arise out of the same competitiveness that American hospitals experience. However, the hospital is one Canadian institution that can help the health care delivery system move toward promotion-oriented services.

Hospitals have retained their credibility among the public even though this credibility may be based on its advances in curative treatment. Thus, it may be assumed that they are in a favourable position to undertake a leadership role in the provision of service to include the well and healthy (Brehens, 1979; Cunningham, 1979). The past success of hospitals in dealing with illness or injury puts them in an enviable position of assuming the additional responsibility in the form of leadership in the development of a health promotion system (Brehens, 1979: Jonas, 1979; Vickery, 1979). This system includes a community-wide network of homes, schools, work sites, institutionalized and non-institutionalized health care organizations and other settings in which responsibility for health can be assumed on an individualized or social bases. The established credibility of the hospital, its high concentration of professional expertise, and its acceptability as a service provider would make it the logical choice over other institutions.

The hospital (the work place of physicians, nurses, social workers, administrators) is already seen by the health consumer as an "authorative source of health information" (Adamson, 1979, p. 87). The opportunity for hospitals to broaden their usefulness and serve the total population, and not just the ailing, should be obvious. Many citizens consider the hospital to be the focal point for the community's health-related activities and concerns (Vickery, 1979). Therefore, most hospitals already have an audience that will listen and participate. The acceptance and credibility of the hospital within the community is an enormous advantage and should not be regarded lightly. The recognition by hospitals of the validity of health promotion as a community health strategy and the inclination of the public in that direction make this type of programming both an appropriate and a feasible direction to take.

Fries (1983), a proponent of health promotion, argues that mortality reductions will cease in the near future because of biological constraints which are due to the species specific processes of senescence. He suggests that present illnesses are universal, have early onset, are progressive, are generally characterized by a symptom threshold at which they become clinically obvious and are mutlifactorial in cause. The

implication of this premise suggests that as risk factors are modified, the progression of the disease process is decreased. This decrease results in delaying or even preventing the symptomatic threshold from being reached. Thus the severity of the symptoms experienced can be decreased or never experienced. The implication of this premise would suggest that health enhancement programs must begin early in adult life and be continued throughout. It also implies that deinstitutionalized programs, which promote individual initiative, should be sought. Therefore, programs should stimulate the independence of individuals and every effort made to reduce adverse incentives which 'subsidize' bad health habits. Frie's paradigm offers a framework within which to view the problems and within which we may begin to develop constructive solutions.

Hospital health promotion programs that have been developed have all had to deal with what health promotion would mean in terms of their respective services. In order to deal with the concept of health promotion, the definition of health must extend beyond the absence of disease. For the purpose of this investigation, health represents a positive state of physical and mental well-being and a high level of function. It is defined as a person's ability to adapt to biologic, psychologic and social

changes in a manner that allows the individual to function at an optimal level in his or her environment (Andreoli et al, 1983). This interpretation regards health as something very specific and concrete, a state in which the potential of the individual is developing in a balanced way (Salk, 1972). It is therefore evident that health is not simply the absence of illness nor the function of professional medical services and treatment. There is rather a spectrum of informal and formal relationships and institutions that are together responsible for the 'state of our health', both individually and collectively (Glossop, 1985). The Ottawa Charter for Health Promotion defines health as "a resource for everyday life, not the objective of living" and "a positive concept emphasizing social and personal resources, as well as physical capacities" (International Conference on Health Promotion, 1986, page 1).

Health promotion, therefore, is seen as a broad conceptualization of the full spectrum of health services and activities and encompasses the means by which health is achieved and maintained.

> "Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete

> physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment" (International Conference on Health Promotion, 1986 page 1).

In this sense, health promotion includes the fostering of positive health habits, the acquisition of health knowledge, the adoption of primary and secondary preventive measures, and even screening and early detection of disease. In this context, health promotion extends beyond being the responsibility of the health sector.

The selection of the arena or setting, in which strategies are planned to provide health promotion programs is a crucial part of the overall health planning process. Because health promotion should be a constant and pervasive part of every person's life, its health-oriented activities are less restricted to specific health care delivery sites than are the disease-oriented activities of traditional, curative medicine. Effective, comprehensive planning for the implementation of health promotion strategies, then, may have to recognize multiple sites as components of the system. With the growing interest in health promotion, it is vital for any hospital to examine whether in its

particular setting it makes sense to get involved. This is a force that isn't hospital based or hospital confined. Health promotion programs will continue to grow, and the issue is who is going to do it and who can do it most effectively. If the goal of the health care system is to improve the health of the people it serves, hospitals would appear to be a logical force in health promotion and disease prevention (Jonas, 1979).

STATEMENT OF THE PROBLEM

The Seven Oaks General Hospital is an acute care, community hospital that is contemplating its role in developing health promotion programs as part of its service delivery. This investigation will serve as part of a data base in order to help the hospital to clarify its role, to determine service needs, and to establish goals and planning directions in health promotion.

The Seven Oaks Hospital is an adult, active treatment general hospital incorporated as a legal entity on May 13, 1970. In January, 1981, it began to provide services to the public of North Winnipeg. In the hospital's by-laws, the objective of "the promotion of educational activities which will improve the care of the sick and injured, and to the maintenance of good and overall well-being" (ARTICLE III, page 3) clearly indicates the hospital's

commitment to health promotion. This is further reflected in the hospital's philosophy statement "To promote general health in the community" (p. 1). It further states that "the Board of Trustees recognize that health care extends beyond the four walls of a physical facility, and consequently wish to encourage involvement in the community" (p. 1). Health promotion planning would appear to be a logical step in assisting the hospital to reach its goals.

In spite of the opportunities presented to hospitals to provide health promotion programs, it is not known where people presently go to attend health promotion programs, why they make those choices and what programs they see hospitals actually providing.

PURPOSE OF THE STUDY

A telephone survey technique will be used to survey adults of households in the North area of Winnipeg. The purpose of this survey will be to:

1. Determine how the adult population of North Winnipeg perceive health and health promotion.

2. Determine present behaviour patterns of maintaining health.

3. Determine public knowledge of the hospital's current involvement in health promotion.

4. Determine public perception of the hospital's possible role in health promotion.

5. Determine program preferences.

6. Determine demographic variables.

STATEMENT OF HYPOTHESES

This investigation was undertaken to test for the following six hypotheses:

HYPOTHESIS I

Research Hypothesis: Adults show concern for their health.

Null Hypothesis: Adults do not show concern for their health.

HYPOTHESIS II

Research Hypothesis: The hospital is viewed as being involved in health promotion.

Null Hypothesis: Adults do not view the hospital as being involved in health promotion.

HYPOTHESIS III

Research Hypothesis: Adult views of the hospital's involvement in health promotion is related to demographic factors.

Null Hypothesis: There is no difference in the view of the hospital's involvement in health promotion

a) between adult males and females

b) among different adult age categories

c) between adults of varying education levels

d) between income categories.

HYPOTHESIS IV

Research Hypothesis: Adult participation in health promotion is influenced by demographic factors.

Null Hypothesis: There is no difference in participation in health promotion.

a) between male and female adults

b) among different adult age categories

c) between adults of different education levels

d) between income categories

HYPOTHESIS V

Research Hypothesis: Adults prefer to participate in health promotion activities outside the hospital.

Null Hypothesis: Adults have no preference for location when participating in health promotion activities.

HYPOTHESIS VI

Research Hypothesis: The sources of health information for adults are related to demographic factors.

Null Hypothesis: There is no difference in source of health information

a) between male and female adults
b) among different adult age categories
c) between adults with different education levels
d) between income categories

LIMITATIONS AND DELIMITATIONS:

One of the study's limitations is the voluntary nature of the study which can bias the sample toward the health concerned individuals. The limitations of the selected research design, descriptive research, is that of lack of response. The telephone

interview method itself may be a limitation. The increased use of telephones for surveys may in fact have created a resistance and/or disinterest within the public. There is also the risk of lack of desire to communicate accurately on the part of the individuals contacted by telephone.

The study is delimited by the fact that the population is defined by the hospital's primary service provision area. Results of the study can therefore be generalized to those participants only. Also, the interviews will be carried out in English. This process risks the possibility of omitting data from non-English speaking individuals which may differ. This is particularly significant because the area being surveyed is multicultural in nature. As well, interviewing only one adult member of a household assumes that he/she represents that household. That may not be the case. The risk of misinterpretation of terms by the interviewers must be considered. As well, incomplete documentation and less than candid responses may be limitations. To the extent that some people had moved or otherwise were not at the designated number, or were unable to speak or understand English, the investigation failed to make contact with a representative sample. The fact that people with unlisted telephone numbers or no telephones were not reached would exclude households at extremes of the socio-economic spectrum. The timing

of the survey was such that families may have been on vacation. This fact would tend to then eliminate the average to higher income level categories.

DEFINITIONS OF TERMS:

HEALTH: A positive state of physical and mental well-being and an optimal level of functioning which emp[hasizes social and personal resources as well as physical capabilities. (WHO, 1984, Ottawa Charter for Health Promotion, 1986).

WELLNESS: Functioning oriented toward maximizing the potential of which the individual is capable. (Mullen, 1986).

DISEASE: Physiological incapacity of the body which hinders or threatens to hinder the achievement of personal goals or the performance of social role tasks. (Baranowski, 1981).

ILLNESS: Non-physiological incapacity of the person which interferes with the fulfillment of personal expectations to perform social role tasks (Baranowski, 1981).

HEALTH PROMOTION: A broad term that encompasses the means by which health and wellness is achieved and ideally, maintained; i.e. any combination of services or activities designed to promote and maintain health and to reduce the occurrence and severity of disease.

CHAPTER II

REVIEW OF LITERATURE

The review of the literature undertaken in this chapter focused on various aspects of health, health promotion and the hospitals' roles in programming. These included sponsorship of health promotion programs, current status of hospitals' role in health promotion; factors that affect participation in health promotion programs; participants of health promotion programs; demographic factors; and the issue of sources of information. The review revealed that very few reports of hospital based- programs were based on empirical evidence. The literature which discusses hospital involvement in health promotion emanates primarily from the United States. The information most frequently describes the location and content of those programs. The information provided only a limited description of the population accessed by health promotion programs. As well, the effectiveness of hospital-based health promotion programs was seldom indicated.

Yoder et al (1985) conducted a study which documented the extent to which persons engaged in health promotion and disease prevention behaviours, and examined demographic and attitudinal

variables associated with those behaviours. Health promotion and disease prevention were differentiated by the absence and the presence of health professionals respectively. The sample in this study was a convenience sample of 104 emergency room patients. The authors found that health was highly valued. Health promotion and disease prevention behaviours were both significantly related to age and living situation. Nearly everyone practiced disease prevention behaviours; fewer practiced health promotion behaviours. Older individuals reported fewer disease prevention behaviours (going to the doctor, dentist). Individuals were more apt to go to the doctor than exercise or eat nutritiously in order to be healthy. Health and Welfare Canada (1987) reported that based on percentages, the majority of Canadians reported positive health habits in the broadly defined self care category.

The popularization of physical fitness is the first step toward learning the art of being well. Citizens still possess the illusion that personal health is only a matter of a clean, safe environment, good luck, good meals and good doctoring rather than it being one of good personal management (Chenoy, 1984).

Gunter and Kolanowski's (1986) findings supported the premise that health status is correlated with age. The older persons reported lower health status than younger persons. However, their study involved a small nonrandomized sample and the volunteer

nature of their study possibly biased the sample toward the healthy elite within the group.

SPONSORSHIP

At present, hospitals compete with non-medical businesses such as fitness centers and diet centers for a market share as it relates to health promotion.

Hospitals themselves are largely uncertain as to their role in health promotion. It is ironic that it is often easier to convince business and industry of the value of health promotion. Jones (1982) indicated from an informal questionnaire that business and industry have not always looked to hospitals for assistance in setting up health promotion programs. In fact, it was estimated that hospitals were contacted in as few as 10% of the instances. Rather, companies have established programs in conjunction with allied health professionals, health and fitness centers or local groups. These companies are employing the people from the community and these people may very well interpret that health promotion originates from locations/agencies other than hospitals.

The public is going to diet centers, spas, and athletic clubs in increasing numbers (Keenan, 1982). This is seen in the increasing numbers of these centers being opened. The marketing

of these centers has greatly exceeded any attempts by hospitals. The Swedish Health Resources Inc. which was established in 1977 as a separate corporation within a hospital did so in an attempt to make an organizational distinction between 'sickness' and 'wellness'. The model developed in order to allow the staff to work with the community to foster cooperative services and relationships among individuals and institutions (Adamson et al, 1979). This separation is but one institution's experience in dealing with a traditional image of a hospital. The traditional image of hospitals is still seen as care and cure (Burrow and Smith, 1981).

Voluntary health agencies are active in promoting programs such as heart health, birth defect prevention, smoking reduction, cancer screening and alcohol treatment. Many organizations, service clubs, YMCAs, although not strictly health oriented, are playing a growing role in health promotion through education and organized activities. The formation of self-care and self-help groups for diverse problems is further evidence of consumer interest and sponsorship diversity.

"A New Perspective on the Health of Canadians" (Health and Welfare Canada, 1974) was the first modern government document in the Western world to acknowledge that emphasis on only a

biomedical health care system was not adequate. The document indicated a need to look beyond the traditional health care system if we wish to improve the health of the public. Similar reports followed from Britain in 1976, Sweden in 1982, U.S.A. in 1979 and elsewhere (Hancock, 1985).

The World Health Organization strongly supports this move away from the biomedical model. The attainment of the social goal of 'Health for all by the Year 2000' is based on the recognition that health is influenced by a complex of environmental, social and economic factors which are related to each other (WHO, 1977). This goal does not mean a total absence of disease, but rather equal sharing of the possibilities for health both in terms of knowledge and resources. This holistic approach by the World Health Organization calls for the efforts of other areas (industry, education, housing, communication) just as much as in medicine and public health. Based on this realization, the health care strategy has three main components: a multi-sectoral approach, community involvement, and appropriate technologies.

The growing emphasis on community health and community care recognizes that local communities need not and cannot continue to be dependent on institutions outside their own control to take care of their health. This changing context for health, which

reflects different possibilities and different values, is an indication of what is actually happening and what the future will probably be like. Robertson (1985) suggests three paths of development: Business as Usual; Hyper-Expansionist (HE); and Sane, Humane and Exological (SHE). He suggests that the changing context of health will be shaped by interaction and conflict between these different visions. However, the most powerful influence in shaping it will be a vision of a future in which people take greater personal responsibility for their own health and develop their capacity to take more control of it; in which the positive creation of health is given a higher priority; and in which we perceive our own personal health to be closely linked with the health of 'the society, the environment, and the whole planet'. It must be further recognized that in the absence of appropriate incentives and healthy institutions only self actualizers are likely to self enhance (Carlson, 1985). The need for community involvement is further supported.

Ironside (1985) in her presentation to a Public Health Conference in Toronto stated that surviving and thriving in the future will depend on our ability to learn. This ability to learn, both as individuals and as communities, is the richest resource we have and it is a renewable resource. People's ability

to learn about themselves, their bodies, their social environment and about their roles as citizens - how to get an anti-smoke by-law, how to achieve safety in the work place - is central to the concept of health promotion. Health promotion must involve citizen education and an understanding of the way in which to influence events. Such articulation is rooted in learning for empowerment.

