COMMUNITY HEALTH PROMOTION PROGRAMS FOR SENIORS:

PROGRAM FOCUS AND CONTRIBUTING FACTORS TO COMPOSITION

by

KIM CALSAFERRI

B.S.R. (O.T.), The University of British Columbia, 1983

A thesis submitted in partial fulfillment of
the requirements for the degree of Masters of Science

in
The Faculty of Graduate Studies
(Interdisciplinary)

We accept this thesis as
conforming to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
OCTOBER 1990

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of GRADUATE STUDIES (Interdisciplinary)

The University of British Columbia
Vancouver, Canada

Date OCT 11/90

DE-6 (2/88)

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

The completion of this thesis was made possible through the encouragement, support and generosity of family, friends, UBC faculty, and professionals and seniors of the health promotion programs studied.

I would like to thank my family whose influence has given me strength to believe in my abilities, to adapt to change, and to meet the many challenges presented throughout my life. I am particularly indebted to my "Gran" whose wisdom and grace have provided me with insight into aging well.

My friends have supplied me unending support and encouragement. They have sensitively provided me with humour, hugs, company to exercise, insights, meals, and most importantly, a belief in my abilities to complete this thesis.

I would like to thank the members of my committee, Dr. John Milsum, Dr. Nancy Waxler-Morrison, Dr. Lyn Jongbloed and Dr. Patricia Vertinsky. Their commitment to the development of their students and to excellence in scholarly activities, is deeply appreciated and respected.

Finally, this thesis is dedicated to the seniors and professionals whose belief in wellness and health promotion is a confirmation that living and dying well is possible.

ABSTRACT

The purpose of this study is to investigate the program focus and contributing factors to program composition of five health promotion programs for seniors. The programs are selected using opportunistic sampling from five different local areas in metropolitan Vancouver. The five areas together constitute metropolitan Vancouver. A theoretical framework based on health promotion as a process which enables people to take control of their health promotion programming and recognizes that social, political, and organizational interventions are as important as individual actions, is used to support the purpose of this study. An ethnographic approach is used to collect observational, interview and documentary data on program focus, process and organization. The data are analyzed qualitatively to further the understanding of health promotion as a process central to individual and group empowerment in program focus and organization. The findings confirm that these programs focus predominantly on individual behaviour change efforts and only minimally on underlying environmental and community change factors. In the process of examining these health promotion programs for seniors, themes emerged which shed light on which factors most influence program composition. Program organization and process which involves multiple historical, theoretical and organizational factors are seen to most heavily influence program composition.

LIST OF TABLES

INTRODUCTION

My interest in this study developed from my perspective as an occupational therapist, which requires that I view health from a holistic perspective. When I work with individuals whose performance is impaired, it is important to view them within the context of their environment. Also, as occupational therapists highly value a client-centered approach this necessitates the involvement of each individual as an active participant in the planning and intervention process. I understood that health promotion is intended to foster the involvement of individuals in decision making processes about their health needs, and was aware that a health promotion philosophy recognizes that both individual behaviour and environmental factors contribute to and influence health and well-being.

Health promotion is a recent addition to the health care delivery system. Although still secondary to disease treatment, health promotion has gained a great deal of support since the mid-1970's and through the publication of a number of charters, frameworks and reports it has been established as a legitimate component of our present health care system (Epp, 1986; Lalonde, 1975; International Conference on Health Promotion, 1986; U.S. Department of Health, Education and Welfare, 1979).

There is no definition of health promotion upon which everyone agrees, but the following two are frequently quoted, and are used in this study:

"Health promotion involves any combination of health education and related organizational, political and economic interventions designed to

facilitate behavioural and environmental changes conducive to health" (Green, 1979).

"Health promotion is the process of enabling people to increase control over, and to improve, their health" (World Health Organization, 1986).

As health promotion recognizes that social, political and organizational conditions are as important as personal actions in determining health, the following two definitions are used in this study:

Individual Behavioural Change Components include programming that focuses upon personal health attitudes, self-management of chronic health conditions, nutrition, exercise, stress management, personal sense of purpose, personal support systems and personal environmental awareness and participation.

Environmental and Community Change Components include programming that includes a focus on those political, economic and organizational factors that affect promotion of immediate individual behavioural change components, e.g. available community supports, self-help groups, outreach services, information networks, environmental hazards, and social and economic factors such as social isolation, poverty and ageism.

Health promotion is viewed as having great potential for improving the health needs of Canada's rapidly growing senior population. However, there are those who suggest that many health promotion programs continue to focus on the isolated individual as the target for behaviour change,

and place little or no emphasis on those underlying social, political and organizational factors that keep seniors impoverished, socially isolated and disadvantaged. (Health Services and Promotion Branch, 1986; Minkler & Pasick, 1986). Although the success of health promotion programs is viewed as dependent on the effective incorporation of both individual behavioural and environmental components, little research has been conducted to describe health promotion program focus or to analyze the factors that contribute to program composition.

This present ethnographic research represents an early attempt to describe the focus of the program components and the contributing factors to program composition, for five health promotion programs for seniors, in the city of Vancouver, British Columbia.

Ethnographic research is viewed as particularly well suited to this study as it focuses on social organizations within specific contexts and provides a holistic perspective without superimposing the researcher's value system on the situation. An ethnographic approach enables the researcher to examine the perspectives of the senior participants and the professionals about the health promotion philosophy, the program focus, the program process and the factors which contribute to program composition of each health promotion program.

Opportunistic sampling is used to select one program from five different local areas of metropolitan Vancouver. In the role of participant as observer, the researcher conducts participant observation of all five programs, for a period of two months. This is followed by

interviews with two categories of senior participants and the professional wellness coordinators. As well, analysis of documents gathered from senior participants and wellness coordinators provides insight about program components, the process of program development and what best explains program composition.

This study lends support for the claim that health promotion programs for seniors remain narrow in focus and continue to concentrate on individual level change. Further, it illustrates how historical, theoretical (the application of a wellness/health promotion approach) and organizational factors (varying degrees of structure, the roles of seniors and professionals, and funding) markedly influence program focus and process and hence enhance or inhibit the ability of the program to fulfill the intentions of health promotion.

Finally, this study focuses on exploring program focus, program process and the factors which best influence program composition, it also raises questions about the role that macro, meso, and micro-level influences play in perpetuating narrowly-focused, individualistic health promotion.

CHAPTER 1

REVIEW OF THE LITERATURE

A study of the focus and contributing factors to health promotion programs for seniors in Vancouver, British Columbia, necessitates an examination of the relationship among the following factors: the shift in emphasis and acceptance of health promotion as an integral part of health care; the emergence of health promotion programs for seniors; the present focus of seniors' health promotion programs; and the factors that underlie program composition and variation. In this chapter, health promotion is defined and aspects of health promotion programs delineated. The factors that contribute to the emergence of health promotion programs are discussed to provide a context within which recent research of existing health promotion programs for seniors can be explored.

I. DEFINING HEALTH PROMOTION

Just twenty years ago health promotion was little understood. Today health promotion attracts the study and attention of academics, health care providers, policy makers, voluntary and community organizations and lay people alike. This interest has generated numerous attempts at defining health promotion and explaining its approach. As yet there is no agreed-upon definition of health promotion and in particular of health promotion for the elderly (Duncan & Gold, 1986; Brown, 1982; Mullen, 1986; Health Services and Promotion Branch, 1986). However, consensus exists that health promotion is more than the treatment of disease, the traditional focus of biomedicine. Proponents of this concept consider physical, mental and social aspects of health. Health promotion, a broad

concept, is concerned with the quality of life. Emphasis is placed on both individual and environmental determinants of health and well-being (Epp, 1986; Estes, Minkler, & Pasick, 1986; Mollenill, 1987; International Conference on Health Promotion, 1986; Kickbusch, 1989).

Although the definitions offered have much in common, they differ in their emphasis on which factors are the appropriate targets for change efforts. More specifically, environmental factors are viewed as particularly important by some health promoters, while the individual determinants of health are often the focus with others. For example, Thatcher (1988) who defines **HEALTH** as:

> "a dynamic state of biopsychosocial well-being in which individuals are able to perform those functions deemed necessary and desirable to maintain existence in their environment,"

affirms Pender's (1982) definition of **HEALTH PROMOTION** as:

> "activities directed toward sustaining or increasing the level of well-being, self-actualization and personal fulfillment of a given individual or group."

This definition implies, that only if the individual or group takes responsibility for health promotion behaviours, will enhancement of well-being follow (Thatcher, 1989).

In contrast, Green et al. (1986) defines **HEALTH PROMOTION** as:

> "any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental changes conducive to health."

The emphasis here, is on a variety of interventions to facilitate both behavioural and environmental changes conducive to health. This is viewed by many as offering a more sophisticated definition than more conventional health promotion concepts because of the focus on the social, cultural and

economic influences on health and health behaviour (Estes, Fox & Mahoney, 1986; Minkler & Pasick, 1986; Minkler, 1985).

The World Health Organization (WHO) defined **HEALTH** as:

> "a state of complete physical, mental and social well-being, not merely the absence of disease" (WHO, 1948).

This definition has gained worldwide recognition and acceptance. During the 1980's various WHO publications proposed an expanded vision of health and health promotion. **HEALTH** was expanded to include:

> "the extent to which an individual or group is able on the one hand to realize aspirations or needs and on the other hand, to change or cope with the environment." (WHO, 1984)

HEALTH is viewed as:

> "a resource for everyday life, not the object of living." (WHO, 1984)

HEALTH PROMOTION was defined as:

> "the process of enabling people to increase control over, and to improve, their health." (WHO, 1986)

and is seen as:

> "a mediating strategy between people and their environments, synthesizing personal choice and social responsibility in health." (WHO, 1986)

This perspective emphasizes social and personal resources as well as physical capacity. Consistent with Green et al. (1986) this implies a more positive and integrated look at health which recognizes environmental influences. This vision attempts to integrate the individual and social components within an ecological framework. Health promotion is seen to complement the existing health care system but is not viewed as synonymous with health care. Of major significance is the fact that less emphasis is placed on the individual and more on the influence of environmental

factors. Thus a trend that began in the early 1950's, which placed most emphasis on individual responsibility for health, is reversed (O'Neill, 1989/90).

A federal publication entitled "A New Perspective on the Health Of Canadians" by Lalonde (1974), translated such findings into the form of a working document which legitimized the idea of developing health practices and policies within a broader context. Lalonde suggested that people's health was influenced by a broad range of factors; human biology, lifestyle, the organization of health care and the social and physical environments in which people live.

Today this concept has been expanded to include an emphasis on broader quality of life issues. The event that played the largest role in publicizing this new health promotion vision was the first International Conference on Health Promotion held in Ottawa in 1986. An important product of this conference was the Ottawa Charter for Health Promotion (1986) which further expanded the World Health Organization's concepts by developing health promotion strategies to realize its definitions namely: building healthy public policy; creating supportive environments; strengthening community actions; developing personal skills and reorienting health services. These strategies captured a vision of health that move beyond the individual to the larger society and the environment within which they are part.

II. THE EMERGENCE OF HEALTH PROMOTION

The shift in emphasis from a biomedical definition of health and well-being toward a broader conceptual framework that encompasses physical, social, political and economic environmental factors, as well as individual lifestyle and behavioural choices, signifies the emergence of health promotion now exemplified by the WHO's ecological paradigm of public health (Kickbusch, 1989). Multiple factors have contributed to health promotion as it exists today.