CURRENT HOSPITAL PROGRAMS

There is inconsistency and variability in what institutions define as health promotion. The concept of wellness is often used synomously with disease prevention and health promotion. The hospital health promotion programs still tend to focus on three basic issues - nutrition, stress management and physical fitness. However, these programs are supplemented by programs in such areas as smoking cessation, counselling and education about life-styles (Ainsworth, 1984). The CHIP (Clinton Hospital Industrial Program) program associated with the Clinton Hospital in Clinton, Massachusettes is an example of a community outreach program (Sheffield, 1978). The emphasis of that program is on health education, prevention, and early detection of health problems. The provision of the service occurred at worksites

in the area rather than at the hospital. Specific programs included first aid, cardiopulmonary resuscitation training, blood pressure screening, cancer screening clinics, stress management courses, stop smoking groups and flu vaccination clinics. The effectiveness of worksite programs has been noted. A small electronics firm realized an increased business volume, fewer employee illnesses, shorter periods of absenteeism, and improved employee morale when an incentive bonus to stop smoking was initiated. (Fielding, 1982). However, the role and responsibility of the hospital to develop such programs must be understood.

Worksite programs are among the most rapidly growing health promotion activities, particularly in the United States (Fielding, 1982). The Pennsylvania Country Health Improvement Program (CHIP) initiated fifty-eight health promotion programs during the first three years (Felix et al, 1985). It was noted that the largest number of programs had involved the least demanding activity - blood pressure screening, although two of these programs included blood pressure monitoring. It also was found that the number of programs increased with time.

Longe and Ardell (1981) found that wellness activities that have been sponsored by hospital fall into five categories. The first category includes festivals, fairs, clinics and similar events. These events tend to feature exhibitions of a hospital's

equipment, programs and services; health risk appraisals and illness screening; nutrition consultations; and testing of fitness and stress levels. The second category includes structured classes. These classes provide "how-to" information regarding specific skills. The classes tend to be illness-based, offering information on diabetes, hypertension and low back pain, with some focus on health enrichment, such as stress management. The design of the classes tend to address very specific groups and groups of persons with widely varying ages and knowledge levels. The third category of programs includes support groups. These groups take varying forms. Some hospital programs offer activities which are supportive of specific lifestyle goals like weight control or jogging. Other support groups have taken the form of discussion groups which enable individuals to support each other. Special services make up the fourth category. This category includes a variety of resources, written and human, which can be made available. The fifth and most popular programs are related to nutritional awareness, physical fitness and stress management. These activities appeared to be perceived as the most enjoyable, the most effective, and the most socially acceptable.

In 1970, the American Hospital Association Health Promotion Centre under the Directorship of R. Behrens reported that over 1,200 hospitals were providing employee health promotion programs to local businesses. More than 2,000 were offering wellness

programs of some level to their communities (Brehens, 1979). In December, 1981, the American Hospital Association surveyed participant hospitals at a health promotion conference. Responses were received from 150 out of a possible 566. Fifty-eight hospitals reported that they were providing health promotion services, again particularly to businesses. The programs were of three major categories - employee assistance programs, occupational health services and wellness programs.

A parallel movement does not appear to be the case in the Canadian hospital system. In February 1975, Peat, Marwick and Partners were commissioned by Health and Welfare Canada to develop a conceptual plan for health promotion in hospitals. This plan received little attention. Follow-up contact by the authors to provincial health associates in 1979 indicated that only two provinces (Manitoba and Ontario) had initiated or were aware of studies, surveys or reports relating to health promotion activities within their provinces (Health and Welfare Canada, 1975).

It is obvious, the potential of the hospital in health promotion has not yet been fully developed. However, enough successful programs are in existence to justify designating the hospital as an arena from which health promotion strategies can be planned and implemented. In the United States, the Swedish

Medical Centre, a 318 bed acute care general hospital in Englewood, Colorado developed a wellness program referred to as The Swedish Wellness Centre. It has become a resource centre that is responsive to a broad variety of community health needs. The Centre offers a diverse and extensive program and works with the community to foster cooperative services and relationships among individuals and institutions (Adamson et al, 1979).

Other examples of hospital-based health promotion programs include Health Strategies, Inc. and Health Aware. Health Strategies, Inc. is a separate non-profit corporation of Wesley Medical, a 798 bed medical centre serving Wichita, Kansas. Health Aware is a separate corporation of Toledo Hospital, a 751 bed teaching hospital serving Toledo, Ohio and surrounding communities. It consists of about twenty activities in such areas as fitness, nutrition, weight loss, stress and smoking cessation (Longe & Wolf, 1984).

Canadian hospitals which are involved in health promotion vary considerably in the type of programs offered. The Toronto General Hospital has a Fitness Centre which provides programs such as fitness testing, fitness classes, instructional classes and health habit classes. The North York Branson Hospital Centre for Health Promotion provides programs related to risk evaluation,

smoking, weight control, fitness, stress, and diabetic education. The Women's College Hospital Wellness Program in Toronto offers nutrition classes, stress management, exercise classes, and other lifestyle activities. The Victoria General Hospital in Winnipeg is a Manitoba hospital that is attempting a wellness program for employees, patient and the community at large (Victoria General Hospital, 1985).

One of the features which is common to nearly every program attempting to promote health is the beginning entry stage of a needs assessment. This process provides an opportunity for a decision to be made about the need for programs.

A National Survey of Canadian hospitals in 1980 showed that 339 hospitals had active wellness programs (Leicester et al, 1981). The programs tended to be staff-directed, patient-directed and community-directed programs focused primarily on nutrition, smoking control, and alcohol and drug abuse. The methods used to promote health included audio-visual material (the most common) with individual assessment and counselling, lectures and small group processes being used almost as much. A more recent survey of all Canadian hospitals was carried out by the Canadian Hospital Association in 1985 (Thompson et al, 1986). The survey found that hospitals did perceive health promotion to be part of their role.

The community was least often the target for hospital-based promotion programs. Hospitals concentrated on health promotion as it relates to their traditional role as healers.

The same survey of all Canadian hospital (1,166) in November, 1985 (Thompson et al, 1986) indicated that health promotion is a higher priority for in-patients. In fact, 83 percent reported this as a high or medium priority. Employee programs ranked second (75 percent high or medium) with out-patients a close third (73 percent high or medium). Only 15 percent of the hospitals felt that health promotion was a high priority for the community. This same study also indicated that there was a relatively high level of involvement in activities or programs that were related to their present disease (60%). Only 23 percent offered on-going programs to help patients deal with risk factors not related to their conditions, with another 37 percent offering this type of program sometimes. More than half of the hospital (52%) provided information sessions for groups in the community. Of this number, only 20 percent offered these programs on an ongoing basis. Health advocacy, such as lobbying government for changes in health-related issues, was an ongoing activity for only 11 percent of the responding hospitals. It is interesting to note that another 36 percent reported this activity on an occasional or rare basis.

The programs offered by the Canadian hospitals to outside businesses and organizations ranged from nutrition counselling and smoking cessation clinics to periodic health examinations and screening programs (Thompson et al, 1986). Some of these programs were offered for a fee. The possibility of generating revenue certainly may alter some hospital's concern regarding program implementation.

An example of program delivery which involved a cooperative venture between a college and a health agency was the Santa Teresa Kaiser Program - Permanente facility (Deeds, 1985). The program was called 'More Effective Living'. The classes dealt with a variety of subjects dealing with daily problems of living. The most popular courses were in the areas of relaxation, weight control, communications, stress reduction and anxiety, marital problems and exercise.

Angus and Manga (1986) in their discussion of the need for a 'New Perspective' indicate that there are projects/programs in the priority areas of smoking, alcohol and drug abuse, nutrition and diet, physical fitness, health risk assessment and more recently a focus on safety, stress and mental health. There is also a much clearer understanding of the need to target programs to children, youth, women, low income groups, the elderly and native people.

This same emphasis is being suggested by "Achieving Health For All" (Health and Welfare, 1986). Whether the public perceives this same priority is not certain.

PARTICIPANTS

The public's perception of hospitals tends to be approached from the treatment perspective. Whether attitudes and practices would remain the same in regards to health promotion is uncertain. Wolinsky and Kurz (1984) examined factors that people consider important in choosing a hospital, as well as their feelings towards hospitals. Although it related to admission, the study suggested that quality of service surpassed that of the price of the service. As well, the study indicated that attitudes of respondents toward hospitals were, in general, negative.

In 1984 the Professional Research Consultants, Inc., Omaha, Nebraska and Hospitals magazine conducted a survey of 1,000 consumers regarding which hospital provides the best care. This survey concentrated on nine service categories (emergency, maternity, and cardiac care; day surgery hospital care for women and the elderly; cancer care; alcohol and drug treatment; and psychiatric treatment). In general, consumers most able to associate a hospital with a specific service have family

physicians, have seen or heard health care advertising recently, are former hospital patients, and work in the health care industry. Those least able to associate the hospital with a service include the elderly, single individuals, those with less than high school educations, and household with annual incomes less than $15,000 (Powills, 1986). Since health promotion has not been seen as a hospital service, associating hospitals with health promotion may also be unlikely.

The learning behaviour of Canadians gives an indication about needed structural changes. The Canadian Association for Adult Education (1980) commissioned a Gallup Poll to assess the learning behaviour of Canadians. The profile of the learner that emerged shows that one in five adults participates annually in organized educational programs. Learners tend to have post-secondary education, an income over $30,000.00 , be employed, be from a city with over 100,000 people, and belong to a union. Men participate more than women. "To be healthy is to be able to be flexible, imaginative, to reflect - to learn" (Ironside, 1985, p. 35). Is it reasonable, then to assume that the profile of those who do or will participate in health promotion activities will be similar?

Klegon et al (1982) in their study on the acceptability of Health Maintenance Organizations and outpatient clinics indicated

that preferences for alternative delivery arrangements were unrelated to specific demographic data which was inexpensive and readily available. Instead, preference for alternative delivery modes was related to attitudes such as satisfaction with the regular source of care.

Jackson and Jensen (May, 1984) surveyed 1,000 consumers of health care in regards to alternative services. Only 23% of those surveyed had participated in hospital-sponsored health education programs. The break down of figures included the following: 34% of those between ages 25 and 34 had participated in some type of hospital-sponsored health education programs, as had 18% of those between 18 and 24, 20% of those between 35 and 44, and 14% of those between 45 and 64. Those with education beyond high school were more likely to have participated than those with less education.

Studies such as these would indicate that demographic factors do influence participation in health care services. Once again, whether this can also be applied to participation health promotion is uncertain.

DEMOGRAPHICS

Morris and Windsor (1985) telephone surveyed 402 adults between the ages of 20 and 69 years of age. The results of this study warrant note, but caution about generalizability is needed because a high proportion of the population was black. Female respondents outnumbered men by a ratio of two to one. Females more often than males responded to telephone interviewing in that study on personal health practices of urban adults in Alabama - Davis Avenue Community Study. This same study identified that about one in four men and one in three women rated their health status as fair or poor. The older men and women in the community perceived themselves as being in poor or fair health. Morris and Windsor also found that one in three of the respondents reported that they were doing a fair to poor job of taking care of themselves. Their data suggested that the older man or woman tends to take care of his or her own health problems first, more so than the more educated, younger respondents. As well, a much larger proportion of women than men (46 versus 29 percent) reported that they worried a great deal about their health. This same study suggested that 68 percent of the men and 79 percent of the women were extremely positive about health promotion programs such as exercise,smoking cessation, diet, stress management and

weight control. Two-thirds of those interested were willing to defray part of the cost.

Inguanzo and Harju (January, 1985) surveyed a stratified random sample of 1,000 geographically represented U.S. house-holds in 48 states by random digit dialing. They found that women were responsible for making most health care decisions including which hospital or doctor. They also found that income made a difference in people's perceptions of hospital services. Households with an annual income of less than $15,000.00 are least able to associate specific services with a hospital.

Rynne (1985) also identified that women are the major customers of health care services because they are the ones who make the decisions where to obtain health services for their families.

Strum (April, 1984) indicates that women continue to maintain control of the family's discretionary health care dollar and are the primary purchasers of health care services. Women, in general, use health services more than men do and they are probably the persons who see to it that the children and male counterpart get appropriate care.

In a more limited focus in health promotion, Kleinman and Kopstein (1981) showed evidence that women at the highest risk of

cervical cancer according to age and socio-economic status have the lowest rate of participation in screening programs. This would imply that the problem lies in overcoming the age and socio-economic factors which prevent participation.

It is the poor who live in dangerous environments, who lack the necessities and amenities, whose work is stressful and unfulfilling, and who are isolated from sources of information and encouragement (Buck, 1985). The elevated rates of death and disability among the poor is a fact even in countries with publicly financed health care (Forster, 1976). Cassel (1976) reviewed supporting evidence that environmental stressors, often created by poverty, act to increase susceptibility to both physical and mental diseases, as well as 'unhealthy' habits.

Earthrowl and Stacy (1977) identified a higher utilization of emergency care over planned diagnostic and therapeutic actions by the poor. However, Rundle and Wheeler (1979) argue that this is the case because the poor are often directed toward providers who do not encourage preventive approaches.

Inguanzo and Harju (1985) indicated that cost was not an important factor to people when deciding on a hospital for non-emergency care. The degree of loyalty to a particular hospital varies. The people indicating the strongest loyalty

included those over 55 years of age and with a household income under $15,000.00. Those exhibiting a significantly low degree of loyalty include those under age 25, college graduates, and with household incomes between $25,000.00 and $40,000.00. The reasons for preferences included good medical care, proximity, tradition, and doctor's recommendations. These factors may also apply to preferences in health promotion if behaviour is assumed to remain unchanged from health care to health promotion. Wechsler et al (1979) in their study of individuals of various socio-economic conditions in the Boston area, found several differences. Perceptions of their health status differed significantly. Individuals of lower socio-economic conditions were more likely to view their health as fair or poor. As well, higher socio-economic individuals more often reported participation in physical activity and reported attempts at having adopted healthier lifestyles.

Inguanzo and Harju (February, 1985) found that the relatively low importance given to hospital costs compared to factors such as type of care was a nationwide attitude in the U.S. Variations do exist in some segments of the population. As age increases, the importance of costs increases, with those over 65 years exhibiting the greatest concern. The more education a person has and the higher the household income, the less the importance attached to

cost. As well, males are less likely than females to attach importance to cost when selecting services.

SOURCE OF INFORMATION

Inguanzo and Harju (April, 1985) found that how consumers receive health information is largely attributed to whether or not the person had a regular family physician. Those more likely to have a family physician were 55 years of age or older, female and married. These individuals were more likely to regard the physician as their source of information. On the other hand, those least likely to have a physician were single, male and under 35 years of age. Those individuals relied on the physician to a lesser degree. Opinions of friends and relatives was the major source of information for 27 percent of the population. The importance of newspapers as a source of information was consistently low across all segments of the population. As well, all segments considered local hospital mailings as unimportant. The segment who most frequently considered such categories as personal experience, television or radio as sources of information were those households with an annual income of $40,000.00 or more.

Nelson and Simmons (1983) in their study of primary care centres found that people generally hold their personal physician in high regard. This would make the physician an important source in influencing health attitudes and behaviours of their patients over the long term. Confidence in the source of information has an impact on any attempt made to change and sustain behavioural change (Mayer, 1982). A Pacific Mutual Life Insurance Company survey in the U.S. (1978) found that a third of the respondents felt that public service messages and publications of the American Heart Association, American Cancer Society and like organizations were useful and reliable sources of information about health. Even fewer believed what they read about health in newspapers and magazines and saw on television. Government publications, advertising and insurance company booklets were far down the list of credible sources. Employers, unions, friends and neighbours were at the very end. However, 70% indicated that their own doctors would be considered useful and reliable sources even though less than half of them indicated they were actually getting much information about health. This of course refers to people who see doctors. What about those who don't go to doctors because they are 'well'? Since hospitals are seen as representing doctors or at least closely associated with doctors it would seem logical

to give hospitals the same status and credibility (Cunningham, 1979).

SUMMARY

Health promotion programs in which hospitals are involved vary considerably. Their variability is often closely associated with the acceptance of health promotion as a part of the health care delivery system, as well as how health promotion is defined. The acceptance comes from government, the institution(s) and the individuals.

Many programs which are labelleed as wellness or health promotion in fact aim solely at the prevention of disease. The terms and their modes of practice are intermingled creating confusion for the public as well as for health care practitioners.

Sponsorship of health promotion programs has tended to be by fitness centres, voluntary agencies, spas and diet centres. The ever increasing numbers of such centres and their extensive marketing of the programs contests to their popularity. The uncertainty of hospitals as to their role in health promotion has deterred sponsorship of such programs.

The scope of hospital-based programs is still limited. The programs provided vary in relation to the groups being targeted.

The community is least often the target for health promotion programs. The hospitals in the United States have had more experience with health promotion programs and therefore, have ventured further into community programs. The tendency has been for hospital to concentrate on health promotion as it related to their traditional role as healers. The audience being the patients admitted to the hospital.

Participation in hospital-based health promotion has been identified based on participation in services traditionally provided by hospitals. The literature suggests that sex, age, income and education most often influence participation in health care services. The amount of influence of any specific demographic factor varies considerably.

The public's source of health information seems to be primarily from the physician. The physician continues to be a credible source. The literature suggests that the source of health information is influenced by age, sex, income and education.

CHAPTER III

METHODOLOGY

RESEARCH DESIGN

This investigation was a descriptive survey. This design was chosen because it would describe some aspects of the public's perception of health promotion. The survey was a form of needs analysis. The initial phase of the needs analysis was aimed at determining current perceptions and behaviours of adults sampled by households within a defined area. This process aids in determining what people are looking for and the reasons underlying their decision to take advantage of or to reject a service (Ireland, 1977; Seaver, 1977). Proponents of strategic planning for hospitals have advocated this shift from product to consumer orientation (Flexner & Berkowitz, 1981; Thieme et al, 1981; Flexner, 1981). This concept calls for the effort to be spent on discovering the wants of a target audience and then creating the goods and services to satisfy them (Kotler & Zaltman, 1983).

Muller (1984) suggests that consumer surveys regarding health promotion and maintenance for the healthy population do not necessarily solicit stereotypical response which are believed to be due to limited knowledge, negative feelings, and lessened

control of the purchase decision.

POPULATION

Seven Oaks General Hospital is a community hospital that provides services to residents in the North End of Winnipeg, Manitoba. Although it's clientele do come from other areas, a defined catchment area is identified for the purpose of planning. The target population for this investigation was restricted to that catchment area. The geographical area is that identified by Seven Oaks General Hospital for service provision planning. Although not defined in this way by the funding body (Manitoba Health Services Commission), it is accepted for the purposes of the hospital's planning base. The specific area (See Appendix A) is bounded by Brookside Boulevard on the west, the Canadian Pacific Rail tracks on the south, the Red River on the east, and the Perimeter Highway (#101) on the north. The population of the area was estimated at 115,000 people, based on Seven Oaks General Hospital figures (Annual Report, 1986).

The population frame for the investigation composed all the adults in the catchment area who lived in households with telephone numbers. Adult is defined as any person 18 years of age or older. Housesehold, is defined as a housing unit (house,

apartment, group of rooms or a single room) which was occupied or intended for occupancy, as separate living quarters. There are an estimated 40,000 household in the defined area (Stats Canada, 1981). This particular area is multicultural in nature, a cultural mosaic of peoples represented by Ukrainian, Polish, Jewish, Phillipino, Asian, Oriental, Native Canadian and other cultures to a lesser degree.

SAMPLING PROCEDURE

Since the population from which the sample was selected was large, the formula for calculating sample size for large populations was used (Sampling and Statistics Handbook For Research in Education, California, 1980). The calculations were based on having the sample proportion within 0.05 of the true proportion with an associated confidence of 0.90. The rationale for this choice was in the interest of time and resources. Based on a 50% response rate, a sample size of 542 households was selected. Even though response rates to telephone surveys have been as high as 72 - 74 % (Siemiatycki & Campbell, 1984; Groves & Kahn, 1979; Frey, 1983; Dellman, 1978; Roger, 1976), response rates in health related surveys are uncertain. Therefore, 50% was chosen to be on the side of caution.

The sample was selected through random selection of household phone numbers. The area of interest is represented by nine (9) different three (3) digit prefix numbers. The four suffix numbers were randomly selected from random digit tables listed in "Sampling and Statistics Handbook For Research in Education: A Technical Reference for Members of the Research staff of the National Education Association and Its State and Local Affiliated Associations", California, 1980. The prefix numbers were then randomly selected. The January 1987 issue of "Who Called Me; telephone directory (Manitoba Telephone System, 1987) was used as a reference for discarding non-listed and nonresidential telephone numbers.

At the time of the telephone contact with the household, one adult was interviewed. Adult in this case was defined as an individual who was 18 years or older. The adult, interviewed was restricted to the one who was English speaking. English speaking meant that the individual was able to converse, comprehend and respond in the English language. Stats Canada (1981) indicated that about 70% of the population identified English as their mother tongue. It is assumed, however that a larger proportion can speak and understand English.

INSTRUMENT

The data were collected through phone interview. The interview schedule was developed for this investigation by the author (Appendix B). The guides used for the development of the questionnaire included the literature reviewed, the Oakwood Hospital Survey (Lichter et al, 1986) and the Durham Region Community Health Survey (Durham Region District Health Council, 1985).

The face sheet recorded the phone number and the interviewer's name. Similarly, information in terms of the date and day of the interview, the time the interview started, the time the interview terminated, and the number of attempts to reach the household were recorded. The interview itself started with questions that related to the individual's perception of health, how he/she rated their health, and how important health was to him/her. Literature indicates that men and women differ in how they rate health (Morris & Windsor, 1985; Strum, April 1984). Rating of health status also varies with age (Morris & Windsor, 1985; Gunter & Kolanowski, 1986) and socioeconomic status (Wechsler et al, 1979).

Questions relating to the individuals knowledge of and

participation in activities for maintaining health followed. Respondents were given an opportunity to indicate other activities in which they were involved. As well, they were asked whether they saw the hospital providing any activities and where such activities might be held. Information regarding where they heard about such programs and whether they would attend hospital sponsored programs was obtained. Inguanzo and Harju (April, 1985) suggested that an individual's source of information varied with age, income and sex. Klegon et al (1982), however, indicated that preference for alternative care was related to attitude such as satisfaction with source of care rather then demographic factors.

The final section focused on demographic information. Demographic data were limited to sex, age, education and income. The literature suggests that females are the prime decision makers in the area of health both for themselves and their families (Inguanzo & Harju, April 1985; Strum, April 1984; Rynne, 1985; Inguanzo & Harju, January, 1985). This would suggest some variation between sexes. Participation in activities aimed at health maintenance appear to vary with sex (Kleinman & Kopstein, 1981; Canadian Association for Adult Education, 1980; Morris & Windsor, 1985).

Age is shown to be a factor in relation to participation in as well as perception of health promotion activities. The older age group tends to have a stronger loyalty to a hospital (Inguanzo & Harju, 1985), and in fact look after their health needs (Morris & Windsor, 1985) but participate less in disease prevention (Yoder et al, 1985; Gunter & Kolanowski, 1986). Jackson and Jensen (May, 1984) suggested that there was variation in participation for the various age groups. In much the same way, both education (Powills, 1986; Jackson & Jensen, May 1984; Morris & Windsor, 1984 Inguanzo & Harju, 1985) and income (Powills, 1986; Canadian Association for Association for Adult Education, 1980; Kleinman & Kopstein, 1981; Inguanzo & Harju, 1985; Wechsler et al, 1979; Earthrawl & Stacy, 1977) are factors in participation. Just as these demographic factors are shown to influence participation, so do these factors influence people's willingness to pay for programs (Inguanzo & Harju, February, 1985).

The interview schedule/questionnaire was piloted on eighteen (18) people from another area of Winnipeg. The conditions of administration were the same as for the actual survey. The purpose of the pilot was to review the questions and the directions/instructions for errors and clarity; to determine the length of the questionnaire; and to clarify the recording

procedures. There was no difficulty with the pilot and only minor wording changes were made.

Categories for rating the responses were based on categories established by Longe and Wolfe (1984) (See Appendix C) as well as through eight (8) separate interviews of random individuals.

Content validity (the degree to which the questions measured the intended content area) of the interview schedule/questionnaire was established by having the questions reviewed by a panel of five (5) people. The panel of experts included individuals who worked in or were familiar with health promotion. All of the individuals were adults who held a minimum of a Master's Degree in related fields - Health Education, Adult Education, Health Administration and Social Work. One of the panel members was included in the target population.

DATA COLLECTION

Four interviewers were involved in the investigation, the investigator and three recruited individuals. The interviewers were paid a stipend for their involvement in the survey. The interviewers were recruited based on the following criteria.

The individual(s)

1. was an adult (over 18 years)
2. had a minimum of high school education
3. had a good work history
4. was able to express him/herself well in English
5. had a genuine interest in people
6. had a pleasant telephone manner
7. had self discipline
8. was available for the time frame

The interviewers were trained using several training techniques. These included home study, interviewing non-informed respondents, supervised interview and an interviewer's guide (Appendix D). The training included three (3) one and one half hour (1 1/2) sessions plus the provision of the interview schedule/questionnaire and interviewer guide for self study. The training agenda included the following topics:

1. presentation of nature, purpose and sponsorship
2. discussion of survey process
3. role of survey interviewer
4. profile of questionnaire
5. importance and advantage of following instructions

6. how to read questions
7. how to record answers
8. how and when to probe
9. working on the phone
10. editing
11. reporting to investigator

Inter rater reliability was achieved on the basis of 100% agreement on demographic factor information and an 88% mean agreement on the remaining questions (range 75 - 100%). This was established on three (3) taped interviews. The reliability was calculated for each question by percentage agreement with the predetermined acceptable rating.

Each interviewer was given a list of phone numbers and instructed to call them in the order listed. The interviewers identified themselves as calling from Seven Oaks General Hospital. The calls were made at various times of the week. The hours included between 6:00 p.m. to 9:00 p.m. Sunday through Friday and between 10:00 a.m. and 5:00 p.m. on Saturday. These hours were chosen to maximize the chance of finding an adult at home. Studies by Vigdenhaus (1981), Weeks et al (1980), and Fitti (1979) supported the times chosen for this investigation. If the

telephone was busy or was not answered, the interviewer was instructed to call back. The maximum number of tries was set at three (3). The interview was conducted in English with only one adult of a household. The interviews were completed during the time frame June 11 - June 30, 1987. Due to the multicultural nature of the area, if language difficulty was encountered, an English speaking person was requested or the call was made at another time when an English speaking person from that household was present. To control for interviewer effect several precautions were taken. These included central phoning and the provision of the interview guide for reference. Field editing was used also. The interview schedule was edited by the interviewer immediately after the interview and edited by the investigator within forty-eight hours. During the survey period, sporadic observations of interviews were made.

Every effort was made to encourage response. These included:

1. the time of the call - alternate arrangements were made if the call was inconvenient
2. the use of an introduction format
3. the length of the interview - the average time was found to be about 10 minutes
4. the emphasis on the importance of the response

5. the answering of common questions - for consistency, the responses to common questions were available in the interviewer guide.

Since initial contact and follow up were by phone, information from those refusing to respond to/participate in the interview was requested at the time of the initial phone contact.

The information requested was limited to the reason for refusal and demographic data. Recognizing the decreasing tolerance of phone surveys, no further contact was made to those who refused to participate. It was important to maintain as positive a relationship as possible with the public by minimizing the risk of antagonizing them. Comparisons on demographic factors were made between those refusing to respond and those responding.

A follow-up of non-respondents was made within a few weeks of the initial survey. Non-respondents were defined as those households where contact with an English-speaking adult could not be made during the initial three attempts. Contact of a sample of the non-respondents was made by telephone. The same procedures were used in surveying this sample as was used in the initial survey. The telephone calls were made during the week of July 20, 1987.

The sample of non-respondents was selected by systematic random sampling. The numbers of the households not responding were ordered numerically, based on their original household number. That population size (94 households) was not an exact multiple of the sample size (13 households). Therefore, the sampling interval was chosen to be the whole number immediately below the ratio $\frac{N}{n}$ or $\frac{94}{13}$ or 7. Thus a unit/household telephone number was selected at random from among the first seven (7) households in the frame. Random number tables from "Sampling and Statistics Handbook For Research in Education" (1980) were used to select the first household telephone number. Then every seventh household telephone number thereafter was selected until the sample size of 13 was determined.

Comparisons were made between the non-respondents and respondents to determine if there was a difference.

O'Neil (1979) studied the bias introduced by non-respondents in a general topic telephone survey in Chicago. The findings indicated that non-respondents differed from respondents in occupation, education, income, race country of ancestry and housing status. The differences however, never

exceeded 2.2 percentage points. He concluded that for most general topic telephone surveys, the bias introduced by refusals does not alter major findings. Even though this survey is more specific in nature, it is assumed the differences will be similar and will not alter findings.

More recently, Siemiatycki and Campbell (1984) used a similar approach by comparing initial telephone respondents with all respondents participating in a 1974 health survey in Montreal. The initial response rate of the telephone survey of 1,595 adults was 72.7%. This rate increased to 88.2% with mail and in-person follow-up. The researchers noted that when the initial telephone sample was compared with the final sample, very few differences were found.

Groves and Kahn (1979) reported response rates for national telephone samples of 70.4 percent and of 74.3 percent for the face-to-face surveys. In general, response rates for face-to-face surveys have been found to be higher than those for telephone and mail surveys (Frey, 1983). In addition, all categories of non-response tended to be higher for metropolitan areas. When comparing the response rates for all three methods, Siemiatycki (1979:241), using a regional sample, found rates of 70.3 percent for mail, 73.5 percent for telephone, and 84.1 percent for

face-to-face. Dellman (1978) and Roger (1976) provided ample evidence for a similar distribution of rates.

Telephone surveys are increasingly being used in public health research (Marcus & Crane, 1986). Telephone surveys have become a viable alternative to the more costly mail out questionnaire. The popularity of telephone surveys has increased because of the increase in proportion of households with telephones - from 81% in 1967 to 93% in 1981 (Massey, 1986). Figures were not accessible from Manitoba Telephone. However, Health and Welfare Canada (1987) indicated that about 3% of Canadians did not have telephones. Therefore it is estimated that about 4% of the population may have been excluded.

DATA ANALYSIS

The data were coded and computerized for analysis. Descriptive procedures were used to analyze the data. Frequency distributions were used to profile the respondents and to report response patterns in percentages. Differences between percentages were examined using the chi square test. The chi square, a nonarametric test of significane, was selected because the nominal scale of measurement was used for responses on the interview questionnaire. The chi suare test of significance is appropriate

for data using percentages or proportions (Gay, 1981). In this test the null hypothesis is assumed to be true, that is, there is no difference between the groups being compared. The statistical evaluation of the null hypothesis is based on an index that compares the observed fequency with the expected frequency in each cell. The X^2 statistic consists of the sum of the observed frequency of each cell minus the expected frequency for that cell, squared and then divided by each cell's expected frequency. This sum is then compared to the critical value of X^2 at the appropriate degree of freedom and desired level of significance. If the calculated value of X^2 exceeds the critical value the null hypothesis is rejected.