The work of Dubos (1979), in enlarging the understanding of the individual's adaptation to the social and physical environment, of McKeown (1976), who pointed out the role of improved nutrition, changing personal habits and sanitation, in achieving marked improvements in health status, and of Belloc and Breslow (1972), who demonstrated an association between lifestyle habits and physical health status, has contributed to an overall understanding of determinants of health and the importance of environment, social factors and lifestyle as major determinants of health status.

Fries and Crapo (1981), noted that an increase in the incidence of chronic disease was likely as more people survive illness that previously caused death earlier in life. They postulated that lifestyle modification and promotion of healthful behaviour can:

a) alter the aging process;

b) improve the social, physical and mental functioning of seniors;

b) reduce the disabilities of aging; and

c) extend a vigorous life up to the end of the "natural biological life span" through the "compression of morbidity". (Fries, 1980; 1983; 1984)

Now that chronic disease is a major precursor of death, many people believe the major emphasis of health care must shift from acute illness treatment towards removal of and assistance with those risk factors associated with chronic disease (Labonte, 1988; Fries, Green, & Levine, 1989; International Conference on Health Promotion, 1986; Epp, 1986; Mollenill, 1987; Larson, 1988; Evans, 1989; Kickbusch, 1989).

The 1986 federal document "Achieving Health for All: A Framework for Health Promotion" reinforces this emphasis and the necessity for developing health practices and policy within a broadened context. The fact that "health equity between high and low income groups" was identified as "a leading challenge" indicates that this framework has gone far beyond Lalonde's (1974) perspective (Epp, 1986).

This document calls for the integration of ideas from public health, health education and public policy and also for an expansion of the traditional use of the term health promotion. Here, health is portrayed as part of everyday living and as an essential dimension of the quality of our lives. This view recognizes the role of individuals and communities in defining what health means and in striving to achieve, maintain or regain it. The creation of healthy environments through altering or adapting the social, economic and physical surroundings is recognized as necessary to preserve and enhance health. Improvements in health are viewed as being dependent, not only on individual change, but also on concurrent health promotion changes within the broader physical, social, political and economic environment (Epp, 1986).

Applying these concepts to health promotion for the senior population would necessarily include attention to the multiple

determinants of their health and well-being. Reduced incomes, diminished power and social standing, the threat of economic and social dependency, chronic illness and disability, the loss of social supports, as well as individual lifestyle, are all potent determinants of health and well-being of seniors in our society (Health Services and Promotion Branch, 1986).

III. THE EMERGENCE OF HEALTH PROMOTION FOR SENIORS

Until recently seniors were excluded from popular wellness and health promotion activity. Probable reasons for this are that the majority of health promotion programs focus on:

a) life extension with seniors being viewed as having no future;

b) reducing risk factors associated with premature death and disability, but the majority of seniors have lived beyond this risk;

c) youth, and are concerned with the individual's responsibility for reducing risks, so that seniors are viewed as inappropriate participants; and

d) absence or avoidance of disease, which is an inappropriate goal for most seniors who already suffer from at least one chronic health problem (Estes, Fox & Mahoney, 1986; Roadburg, 1985; Health Services and Promotion Branch, 1986; Somers, Kleinman & Clark, 1982).

The shift in the causes of morbidity and mortality, the increased proportion of people living longer lives and the increased costs of health care are some of the factors which have given rise to the increased emphasis on health promotion as a legitimate component of health care (Labonte, 1988).

More specifically, several reasons underlie the increasing emphasis on this type of intervention among seniors:

a) this group is the fastest growing segment of this nation's population;

b) 86% have chronic conditions;

c) the consequences of chronic health conditions typically are disproportionately severe for seniors, resulting in restrictions on personal independence and overall quality of life;

d) while representing only 11% of the population, seniors account for about one-third of all health care costs; and

e) they are the most likely to need high cost personally restrictive long term care (McDaniel, 1986; Marshall, 1987; Health Services and Promotion Branch, 1986; Statistics Canada, 1985; Smith, 1988).

Also, as noted, health promotion has gained visibility as a major policy issue in response to a number of federal health documents (Lalonde, 1974; Epp, 1986). Although these publications do not specifically highlight the elderly, together they have contributed to a conceptual framework for national health promotion activities for all individuals.

IV. THE FOCUS OF HEALTH PROMOTION PROGRAMMING FOR SENIORS

To physicians, health promotion may mean providing prescriptive lifestyle advice; to hospitals, it might assume the appearance of patient education programming in chronic illness management; to health departments, it may appear as programming which promotes healthy behaviour; and at the community level, it might be expressed as concern in

terms of adequate financial resources, transportation, housing and access to services (Labonte, 1988).

To date, the literature suggests that health promotion programs for seniors, as for other groups in society, tend to focus on the isolated individual as the target for behaviour change efforts (Estes, 1983; Kickbusch, 1989; Draper, 1988; Minkler & Pasick, 1986). However, some experts in the field believe that by focusing programming on individual change efforts, attention is deflected from those environmental factors that heavily influence health practices and over which seniors may have little control.

Although these experts claim programs focus predominantly on lifestyle change and only minimally on the underlying environment and community change, no direct research exists to support or negate these claims. Two national surveys in the United States on senior centers and services (National Council on the Aging; Krout, 1985) and a review of a random selection of health promotion programs for seniors in Canada (Taylor, 1983) and the U.S. (Gilbert, 1986; Brown, 1982; Minkler & Pasick, 1986; Weiss & Sklar, 1983; Barbaro & Noyes, 1984; Dunn, 1985; Gesham-Kenton & Wisby, 1987; Wilson, Patterson & Alford, 1989; Higgins,1988) reveal the major areas of concern to be drug use and abuse, chronic health monitoring, smoking cessation, health education, nutrition awareness, stress reduction, promotion of fitness, mental health and recreation. All these are individual lifestyle and behavioural components.

This emphasis is not felt to include an attack on the underlying causes of environmental determinants of health. Minkler & Pasick (1986) noted that seniors are: taught the importance of exercise but not how to

participate safely if they live in a high crime area; told which foods are nutritional, but not how to afford them if living near or on the poverty line; and taught to identify and manage life stresses but rarely encouraged or helped to work individually or collectively towards eradicating the root causes of these stresses.

Some health promotion programs do combine lifestyle change elements with a broader focus on increasing responsibility for oneself and control over the social, physical and economic environment (Lalonde and Fallcreek, 1985; Minkler, 1985; Wechsler & Minkler, 1986). This broader focus emphasizes the ability of individuals to bring about change in their environment rather than simply helping them to cope with and adjust to lifestyle and health problems. However, as these programs remain few in number, the message is clear; individual responsibility for health still remains the predominant focus today (Labonte, 1988; Smith, 1988; Health Services and Promotion Branch, 1986).

Little empirical information exists that would allow for an assessment of how comprehensive are senior center and health promotion activities and services (Krout, 1986), let alone their specific focus or how and why programs vary. Almost without exception, research has focused on the elderly individuals' socio-demographic characteristics, the factors that differentiate participants from non-participants, and the degree to which they utilize senior centers and health promotion programs (Krout, 1986; Krout, 1990; Buchner & Pearson, 1989).

V. RECENT RESEARCH ON HEALTH PROMOTION PROGRAMS FOR SENIORS

Although some research is being conducted in the specific area of health promotion and the elderly, it is extremely limited in scope and quantity. The predominant focus is on program evaluation in the areas of cost containment, health maintenance, functional independence, illness risk reduction, health knowledge, and health behaviour change (Rakowski, 1986). Some researchers (Weiss & Sklar, 1983; Nelson et al., 1984; Ho et al., 1987; Gresham-Kenton & Wisby, 1987; Bender & Hart, 1987; Krout, 1988; Smith, 1988; Weiler, Chi & Lubben, 1989; Wilson, Patterson & Alford, 1989) seek alternatives to a biomedical approach.

For a long time data were not available to link seniors' health with medical utilization and costs. Some writers do claim that seniors health promotion programs provide more cost effective care and have potential to decrease excessive biomedical utilization and health care costs (Minkler, 1985; Weiss & Sklar, 1983; Barbaro & Noyes, 1984; Vickery, Kalmer, Lowry, Constantine & Loren, 1983; Ho et al., 1987). Others suggest that costs will not decrease as this necessitates broadened service delivery (Nelson et al., 1984; Russell, 1984; Gori, Ritcher & Yu, 1984).

Those studies which address the benefits of health promotion for seniors focus predominantly on individual behaviour and lifestyle changes. Some researchers suggest older people who participate in programs demonstrate:

a) maintenance of health and functional independence (Weiss & Sklar, 1983; Nelson et al., 1984; Wilson, Patterson & Alford, 1989);

b) a reduction in health risks (U.S. Public Health Service and Administration on Aging, 1984; Lalonde & Fallcreek, 1985; Weiss & Sklar, 1983; Kempner, 1986; Cox & Monk, 1989);

c) increased personal knowledge, awareness and responsibility in health-related matters (Fitch & Slivinske, 1988; U.S. Public Health Service and Administration on Aging, 1984; Lalonde & Fallcreek, 1985; Nelson et al., 1984; Barbaro & Noyes, 1984); and

d) constructive behavioural changes toward healthier lifestyle behaviours and improved health status (Higgins, 1988; Jordon-Marsh & Neutra, 1985; Smith, 1988; Fitch & Slivinske, 1988; Lalonde & Fallcreek, 1985; Nelson et al., 1984; Barbaro & Noyes, 1984; Minkler, 1985; U.S. Public Health Services and Administration on Aging, 1984).

Few documents and research efforts identify seniors' health promotion programs which focus on individual health behaviour and efforts aimed at enabling seniors to take control of health decisions, to create healthy environments and coordinate healthy public policy, as laid out by Epp (1986), WHO (1986) and Green, et al. (1980). Although the idea of developing programming and research within a broader context has been legitimized, the literature indicates its presence is extremely rare in practice. Of two well documented U.S. programs, the Wallingford Wellness Project and the Tenderloin Seniors Outreach Project, only the former has undergone empirical study. One outcome study confirmed effectiveness in promoting and sustaining information, attitude and behaviour change in seniors over 54 years of age (Lalonde & Fallcreek, 1985). Programming components were clearly identified and the description clearly indicated a focus on both individual behaviour and environmental issues. More

recently in Canada, Meeks & Johnson (1988), documented a project undertaken at a suburban seniors' center, where a comprehensive health promotion program was developed based on health promotion literature, on assessment of the seniors needs and interests and on a review of community resources. Although evaluation has not yet occurred, the program was designed with this in mind. The involvement of seniors and relevant community services in the program planning stage is a noteworthy feature.

From the literature reviewed, it is clear that the type and quantity of research required for knowledge development in health promotion as envisioned by Epp (1986), WHO (1986), and Green et al. (1980), differs considerably from the lifestyle-oriented research that has been the trademark of health promotion until recently. Research that investigates the process, focus and variation of health promotion programs, which is the intention of this present research, will add to research in health promotion.

This literature review has indicated that much work lies ahead for health promoters, researchers, care providers, policy makers, the media and other segments of society if health promotion is to be assured an integral place in the health care system.

CHAPTER 2

METHODOLOGY

This chapter is divided into three sections for the purposes of describing, defining and applying the ethnographic research tradition as a research methodology. Section one gives a general account of the ethnographic research tradition. Section two discusses the research design, purpose, goals and foreshadowed questions of this study. Section three describes the application of the ethnographic research tradition to this study by presenting the data collection techniques, the role of the researcher and the process of analysis.

I. THE ETHNOGRAPHIC RESEARCH TRADITION

A. THE ETHNOGRAPHIC RESEARCH TRADITION

Social science research has been described "as a choice between two conflicting research paradigms" (Hammersley & Atkinson, 1983). These paradigms are often labeled quantitative and qualitative (Schwartz & Jacobs, 1979) and naturalism and positivism (Hammersley & Atkinson, 1983). The issue between the two paradigms, is the nature of the social world and how it should be studied.

In recent years qualitative research has received increasing attention. This is partly due to the ongoing discussion of qualitative versus quantitative research, but also to the realization that there are many problems in the social sciences that can best be studied with a qualitative approach.

Terminology in this tradition "varies from user to user" (Bogdin & Biklen, 1982). Also, this tradition has many labels. It is known as

"field work, ethnography, case study, qualitative research, interpretive procedures, field research," (Burgess, 1984), naturalistic inquiry and participant observation. In this study the term **ethnography** will be used to identify the tradition.

Ethnography has been associated with the collection of "soft" data (Bogdin & Biklen, 1982), collected in the field or natural setting (Hammersley & Atkinson, 1983), and studied from the participants' point of view (Burgess, 1984). Ethnographers "focus upon the ways in which participants interpret their experience and construct reality" (Burgess, 1984) rather than on an objective reality. In this way there is a fundamental difference between ethnography and positive science. Ethnographers must understand the world as the participant does, unlike positive scientists who study objective facts that exists outside the person.

This tradition which goes back to the latter part of the nineteenth century, has its roots in more than one academic discipline (anthropology, sociology, social psychology and education) and includes particular schools and methods such as "symbolic interactionism, inner perspective, the Chicago School, phenomenological, case study, interpretive, ethnomethodological, ecological and descriptive" (Bogdin & Biklen, 1982).

B. THE HISTORICAL DEVELOPMENT OF ETHNOGRAPHY

Because ethnography has multiple names, takes many forms and is conducted in a wide variety of settings, confusion exists about what it is. In order to appreciate the usefulness of this tradition, this section will define and explore the different labels and describe the historical context and genesis of ethnography.

This tradition emerged towards the end of the nineteenth century during the era of urbanization. The impact of mass migration from rural to urban areas created vast social problems. It was the descriptive, indepth documentation of this social suffering by journalists, social workers, social surveyors and photographers, that laid the foundation for this research tradition (Bogdin & Biklen, 1982).

The term ethnography comes from anthropologists who studied foreign cultures in their natural settings. Ethnography is defined as "the branch of anthropology that deals descriptively with specific cultures" (Websters New World Dictionary, 1980). This branch of anthropology is known as social anthropology. Ethnography is the label given to the methodology that generates the basic descriptive data on which social anthropology is founded.

Two anthropologists, Boas and Malinowski contributed much to this field. Boas and his co-workers were amongst the first anthropologists to spend time in the field or natural setting. This time was, however, brief and much reliance was placed on informants who spoke the native language. Boas, a cultural relativist, contributed the concept of culture and stressed the belief that each culture under study should be approached inductively (Bogden & Biklen, 1982). Malinowski (1922), who first

documented these field work techniques also insisted that a theory of culture had to be grounded in specific human experiences, based on observations and inductively sought (Malinowski, 1960). Unlike Boas, who had acquired his data predominantly from documents and informants, Malinowski was the first social anthropologist to draw his data primarily from the experience of living among and participating in the daily lives of those primitive societies he studied (Wax, 1960).

On a similar search for meaning and understanding in human experiences, a significant number of sociologists in the classical tradition have recognized and stressed the importance of participant observation in methodology (Bruyn, 1962). One of the first and classic statements on the technique and purpose of participant observation was made by Florence Kluckhohn (1940: 331).

> "**Participant observation** is the conscious and systematic sharing, insofar as circumstances permit in the life activities, and on the occasion in the interests and affects of a group of persons. Its purpose is to obtain data about behaviour through direct contact and in terms of specific situations in which the distortion that results from the investigator being an outsider, is reduced to minimum."

In the 1920s and 1930s the Chicago School, a group of sociologists at the sociology department in Chicago, began contributing further to this field of multiple labels. While these sociological researchers differed in some ways, they also shared common theoretical and methodological assumptions. Theoretically, personalities and symbols were viewed as emerging from social interaction (Faris, 1967) and methodologically they

relied on the study of a single case or unit such as an individual, a group, a neighbourhood, or a community (Wiley, 1979).

Although the characteristics of the Chicago School methodology are numerous, the following are frequently highlighted. Researchers relied on first hand data gathering, a technique that was heavily influenced by W.I. Thomas and Robert Park. Also, as by this time few settings existed that had been untouched by contact with the west, these ethnographers turned to the study of subcultures. The emphasis on intensive study of city life provided the beginning of a trend, which continues to be the focus of those trained in the anthropological tradition today. Some important works emerging from this focus on subcultures include: The Gold Coast and The Slum (Zorbaugh, 1929); The Boys Gang (Thrasher, 1927); The Hobo (Anderson, 1923); Boys in White: Student Culture in Medical School (Becker, Geer, Huges & Strauss, 1961); and, Timetables (Roth, 1963). As all these studies have a number of commonalties (e.g., meaning is of essential concern, the natural setting is used as the direct source of data, participant observation is used as a data collection method, and descriptive data are analyzed inductively), it becomes apparent that these researchers have a similar understanding of what is meant by ethnography and work from a common methodological tradition.

The term **naturalistic inquiry** is also used in conjunction with ethnography. However, existing formulations of naturalistic research differ markedly. Naturalistic theorists and practitioners have seldom been in agreement on what they meant by this method (Denzin, 1971). Catton (1966) views it as a rigorous positivism. For Matza (1969) it is seen as humanism in disguise. In education qualitative research is often

called naturalistic inquiry as the researcher is found where events occur naturally and the data is gathered by people engaging in natural behaviour (Guba, 1978: Wolf, 1979). For still others such as Barker (1968), and Hutt and Hutt (1970), naturalistic inquiry is equated with **ecological psychology and/or ethology.**

Lofland (1971) describes naturalism as a deep commitment to the collection of rich and often atheoretical ethnographic specimens of human behaviour. Denzin (1971) perceives all such formulations of naturalistic inquiry as deficient due to what he perceives as an absence of a more general theoretical perspective. He proposes a view of naturalism which stems from Mead's behaviourism (1934, 1938) and Blummer's (1969) symbolic interactionism.

"I call this version of the research act naturalistic behaviourism and mean by the term that studied commitment to actively enter the worlds of native people to render those worlds understandable from the standpoint of a theory that is grounded in the behaviours, languages, definitions and feelings of those studied" (Denzin, 1971: 168).

Once again an umbrella term, naturalistic inquiry, exists that refers not only to ethnography but also to several other different theoretical and methodological strategies.

The term **qualitative research** appears to have become more popular in the 1970s among educational ethnographers. At this time these methods could not claim a central position in research methodology but they were no longer labeled fringe efforts. As methodological debates continued between quantitative and qualitative factions, qualitative evaluation research gained prominence (Guba, 1978; Patton, 1980), and some well known

researchers in quantitative circles (Cronback, 1975; Glass, 1975; Bronfenbrenner, 1976), discovering that "hard science" was not adequate, began exploring and advocating qualitative approaches (Bogdin & Biklen, 1982).

Although some qualitative researchers (Wolcott, 1973; Metz, 1978; Rist, 1978) in education were doing what they considered "fieldwork, participant observation, indepth interviewing or ethnography-by spending extended amounts of time at the research site with the research subjects or with documents" (Bogdin & Biklen, 1982), there did not then and does not now, appear to be a clear common understanding of the term ethnography as it relates to education.

It is apparent that the exact use and formulation of labels associated with ethnography vary markedly from person to person and from discipline to discipline, and continue to evolve and change over time.

C. THEORETICAL FOUNDATIONS OF ETHNOGRAPHY

Ethnography has important theoretical and epistemological foundations. These include phenomenology, symbolic interactionism, cultural ethnography and ethnomethodology. Phenomenology and symbolic interactionism are discussed further as both have relevance to this study.

Phenomenology

Phenomenology, which represents the effort to describe human experience as it is lived (Merleau-Ponty, 1964), is not just a research method but is also a philosophy and an approach (Psathas, 1973). It has been suggested that the failure of researchers to understand the difference between phenomenology as a philosophy, as an approach or as a research method has lead to those more comfortable with quantitative methods claiming phenomenolgy is "ambiguous and ill-defined and full of cryptic yet pregnant slogans" (Koch, 1964). Contrary to this accusation, phenomenology, as a research method , can be differentiated as a viable and useful qualitative approach (Omery, 1983).

The phenomenological method is both descriptive and inductive. Researchers who utilize this mode attempt to understand the meaning of experiences, events and interactions to ordinary individuals in particular settings and situations (Bogdin & Biklen, 1982). The task of the phenomenological method is to describe through investigation all those phenomena, including human experience as these appear "in their fullest breadth and depth" (Spiegelberg, 1965). In order to ensure that the phenomenon is investigated as it is experienced or truly appears, "phenomenological inquiry begins with silence" (Psathas, 1973). The

researcher must prepare to see rather than think about the phenomenon (Spiegelberg, 1976). To do this the individual must approach the phenomenon with no anticipated expectations or categories.

Also as the phenomenologist has no preconceived operational definitions and is not seeking to validate an existing theory or concept, all research data can be accepted as given. The researcher attempts to understand and emphasizes the perspective of the participants in the experience. Phenomenological researchers strive to enter the conceptual world of their subjects in order to appreciate the meaning individuals construct around activities and events in their daily lives (Geertz,1973).

The concern, then, of the researcher is both to understand the subjective perspective of the individual who has the experience and the effect that it has on the behaviour or lived experience of that person (Morris, 1977). The goal of the method is to describe the total picture of the lived experience, including the meanings those experiences have for individuals who take part in them. Blumensteil (1973) describes the method succinctly as "the trick of making things whose meanings seem clear, meaningless and then, discovering what they mean."

So where did this phenomenological method come from? Phenomenology as a method for the human sciences grew out of a philosophical movement that is still in a process of clarification. Researchers in the social sciences who gave form to the phenomenological methods were inspired but not bound to phenomenological philosophy. Edmund Husserl (Davis, 1973) can largely be credited with the birth of the phenomenological philosophy as a school of thought and as a method. It appears that this method began to crystallize in reaction to the denigration of philosophical knowledge

and the objectification of humans (Omery, 1983). The resultant method is a solitary, introspective process that aims at "seeing the clear apprehension of the evident giveness" (Kohak, 1978).

Spiegelberg (1960,1970) identified six methodological steps that are common to all interpretations or modifications of phenomenological philosophy- descriptive phenomenology; phenomenology of the essences; phenomenology of the appearances; constitutive phenomenology; reductive phenomenology; and hermeneutic phenomenology. Most phenomenological researchers in the social sciences have been inspired by, rather than directly applying, Spiegelberg's philosophical phenomenological method, and prefer not to restrict the phenomenological approach to a sequence of steps or a structured methodology (Psathas, 1973; Morris, 1977; Swartz, 1979).

The impetus for the human sciences evolved out of what researchers perceived as the failure of the method of natural sciences to adequately explain the phenomenon the human scientists were investigating. Human science researchers believed the traditional methods of the natural sciences were too simplistic and demeaning (Omery, 1983). The strongest impetus for this methodological development was in psychology. Van Kaam (1959, 1966) formulated the first approach. Two other much-utilized phenomenological methods are those identified by Giorgi and associates (1975) and later Calaizzi (1979).

It is clear that while researchers who advocate the use of phenomenology display theoretical and methodological differences they all share to some degree the goal of understanding human subjects from their

point of view and describing human experience as it is lived. This is one of the goals of this study.