The null hypotheses were tested at a significance level of 0.05. This significance level of 0.05 was used to protect against the high possibility of Type II error which could result in abandoning or misdirection of a potentially preferred direction of service for the institution. The large sample size of 326 subjects also protects against the possibility of Type II error at a 0.05 significance level. This level of significance still allows for maintaining the maximum probability of a Type I error at 0.05 which is reasonable for the purposes of this investigation

(Gay, 1981). The critical values of X^2 0.05 were obtained from 'Statistical Reasoning in Psychology and Education Second Edition (Minum, 1978).

The analysis of Hypothesis I was based on the response to the importance of health (#1). The analysis of Hypothesis II and Hypothesis III was based on the response to what the hospital should be doing to promote health (#9). However, Hypothesis III tested the significance of demographic factors (questions #14, #15, #16, and #17) in relation to what the hospital should be doing. Hypothesis IV analysis tested the significance of demographic factors in relation to programs and activities in which individuals were presently participating (#5). The analysis of Hypothesis V was based on the response to preference of location for programs (#10). Hypothesis VI tested the significance of demographic factors in relation to source of health information (#7). The remaining data were summarized to indicate response patterns which further identified perceptions in relation to health promotion and programs.

CHAPTER IV

RESULTS

DEMOGRAPHICS AND GENERAL FINDINGS

The total number of household phone numbers selected for the sample was N=542. Of that total, 71 household telephone numbers were excluded due to the numbers being out of service, the numbers having been changed, the persons reached being non-English speaking individuals (less than 5%), or the persons reached were not adults (ie. over 18 years). The sample for the survey consisted of N=471 respondents. Three hundred and twenty-six (326) of the sample responded, 51 refused to participate, and 94 were unable to be reached even after three attempts. The response rate was 69.21%. Of the 326 respondents interviewed, 68.10% (222) were female and 31.90% (104) were male. This sex distribution under represented males and over represented females when compared with the distribution provided by Stats Canada, 1981 (Males 47%, Females 53%).

The age distribution of the respondents was similar to the age distribution data from Stats Canada, 1981 for the region.

Table I indicates the age distribution provided by Stats Canada (1981) as compared with the sample.

TABLE I: AGE DISTRIBUTION

AGE CATEGORY	STATS CANADA (1981)	STUDY SAMPLE
18 - 24 *	22.5%	12.88%
25 - 34	21.8	22.39
35 - 44	13.47	17.48
45 - 54	12.42	12.58
55 - 64	14.25	12.58
65 +	15.5	21.6

* Stats Canada (1981) age category is 15-24 years while the sample age category was 18-24 years.

The sample in this investigation was over represented by the 65+ age category and slightly under represented by the 18 - 24 age category. The high percentage of older adults may not be unusual in that Manitoba has the highest number of older adults in Canada (Stats Canada, 1981). A large number of the older adults may in fact be concentrated in the area being studied.

The distribution of the education levels of the respondents of the sample suggests an under representation of the lower education level. Table 2 compares the distribution of educational levels between the population and the sample.

TABLE 2: DISTRIBUTION OF LEVELS OF EDUCATION

LEVELS OF EDUCATION	STATS CANADA (1981)	SURVEY SAMPLE
Grade School	24.63%	17.48%
* High School	43.2	59.45
* University	13.5	17.99
* Other **	18.67	4.57

(Weighted N = 324)

* Includes that level of education with or without certification.

** 'Other' includes trade certification or diploma and any other non university education.

The income categories of the respondents are compared to that of the population in Table 3. Stats Canada (1981) figures are based on differential income levels for males and females. As a result, the comparisons are based on different income categories. The comparison indicates that the lower income category was under represented in the survey sample.

TABLE 3: DISTRIBUTION OF INCOME CATEGORIES

INCOME CATEGORIES	STATS ** CANADA (1981)	SURVEY SAMPLE
9,999	52.03%	28.72%
10,000 - 19,999	35.67	30.07
* 20,000 +	12.3	41.22

(Weighted N = 296)

* Stats Canada, 1981 excludes females

** Stats Canada, 1981 includes incomes from age 15 and up.

The sample in this investigation is reasonably well representative of the age distribution and educational level of the population. The age groups 25 - 64 years were within 4% of the actual distribution. The category 18 - 24 years was under represented by about 10% while the 65 + age category was under represented by about 6%. The sex distribution, however, over represents females. This may bias the results somewhat. However, the literature suggests that women make most of the decisions related to the health issues in the family. As a result, this may not influence the representativeness of the population in this regard. That is, assuming that females also make decisions related to health promotion. The degree to which the lower income category is not represented makes the generalization of the results tentative. The effect of income as a factor influencing health behaviours cannot be ignored.

Table 4 shows total respondents' perceptions of their health. The data in this table suggest that the respondents had a favourable perception of their health status. These findings mirrored those in Canada's Health Promotion Survey described in the "Active Health Report Highlights" (Health and Welfare Canada, 1987).

TABLE 4: PERCEPTION OF HEALTH STATUS

RATING	RESPONDENTS %
Excellent	15
Very Good	43
Good	29
Fair	12
Poor	1
TOTAL	100

Respondents were asked what health meant to them. Five percent of the respondents (19) indicated that they didn't know or had not thought about it; 38% (149) indicated health to be a general feeling of well-being; 22% (85) indicated it to be the absence of disease; and 23% (89) indicated that it meant being able to perform usual activities. The remaining 12% (46) indicated that health meant other things such as living a good lifestyle, enjoying life and longevity. This data suggests that there is still a tendency to view health in physical and functional terms.

Responses to what respondents were presently doing to maintain their health were as follows: 6% (35) of the

respondents were doing nothing; 35% (218) were eating a balanced diet; 31% (194) were involved in some form of exercise; 10% (61) were getting adequate rest; 10% (61) were visiting their doctor regularly; and 9% (55) were involved in other forms of behaviour (eg. not smoking, not drinking). Only 0.32% (2) respondents participated in any form of class-type presentations related to health programs. Responses indicate that exercise and proper nutritional intake were the primary health-maintaining behaviours. It is interesting that visiting the doctor regularly was not as frequently identified. This data suggests that the emphasis in the media on 'Participaction' and nutrition may be encouraging these behaviours over other behaviours.

ANALYSIS OF SURVEY DATA RELATED TO HYPOTHESES

HYPOTHESIS I

Research hypothesis (HR 1)

Adults show a greater concern for their health.

Null hypothesis (H01)

Adults do not show concern for their health.

As part of the questionnaire the subjects were asked about the importance of health to them. The distribution of responses is indicated in Table 5. An examination of the response distribution indicates that the majority (90.18%) of the adults rated their health as very important.

The hypothesis was tested with the chi square one variable test at 0.05 significance (Table 5). The critical value of $X^2_{0.05}$ with 3 degrees of freedom is 7.81.

Since the value of computed chi (744.94) > 7.81, the null hypothesis was rejected. Concern shown for health by adults is significant. Therefore, the research hypothesis is supported.

TABLE 5: IMPORTANCE OF HEALTH

RESPONSES	RESPONDENTS N	%
Very Important	294	90.18
Somewhat Important	29	8.90
Not Important	2	0.61
Don't Know	1	0.31

HYPOTHESIS II

Research hypothesis (HR2)

The hospital is not viewed as being involved in health promotion.

Null hypothesis (H02)

Adults do not view the hospital as being involved in health promotion.

As part of the questionnaire, the subjects were asked what the hospital should be doing to promote health. The distribution of responses is indicated in Table 6. An examination of the distribution indicates that 37.25% do not know what the hospital should be doing.

The hypothesis was tested with the chi square one-variable test at 0.05 significance (Table 6). One category, life saver programs, was excluded from the calculations because there were no responses in that category. As well, the refusals were excluded because there was only one refusal and this made up only 0.28% of the responses. The critical value of X^2 0.05 with 5 degrees of freedom is 11.07. Since the value of computed chi (58.79) > 11.07, the null hypothesis was rejected. In this case, the research hypothesis could be supported and the assertion was

made that adults do in fact believe the hospital should be involved in health promotion.

TABLE 6: WHAT THE HOSPITAL SHOULD BE DOING FOR HEALTH PROMOTION

RESPONSE CATEGORIES	RESPONDENTS N	%
Health Education Programs	52	14.57
Behaviour Change Programs	18	5.04
Wellness & Lifestyle Programs	39	10.92
Self-Care Programs	8	2.24
Other	64	17.93
Nothing	42	11.76
*Don't Know	133	37.25

(* Response Category Excluded From the CHI Calculations)

Even though 37.25% of the respondents didn't know what the hospital should do to promote health, 14.57% felt that health education programs particularly related to heart, cancer, arthritis, diabetes and AIDS should be provided. The behaviour change programs identified were primarily weight control. The wellness and lifestyle programs referred mostly

to nutrition and physical fitness. The 'other' category made up 17.93% of the responses. The activities identified in the 'other' category are detailed in Table A, Appendix E. Of note, is that 11.76% of the responses indicated that the hospital should not be involved in health promotion. The primary reason was that hospitals should 'look after the sick' and any further programs would only cost more money.

HYPOTHESIS III

Research hypothesis [HR3]

Adult views of the hospital's involvement in health promotion is related to demographic factors.

Null hypothesis HO3

There is no difference in the view of the hospital's involvement in health promotion

a) between adult males and females

b) among different adult age categories

c) between adults of varying education levels

d) between income categories

Subjects were asked to indicate what they thought the hospital should be doing to promote health. The distribution of responses by sex, age categories, education levels and income

category were tabulated. The distribution of responses for these demographic factors are indicated in Table 7, Table 8 Table 9 and Table 10 respectively. The hypothesis was tested with the chi square test of the independence of paired categorical variables at 0.05 significance. One category, life saver programs, was excluded from the calculations because there were no responses in that category. The refusals (10.28%) were excluded from the calculations. Due to the low number of responses in some of the cells and in order to meet the condition of having adequate numbers in each of the cells; age categories, education levels and income categories were combined. The combining of the age categories was based on the ages frequently identified in the literature (Inguanzo & Harju, Apr. 1985, Feb. 1985; Zapka & Love, 1985; Kleinman & Kapstein, 1981; Powills, 1986; Jackson & Jensen, May, 1984; Morris & Windsor, 1985). The combining of education levels was based on those of Powills (1986) and Jackson & Jensen (May 1984). Income categories were based on the work of Inguanzo & Harju (April, 1985 & Jan. 1985).

TABLE 7: DISTRIBUTION OF RESPONSE FOR EACH CATEGORY OF THE HOSPITAL'S ROLE IN HEALTH PROMOTION BY SEX

CATEGORY	SEX	
	MALE	FEMALE
Health Education Programs	14	38
Behaviour Change Programs	5	13
Wellness & Lifestyle Programs	12	27
Self-Care Programs	1	7
Other	28	36
Nothing	19	23
Don't Know	35	98

Value of calculated chi (11.60) $< X^2_{0.05\ df6}$ (12.59)

TABLE 8: DISTRIBUTION OF RESPONSES FOR EACH CATEGORY OF THE HOSPITAL'S ROLE IN HEALTH PROMOTION BY (COMBINED) AGE CATEGORIES.

	AGE CATEGORY					
RESPONSE CATEGORY	18-24	25-34	35-44	45-54	55-64	65+
Health Education Programs	8	14	10	4	7	8
Behaviour Change Programs	3	4	6	3	1	1
Wellness & Life-Style Programs	7	9	10	6	0	7
Self-Care Programs	0	1	1	2	1	3
Other	12	15	16	11	4	6
Nothing	3	6	9	5	3	16
Don't Know	14	31	17	14	25	31

The value of calculated chi (46.70) > X^2 0.05 df30 (43.77)

TABLE 9: DISTRIBUTION OF RESPONSES FOR EACH CATEGORY OF THE HOSPITAL'S ROLE IN HEALTH PROMOTION BY INCOME

	INCOME					
RESPONSE CATEGORY	<9,999	10,000-19,999	20,000-29,999	30,000-39,999	40,000-49,999	>50,000
Health Education Programs	11	17	12	5	3	2
Behaviour Change Programs	6	4	2	3	2	0
Wellness & Life-Style Programs	5	13	9	7	2	0
Self-Care Programs	3	1	2	1	0	0
Other	12	15	16	11	5	2
Nothing	12	8	11	5	0	1
Don't Know	41	39	20	13	1	1

Value of calculated chi $(32.66) < X^2$ 0.05 df30 (43.77)

TABLE 10: DISTRIBUTION OF RESPONSES FOR EACH CATEGORY OF THE HOSPITAL'S ROLE IN HEALTH PROMOTION BY EDUCATION LEVEL

CATEGORY	EDUCATION LEVEL NONE	Gr. 1-8	Gr. 9-12	UNIVERSITY
Health Education Programs	1	4	27	17
Behaviour Change Programs	1	1	10	6
Wellness & Life-Style Programs	0	4	25	9
Self-Care Programs	0	2	4	0
Other	0	2	42	16
Nothing	2	7	25	7
Don't Know	3	32	79	14

The value of calculated chi (39.11) > X^2 0.05 df18 (28.87)

The difference in view of the hospital's role in health promotion was significant only for age categories and education levels ($p < 0.05$). Sex and income categories were not found to be significant. Therefore, the null hypothesis was rejected and the research hypothesis supported for only the age categories and education levels.

Regarding the respondents knowledge of what Seven Oaks General Hospital is presently doing, 79% were not aware of any health promotion programs. Twenty-one percent were aware of programs but were only able to identify fitness, seniors classes and self-help groups.

HYPOTHESIS IV

Research hypothesis (HR4)

Adult participation in health promotion is influenced by demographic factors.

Null hypothesis (H04)

There is no difference in participation in health promotion a) between male and female adults

b) among different adult age categories

c) between adults of different education levels

d) between income categories

Subjects were asked to identify the programs/activities related to health promotion in which they were presently participating. The distribution of responses are indicated in the following tables: Table 11 (responses by sex), Table 12 (responses by education level), Table 13 (responses by income category), and Table 14 (responses by age category).

The hypothesis was tested with the chi square test of independence of categorical variables at 0.05 significance. For all demographic variable there were no responses for the life saver program category and refusals, therefore they were excluded. The age categories, education levels and income categories were combined in the same manner and for the same reasons as in the hypothesis 3 testing.

TABLE 11: DISTRIBUTION OF MALES AND FEMALES PARTICIPATING IN CATEGORIES OF HEALTH PROMOTION

ACTIVITY CATEGORIES	SEX	
	MALE	FEMALE
Education Programs	1	3
Behaviour Change Programs	3	7
Wellness & Lifestyle Programs	34	49
Self-Care Programs	0	4
Other	13	15
None	56	150

Value of calculated chi (9.94) < X^2 0.05 df5 (11.07)

TABLE 12: DISTRIBUTION OF PARTICIPATION IN CATEGORIES OF HEALTH PROMOTION PROGRAMS BY EDUCATION LEVEL

	EDUCATION LEVEL			
ACTIVITY CATEGORY	NONE	GR. 1-8	GR. 9-12	UNIV.
Eduction Programs	0	1	0	2
Behaviour Change Programs	0	0	6	2
Wellness & Lifestyle Programs	2	7	51	20
Self-Care Programs	0	1	1	1
Other	1	2	18	7
None	4	39	123	30

The value of calculated chi (18.80) $< X^2_{0.05\ df15}$ (25.00)

TABLE 13: DISTRIBUTION OF PARTICIPATION IN CATEGORY OF HEALTH PROMOTION PROGRAMS BY INCOME CATEGORIES

ACTIVITY CATEGORY	INCOME CATEGORIES					
	<9,999	10,000-19,999	20,000-29,999	30,000-39,999	40,000-49,999	>50,000
Education Programs	1	0	1	2	0	0
Behaviour Change Programs	3	2	4	0	0	1
Wellness & Life-Style Programs	17	27	16	9	5	4
Self-Care Programs	2	0	1	0	0	0
Other	8	7	5	5	2	0
None	58	54	42	23	4	2

The value of calculated chi (26.82) $< X^2_{0.05\ df25}$ (37.65)

TABLE 14: DISTRIBUTION OF PARTICIPATION IN CATEGORIES OF HEALTH PROMOTION PROGRAMS BY AGE CATEGORIES

	AGE CATEGORY					
ACTIVITY CATEGORY	18-24	25-34	35-44	45-54	55-64	65+
Education Programs	0	1	0	0	2	1
Behaviour Change Programs	3	3	3	1	0	0
Wellness & Life-Style Programs	21	26	16	5	4	11
Self-Care Programs	1	0	0	1	0	2
Other	5	11	4	1	1	6
None	14	36	35	34	34	51

The value of calculated chi $(61.84) > X^2_{0.05\ df25}\ (37.65)$

The difference in participation in health promotion program/activities was significant only for age categories ($p < 0.05$). Sex, education level and income categories were not found to be significant. Therefore, the null hypothesis was rejected and the research hypothesis supported only for age categories.

The subjects who do participate in programs/activities related to health promotion do so independently. That is, 46% participate in self initiated activities. These are primarily exercise activities. Eighteen percent participate in government agency sponsored programs and 25% participate in private organization sponsored programs. Only 5% participate in volunteer agency sponsored programs and less than 1% participate in any health promotion programs sponsored by the hospital.

The manner in which the subjects found out about the programs was primarily through brochures (19.48 %) newspaper (16.67%), by word of mouth (5.26%), television (14.46%), and other (14.06%). The 'other' category was primarily through their own initiative, or through posters at places they frequent. The least identified source of communicating what programs were available was the radio (4.82%).

HYPOTHESIS V

Research hypothesis (HR5)

Adults prefer to participate in health promotion activities outside the hospital.

Null hypothesis (HO5)

Adults have no preference for location when participating in health promotion activities.

As part of the questionnaire the subjects were asked about their preference for location of health promotion programs. The distribution of responses is indicated in Table 15.

The hypothesis was tested with the chi square one-variable test of 0.05 significance. The one refusal which made up only 0.39% of the responses was excluded from the calculations.

Since the value of calculated chi (65.09) exceeded the critical value (X^2 0.05 df3 = 7.81) the null hypothesis was rejected. Preference for location of health promotion is significant. Therefore, the research hypothesis is supported.

TABLE 15: LOCATION PREFERENCE FOR HEALTH PROMOTION ACTIVITIES

LOCATION	ADULTS N	%
At the Hospital	59	23.23
In the Community	107	42.13
Either	70	27.56
Don't Know	17	6.69

Even though 6.69% didn't express an idea as to which location they would prefer and 27.56% did not have a preference for either, nearly half (42.13%) of the 254 respondents indicated a preference for programs to be in the community. It is interesting to note that when respondents were asked whether they would attend programs held at the Seven Oaks General Hospital 38% indicated they would, and 35% indicated they would not and 27% were uncertain. The primary reason for not attending programs at the hospital was a lack of interest or desire and other resources met

their needs. When asked whether they would attend hospital-sponsored programs in the community 40% indicated 'yes', 30% indicated 'no' and 30% were uncertain. Reasons for not attending remained the same.

The location of choice in the community were community clubs (35.95%), schools (27.19%), and other health centres, and sports complexes. The locations least identified were church (1.51%) and the workplace (0.91%). No preference for location in the community was 7.55%.

HYPOTHESIS VI

Research hypothesis (HR6)

Adult sources of health information are related to demographic factors.

Null hypothesis (H06)

There is no difference in source of health information

a) between male and female adults

b) among different adult age categories

c) between adults with different education levels

d) between income categories

Subjects were asked to identify their present source of health information. The distribution of responses are indicated as follows: responses by sex in Table 16, responses by age category in Table 17, responses by education level in Table 18, and responses by income category in Table 19.

TABLE 16: SOURCES OF HEALTH INFORMATION AS INDICATED BY MALES AND FEMALES

	SEX	
SOURCE OF INFORMATION	MALE	FEMALE
Doctor	43	122
Print Media	26	45
Radio	11	12
Television	21	34
Magazines	18	36
Pamphlets/Brochures	11	31
Friends/Relatives	10	13
Formal Presentations	1	12
Other	12	21
None	11	11

The value of calculated chi (16.71) $< X^2_{0.05\ df10}$ (18.31)

TABLE 17: SOURCE OF HEALTH INFORMATION BY AGE CATEGORY

	AGE CATEGORY					
SOURCE OF INFORMATION	18-24	25-34	35-44	45-54	55-64	+65
Doctor	18	29	22	22	27	46
Print Media	8	15	13	7	11	17
Radio	2	6	3	3	4	5
Television	4	16	5	10	7	13
Magazines	4	18	13	7	6	6
Books	3	8	9	5	3	7
Pamphlets/Brochures	7	12	9	6	4	4
Friends/Relatives	9	4	3	4	1	2
Formal Presentations	4	4	3	1	1	0
Other	7	13	3	3	3	4
None	4	5	4	1	2	5

The value of calculated chi ^{2} (65.88) < X 0.05 df50 (67.50)

TABLE 18: SOURCE OF HEALTH INFORMATION BY EDUCATION LEVEL

	EDUCATION LEVEL			
SOURCE OF INFORMATION	NONE	GR. 1-8	GR. 9-12	UNIV.
Doctor	6	31	97	27
Print Media	1	11	38	16
Radio	0	5	15	3
Television	1	12	31	7
Magazines	0	3	34	14
Books	0	5	21	7
Pamphlets/Brochures	0	2	24	15
Friends/Relatives	0	2	11	9
Formal Presentations	0	0	7	5
Other	0	6	15	10
None	1	2	13	3

The value of calculated chi $(39.93) < X^2_{0.05\ df30}\ (43.77)$

TABLE 19: SOURCE OF HEALTH INFORMATION BY INCOME CATEGORY

SOURCE OF INFORMATION	INCOME CATEGORIES					
	<9,999	10,000-19,999	20,000-29,999	30,000-39,999	40,000-49,999	>50,000
Doctor	49	49	28	15	5	2
Print Media	15	20	17	11	2	2
Radio	4	4	5	5	2	0
Televsion	15	11	10	9	4	1
Magazines	11	11	17	9	2	1
Books	10	8	6	6	2	0
Pamphlets/Brochures	9	14	6	8	2	0
Friends/Relatives	6	7	6	1	1	0
Formal Presentations	4	3	1	4	0	2
Other	7	8	12	2	0	0
None	8	8	3	2	0	0

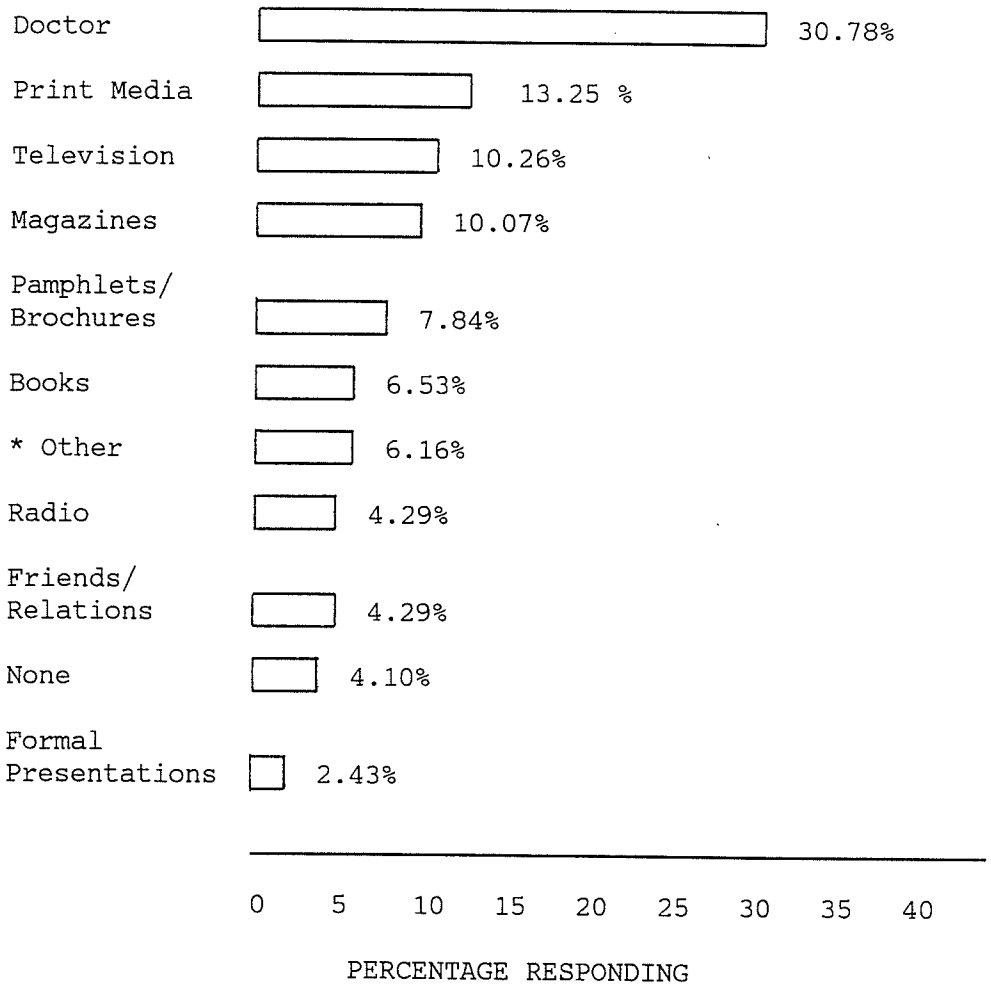
The value of calculated χ^2 (56.83) < $X^2_{0.05}$ df 50 (65.70).

The hypothesis was tested with the chi square test of independence of categorical variable at 0.05 significance. There were no refusals, thus refusals were excluded from the calculations. For the age, education and income variables, the categories were combined in the same manner and for the same reason as previously indicated.

The source of health information was not significant for sex, age, education level nor income. Therefore, the null hypothesis for all demographic factors was accepted. The research hypothesis could not be supported and the assertion made that the source of health information is not related to these demographic factors.

Multiple sources of health information were identified (Figure 1). The most common sources of health information were as follows: doctor (30.78%), print media (13.25%), television (10.26%) and magazines (i.e. Chatelaine, Readers Digest) (10.07%). The other sources mentioned as the sources of health information each have less than a 7 percent frequency of response. The type of information provided tended to be of a general nature. Disease specific (19.10%) and treatment oriented (21.44%) information was identified as being provided by the doctor while prevention/ promotion (23.9%) and general health information (other = 19.3%) was provided by television and written materials. Radio served as a source for some subjects as well.

Figure 1: PERCENTAGE UTILIZING VARIOUS SOURCES OF HEALTH INFORMATION



(* Others Includes Private Organizations, Workplace, & Hospital)

When asked what specific kinds of health programs respondents would be interested in participating, 27% of the respondents (108) indicated they were not interested in any programs at this time. Thirty-five percent (139) identified lifestyle and wellness programs, namely some form of exercise and nutrition. Sixteen percent of the respondents (63) identified educational programs on a variety of diseases (heart, cancer, AIDS) as well as child care. Thirteen percent of the respondents (5) indicated an interest in behaviour change programs such as weight loss, smoking cessation and stress management. The other categories were identified by less than 6% of the respondents.

Over half of the respondents who were interested in health programs (54%) preferred that the programs be held in the evening. Afternoon was preferred by 16% of the respondents (38) and these were primarily young mothers who also identified a need for child care. Eleven percent of the respondents preferred early morning because their preference was some form of exercise. Other times were identified as preferred times due to individual circumstances.

The respondents who were interested in health programs were primarily prepared to pay the cost of the programs (29% totally; 33% partially). Twenty percent were not prepared to pay, while

19% were uncertain. Those who were prepared to pay for part of the cost identified half the cost as a reasonable personal commitment.

ANALYSIS OF REFUSALS:

Fifty-one (51) subjects in the sample refused to participate in the telephone interview. Twenty-four percent (12) provided demographic information: 3 males and 9 females. Seventy-six percent (39) refused to provide any further information: 14 males and 25 females.

The age distribution of the subjects who refused to participate but provided demographic information were as follows: 17% of the subjects (2) were 18 - 24, 25% (3) were 35 - 44, 58% (7) were 65 and over.

Education levels of the subjects who refused to participate were provided by only nine of the respondents. Forty-four percent of the subjects (4) had attended or completed grade school (grade 1 - 8), 44% (4) had attended or completed high school (grade 9 - 12), and 11% (1) had attended or completed university.

Subjects who refused to participate provided information concerning income in only eight interviews. Sixty-two

percent of the subjects (5) had individual incomes of $9,999 or less; 13% (1) had incomes of $10,000 - $19,999; 13% (10) had incomes of $20,000 - $29,999; and 13% (1) had incomes of $40,000 - $49,999.

The sample of subjects who refused to participate but who did provide demographic data is not adequate to determine whether they are in any way demographically similar to the sample that did participate. However, the information provided would tend to suggest that those who did refuse were older, had lower incomes, and had less education.

The reasons given for not participating varied among the subjects. Thirty-three percent of the subjects (17) simply refused to give any reason and hung up the telephone; 51% (26) were not interested and did not like telephone surveys; and 16% (8) had no time to spend on the telephone.

ANALYSIS OF NON-RESPONDENTS:

Non respondents were defined as those household numbers where contact with an English-speaking adult could not be made during the initial three attempts. The sample size selected from the non-respondent households was 13. One household telephone

number was not a working line, therefore the final sample size was twelve (12) household numbers. Six (6) respondents were eventually obtained. The response rate was 50% which was lower than the response rate of the original sample. There were no refusals. There was no response from the remaining six household telephone numbers even after three separate attempts. Of the six respondents interviewed, 67% (4) were female and 33% (2) were male. This distribution is similar to that of the original sample.

The age distribution of the respondents was not represented by the 45 to 54 and the 55 to 64 age categories. Thirty-three percent of the respondents (2) were 18 - 24; 17% (1) were 25 - 34; 17% (1) were 35 - 44; and 33% (2) were 65 and over. The 18 to 24 and 65 and over age categories were over represented.

Education levels of the respondents were as follows: 17% of the respondents (1) had attended or completed grade school (grade 1 - 8) and 83% (5) had attended or completed high school (grade 9 - 12). The other education levels were not represented.

Income levels of the respondents were as follows: 33% of the respondents (2) had individual incomes of $9,999 or less; 50% (3) had incomes of $10,000 to $19,999 and 17% (1) had incomes of $20,000 to $29,999. The higher income levels were not represented.

The demographic difference between this sample and the original sample may be related to the time of the survey. The age category and income levels of those not represented may be accounted for by the fact that these households may have been on summer vacation.