Symbolic Interactionism

Symbolic interactionism, the dominant perspective in Social Psychology, also guides the thinking and research of many sociologists. It is a social-scientific perspective which takes a less deterministic view of human beings than quantitative perspectives and a more critical approach to science. Here, theorizing is generally limited to the micro level. Instead of focusing on the individual and their personality characteristics (as have classical psychologists), or on the social structure or the situation which causes individual behaviour (as have social psychologists who draw from classical sociology), symbolic interactionism focuses on the nature of the interaction and on the dynamic social activities taking place between persons. (Wells, 1978; Bogdin & Biklen, 1982). Symbolic interactionism emphasizes that the self evolves through the exchange of meaningful symbols with other human beings. Social life and its rewards are viewed as an emerging product of interaction (Berger & Luckman, 1967).

Other important ideas distinguishing this perspective and related to its focus on interaction are the attention symbolic interaction pays to defining interaction, the present and the individual as an active rather than passive participant in the world. Interaction is not simply defined as what is happening between people, but also by what is happening within the person. Each individual is viewed as acting in the present. The past only enters the present as it is recalled in the present. Finally,

symbolic interactionists view individuals as being unpredictable and active in their world. Individuals are seen as making conscious choices about their actions in relationship to both themselves and others, and thereby directing and redirecting themselves accordingly (Charon, 1985).

Congruous with phenomenology and basic to symbolic interactionism is the assumption that human experience is mediated by interpretation (Blummer, 1967). Individuals, objects and experiences are not viewed as possessing their own meaning; meaning is given to them. People act as interpreting, defining, symbolic animals rather than on the basis of predetermined responses to previous interactions or to predefined objects. Interpretation is aided through interaction with others and through this interaction the individual constructs meaning (Bogdin & Biklen, 1982).

There are specific schools within symbolic interaction tradition, the most common division being between the Iowa School and the Chicago School. Social scientists such as Koch in the Iowa school conduct quantitative research, while the Chicago school which is derived directly from the work of the founders of symbolic interactionism, conduct qualitative research (Well, 1979; Bogdin & Biklen, 1982). Although symbolic interactionism can claim some heritage from German sociologists Max Weber and George Simmel and French psychologist Gabriel Tarde, it is usually traced back to the work of Americans George H. Mead, John Dewey, James W.I. Thomas and Charles Cooley (Meltzer, Petras & Reynolds, 1975).

Cooley is best remembered for his concepts of "primary group" and "looking glass self"- the notion that each individual's self perception emerges from how we believe others perceive us. Thomas is known for his emphasis on " the definition of the situation"- the idea that in terms of

social consequences it is the person's perception of reality, not the reality itself that matters. Dewey, the pragmatist and philosopher, taught at the University of Chicago and was the center of the symbolic interaction circle. Much of Mead's influence comes through the publishing of his lectures and notes by students. Equally as important is the integration and interpretation of his work by sociologists such as Herbert Blummer. He is symbolic interactions leading exponent. Blummer stresses the symbolic nature of human interaction, the existence of self and the conscious construction of the interaction within the social context (Blummer, 1969; Charon, 1985; Wells, 1979).

Symbolic interactionists are critical of the traditional social science, with its use of scientific methodology for studying human beings. They believe that human study must be determined by the nature of the empirical world under study. Symbolic interactionists believe they must understand how humans; define situations, act in the present, and solve problems confronting them. This would mean a major shift in thinking for other scientists who contend the past causes present action. The symbolic interactionist calls for a different direction, as summarized by Blummer (1969, p. 48):

"Symbolic interactionists believe that the determination of problems, concepts, research techniques, and theoretical schemes should be done by the direct examination of the actual empirical social world rather than by working with a simulation of that world, or with a preset model of that world, or with a picture of that world fashioned in advance to meet the dictate of some imported theoretical scheme or of some scheme of scientific procedure, or with a picture of the world built up from partial

and untested accounts of that world. For symbolic interactionists the nature of the empirical social world is to be discovered, to be dug out by a direct, careful and probing examination of that world."

A central goal then of social science, viewed by the symbolic interactionist, is the careful description of human interaction. This is achieved through careful observation of social action, description of the important elements involved, followed by description and redefinition of these elements. Another important rule is the gathering of data through observing real life situations (Charon, 1985).

Denzin, who has done significant empirical work within the perspective of symbolic interactionism coined the term "Naturalistic Behaviourism" for a methodology which outlines the principles that he believes should govern scientific inquiry within this tradition (Denzin, 1971). Both Denzin's description of naturalistic behaviourism and his own work in the study of deviance stand as examples of a symbolic interactionist approach to scientific investigation.

Although empirical studies drawing from symbolic interactionism are tremendously diverse, each focuses on interaction, definition, meaning and social worlds. This is the case with the present study. As such, they all conform to a great extent to the scientific principles outlined by Denzin and are based on the data from real life situations.

D. RESEARCH TECHNIQUES EMPLOYED IN ETHNOGRAPHY

This section reviews the various techniques and methods employed in ethnography. Usually, ethnographers are found in natural settings and study a defined social unit such as "a person, a status, a type of behaviour, a relationship, a group, or a nation" (Strauss, 1970). The goal of the research

> "is focused on analytic abstractions and constructions for the purpose of description, or verification, and/or generation of theory" (Strauss, 1970).

In the first stage of research, the ethnographer must gain access, cultivate rapport, begin developing sensitizers and remain open to the participants and the setting(s).

The ethnographer "**gains access**" to the selected setting(s) by obtaining both formal and informal permission to carry out the research (Bogdin & Biklen, 1982; Burgess, 1984; Hammersley & Atkinson, 1983). At times, formal access is obtained from an authority who is not a participant in the setting(s) under study. Informal access is the primary mechanism for establishing rapport with the participants. When the goal of the research is to achieve the participants' perspective, informal access is of primary importance. Once access has been gained and **rapport** is developed the research can proceed.

The methods an ethnographer uses to collect data in the setting include the use of a field journal, recording of field notes, formal and informal observations, indepth interviews and documentary analysis.

The ethnographer must draw up an **observation schedule** to outline the times when observations will be conducted. This schedule must be

comprehensive so as to ensure that observations will thoroughly reflect the activities, events, places and people in the setting(s). Once the observation schedule is formulated the ethnographer will observe in accordance with the plan. Two types of observations are recorded; **informal and formal observations.** Informal observations build a general data base about the setting and the participants, while formal observations provide detailed observations of specifically chosen activities, events and people.

The **field journal**, a record of the research process and the reflexivity of the ethnographers role on the setting, contains recorded impressions, analytic notes, personal reflections and feelings, thoughts, ideas and important events as perceived by the ethnographer.

Two other important techniques documented in the field journal are **reflexivity** and the development of **sensitizing concepts.** The reflexive character of social research recognizes that we are part of the social world we study. Therefore, there is no way we can escape the social world in order to study it. This is a fundamental tenant to this tradition and means the process of social inquiry, the researcher, the participants and the setting are all part of the same reality and therefore are all a component in understanding the social world. Reflexivity means ethnographers must take into account their effect on the setting. This can be accomplished by testing hypotheses against other information and data collected in the setting(s). Sensitizers are ideas, concepts and theories that emerge out of the data or are those brought to the research by the researcher. Sensitizers enable the researcher to develop awareness

of patterns and understanding of the participants in the setting(s) (Hammersley & Atkinson, 1983).

The beginning stages of the research process have been described as being on the top of a funnel. At this time, the funnel is wide open and the ethnographer experiences a sense of confusion and bewilderment. At this time, it is important that the ethnographer remains open to ideas, experiences and concepts. As research continues the funnel narrows and the ethnographer becomes progressively more focused and clarity develops.

Stage two of the research process involves the development of an extensive data base. The informal and formal observations, followed by the interviews, serve to build this data. Ethnographic interviews are reflexive. Usually, ethnographers do not decide beforehand on the interview questions, though the researcher may develop a list of issues to be covered which may reflect observations. By now the ethnographer should be an accepted and unobtrusive part of the setting(s). Sensitizing concepts, ideas, hunches and analytic notes continue to be documented in the field journal. If the sampling plan is not comprehensive enough, it should be modified to capture the full experience of the participants and ensure an adequate data base. At this time there can be a danger of "going native" (Burgess, 1984). This only occurs if the ethnographer becomes so involved with the participants that there is an over identification with their perspective. The field journal is the place where "going native" is monitored to avoid premature saturation in the setting.

The ethnographer constantly reviews the data base. Sensitizing concepts, hunches and analytic notes must be explored to determine their

efficacy in analyzing the data. The ethnographer should take a break from the setting from time to time (between processes such as observations, interviews and formal analysis), to maintain perspective and to review the emerging sensitizing concepts. This allows the theory to emerge from the data. Now, the data is reviewed for key words, phrases, ideas, topics, activities, patterns and themes in preparation for coding and analysis. Also the researcher should be aware of inconsistencies and exceptions or negative instances to emerging patterns. As the researcher focuses more specifically on the setting the research process moves down the funnel.

When the data base is complete stage three, the coding process can begin. **Coding** (Glaser, 1978: 55):

"(1) both follows upon and leads to generative questions;

(2) fractures the data, thus freeing the researcher from description and forcing interpretation to higher levels of abstraction;

(3) is the pivotal operation for moving towards the discovery of a core category or categories; and so

(4) moves toward ultimate integration of the entire analysis; as well as

(5) yields the desired conceptual density".

The coding categories must allow for the inconclusiveness of all the participants, activities, events and setting(s).

Also, the sensitizing ideas, concepts and theory must be constantly reviewed for the inclusiveness of data. As such the analytic framework that is developed from this process arises from the data. The ethnographer uses induction to develop a comprehensive analysis of the data. The data are coded through sensitizing concepts to develop

categories, themes and typologies which form a model for the analysis of the data. To check the analytic framework the frequency, distribution and typicality of the categories in the emerging model are taken into account. **The constant comparison method** (Glaser, 1964, p. 439) is used for:

"(1) comparing incidents applicable to each category;

(2) integrating categories and their properties;

(3) delimiting the theory; and

(4) writing the theory".

This method provides a process where by the ethnographer can inductively develop theory from the data.

At this point the ethnographer is ready to triangulate the data and the model. **Triangulation** entails cross validation or comparison of data to determine whether there is corroboration between the multiple data sources (e.g. documents in and between settings) and multiple data collection procedures (e.g. documents, interviews and observations).

The final stage of ethnographic research is linking the researchers model to theory. This is viewed as an important part of the ethnographic research process. Glaser & Strauss (1967), who developed "grounded theory", believed the emergence of theory from data ensures a "fit" between the theory and the social phenomena being studied. Grounded theory requires that researchers inductively compare their data and theory, with other data and theory concerning the social world. Theoretical integration is important if substantive and formal theory is to be generated.

E. SUMMARY

In recent years interest in ethnography has grown as a reaction to positivism and as recognition that this tradition is better able to provide an adequate framework for social research. Ethnographers are interested in the ways in which individuals construct reality and they acknowledge the fact that the researcher is also part of the social world they study.

The research process consists of defining the social unit, gaining access to the setting and developing rapport to explicate the participants' perspective and their experience of the social world (Hammersley & Atkinson, 1983; Strauss, 1987; Bogdin & Biklen, 1982, Strauss & Glaser, 1970).

II. THE RESEARCH DESIGN

This section reviews ethnographic research as a methodology for this research project. The research design is presented following which the purpose, goals and foreshadowed questions of the study will be outlined.

A. ETHNOGRAPHIC RESEARCH AND HEALTH PROMOTION FOR SENIORS

Despite a long standing tradition in sociology and anthropology (Becker, 1970; Blummer, 1969; Glaser & Strauss, 1967), qualitative methods that attempt to understand the reality of people's lives, are only recently gaining credibility in human and social service research. Most research in this field has relied on quantitative methodology which utilizes precise sampling strategies and statistical analysis, in an attempt to seek the facts or causes of social phenomenon and human

behaviour. In contrast, ethnographic research in the phenomenological and symbolic interactionist traditions, strives to understand human experience and behaviour from the actors' perspective. Ethnographic methods emphasize the individual and their perception of experiences, events and interactions in the world, and therefore, produce data that is rich, in-depth and detailed (Patton, 1980).

In the field of health promotion "research questions identified are wide-ranging and complex" and "as such they are not easily adaptable to narrowly focused short-term investigations that use only quantitative methods" (Health and Welfare Canada, 1989/90). Many advocates of health promotion for seniors believe health promotion research needs to place increased emphasis on qualitative methods (Mollenill, 1987; Martin, Robertson & Altman, 1988; Minkler & Pasick, 1986).

Ethnographic research is particularly well suited to the present study which emphasizes individuals' perspectives about the program components and process in five health promotion programs for seniors in the Vancouver area. A health promotion program involves a social organization where groups of seniors interact with health promotion coordinators in regular and structured ways. Potentially the behaviour of seniors and coordinators are mutually influenced. Also, both groups' behaviour may be influenced by rules and relations developed over time. In order to describe the components and factors contributing to program composition (the purpose of the research), an understanding of the perspectives and activities of the coordinators and seniors involved, is vital. As ethnographic inquiry focuses on organizations within specific contexts and provides a holistic perspective, without superimposing the

researcher's value system on the situation, it is deemed the most appropriate method for this study.

B. THE RESEARCH PURPOSE

The purpose is to study the programming components and contributing factors to composition in health promotion programs for seniors in the city of Vancouver, British Columbia.

C. THE RESEARCH GOALS

In this ethnographic research the goals were developed to enable the researcher to gather information from a variety of perspectives on vital functions and processes. The specific goals are:

1) To examine the perceptions of both the participants and coordinators, with regard to both the program components and the factors contributing to program composition.

2) To describe and analyze program planning processes, program components and the factors which contribute to program composition.

3) To identify themes, patterns and categories from an analysis of the various perspectives.

4) To identify implications of the information gathered for future program process and development.

D. FORESHADOWED QUESTIONS

Health promotion programs for seniors in the city of Vancouver have a variety of components. Questions arise about these components which include:

1) What is the focus of program components?

(A topic of interest to the researcher is the balance of focus among programs between individual behavioural change and underlying environmental and community change components. As these categories are brought to the research by the researcher they would have been abandoned, if not applicable, as the research proceeded.)

2) Does the profile of program components vary among health promotion programs?

3) What factors best contribute to explain this variation? Some possible explanatory factors may be:

- organizational structure, e.g., funding sources, program control, organizational goals and frameworks
- perspectives of coordinators
- perspectives of participating seniors
- program size
- cultural, economic, and social characteristics of the community.

E. DEFINITION OF TERMS

Health Promotion Program: A program which incorporates "any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental changes conducive to health" (Green, 1980). A health promotion program enables people "to increase control over and to improve their health (World Health Organization, 1986)."

Individual Behavioural Change Components: Programming that focuses upon personal health attitudes, self-management of chronic health conditions, nutrition, exercise, stress management, personal sense of purpose, personal support systems, and personal environmental awareness and participation.

Underlying Environmental and Community Change Components: Programming that includes a focus on those political, economic and organizational factors that affect promotion of immediate individual behavioural change components, e.g., available community supports, self-help groups, outreach services, information networks, environmental hazards, and social and economic factors such as social isolation, poverty and ageism.

Seniors: Individuals 55 years and older.

Ethnographic inquiry proceeds from the position that hypotheses may emerge as the data collection occurs and the researcher is better able to appreciate the meaning individuals construct around activities. Therefore as events and experiences occur, initial tentative questions may be abandoned if subsequent data fails to support them.

III. THE RESEARCH METHODOLOGY

This section applies the ethnographic research approach to this study, in terms of the details of selecting the sample; the role of the researcher; gaining access; data collection techniques; and analyzing the data of the study.

A. THE SAMPLE

In order to explore the purpose of this study the researcher identified seniors' health promotion programs from a sample of Vancouver Health Department seniors' health promotion programs. The particular programs were selected for the following reasons:

1) These programs were specifically labeled seniors' health promotion programs. In fact, in November 1984 the Vancouver Health Department established seniors' wellness (health promotion) positions in each health unit in response to a request by the Council Committee for Seniors for seniors' programming. The staff has been at work for six years implementing seniors' health promotion projects in conjunction with seniors and seniors' interest groups in five different areas of urban Vancouver. Together these five areas make up the parameters of Vancouver City. Twenty three programs were in operation when this research began. The five coordinators either identified existing seniors' interest groups or agencies in the community, or were approached by them. The development of health promotion activities/programs was facilitated through these community groups or agencies.

2) Satisfactory access to the necessary groups and data appeared likely because two coordinators were approached and were supportive of the research as it would explore program process. Program process was viewed as the key aspect of each program, and qualitative methods which could describe the structures and dynamics of this ongoing program process were deemed essential to program evaluation. Also, access to individual programs and seniors appeared likely because a working relationship

already existed between the coordinators and the seniors in the selected programs.

B. THE PROGRAM SELECTION PROCESS

One health promotion program was selected from each of the coordinator's areas:

Area One: 1 coordinator, 4 programs

Area Two: 1 coordinator, 8 programs

Area Three: 1 coordinator, 1 program

Area Four: 1 coordinator, 6 programs

Area Five: I coordinator, 4 programs

Opportunistic sampling was used for program selection i.e., the researcher conducted the study in one setting per area where cooperation was most easily obtained.

C. THE SUBJECT SELECTION PROCESS

All five coordinators were interviewed. In each of the five settings, two categories of seniors were asked to volunteer to be interviewed. There were at least one senior from category one, and at least two seniors from category two. Table 1 outlines the subjects selected from each setting. The number of senior interviewees increased with the program size. Twenty one seniors were interviewed in all. Senior interviewees from category one, were based on the following criteria: they were active participants in program development and/or implementation; they had been program participants for at least one year; they were viewed by other seniors as a senior leader; and they were able

TABLE 1
NUMBER AND TYPE OF SUBJECTS SELECTED FOR INTERVIEW

PROGRAM	SIZE	PROFESSIONAL	SENIOR CATEGORY 1		SENIOR CATEGORY 2	
			Female	Male	Female	Male
A	20	1	1	0	2	2
B	35	1	0	2	2	2
C	20	1	2	0	2	0
D	10	1	2	0	2	0
E	55	1	3	0	2	1

historians of the program. Seniors in category two met only one criterion; they were program participants. Where possible a male was selected as one of the two in category two, because very few men attended these programs and it was deemed important to obtain a male perspective.

D. CONFIDENTIALITY AND RESEARCH CONSENT

In order to protect the integrity and rights of the participants, the names of the seniors, the coordinators, the programs and their locations have not been identified. Confidentiality was guaranteed to everyone as part of the consent process for participation in the research study.

The coordinators were unanimous in their approval of the research proposal. Each health promotion program was then approached by the researcher, and approval and permission was unanimous from the seniors. Letters of research consent and agreement to participate in the study are in Appendix A.

E. THE ROLE OF THE RESEARCHER

The role of the researcher can be regarded as a range of possibilities that fall on a continuum between the 'complete participant' and the 'complete observer.' Two other roles which fall between these are the 'participant as observer' and the 'observer as participant' (Gold, 1958; Junker, 1960; Hammersley & Atkinson, 1983; Williamson, Karp, Dalpin & Gray, 1986).

The 'complete observer' and the 'complete participant' remain totally disguised, with the 'complete observer' observing from a concealed position and the 'complete participant' observing by becoming almost fully involved in the setting, both emotionally and behaviourally. The two remaining roles differ according to the emphasis placed on the amount of detached observation versus active participation. The 'participant as observer' tends to participate yet openly states her/his research intentions to those being studied. The 'observer as participant', on the other hand, is a more formal role and the contact with the participants tends to be brief and essentially observation only.

The 'participant as observer' role was the goal of the researcher for this study. The researcher met with the coordinators and seniors to explain the purpose of the study. The researcher's role conflict was minimal as she retained sufficient elements of 'the stranger' (Gold, 1958) yet was able to develop her relationships with informants to the point of intimate sharing.

There was little danger of over-identifying or 'going native' (Malinoski, 1922) with the seniors, because the difference in age and needs were sufficient to preclude the 'going native' dynamic. The

relationship between the researcher and coordinators was somewhat different for the professionals had similarities with the researcher in age and social role. However, the coordinators did not attend all portions of the programs which decreased the opportunity for 'over rapport' (Hammersley & Atkinson, 1983) to develop. The researcher was aware of the dynamic and tried to guard against the tendency to accept the ideas and opinions of the coordinators.

The seniors and coordinators were briefed on the nature of the study and the role of the researcher. All observations were openly recorded in front of the participants

The researcher had conducted a small pilot project five months earlier in one selected setting. Due to the low turn over in coordinators and seniors most individuals were familiar with the researcher in this setting. The pilot project served to acquaint and sensitize the researcher to seniors and the role of the coordinator.

F. DATA COLLECTION AND RESEARCH TECHNIQUES

The researcher maintained a field diary, recorded field notes of observations, conducted audio-taped interviews, collected pertinent documents, and typed the observations and interviews into a computer in a protocol format for analysis. This process was simplified with the use of a computer program called The Ethnograph (Seidel, Kjoiseth, Seymour, 1988) which assisted the researcher with the mechanical tasks of protocol formatting and the categorization of data. It in no way interfered with the analytical process of the study.

The Field Diary

The field diary or journal was maintained throughout the study to monitor reflexivity, inferences, and impressions held by the researcher. It was used to record the researchers impressions, hunches, reflections, ideas and analytic notes while in the setting. An example of an impression, a reflection and a hunch in the field dairy is the entry on May 1st, 1989 which reads;

> When one of the wellness coordinators spoke with me today and mentioned she likes to close things down in the summer as feels the seniors need a break, I wondered who closing down the program was for, her or the seniors and who makes this decision; professionals, seniors or both. I made a mental note to observe the decision making process in this group as my hunch was professionals decide.

The diary was also used to record and to monitor thoughts and feelings about the researcher's role and her relationships with seniors and coordinators. As the study proceeded, the field diary was used to

speculate on emerging themes, patterns and possible categories for the analysis of the data.

The Field Notes

As a participant observer the researcher kept field notes each time she was in each setting. As the researcher was involved in all aspects of the programs, the fieldnotes recorded all activities and events that transpired in the programs during the informal, formal and focused observation periods. (The observation schedule is listed in Appendix B. Examples of informal, formal and focused observations are in Appendix C.)

The overt role of the researcher allowed her to openly record observations. These observations were noted in five note pads (one for each setting). At the start of each observation the format was recorded i.e. the date, time, place and people.