The responses of this sample of non-respondents paralleled those of the original sample. All of the respondents rated their health as very important. All rated their health as good, very good or excellent. The responses regarding what health meant to them indicated a similar distribution. Most of the respondents did exercise and ate a balanced diet to maintain their health. Only one participated in a formal program and that was privately sponsored. Television was the primary source of information about the programs. The doctor was the main source of information (67%) and the information tended to be disease specific or very general in nature. Only one (1) person was aware of any existing programs at the Seven Oaks General Hospital. The majority did not know what a hospital should do to promote health. However, all would consider attending hospital-sponsored programs that were held at the hospital or in the community. The community club tended to be the preferred location in the community. The type of programs preferred were weight control and information regarding heart and

cancer. Evening was the preferred time and all were prepared to pay the total cost of the program(s).

CHAPTER V

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

DISCUSSION

The purpose of the investigation was to determine a community's perception of one hospital's role in health promotion. A form of needs assessment was carried out in the geographical area served by the Seven Oaks General Hospital. This descriptive study investigated the adult population's perception of health and health promotion; their present behaviour patterns of maintaining health; their knowledge of the hospital's current involvement in health promotion; their perception of the hospital's possible role in health promotion; their program preferences; and their demographic variables.

The investigation involved 542 adults from household selected by random selection of household telephone numbers. One English-speaking adult was interviewed per household. The interviews were administered by telephone by selected and paid interviewers. Three attempts were made to contact an adult in the household. The interviews were carried out during June and July, 1987.

The questionnaire used was developed for this investigation.

It was piloted on a group of people from another area of the city. The content validity was established by having the questionnaire reviewed by a panel of experts. The categories for rating the responses were based on established categories and by interviews with random individuals.

The final sample surveyed was N = 471 respondents with a response rate of 69.21%. This sample was reasonably well representative of the age distribution and educational level of the population. The sex distribution over represented females and the income categories under represented the lower income group.

The following section outlines the summaries of the findings in relation to the six (6) major hypothesis established.

HYPOTHESIS 1

Research Hypothesis: Adults show a greater concern for their health.

Null Hypothesis: Adults do not show a greater concern for their health.

The null hypothesis was rejected (x^2 0.05 df3 = 744.94 > 7.81), therefore, the research hypothesis is supported. The greater concern for health indicated by the respondents

is consistent with the general increasing public concern regarding health and health care services. The significantly greater concern may be influenced by the high proportion (86%) of the respondents rating their health as excellent, very good or good. The meaning of health to the respondents is very individual and the perception of health is influenced by one's cultural belief system. Therefore, the varied responses may be a reflection of the multicultural nature of the sample. However, health continues to be viewed primarily from a physical and illness/wellness perspective.

HYPOTHESIS II

Research Hypothesis: The hospital is not viewed as being involved in health promotion.

Null Hypothesis: Adults do not view the hospital as being involved in health promotion.

The null hypothesis was rejected (x^2 0.05 df5 = 58.79 > 11.07). The research hypothesis can be supported and the assertion made that adults believe that the hospital should be involved in health promotion.

Seventy-nine percent of the respondents were not aware of any

health promotion programs at the Seven Oaks General Hospital. The 21% who were aware of programs , identified the fitness program 70% of the time. The fitness program is sponsored by the Parks and Recreation Department and the space is provided by the hospital. Awareness of this specific program would suggest that it had more advertising within the community. The increased advertising may be related to its sponsorship. Hospitals have not been involved or have not seen the need to be involved in advertising their services. The care/cure role does not necessitate advertising while health promotion has to be marketed.

HYPOTHESIS III

Research Hypothesis: Adult views of the hospital's involvement in health promotion is related to demographic factors.

Null Hypothesis: There is no difference in the view of the hospital's involvement in health promotion

a) between adult males and females
b) among different adult age categories
c) between adults of varying education levels
d) between income categories.

The difference in the view of the hospital's role in health promotion was significant only for age categories (x^2 0.05 df30 = 46.70 > 43.77) and education levels (x^2 0.05 df18 = 39.11 . 28.87). Therefore, the null hypothesis was rejected and the research hypothesis supported for only the age categories and education levels.

Thirty-seven percent of respondents did not know what the hospital's role should be in health promotion. These respondents were primarily in the 35 - 44 and 55 - 64 age categories. Yet the findings of Powills (1986) suggest that the elderly were least able to associate a service with a hospital. The hospital's role in health promotion varies significantly with age of the respondents. The 65 and over age categories tended to see the hospital as not being involved in health promotion. Self-care programs tended to be identified more frequently with increasing age. This is consistent with the findings of Morris and Windsor (1985) which suggested that the older adults tend to participate in those activities that focus on their own health first. The life-saver programs were not identified by any of the age groups.

The 'other' category was most frequently identified. The programs suggested included various means of increasing

awareness about health. This included pamphlets displays, posters and classes - both in the hospital and in public places. It is interesting that even though this was frequently identified by the respondents, only 8% actually used pamphlets as a source of information. Clinics of various types were suggested. The 25 - 34 and 35 - 44 age categories identified that hospitals could promote health in the schools and provide various programs for the youth. Health education programs were equally identified by all age groups. The types of health education programs included cancer, heart disease, arthritis, hypertension and AIDS. Wellness and lifestyle programs were identified 11% of the time. These included various forms of physical exercise and nutrition. Although identified by most age categories, the 55 - 64 age category did not identify it as a role. The behaviour change programs included weight control and stress management and was identified mostly by the age categories below 54 years of age.

The level of education of the respondents was also significant in relation to the hospital's role in health promotion. The respondents with University education identified a greater role for hospitals in health education programs. This is supported by the finding of the Canadian Association for Adult Education (1980) which suggests that people with post-secondary

education have a greater propensity to continue to learn. This may include learning about ones health and how to maintain it. Those with elementary education (Grade 1 - 8) tended to identify the 'other' category more frequently. These again included pamphlets, displays and classes. Sex and the category of income of the respondents were not significant in relation to the hospital's role in health promotion.

HYPOTHESIS IV

Research Hypothesis: Adult participation in health promotion is influenced by demographic factors.

Null Hypothesis: There is no difference in participation in health promotion:

a) between male and female adults
b) among different adult age categories
c) between adults of different education levels
d) between income categories

Participation in health promotion activities was found to be not significant with the sex, education level and income categories of the respondents. The only demographic factor that was significant was the age category of the respondents

$(x^2\ 0.05\ df25 = 61.84 > 37.65)$ Therefore, the null hypothesis was rejected and the research hypothesis supported only for age categories. This would seem to suggest that energies available vary with age as may the state of health.

Sixty-one percent of the respondents were not involved in any health promotion activities at the time. The least involvement in health promotion was indicated by the age categories 45 - 64 years. The 25 - 34 age category was most frequently involved in health promotion activities. These activities tended to be wellness and lifestyle programs which included physical exercise and nutrition. The other age categories that did participate tended to favor the same types of programs. Lifesaver programs were not identified by any of the age categories. They may not be associated with the idea of health promotion. Self-care and behaviour change programs were identified to a lesser degree by all categories. This frequency of participation of the various age categories is consistent with Jackson and Jensen (May, 1984) for only the 25 - 34 age category which participated the most frequently. Personal motivational factors may in fact be greatest in that age category. As well, publicity may be geared to or at least is internalized by that particular group.

HYPOTHESIS V

Research Hypothesis: Adults prefer to participate in health promotion activities outside the hospital.

Null Hypothesis: Adults have no preference for location when participating in health promotion activities

The null hypothesis was rejected (x^2 0.05 df3 = 65.09 > 7.81) and the research hypothesis is supported. Thus, preference for location of health promotion programs/activities was found to be significant. The preference for location of hospital-sponsored programs was in the community. The general consensus of the respondents seemed to indicate that the location in the community be accessible and convenient.

How the respondents came to know of the programs varied considerably. Primarily the information about the programs was found in brochures, from other individuals, from the newspaper or from the television. This would suggest that several forms of advertising of programs would be preferable.

HYPOTHESIS VI

Research Hypothesis: The sources of health information for adults is related to demographic factors.

Null Hypothesis: There is no difference in source of health information.

a) between male and female adults

b) among different adult age categories

c) between adults with different education levels

d) between income categories

The source of health information was not significant for sex, age, education level nor income. Therefore, the null hypothesis for all demographic factors was accepted. The research hypothesis could not be supported and the assertion made that the source of health information is not related to these demographic factors.

Health information is obtained from the doctor 31% of the time. This is similar to the findings of Inguanzo and Harju (April, 1985) which was 45%. The source of information was not significant for any factors - age, education, sex or income. Even though only 10% of the respondents indicated that they visited their doctor as a way of maintaining health, the doctor was still seen as an important source of health information. This would suggest that doctors are seen as credible sources of information and therefore have a vital role to play in health promotion. Less than one half of one percent of the respondents attended any class-type of presentations and about 2% saw such presentations as a source of health information. This would suggest that other

methods should be considered when developing health promotion programs. The traditional type of presentation which has tended to be utilized in such programs may account for ineffectiveness of some programs. It is necessary for hospitals to know how the public/consumer receive health information. The more hospitals know of how the public is educated about health, the more effectively they can become better sources of information and the more effectively they can target their messages.

While there was some variation in the respondents present health-maintaining behaviour, exercise and eating habits are predominantly identified. This is contrary to the finding of Yoder et al (1985) who found that visiting the doctor rather than exercising and eating nutritionally was the major behaviour. This difference may be partially related to their interpretation of health promotion. The responses may also be affected by the emphasis on these behaviours and by the presence of information related to those behaviours that appear on buses, newspapers, radio, television, posters and pamphlets. "Human behaviour is largely dependent on the nature and quantity of information existing in the environment" (Labonte & Penfold, 1981; pg. 4).

The majority of respondents (62%) were not participating in any health promotion programs/activities. Those that were

participating in any such activities were primarily involved in some form of exercise. Most of those exercise programs were sponsored by private organizations. A large number of respondents, however, had individual regimes set up for themselves. This would indicate that at the present time health promotion programs generally and hospital-sponsored programs more specifically (few as they may be) are not being accessed. This is consistent with the finding of Keenan (1982).

CONCLUSIONS

It is clear from this investigation that health promotion is still viewed in a limited sense. Activities/programs are still viewed as individual behaviours primarily focused at exercise, nutrition and weight control to list a few. Efforts must be made to unify individual responsibility with social responsibility. "Health promotion programs would then include collective actions to alter the health-damaging aspects of our social environment as well as individual action to alter personally damaging habits" (Labonte' & Penfold, 1981; page 8).

Health and health promotion are attracting attention, even though this attention is only in its infancy in terms of

programs. The new vision of health is one where health is seen as "a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture, and our social, economic and physical environments" (Health and Welfare Canada, 1986; page 3). This focus implies the need for "public participation, the need for strengthening community health services and the need for strengthening community health services and the need for coordinating healthy public policy" (Health and Welfare Canada, 1986; page 3). Health promotion is therefore an approach which can develop along with and be integrated into the existing health care system. The hospital is one part of the health care system which may begin to take more of a responsibility to facilitate the promotion of health to its entire community. At Seven Oaks General Hospital this has been articulated in its mission statements and by-laws. The hospital has taken steps in that direction. These include the establishment of facilities for fitness for the staff and the public, the establishment of patient education programs, the development of weight control groups, the development of a 'Feeling Great' lecture series for Seniors, and the allocation of space for Support Groups. The need for this investigation was to begin to identify the publics/ consumers

perception of health promotion and their perception of the hospital's role in promoting health, as well as their interests in health promotion activities.

The issue selected for investigation was to establish a profile of a community's perception of a hospital's role in health promotion using a needs assessment process. As part of this process the data were analyzed in order to shed light on the potential role for the hospital in health promotion and to provide the basis for developing services and communications and estimating demands. The indication is that the hospital is seen to have a role to play in health promotion. However, this can occur only if efforts are made at marketing health promotion and the hospital's role in it. The planning of any such programs would do well to target groups, particularly age categories. Consideration of location outside the hospital is certainly warranted. Alternate sites in the community make health promotional activities more convenient to the public. This direction would also serve to establish the hospital as a health care service within the community and not separate from it. These factors support the findings of Jones (1982) who suggested that in developing health promotion programs, public relations and community image were the predominant reasons for program involvement.

Health promotion will undoubtedly emerge as a major feature of health care in the next several years. There is no doubt that the challenge exists. To ensure that the hospital does play a central role, it will have to respond affirmatively to that challenge. In today's complex world of health care, health promotion would seem to be one of the few areas in which everyone can be a winner - the hospital, it's patients and their families, it's employees, and the community at large. The role of the hospital in health promotion may vary from one of active participant to one of community catalyst. As a respected institution and as a resource of knowledge and expertise, the hospital must be willing to play a role in making the community healthier. It is important, however, to maintain perspective. The medical intervention model should be part of the health system, but not the entire system. This reorientation encourages the development of an expanded role for the institution and supports the needs of individuals and communities for a healthier life.

Hospitals are adaptive. This is witnessed by the growth in alternative systems and other organizational arrangements. The changes tend to occur in response to a changing environment. How successful hospitals are in the future in remaining the major

providers of health care depends on whether they are able to redefine their role in a changing environment and, equally important, on whether they are able to change their relationships with other providers.

RECOMMENDATIONS:

The concept of community focus is stated in the mission statement of the hospital. Support for integrating health promotion into the overall management plan of the institution is essential. The decision to develop health promotion as part of the service delivery must include consideration of the public, their physical and social environments, as well as their transactional nature.

The following recommendations are based on the findings and the conclusions drawn from this study. The recommendations emanating from this study are categorized into broad categories, namely staff development, community awareness, collaboration, program development, and public relations.

1. Staff Development

All health professionals within the institution have an opportunity and an obligation to promote better health and

prevent disease. These professionals need to be trained to view themselves as educators and models, as well as practitioners of a particular discipline. A well-informed and strongly committed group of professionals is required to overcome the obstacles which are confronted. Professionals also have a responsibility to share information they have acquired about health and disease with the general public, decision-makers and other professionals.

2. Community Awareness

Efforts must be made to increase community knowledge and awareness of the mental, emotional, physical, social and spiritual aspects of health. This awareness provides the opportunity for creating an informed, active public opinion regarding health and health promotion. Public opinion enables people to persuade governments to identify changes in policy that could make a contribution to better health. Hopefully, such a change in policy considers other sectors (housing, education) in society.

3. Collaboration

It is necessary for the hospital establish networks with other health and community organizations. This is necessary to sustain collaborative efforts through common concerns, common

goals, common strategies, common priorities, perhaps shared resources and cooperative action. The cooperation between organizations reduces the need for any special facilities. These facilities may and often do already exist in the schools and workplace. Continuous consultation, dialogue and exchange of ideas eliminates fragmentation, friction and duplications. The coordinated approach among the public, private and voluntary agencies can often assist in dealing the multiplicity of social, educational, and economic factors that influence health.

Collaboration enhances goodwill and cooperation between the hospital and the community. This process enables the hospital to begin to change its image from that of an institution that treats only the sick to one that is concerned about the health of the community.

The collaborative efforts must also include the physicians in the community. Having been identified as a credible source of health information, the physician is a necessary ally. Collaboration with individuals and groups within the community would enable the hospital to verify the results of this or any future investigation. This process serves to build a stronger base of understanding of the community and a more accurate perception of its needs.