The field notes began with **informal observations.** Two informal observations were conducted in each setting. The researcher recorded the format, a general description of the settings, the tone, dress, and a checklist of descriptive observations outlined by Spradley (1980, p. 78). The informal observations were general and descriptive. One example of a protocol which recorded an observation of the scene on first entering a program on May 3rd, 1989 follows:

> OB: I arrive at approx. 12:45 pm and walk into the C.C. It is a very large building with many recreation activities. I am instructed to move upstairs to the Room where

Program E is held. The doors are locked but a number of women are inside. I meet one volunteer (V.1) who I introduce myself to. I was able to get in saying I am the researcher. There are 9 woman busy at booths and wandering back and forth chatting.
I notice 8 seniors are locked out. Inside the door there is a long table where 3 people are stationed. I understand from V.2 who approached me and introduced me to a number of the Seniors that this area is the Registration area. Two woman, V.1. and V.3. are behind the table now chatting. The table has a sign "registration" on it. V.5. approaches me and tells me about the "Seniors in Action" day. He has some pieces of paper with him and explains that they are info about this event on May 6th at a C.C.
He also has Program E's philosophy and goals. He offers them to me and tells me I can Xerox them in the library down stairs. V.1. has pointed out

all the seniors volunteers and their
stations and takes me around and
introduces me to everyone.

BR: I am aware I am made very welcome.

The informal stage provided the researcher with the opportunity to develop acceptance in the setting and sensitized her to the seniors, the professionals and the program schedule.

The **formal observation** notes were more specific. Two formal observations were conducted in each setting. The researcher documented format, routine, verbatim 'native language' and any emotional responses that were expressed. For example, a protocol from one program describes an interaction between a volunteer and two seniors at the massage area:

OB: I move to the foot massage area.
A volunteer, 1 female and 1 male are
present. The female was at the shoulder
massage area before. The male is having
a foot massage.

MALE: Is it still raining hard?

FEMALE: No. I go to get my nails done. I'm
spoilt. I wasn't cutting them right.
The RN does a good job. Then I go to
Eatons for a coffee.

VOL: And make a day of it.
So your muscles are good. There you go.

MALE: Thank-you.

OB: Woman changes place with man.

FEMALE: Isn't she good.

OB: She makes this comment to me

FEMALE I feel so good

after this treatment. I had my

shoulders done too.

It was during these observations that a rapport between the researcher and participants seemed to heighten.

The **focused observation** notes were the most specific. These focused on program process and planning in each setting. For example, the following from a protocol is a segment of a planning meeting which was attended on July 17th, 1989, were a professional is discussing senior participant involvement in decision making about program content with the senior volunteers.

PROF: One thing I got to let you guys

know about on the 1st day back in

September in stead of having a guest

speaker we'll use the time as an open

discussion with the attenders as to

what it is that they will like to have

at Program E. Now we are thinking of

things in terms of guest speakers but

we might come up with some ideas if

you like this kind of impute for the

activities and that kind of thing and

they might even suggest...It sorta

will be a chance to find out what kind

of things they would like to see.

What do you think?

OB: A # speak at once nodding

in agreement and verbalizing

they think this is a good idea.

No further comments are made from

the seniors.

PROF: So that would be between 3:00 &

4:00 instead of a guest speaker.

Two focused observations were conducted in each setting. In those settings where specific committee meetings were held, these were attended. Where planning meetings did not exist, the portion of the program which involved program planning was observed.

The Interviews

Three approaches to interviewing approaches were combined in this study: the **informal conversational interview**, the **general interview guide approach**, and the **standardized open-ended interview** (Patton, 1980). The researcher used the two latter interview approaches to obtain data that was systematic and thorough, while informal conversational interviewing was used to maintain the flexibility and spontaneity of responses. The common characteristic of all three ethnographic interviewing approaches is that they provide "a framework within which respondents can express their own understandings in their own terms" (Patton, 1980, p. 205).

The purpose of these interviews was to understand how seniors and coordinators viewed the program. Also, it was important to learn the

participants terminology and to capture their individual perspectives and experiences.

Prior to the formalized interview period, informal conversational interviewing took place in the observation period. This type of interview is a phenomenological approach to interviewing in which the researcher has no preconceived ideas about what can be learned by talking to the seniors and coordinators in the program. The responses from these informal interviews and data gathered from the field observations were reviewed to move the researcher from a level of generality to that of a more specific nature where a set of issues could be explored in the formal interview phase (Becker, 1954).

Following the observation period, the researcher conducted audio-taped, semi-structured interviews with all five coordinators and 21 seniors. The coordinators and seniors in category one were each interviewed for one hour, and the seniors in category two for half an hour. These interviews combined the general interview guide approach with a standard open-ended interview. A set of topics served as a check list to construct open-ended questions. Interviews conducted with coordinators and seniors from category one allowed examination of the following topic areas: history of wellness/health promotion for seniors in Vancouver; funding; program history; program frameworks and goals; program focus and content; program process; senior and coordinator participation in program planning and implementation; attendance patterns; and, specific program themes. Topics differed slightly for the seniors in category two, where the focus was specific to each program The topic areas comprised: program history; program content and process; attendance patterns;

community characteristics; and, emerging program themes. (The interview schedule is outlined in Appendix D. Interview Questions are listed in Appendix E.)

The Documents

Documents which provided insight about program activities and the process of program development were gathered from seniors and coordinators throughout the data collection phase . These included Health Department and specific program conceptual frameworks, goals, schedules, funding sources and minutes of pertinent committee meetings.

The Protocols

The written observations from the field notebooks and the interview data were typed into protocol format. This allowed for ease of reading and coding of the details and descriptions of the activities and interactions in each setting. See Appendix C for examples of informal, formal, focused observation protocols. See Appendix F for examples of interview protocols of a coordinator, a category one and a category two senior.

The observation and interview data were typed into a computer at the end of each data collection period. The process of transcribing data was useful in itself as it provided the researcher with another opportunity to reread the information thus increasing her familiarity with the data. Ideas, hunches and insights were often added to the field journal during this process.

Once the protocols and the documentary data were reviewed for patterns, categories and themes this became the data base for coding and analyzing.

G. DATA ANALYSIS

The underlying assumptions of ethnographic research suppose a lack of separation between the data collection and the analysis phases. As such, data analysis was continual throughout this research study.

Like most ethnographic studies, this project did not begin with a theory or hypothesis to test. It should be noted however, that the researcher was interested in the balance of focus among selected health promotion programs between individual behaviour change and environmental and community change components, which is an idea brought to the research from the literature (Minkler & Pasick, 1986; Minkler, 1983). However, this tentative question would have been abandoned if subsequent data failed to support it. In this way the researcher was most interested in the perceptions, experiences and processes that emerged from the setting and these data were analyzed to identify **patterns, themes and categories of understanding** (Glaser & Strauss, 1976). Ideas, hunches, emerging sensitizers, patterns, themes, categories and analytic notes were documented in the field diary as data was collected from observations, interviews and documents. The researcher used sensitizing ideas and concepts to more fully explain the profile of program components and contributing factors to program composition.

The **constant comparison** of data and **sensitizing concepts** resulted in the development of coding themes and categories (Glaser, 1964). This

process of inductive analysis produced themes and categories in two ways. Some emerged directly from seniors and coordinators e.g. social interaction and support, housing, outreach, and from the program plan (initially identified in the pilot project), while others that they did not label or name were noted by the researcher e.g. program organization and process, attendance and community issues. It should be noted that social support and attendance were unanticipated categories. Social support, a significant theme to the seniors, emerged from the program plan category.

Although program plan was a frequent category in the pilot project, it was unnecessary to further explore this as a theme in the research study. Instead the comparison of program profiles became important using the sensitizing concepts 'Individual Behaviour Change' and 'Environmental and Community Change Components,' brought from the literature.

Program process and organization was the most frequently occurring category within and across the settings. It was also evenly distributed across the data sources. This category became the core concept of the developing model.

Triangulation was used to cross validate or compare information in order to determine whether there was corroboration of the data across time, across people, across methodological techniques and to pinpoint theory pertinent to the research.

In social research the researcher is warned to avoid reliance on a single piece of data as there is danger that undetected error in the data production process could render the analysis incorrect. In this study it was just as important and illuminating to look for differences between the

types of data as to look for diverse kinds of data that lead to the same conclusion. For example, a Health department document proposed a framework for health promotion for older adults that would address both individual behaviour change and underlying environmental and community change components in health promotion programming for seniors (Martin, Robertson and Altman, 1988), yet specific program outlines included no community and environmental change elements. Similarly, interviews conducted with coordinators and seniors shed light on similarities and differences in perspectives. Participant observation allowed the researcher to view which program components actually existed. In this example triangulation promoted comparison of information between multiple data sources and among multiple data collection procedures, as it involved that which was documented, which was commented on through interview and which was observed by the researcher.

It is an important technique in field research that theory must arise from and "fit" the data (Bogdin & Biklen, 1982; Burgess, 1984; Hammersley & Atkinson, 1983). The researcher reviewed the data and categories to link the theoretical concepts emerging from the data to existing theory. For example as concepts related to personal autonomy and control were outlined in documentary data and made reference to by coordinators and seniors, it became evident that victim blaming, empowerment and helplessness were concepts emerging from the data. Also as seniors' involvement in program process and organization was a clearly desired objective, and as organizational goals are a facet of organizational behaviour, organization theory is relevant to this study.

The conclusions will discuss literature and theory related to senior participation in program process and organization of health promotion programs and how this affects seniors' empowerment and control, and the focus of the programming. If however, the researcher was to conduct additional analysis of the substantive theory and acquire material from other studies which pertained to a data category, she could end up with a formal theory for a conceptual area such as how the decision making process affects autonomy and control of groups within society. This final stage is beyond the goal of this present research.

CHAPTER 3

THE PLACES, THE PEOPLE AND THE EMERGING ISSUES

This chapter provides a description of five wellness/health promotion programs from observation, interview and documentary data. Each description includes program history, content, funding, organizational structure, wellness/health promotion approach and the demographics of each local area in which the program is located. A description of the participants and professionals involved is given. Emerging issues from each program are discussed using the analytic headings; program organization and process, attendance, social interaction and support, and community issues (housing, community involvement, outreach). These emerging issues are presented in the order of the frequency they occurred in each program. Finally, each program is summarized outlining pertinent data from the description and discussion of emerging issues.

I. PROGRAM A

A. DESCRIPTION

Program A began in 1987 at a local community center in urban Vancouver. The community in which it is located contains about 32,000 residents (Canada Census, 1986), 21% of whom are seniors 55 years and older. Although 85% of the residents have English as their mother tongue, the ethnic diversity is large. Ethnic representation at Program A includes; English, Scottish, French, East Indian, Chinese and Ukrainian. The community contains a mix of low to high income families and single residents. Housing varies from single to multiple dwellings, of which 70% are rented and 77% are apartment and duplex in type. This is a community

in transition where affordable multiple resident dwellings are steadily being demolished and replaced by expensive duplex and quadruplex condominiums.

Program A is a jointly sponsored endeavour between the Vancouver Health Department and a community center. A needs assessment conducted by a community developer, hired by the Health Department led to its inception. Seniors were asked to identify health promotion needs at a health forum. Following this a Seniors Advisory Committee was formed and seniors, in partnership with Health Department staff, began to plan and implement neighbourhood health programs. Program A is one of these. Although this program has no directly funded positions, a wellness coordinator who is paid by the Health Department, implements and, where necessary, facilitates this and other senior wellness programs in Community A. As well, one community center staff member who conducts seniors programming, has input into the development and ongoing running of the program. Space is provided by the community center. Program planning occurs on an ad hoc basis between seniors and professionals. The community center provides an exercise instructor and the wellness coordinator facilitates discussions.

The program is a "free health-related program for individuals 55 years plus." It operates on Wednesdays 10:00 a.m. - 12:00 p.m., throughout the year. The average attendance is 20 people, four of whom are men. Program components include; "fun and fitness exercise", "once a month blood pressure monitoring","refreshments", and "discussion on health related topics, chosen by the participants."

Although there is no official wellness/health promotion approach, the wellness coordinator adopts "A Framework for Health Promotion: Older Adults", a draft document produced in 1988 by the Vancouver Health Department. Here the goal is to "promote the physical, mental, social, and personal well-being of older adults, using strategies affecting both the individual and the environment." Seniors support this broad perspective, though their primary focus is on individual lifestyle change.

B. EMERGING ISSUES

Program Organization and Process

Program organization and process, which concerns how seniors are involved in the decision making process and the running of the wellness program, is the most typical of all issues that emerged about Program A. The professionals and seniors differ in their beliefs. Though seniors are verbally encouraged to be involved through mechanisms such as the Seniors Advisory Committee, active participation is often blocked by professionals. Conversely, seniors give a double message to professionals; while they say they want to be involved, their action often indicates they would rather not take on planning and leadership responsibilities.

One professional gave the message that "seniors should be helped to feel like they are getting control over programming," which can be "achieved by (us) starting where they are and working in partnership with them, "where they are seen as a resource and we are working with what they have rather than with what we think they need"; however other professionals have taken actions that do not support this philosophy. For

example, when a proposal for an Outreach Program was submitted to a federal funding agency by the seniors, it was vetoed by a community center professional group which had designated itself to address seniors needs. The seniors wanted a part-time coordinator of outreach activities. However, the professional group contacted the funding agency and suggested the seniors were capable of running the program themselves. Over time the seniors felt so stymied by these professionals that they "got discouraged" and "gave up" on the idea. The message from professionals is that they know what seniors need. This message is also given by the Seniors Advisory Committee. This committee though formed to act as a consulting body on seniors needs, has not allowed senior leaders to share their perspectives.

In turn, the seniors present a mixed message about their involvement in program organization and process. On the one hand some speak about how they have tried to be involved in program planning but are constantly disregarded by professionals. "We tried to acquire outreach funding" but "got discouraged." "We make suggestions to professionals like what topics we want to talk about, but as far as running the group we don't have any say." One senior's perspective represented others on the functioning of the Seniors Advisory Committee by saying, "I get the impression that there are certain professionals within that group who are making the decisions for people."

The other common response from seniors was one of reluctance and lack of motivation to participate in program decision making. Comments varied from "seniors lack the commitment" and "seem reluctant to be

involved" to "we are supposed to make decisions" but "we only have so much energy" and "we don't want to give that much time."

Attendance

Seniors and professionals agree that although there are multiple reasons for senior attendance at Program A, social interaction and support is of primary importance. Attendance patterns are influenced most by gender differences and the individual's proximity to the program.

Although the program is predominantly utilized by women, there is a belief that "there are men out there", who could come but "are reluctant." One of the attending men believes "reluctance is a psychological thing. I think men are on the whole quite intimidated by large quantities of women." Other seniors believe "men are not interested in exercises and socializing", that "maybe they don't see it (the program) as their thing", or that "they are too shy" and "not as motivated as women to join things." Many seniors and professionals however are surprised at the number of men who do come. It is interesting to note that this program began with one man and three women, and there has always been a man in the group.

Another factor affecting attendance patterns is the proximity of individuals to the program. A number of people felt that the community center is "too far away for many to come" and that others are put off by "a big hill to climb when coming from a certain direction." Some seniors had been keen to start an out reach program in another part of this community because of those access problems.

Community Issues

Housing. Housing emerged as an issue for this group as seniors had concerns about tax and rental increases, and felt their neighbourhoods were changing adversely. Although professionals indicated seniors could take control by "speaking out," seniors were left feeling "discouraged" and "without alternatives."

The housing crisis was viewed as a "very serious business". "What seniors are worried about is how much their taxes have increased this year", "rents doubled but incomes didn't" and "with taxes up what is the single person going to do about an apartment. It's very expensive, more than any amount of money that most of us have with the old age pension". These concerns lead to discussions on the "lack of alternatives" and expression of "fears and resentments" such as "to live within our means a lot of people are having to leave this area" and "rental stocks are decreasing." Many were "angry" and concerned that "the neighbourhood is changing" and fears were expressed that "seniors are being kicked out of their places and having to go to another area altogether that is affordable". Those who owned homes were concerned "if we sell where do we go?"

Professionals suggested taking control in some way. Such as "writing letters to government", attending "housing forums" and making "phone calls to a local number established to deal with tax and rental concerns." Though some seniors followed through with these ideas many felt the changes "were inevitable" and felt "discouraged" and helpless as there was little they could do to effect change.

Out Reach. Out reach is the process and programming involved in reaching out to seniors who are not attending a wellness/health promotion program. A group of seniors, with the support of one professional, submitted a proposal to a federal agency to fund a part-time position to coordinate out reach activities. Professionals interfered with this process and eventually the seniors gave up and withdrew the proposal. There were however, seniors in the group who were unenthusiastic about involvement in out reach activities.

One professional stated that "at one point seniors wanted to do out reach and organized a proposal requesting funding for a part-time out reach person, where that person could work with the group to find out what programs seniors want. In the middle of this process along came a group of professionals, and they all said they (the seniors) didn't need a programmer, that they could to it themselves." However the seniors "didn't want to take the responsibility on, they wanted to work with someone to do the out reach". They "never agreed" with the professionals but then the funding agency "agreed the seniors should do it themselves". Seniors supporting these comments said "we tried to get the grant and all we got was the run-around so we dropped it for a while", as the funding agency kept "changing the rules". One senior said we "don't want to go from door to door as we find it hard to knock on doors of perfect strangers". This comment was made in support of an out reach coordinator who would investigate how best to acquire information and utilize the seniors in the program in a way they feel comfortable.

Although professionals were viewed as interfering in this process, it should be noted that there are those seniors that don't appear enthusiastic about out reach. The following comments highlight this: "a considerable number of people are happy to come on Wednesday but they are not particularly concerned with having more people", or "they think it would be desirable but not essential" and "so some are for out reach, but if you look at the 14 other people here and ask them about out reach, I think you would get a tacit agreement, yes that would be a good thing but don't involve me in it".

Community Involvement. Community involvement includes seniors' participation in activities outside the wellness/health promotion program. Although community center staff encouraged senior involvement in organized trips into the community, those community oriented activities most pursued by seniors, such as volunteering and out reach, did not receive support by most professionals.

Although Seniors were encouraged to attend organized trips, volunteering was the community activity most frequently discussed by seniors. Many of those who attend Program A are involved in volunteering and indicated that this has been and will continue to be an important aspect of their lives. Seniors suggested "we all were used to doing community work and volunteer work" or that they do it because "seniors have to keep busy if they don't they stay at home all the time and that's no life." A number spoke of the importance of the social component of volunteering. "Although we are working, so we don't have a chance to chat that much, I've made a lot of friends there (Red Cross)."

It is noteworthy here that volunteering was pursued without much professional encouragement. Out reach was one example of senior involvement in a community activity which was not supported by professionals. The exception was the wellness coordinator who saw "the program as an entry point for a number of women who then volunteer or get involved on some committee." Also this individual kept the participants abreast of issues in the community that affect seniors, so they had information of meetings and forums in which they could participate.

Social Interaction and Support

Social interaction and social support are the primary reasons why seniors participate in Program A. Seniors come early and leave late, taking time to chat on a one-to-one basis or in small groups. Both seniors and professionals acknowledge the importance of this aspect of the program.

"Friendship is the primary component of the program" and "friends are (viewed as) a health issue." The program is seen as a place for "fellowship", "social support", "companionship" and "to make friends." The program is considered to be important as it provides "a place to talk" and "a chance to be with adults" following retirement. Program A is seen to provide "a caring environment" where there is "support when spouses die" and "a lot who are isolated can come and met new friends." It is seen as "more social than physical" and that seems to explain "why we start a half hour early to have a little chat before we get into the exercise." I also noticed that people stay late and chat after the

program and some commented they "walk home" together and sometimes "go out for lunch".

C. SUMMARY

Program A has operated for over three years at an urban community center. On average twenty women and four men regularly attend a predominantly life-style oriented program. Components include; exercise, once monthly blood pressure checks, refreshments and health-related discussion groups. Seniors acknowledge the importance of a social component through their early arrival and staying after the program to chat. The only community issue discussed was housing. Although Program A is based on a wellness/health promotion approach which claims to promote senior involvement and participation in program planning and implementation, professional dominance has negatively influenced seniors attempts to take control of, and to expand programming.

II. PROGRAM B

A. DESCRIPTION

Program B began at a Unit of the Vancouver Health Department in the fall of 1984. This unit is in a local area of Vancouver which contains a population of 25,000 people of which 26% are seniors. Here, there is a mix of low to middle income families and single residents. This community has a variety of ethnic populations of which English, Chinese, Punjabi, and German make up 88% of the population (Canada Census, 1986). The mix of program attenders was as follows; English, German, Chinese, Italian, and one East Indian. The housing mix is predominantly single-detached homes (76%) and multiple family dwellings (13% duplex, 7% apartment). 68% of these dwellings are owned (Canada Census, 1986).

Program B is jointly sponsored by the local Seniors Network Society and the Vancouver Health Department. This program began after the Seniors Network was approached by a wellness coordinator to jointly implement a seniors wellness program. The wellness drop-in has no directly funded positions, but the services of the wellness coordinator, a nurse, and a volunteer coordinator are funded by the Health Department and a paid Seniors Network member plays a leadership role. Senior volunteers provide the manpower to maintain the weekly programming and the space is furnished by a Health Unit.

The program is free and operates every Monday, year round between 10:00 a.m.- 1:30 p.m. The average attendance is 35 people, a third of whom are men. It is "for persons 55 years and better" and "is based on the belief that people who have access to health information and opportunities for physical fitness and getting to know each other, will

feel better and have more energy." Program components include: blood pressure and weight checks, neck, shoulder and foot massage, exercises, relaxation, a luncheon and a wellness topic of interest.

Although there is no official definition of wellness/health promotion, both seniors and professionals embrace a "wholistic" focus to health in which "physical, mental and social aspects" are all important to "quality of life". The professionals add a focus on the "environment", "self care", and the use of "community development strategies" to "try to give seniors the skills to look after and maintain their health."

B. EMERGING ISSUES

Program Organization And Process

Program organization and process, the most typical theme of Program B, concerns issues of senior leadership, "cooperative decision making" and whether or not seniors are "encouraged to use and share their own resources." In fact, decisions are made by seniors via volunteer committees, and then presentation to the larger group where discussion and consensus occur. A partnership exists between leaders (both professional and senior) and seniors (both volunteers and non-volunteers), that fosters seniors drawing on their own resources to run the wellness/health promotion program themselves.

Although one senior and one professional were identified as the principal leaders or "the spark plugs", the primary decision making occurs through planning meetings of small groups of senior volunteers. One senior put this well- "there are different ones, (who) form a group of people who will run the speakers or what ever we do." Suggestions are

then "put before the group and we see what they think." Leaders are not viewed as interfering in this process. "Well there is a leader you know, but the leader we can not call a leader in the sense of saying, you do this and that. The leader keeps every thing in order and keeps a link between one thing and another."

The majority of seniors who attend the program are involved in some way. The volunteers "meet in September each year and organize for the registering, massage, talks and other jobs." Cooperative decisions are made about most aspects of the program including; "volunteer involvement", "program changes", "problem solving", issues of space", "summer programs", planning the "talks" and selecting and scheduling "summer trips." As one senior said "we kind of keep it as democratic as possible."