4. Program Development

The hospital may consider establishing programs in conjunction with other community agencies and around the enthusiasm and positive experiences of professionals in the community. These individuals serve as positive role models and are seen as credible sources of health information (eg. physicians, employers, etc.). The initial focus of such programs may be to assist people in acquiring the art of being well. To provide persons or organizations with the knowledge and motivation to make informed choices. As well as to provide skills and support to assist them in effectively caring for themselves and others. The program development could give consideration to the framework for health promotion as suggested by Health and Welfare Canada (1986). The programs may include:

a) educational programs

b) workplace and community located health promotion

c) health resource centre

The programs would do well to support and build upon those activities the people are engaging in to maintain or improve their health. It is necessary to recognize programs will vary with age. These include fitness, sports,

nutrition, stress management and participation in community groups working to improve local facilities or to change the environment.

The utilization of identified sources of health information (eg. physicians print media) and/or the support from these sources would facilitate in program delivery and program acceptance.

5. Public Relations

The hospital could take a leadership role in promoting the idea and practice of health promotion. This may be by way of serving as an exemplary model or it may include providing information to its constituents.

The hospital may be more aggressive in undertaking to let the public know that health promotion programs are offered and/or supported by the hospital. This process would increase public awareness of programs and enhance the hospital's role in health promotion programs. The greater direct role that the hospital is able to play in this consumer education process, the better chance it has of enhancing its image and creating favorable perceptions.

As well, utilizing the support of credible individuals (physicians) and organizations within the community reinforces the program's credibility and acceptance and the hospital's dedication to health promotion.

In addition to the information from this investigation, the personnel involved in health promotion planning in the future may require additional data and information. Some of this data is currently available from the statistics being maintained on a regular basis. However, there are three areas of investigation which may be considered. These include:

1. How do staff and physicians perceive health and health promotion?
2. What are the current public relation practices/ strategies of the hospital as it relates to health promotion?
3. Is there variability in perception of health and health promotion by the major cultural groups in the area?

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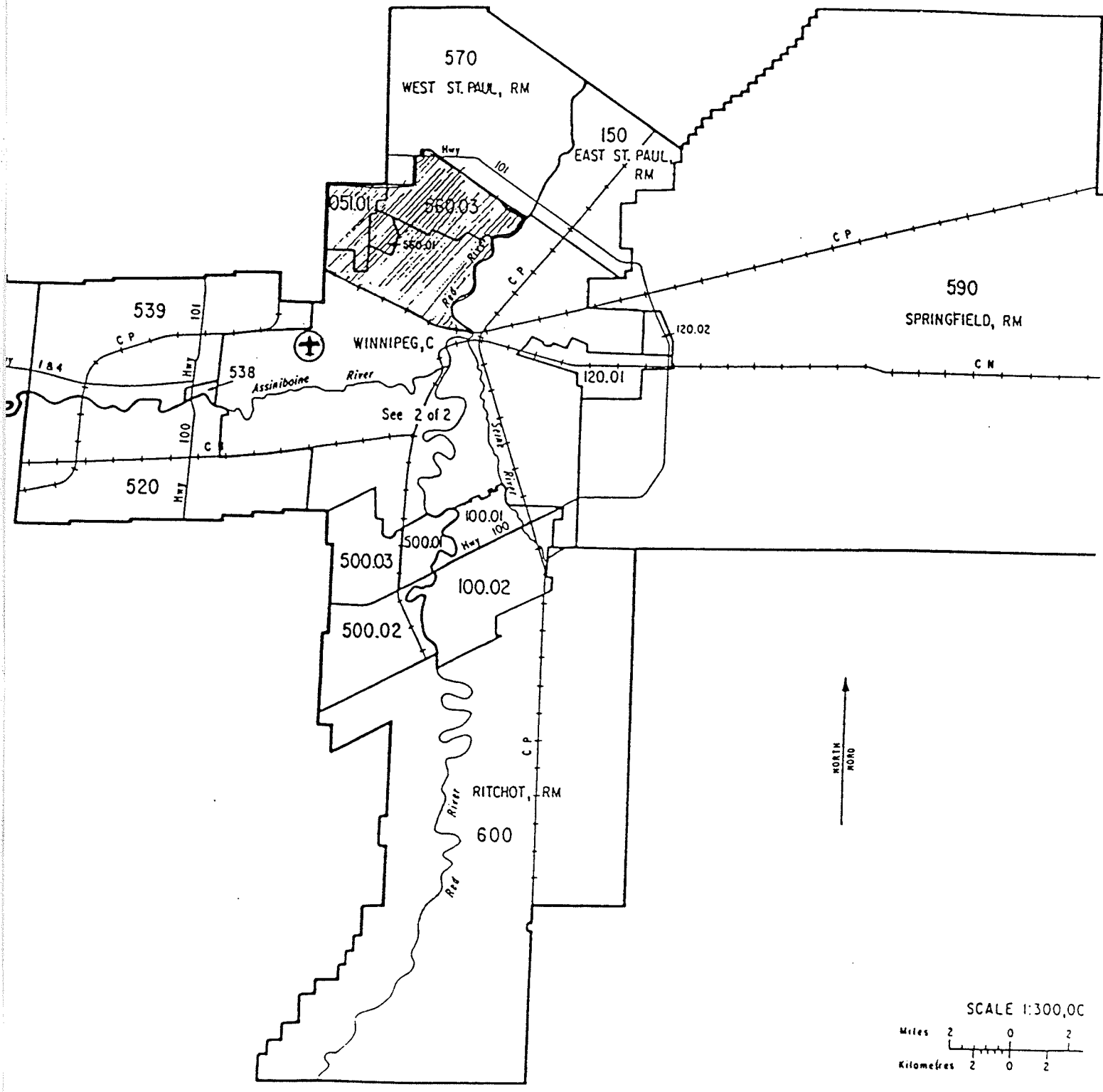
APPENDICES

Appendix A

Area Map of Winnipeg



Appendix B

Questionnaire

FACE SHEET:

PHONE NO.: _____ HOUSEHOLD NO.: _____

DATE OF INTERVIEW: _____

DAY (Circle): Mon., Tues., Wed., Thurs., Fri., Sat., Sun.

LENGTH OF INTERVIEW: _____ Minutes

NUMBER OF ATTEMPTS (Circle)

1 2 3

REASON FOR MORE THAN ONE ATTEMPT (Circle)

_____ NO REPLY 1

_____ BUSY LINE 2

_____ NO ONE OVER 18 YEARS 3

_____ LANGUAGE PROBLEM 4

_____ OTHER (State) _____ 5

COMPLETION:

TOTALLY COMPLETED 1

PARTIALLY COMPLETED 2

REFUSAL 3

INTERVIEWER'S FIRST NAME: _____

TIME STARTED: _____

SECTION I:

"HELLO, is this _ _ _ - _ _ _ _?"
(telephone no.)

(If it NOT the stated number: Terminate the call with something like "SORRY TO HAVE BOTHERED YOU". Also terminate if a nonresidential number is reached.)

(If it IS the stated number, proceed with the introduction.)

"My name is (full name) _____. I'm calling from the Seven Oaks General Hospital. We are conducting a study about health and are interested in your opinion. We would really appreciate your help. There are a few questions we would like to ask you. These questions should take only a few minutes (about 10 minutes). Feel free to ask questions at any time. OKAY? (Pause here!)

"First, are you 18 years of age or over?"

(If not, ask for someone who is and repeat "My name ..... your help").

"I want to assure you that everything you say is confidential and your name will not be used. We do not know your name because your phone number was randomly chosen."

(If the person agrees to participate, PROCEED to the interview schedule in SECTION III).

(If the person indicates he/she does not wish to participate, express the fact that you respect their wish not to answer the questionnaire. HOWEVER, ask than if they would be willing to answer just a couple of questions. PROCEED to ask the person the questions in SECTION II.

SECTION II:

Ask the following questions ONLY of those who DO NOT wish to participate in the entire questionnaire.

1. Reason for not participating (state verbatum).

_____

_____

_____

_____ NOT INTERESTED 1

_____ NO TIME 2

_____ TOO SICK OR DISABLED 3

_____ WASTE OF TIME/SERVE NO PURPOSE 4

_____ OTHER (Specify) _____ 5

_____ REFUSE TO SPECIFY 9

2. Sex:

male 1

female 2

3. What age category are you?

18 - 24 1
25 - 34 2
35 - 44 3
45 - 54 4
55 - 64 5
65 - 74 6
75 - 84 7
85 + ... 8
Refused 9

4. What is the highest grade of school or level of education you completed:

no formal schooling	1
Grade 1 - 8 (some grade school)	2
Grade 9 - 12 (some high school)	3
University	4
Other (specify) _____	5
refused	9

5. In which of the following broad categories does your income fall into: (before taxes)

less than $9,999	1
between $10,000 - $19,999	2
between $20,000 - $29,999	3
between $30,000 - $39,999	4
between $40,000 - $49,999	5
more than $50,000	6
no income	7
don't know	8
refused	9

(Stop here if the person has indicated he/she does not wish to participate. If they have changed their mind, continue to the remaining questions -- excluding those on sex, age, educational and income if already answered.)

TIME COMPLETED: _____.

SECTION III:

QUESTIONNAIRE
(Interview Schedule)

I would first like to ask you some questions concerning your opinions about health.

1. How important is health to you? (read the categories)

very important 1
somewhat important 2
not important 3
don't know 8
refused 9

2. How would you rate your health: (read the categories)

excellent (never prevents activities) 1
very good (rarely prevents activities) 2
good (occassionally prevents some activities) . 3
fair (very often prevents activities) 4
poor (prevents most activities) 5
don't know 8
refused 9

3. What does health mean to you? (record verbatum then categorize)

_____ general feeling of well-being 1
_____ absence of symptoms, disease 2
_____ able to perform usual activities 3
_____ other (specify) _____ 4
_____ don't know 8
_____ refused 9

4. What do you do to maintain (look after) your health?

_____	exercise	1
_____	eat balanced diet	2
_____	get adequate rest	3
_____	visit doctor regularly	4
_____	attend classes	5
_____	other (specify) _____	6
_____	nothing	7
_____	refused	9

5. a) What programs/activities related to health are you presently participating in? (Eg. exercise program, weight loss program, classes)

_____

_____

_____

_____

_____

education programs 1
behaviour change programs 2
wellness & lifestyle programs 3
self-care programs 4
life saver programs 5
other (specify) _____ 6
none 7
refused 9

(IF RESPONSE IS NONE OR REFUSED, PROCEED TO QUESTION #6.)

5. b) Who sponsors/provides each of these programs? (INDICATE FOR EACH PROGRAM LISTED IN 5.(a).)

#1	#2	#3	
1	1	1	government agency (Public Health, Parks & Rec.)
2	2	2	volunteer organization (heart foundation)
3	3	3	hospital
4	4	4	personal/self
5	5	5	other (specify) _____
6	6	6	not applicable

6. How do (did you) find out about programs/activities related to health that are available?

newspaper 1
radio 2
television 3
friends/family 4
special notification (brochure) 5
other 6
not applicable 7
don't know 8

7. a) Where do you presently get information about health? (doctors, magazines ---- which ones).

_____

_____

_____

doctor 1
print media (eg. newspapers) 2
radio 3
television 4
magazines (specify) _____ 5
books 6
pamphlets/brochures 7
friends/relatives 8
formal presentations (lectures, classes) 9
other (specify) _____ 10
none 11
refused 12

b) What kind of information does each source provide?

_____

_____

_____

A	B	C	
1	1	1	disease specific 1
2	2	2	treatment/management of ailments 2
3	3	3	behaviour change 3
4	4	4	prevention/promotion 4
5	5	5	other _____ 5
6	6	6	none 6
9	9	9	refused 9

8. a) Do you know of any health programs presently offered by Seven Oaks General Hospital?

yes ..... [GO TO #8. b)] 1
no ..... [GO TO #9] 2

b) What programs (list the programs) do you know that are offered by Seven Oaks General Hospital?

_____

_____

_____

_____

health education programs 1
behaviour change programs 2
wellness & lifestyle programs 3
self-care programs 4
life saver programs 5
other (specify) _____ 6
don't know 8
refused 9

9. What should the hospital be doing to promote health?

_____

_____

_____

health education programs 1
behaviour change programs 2
wellness & lifestyle programs 3
self-care programs 4
life saver programs 5
other (specify) _____ 6
nothing 7
don't know 8
refused 9

10. a) If health programs were offered <u>at</u> the Seven Oaks General Hospital (ie. located <u>in</u> the hospital) would you go?

yes 1
no ..... (WHY NOT) 2
maybe 3
refused 9

IF "NO" INDICATE WHY NOT _____

_____

_____

too far 1
no transportation 2
no time 3
other _____ 4
don't know 8
refused 9

b) If Seven Oaks General Hospital offered programs <u>outside</u> the hospital (ie. in the community) would you go?

yes .....[GO TO #10.(c)] 1
no .. (INDICATE WHY NOT) .. GO TO 11) 2
maybe 3
refused 9

<u>IF "NO"</u> WHY NOT _____

_____

_____

offered by other organization(s) . 1
won't meet my needs 2
other (specify) 3
don't know 8
refused 9

c) Where do you think such programs should be held?

_____

_____

_____

community club 1
church 2
school 3
workplaces 4
any place (no preference) 5
other _____ 6
don't know 8
refused 9

d) What would be your preference?

at the hospital 1
in the community 2
either 3
don't know 8
refused 9

11. What specific kinds of health programs are you interested in?

_____

_____

_____

_____

health education programs 1
behaviour change programs 2
lifestyle & wellness programs 3
self-care programs 4
life saver programs 5
other (specify) 6
none 7
refused 9

IF "NONE" PROCEED TO #14.

12. What time of the day would you prefer such programs to be held?

_____	early morning	1
_____	mid-morning	2
_____	noon hour	3
_____	afternoon	4
_____	evening	5
_____	doesn't matter	6
_____	refused	9

13. If the hospital offered health programs, are you prepared to pay for these programs?

yes	totally	1
yes	partially	2
no		3
maybe		4
refused		9

IF "PARTIALLY", WHAT PROPORTION _____

one half ($\frac{1}{2}$)	1
one third (1/3)	2
one quarter ($\frac{1}{4}$)	3
other (specify) _____	4
don't know	8
refused	9

Now, I would like to know a little about you.

14. Sex of respondent:

male	1
female	2

15. What age category are you?

18 - 24	1
25 - 34	2
35 - 44	3
45 - 54	4
55 - 64	5
65 - 74	6
75 - 84	7
85 +	8
refused	9

16. What is the highest grade of school or level or education you completed?

no formal schooling	1
Grade 1 - 8 (some grade school)	2
Grade 9 - 12 (some high school)	3
University	4
other (specify) _____	5
refused	9

17. In which of the following broad categories does <u>your</u> income fall (ie. gross income -- before taxes).

less than $9,999	1
between $10,000 - $19,999	2
between $20,000 - $29,999	3
between $30,000 - $39,999	4
between $40,000 - $49,999	5
more than $50,000	6
no income	7
don't know	8
refused	9

This concludes the interview. I would like to remind you that your answers to the questions will be kept in strict confidence. Thank you very much for your co-operation. Your help in the project is greatly appreciated.

The study results will be available within the next 6 months. If you are interested in the results, you may call at that time. Call L. Kaban at 632-3242. THANKS AGAIN!!

TIME INTERVIEW COMPLETED: _____

Appendix C

Categories of Health Promotion

1. Community patient education - hospital patient services extended to the community.

   - cancer prevention
   - hypertension control
   - cardiac rehabilitation
   - self-help groups
   - support groups
   - death and grieving
   - mental health
   - diabetes education
   - vision screening
   - audiology testing
   - arthritis education
   - health information

2. Behaviour change - any activity that attempts to change a participant's unhealthy behaviour.

   - weight control
   - alcohol/drug abuse
   - stress management
   - smoking cessation
   - health risk appraisal
   - time management
   - relaxation classes
   - assertiveness training

3. Wellness and lifestyle - integrate healthy practices into an individuals's lifestyle.

   - physical fitness
   - nutrition
   - back care
   - healthy aging
   - communication with children
   - conflict resolution
   - healthy cooking
   - family life

4. Medical self-care - provide skills and knowledge that prepare individuals to take responsibility for their medical care or that teaches them how to gain access to the health care system.

    - using health care resources
    - understanding medications

5. Lifesavers - deal with health protection and safety.

    - accident prevention
    - home safety
    - first aid
    - cardiopulmonary resuscitation

6. Workplace applications - specifically designed for the worksite. These consisted of components from the other five content areas, therefore, was omitted as a category for this investigation.

SOURCE: Longe and Wolf (1984). The categories were based on emphasis of the offering and on strategies used to organize and deliver it.

Appendix D

INTERVIEWER'S GUIDE

For

"COMMUNITY PERCEPTIONS OF A HOSPITAL'S ROLE IN HEALTH PROMOTION"

BY: LEONA KABAN

PURPOSE:

1. To serve as researcher's tool to communicate with interviewers and therefore provide all the information necessary to enable the interviewer to feel prepared to embark on the survey.

2. To serve as a document of orientation to the survey and as a reference throughout the survey period.

CONTACT PERSON

Leona Kaban

Home Number: 1-444-3017

Work Number: 632-3242

Call either number if you have questions or concerns or if you have suggestions

SHORT DESCRIPTION OF BACKGROUND

Health promotion programs are increasingly becoming an issue. The question remains as to what people feel they need. The issue of effective use of health resources questions where such programs would be held and who should sponsor them.

PURPOSE

A random sample of adults in the North Winnipeg area. The total sample size is 542. The purpose is to get people's ideas on a number of topics relating to health. This information is aimed at assisting the hospital in determining the needs of the population as it relates to health promotion.

SPONSORSHIP

The survey is being conducted by a Masters Degree student of the University of Manitoba as part of her degree requirement. The survey is endorsed by the Seven Oaks General Hospital.

INTERVIEWER'S JOB IN THE SURVEY

I know that some people will refuse to be interviewed on this topic. However, I expect that you will be able to interview successfully at least 7 or 8 out of every 10 households you contact.

You will be required to explain the nature of the study, the purpose of the survey research and the reason you called. Your interest in people and thorough knowledge of the instructions you receive will make the task easier. You also must bring all your intuition and intelligence into play when the person answers the phone.

There is no way to accurately predict responses. However, the person who answers is likely to act with a combination of curiosity and formal courtesy.

SECURING THE INTERVIEW

Your approach may have to vary in accordance with you intuitive feelings. Some respondents will be quite willing to be interviewed with only a brief explanation of your purpose; for others you will need to go into some detail. Remember not to be too specific, it is important that you avoid introducing a bias into the interview which might predispose the respondent to answer in a particular way. Very general statements such as "We are interested in how people view health".

You can use the brief introductory statement at the beginning of the questionnaire.

INTRODUCTION

Refusal usually occur between the introductory message and the first question.

Therefore, it is crucial that you state clearly who you are, who you represent, and why you are calling. Respondents need to feel that their opinions are important and necessary for the survey to be valid. If they hesitate, even after the introduction, you may have to do some prodding.

- "This won't take much time and we really do want your opinion"

- "Since your number was drawn, we need to talk to you in order for our survey to be valid, a true representation of the community."

- "Let me remind you that your responses will be confidential."

WHO TO INTERVIEW

1. We are seeking the opinion of an adult member of households, age 18 and over.

2. You may talk to either males or females.

3. Try to interview the person who answers the phone. If he or she is unable or unwilling to cooperate, try to get another adult member of that household.

4. If no one will talk at this time, try to establish a time that will be convenient for a call-back (we are not limited to early evening hours).

HOW MUCH INFORMATION TO GIVE

1. Read questions precisely as written.

2. I repeat, read them precisely as written, It is extremely important that everyone be asked the same question in the same way. Even a difference in one word could drastically change the meaning and, thus, the response.

3. Information that you can provide to the respondent is indicated elsewhere. Do not go beyond this information to interpret questions from the respondent. Key phrases you might use to answer questions are:

   - "This is all the information available to us."

   - "We would like you to answer the question in terms of the way it is stated. Could I read it again for you?"

   - "I'm sorry I don't have that information."

   - "I will write on the questionnaire the qualifications to your answer you have just mentioned."

4. If the respondent still requires some information, call for assistance.

PROBING AND OTHER INTERVIEWING TECHNIQUES

1. If no open-ended questions are used in the interview schedule, probing for better clarity or for additional information is not necessary.

2. However, if a respondent is reluctant to answer a question, you may have to coax him to answer with statement like:

   "Is there anything else you would like to say?"

   "Are you sure that is all?"

   "Could you elaborate on ...?"

3. Be careful about leading the respondent. Probes are to be neutral requests for information.

4. If unsure of respondent's final response, repeat what you think it was so that he can confirm or correct it.

5. Kinds of probes:

   - repeat the question
   - an expectant pause
   - repeat respondent's reply
   - neutral questions or comments

Probe	Abbreviation
Anything else?	Else?
Any other reason?	AO?
Any others?	Other?
How do you mean?	How mean?
Could you tell me more about what you have in mind?	What in mind?
What do you mean?	What mean?
Why do you feel that way?	Why?
Which would be closer to the way you feel?	Which closer?

- Asking for further clarification?

  e.g. "I'm not sure what you mean by that, could you tell me a little more?"

WHOSE OPINION TO ACCEPT

Everything should be in terms of what the RESPONDENT thinks - not the respondent's kids, friends, boss, bartender, etc.

Therefore, you might need to say:

"I see. Now, is that what you think?"

"It's your opinion that we really want?"

ALSO, DON'T GIVE YOUR RESPONDENT YOUR OPINION.

RECORD EVERY CALL YOU MAKE

Even if the number was not working, no answer was received, or the interview was not completed, still record the call.

You will be provided with numbers to call on a separate sheet. Do not call any other numbers.

Please record any pertinent comments on the cover of the questionnaire or in the margins.

Do not smoke, eat, or drink coffee, tea, or milk, etc. while conducting the interview. You have too much to concentrate on without having to worry about dropping an ash or spilling a drink onto inappropriate (and perhaps painful) places.

THE NEUTRAL ROLE OF THE INTERVIEWER

1. Your are a neutral medium through which questions and answers are transmitted. Therefore:

   a. Avoid interjecting your own opinion.

   b. Avoid being "Clever"

   c. Avoid any unnecessary or overly enthusiastic reinforcement such as "DY-NO-MITE".

   d. Be an active listener, but only give the minimum of reinforcement, such as "OK" - "I see"" or "uh-huh".

   e. Never suggest an answer.

2. BALANCED RAPPORT

   Remember, the telephone interview is still a social interaction situation. You will not only relate to each other according to your respective roles, but also as individuals. Therefore, it is necessary to achieve some kind of "Balance" or rapport. A relationship must be established that will not stimulate either incomplete responses or biased responses based on "over-rapport" or an overly "Mechanical" interviewing style. Usually the respondent will try to please you and will often give "Socially desirable" answers in order to get your reinforcement.

   Neutral responses are difficult for most of us. Telephone interviewing calls for us to drop this persuasive tactic, except when introducing the interview. It is then and only then what we use our powers of persuasion to get a prospective respondent to agree to an interview.

3. GENERAL TASKS OF INTERVIEWER

   a. accurate communication of questions

   b. maximizing the respondent's ability and willingness to answer

   c. listening actively to determine what is relevant

   d. probing to increase the validity, clarity, and completeness of the response.

4. SPECIFIC TASKS

   a. be familiar with the questionnaire

   b. follow question wording and question order exactly; ask all of the questions

   c. record responses exactly

   d. be casual, conversational and friendly

   e. record first answer; it is usually closer to the truth

   f. doublecheck your instructions before you begin

   g. repeat answers for respondent if there is any doubt or has misinterpreted.

   h. doublecheck questionnaire to be sure that all items have been answered, answers recorded correctly, and status information (phone number, location) completed.

5. FINAL COMMENT

   Most people like to talk about themselves and what they know. Once their initial anxieties are relieved, the respondent will talk because of this fact and the guarantee of a good listener - you.

RECORDING AND EDITING THE INTERVIEW

- Information must be conveyed in a full and unbiased form.
- Record the respondent's replies as well as your own probes right on the questionnaire in the space provided.
- With open-ended questions, document the respondent's replies on the lines provided, during the interview and as the respondent is talking.

Rules for Recording

a. record responses during the interview

b. use the respondent's own words (verbatim)

c. do not summarize or paraphrase the respondent's answers

d. include everything that pertains to the question objectives

Rules for Recording Continued:

e. include all of your probes - enter them in parenthesis

f. hold the respondent's interest - i.e. focus on the respondent (e.g. repeat the response as you are writing it down)

g. start recording as soon as the respondent starts talking

Tips on Note Taking

a. when starting the interview, try to find a place where you will be able to write comfortably

b. when the respondent starts to talk, begin to write immediately

c. abbreviate sentences - e.g. leave out articles and prepositions

Mechanics of Recording and Editing Interviews

a. use a pencil to record

b. writing must be legible

c. use parenthesis to indicate the interviewer's words

d. account for each question in the questionnaire

Tips on Editing

a. edit the interview right after you complete it

b. be sure that:

- all entries are legible
- inappropriate questions are clearly marked
- all probes are indicated in parenthesis
- all unclear responses are clarified by your parenthetical notes
- edit the cover sheet.

QUESTIONS THAT MAY BE RAISED AND SUGGESTIONS ABOUT HOW TO RESPOND TO EACH

1. HOW DID YOU HAPPEN TO PICK ME? WHO GAVE YOU OUR PHONE NUMBER AND NAME?

We do not have or need your name. Your number was randomly selected from a list of random numbers without using any list such as a telephone directory. Number combinations were selected in the same way as putting the numbers in a hat and picking a certain number of them.

We are trying to find out what people in the North End of Winnipeg think, we cannot talk with everyone. Therefore, we have chosen numbers in an attempt to sample about 524 people.

2. I REALLY DON'T KNOW ANYTHING ABOUT THIS

We are interested in your opinion, not in what information you may or may not have about the topic in the survey. I really think you will find the interview interesting and enjoyable. In a study such as this, there are no right and wrong answers; we are simply interested in learning about your experiences and how you feel about things.

3. WHAT'S THIS ALL ABOUT, ANYWAY?

We'll be talking about several things related to health and what to do to maintain health. (An explanation of the introductory remarks should suffice. If the person is voicing suspicion about the legitimacy suggest they call:

Dexter Harvey	474-9014
Ron Birt	632-3327
Marianna Muzyka	632-3180

to vouch for the fact that you are from a recognized organization.

4. WHAT GOOD WILL THIS DO?

(This is one of the most difficult questions to answer.)

It may be helpful to explain that informed decisions are better than good guesses and decision-makers need this kind of information which can be obtained only by talking to people and finding out how they feel in order to formulate plans and policies.

5. HOW DO I KNOW THIS WILL BE CONFIDENTIAL?

We do not have your name. You were contacted because your number combination was picked from a hat. We are only interested in the combined responses of the nearly 542 people who will be called. No individual's responses will be singled out. All of us who are working on this project are required to follow certain policies and procedures developed for the purpose of protecting everyone's identity. The final report will contain only summary statistics and the hospital or the university will never know what phone numbers were called.

6. HOW WILL THE RESULTS BE USED?

The information generated by this survey will be utilized by the master's degree student in her thesis which will be submitted to the University of Manitoba. In addition, the results will be made available to decision makers at the hospital to assist in planning for the future needs of the area population.

HOW TO HANDLE REFUSALS OR THOSE RELUCTANT TO REPLY

You may have to be prepared to encourage an individual to respond. Some reasons for refusals may include those presented below. Included are possible responses (Mason et al, 1983).

1. "NO INFORMATION IS CONFIDENTIAL"

   Answer: We are all concerned about invasion of privacy. All research at the University of Manitoba is supervised by an ethics committee. Once your information is entered into a computer, no one will be able to identify your response.

2. "I'M TOO BUSY"

   Answer: The survey takes about 10 minutes. Since this is a bad time for you, can we arrange a convenient time when I can call back?

3. "I DON'T LIKE TELEPHONE SOLICITING

Answer: The telephone allows us to get information as quickly as possible and at a saving of money. By talking to your directly, we can make certain your opinions are accurately recorded.

4. "I'M NOT WELL"

Answer: Request if it is possible to call back in a few days. (If not, indicate that as the reason for non-response and do not call again.)

5. "WHY SHOULD I ANSWER THE QUESTIONS"

Answer: We can appreciate that you are busy and that many people seem to be asking you questions and invading your privacy. But we think you opinions about health are especially valuable to the Seven Oaks General Hospital. This is your chance to register your opinion on a vital issue facing everyone and your chance to influence hospital programs.

WHAT TO DO IF A PERSON BECOMES INCENSED, USES FOUL LANGUAGE, OR GOES ON A TIRADE, ETC.

1. Be nice! Do not hang up.

2. Possible responses, as situations warrant:

"Yes, I see." "Uh-huh"

"Yes, I understand you feel quite strongly about this matter, but we really need your opinion."

"Let me repeat the question for you, sir."

3. DO NOT under any condition, argue, insert your own opinion, or lose your temper.

4. DO NOT terminate the interview if a respondent is abusive. Only terminate if subject refuses to respond.

If all else fails, wait for the opportunity, and then say something to this effect:

- "I'm awfully sorry you prefer not to complete the interview, but thank you anyway. Good-bye."

WHAT TO DO WHEN THERE IS NO ANSWER OR IF NO ONE OVER 18 YEARS IS AVAILABLE

1. If there is no answer, call again at another time and/or on another day. Make three attempts only.

2. If no one over 18 years is available, ask for a time when he/she might be back, or simply call at another time and/or day.

WHAT TO DO WHEN RESPONDENT IS NOT ENGLISH SPEAKING

1. Ask for (attempt to ask for) an English speaking adult (18 years or over) and interview that person.

2. If there is no English-speaking person, simply exclude that household from the survey.

ETHICS

1. Participation in the survey by the respondent must be voluntary.

2. The purpose and sponsor of the survey must be identified to the respondent. Deceit should not be used.

3. It is essential to establish and maintain a reputation for confidentiality. Therefore please:

   a. Do not tell anyone the phone number of people you interviewed.

   b. Do not tell anyone the substance of any interview or part of an interview, no matter how fascinating or interesting it was.

   c. Avoid revealing your personal summary of findings. People you tell will tell others, and they will do the generalizing no matter how good you are at qualifying things.

   d. If people hear about responses of others and then are later called on the same survey, it could influence their response.

Appendix E

List of Responses to "Other" Category

TABLE A: RESPONSE CATEGORY 'OTHER' IN TABLE 6

- Displays, Demonstrations in Malls
- Commercials
- Pamphlets
- Advertise Services
- Make Books Available
- Posters
- Special Clinics
- Bulletin Boards
- Education Sessions in Schools
- Practice Holistic Medicine
- Special Education Sessions for Youths
- Open House
- Seminars, Special Classes