Senior leaders and professionals play a different role from the senior volunteers and general program participants. The professionals see themselves as "facilitators and advocates and hopefully stay out of the way so they (the seniors) can run their own show." One year ago the wellness coordinator encouraged the senior leader to ask the group for volunteers. This resulted in the formation of the existing committees. At this time a shift in process took place from a leader taking charge, to the creation of a partnership with seniors, where cooperative decision making results.

Attendance

Although there are multiple reasons for attendance at Program B, the "number one" given is "fellowship." This program is predominantly

attended by women. Gender differences and seniors proximity to the program have the most impact on attendance patterns.

The most cited reason for attendance was, "fellowship." This incorporates; the "company", because "it is a friendly place", where "there are nice people to talk to" and that people are "accepting" and "receptive to new people." Another reason frequently mentioned was "getting out". In exploring this it appears that some feel "there is nothing for older people to do" and "they feel alone by themselves" so "it gets them out" and provides "a place to pass the time". The professionals share this perspective and believe some seniors attend because they have "loyalties" to certain volunteers.

Gender differences were viewed as having the most influence on who does and doesn't come to the program. Although it is acknowledged that there are more women that men in the senior age group, other reasons are given for the marked difference in numbers between the sexes. These include: "we haven't got the pattern of activities they want" or "men tend to be reclusive" and are "more reserved" or "too shy". Some believed "the men in their 60's and 70's (who) come for B.P.s only" attend for "the break in routine" and "to chat." It was felt that "women are more involved in things like this as are more social."

Social Interaction and Support

Seniors and professionals agree that social interaction and social support are the primary reasons why people attend. Comments from seniors support this; "number one is fellowship", and "there's an attitude generated where everybody is welcome." The program provides an alternative from "sitting home" and a place "to get out with other people where "you can shoot the breeze and people know who you are". Many said "when you talk, you find you have the same problems" and "you forget your troubles." A couple of seniors mentioned that "social interaction is important if you are going to have physical health".

Observation clearly indicted the importance of the social aspect to people. Seniors sat and chatted throughout the program in groups, over cards, while waiting for blood pressure checks, over lunch and during the other activities. Some spoke in their own languages and mentioned that this was important to them. There was a constant buzz of chatter.

Community Issues

Community Involvement. Participation in and contribution to a number of community activities and events is supported by seniors and professionals. Volunteer work is the primary means through which people participate. This is not surprising as it is the major mechanism used to encourage involvement in Program B.

Most of the seniors interviewed felt "it's important to help. One senior leader mentioned that "if you analyzed the group, most of them (Seniors) are involved in something else in the community." The types of

activities mentioned were "meals on wheels", "driving people to doctors" and running "exercises and relaxation" at other wellness programs.

Information about community activities was distributed by leaders and non-leaders, usually at lunch time. Small volunteer tasks were undertaken by the group during Wellness Drop-In time. Summer trips were organized to take senior wellness participants out into the community.

It was generally felt that people were encouraged "to contribute" and "share their resources", however there are those who do not participate and this also appears acceptable.

Out Reach. Out reach, although limited, does exist. It was the professional and senior leader who identified present out reach activities and could see the potential for expansion in this area.

The phone tree, a form of social support where seniors who don't attend for 2 or 3 weeks are contacted by phone, was the only outreach activity identified by seniors. All other activities related to out reach were identified by professionals. For example senior volunteers share their resources through running exercise and relaxation classes in two seniors buildings in this community. A health fair is being planned which the professional hopes will encourage seniors to share ideas and resources. Apparently a funding agency has approached the program about providing funding for a short term project and the professional has suggested to the senior leader that the funds could be used "to train seniors to do bereavement counselling."

C. SUMMARY

Program B which is located in a Unit of the Vancouver Health Department has been in operation for over five years. On average 35 seniors attend regularly, of whom a third are men. Though the program components (exercise, relaxation, blood pressure checks, massage, luncheon, refreshments, health related presentations) are predominantly life-style in focus, professionals have stepped back from taking control and seniors direct program planning, implementation and staff program activities. Out reach, though limited, is conducted and the social component is well integrated into program activities.

III. PROGRAM C

A. DESCRIPTION

Program C, one of many seniors programs in a seniors center, began in 1986. This center is located in a part of Vancouver which contains a population of 5,900. Seniors aged 55 years and over make up 26% of the residents. The area contains a mix of low to middle income families and single residents. Housing varies very little with 98% of the dwellings being rental apartments. 79% of the senior population live alone. This local area contains a mix of ethnic populations including: French, Chinese, German, Ukrainian, Hungarian, Polish and Dutch. English (72%) make up the majority group (Canada Census, 1986). Program C draws a mixed clientele of "mostly Caucasian" (English, Scottish, Italian), "a couple of Filipinos", "several Chinese" and "One East Indian." This mix is affected by the fact that many attenders travel here on foot or by bus from other local areas.

The wellness program is jointly sponsored by the Seniors Center and a Unit of the Vancouver Health Department. It began when the wellness coordinator was approached by an existing seniors group at the center. They wanted a wellness program similar to that in another area of Vancouver. Although this program is staffed and funded by the seniors center, services are also provided by a wellness coordinator and a nurse who are paid by the Health Department. Decisions about programming are made by these professionals and two senior volunteers at a monthly Wellness Committee meeting. The senior volunteers also provide the manpower to run the weekly program.

The program is free and operates on Mondays from 1:00- 3:00 p.m. Participants are "55 years and better." The average number of attenders is 20 people, of whom 6 are men. Program components include; weekly blood pressure and weight checks, fun and fitness exercise, and a health related presentation.

There is no official wellness/health promotion approach at this center. However seniors identified "keeping healthy in mind and body" as a common theme, while professionals focused more on the process, seeing the priorities as "building leadership, providing information and working with professionals to teach them how to get seniors to participate."

B. EMERGING ISSUES

Program Organization and Process

Program organization and process was the most typical theme of Program C. Professionals believed seniors should "participate in creating a wellness program" through being given control of decision making and

ongoing program development; however active participation by general participants is not encouraged. Only one mechanism exists for senior involvement. Seniors must become "volunteers" and then they can attend monthly Wellness Committee meetings where program planning and decision making occurs.

Indeed senior participants did not see themselves as involved in program decision making except for those who are designated as senior volunteers. The following comments indicate this; "I don't know who gets them (the speakers that is), I never get asked". In response to being questioned if the group is asked what they want, a senior volunteer mentioned, "no, that's a good idea and we should ask them if they want to participate in the volunteering, some of them could." A unilateral decision was made by the professionals about closing the program during summer as they feel "the seniors need a break". A number of seniors said that although "its good to have (a break), some seniors would come." The only means for participant involvement is through the volunteers. One volunteer commented that "occasionally they (the participants) will come up to you and say I wish we had a program on such and such. I'll say O.K." These suggestions are taken to the monthly meeting.

Two volunteers and two professionals (a program coordinator employed by the seniors center and a wellness coordinator employed by the Health Department), are members of the Wellness Committee. The volunteers perceive the meetings as participatory and that "everyone gives their ideas." However, cooperative brain storming and decision making was not apparent during observation. Seniors did make suggestions about participant involvement, content and timing of activities, but these were

often ignored by professionals leaving communication of ideas on these matters to the professionals alone.

Attendance

The wellness program draws "a mix" of people who attend primarily for the "friends." Non-attenders are said to be those who are not able "to walk" or "catch a bus."

Although there are a number of reasons why people attend the program, a need for social contact is the most frequently mentioned. Seniors said they were "looking for friends", or they "liked the friends they'd made" and "liked to see them every week". A number mentioned how the exercise segment was important to them, and it soon became apparent that they enjoyed interacting with the volunteer who runs this segment of the program. "Blood pressures" were thought to be the biggest drawing card for the men. Other reasons given for attending were, for "something to do", to listen to "the speakers" and because "I like to help."

Program C draws a mixed clientele. "It's a changing drop-in." Even though "most of the people who drop-in live nearby", "there are people from Kerrisdale", the "North Shore" "and quite a few come from Burnaby." A number mentioned they also attend other wellness programs. Mobility influences who does and doesn't attend. Seniors must be able to "walk over" or be "well enough to get the bus." Apparently the attendance of men "has dropped off". One senior wondered if it was because "there are too many women." Another said "men don't come for the exercise as they feel too shy." Apparently "a few men used to come and join in the program but then they dropped off and now a lot play ping pong" instead. Other

reasons given for non-attendance were; "some go to other places and prefer it better", "some people prefer to go to programs in their own area" and one volunteer wondered if the numbers "fell off when the nurse wasn't here and then a couple of times the speakers didn't show." Although "the numbers have increased since winter" (1988), it is felt by both professionals and senior volunteers that "the program could fold at any time." This belief leaves one with a sense of a tentativeness about the future of the program.

Social Interaction And Support

Program C provides a place for social contact and interaction for seniors.

Many said "I like to meet friends and come to talk to them." Others mentioned "they need to mix around with people and talk otherwise they get lonely" or "their friends have died and it's a place to meet some new people." One senior volunteer noted that although it is "a place they kind of get together, they don't really talk."

Seniors and professionals both agree that the social aspect of this program is of primary importance. One professional felt attendance was influenced by the exercise instructor as "they really enjoy her and so at this point if she left, a lot of people would stop coming." It is also interesting to note that many of the men who attend for blood pressure checks socialize over the ping-pong table which is just around the corner from the open space used for the program.

Community Issues

There were no data on community involvement, housing or outreach. This program does not advocate community involvement although the exercise volunteer did mention a "Seniors Strut", and one professional let seniors know what other activities were scheduled in the center. The program components focus on individual lifestyle and behavioural change issues.

C. SUMMARY

This program has operated for over four years and is one of many programs run at a seniors center. Average attendance is twenty people, approximately six of whom are men. Program components include; blood pressure, weight checks, exercise and a health related presentations, which are lifestyle in focus. Although professionals claim to facilitate senior leadership and participation they dominate program decision making and planning. No community issues are addressed by this program.

IV. PROGRAM D

A. DESCRIPTION

Program D began at a community center in 1988. The local area in which the community center is located, comprises about 19,000 (Canada Census, 1986) residents of whom 26% are seniors over the age of 55 years. This community contains a mix of middle to high income families and single residents. 79% of seniors here live alone. Most dwellings are owned (85%), of which 88% are single detached houses and 11% are duplexes and apartments. A number of houses and apartments have recently been demolished and replaced by larger homes and condominiums. Many residents

feel this is changing the face of the neighbourhood. The ethnic combination of this area is primarily English (86%). Also, small numbers of Chinese, German, French, and Greek residents (total 9%) live in this area. The wellness program exemplifies this mix with all attenders being Caucasian except for one Chinese woman.

Program D is co-sponsored by the local community center and a Unit of the Vancouver Health Department. It was implemented by a senior volunteer. Shortly after it's inception a wellness coordinator approached the members of the program and the community center staff, and became involved. This wellness program has no directly funded positions, although it utilizes the services of the wellness coordinator from the Vancouver Health Department and space plus some staff input from the community center. Senior volunteers and a retired nurse offer their services to run sections of the program.

Program D is free and operates on Tuesdays from 9:00 a.m. - 12:00 p.m., all year. It serves seniors "55 years and better." An average of 10 women attend each week. Program components include: once monthly blood pressure checks, shoulder massage, fun and fitness exercise, refreshments, and a discussion section on a broad range of topics.

This program has developed no official definition of wellness/health promotion. However, both senior and professional interviewees agreed, that a wellness/health promotion approach considers; "body, mind, spirit and companionship" as well as "using knowledge" as essential ingredients The professional also adopts "A Framework for Health Promotion: Older Adults" as a health promotion approach. She adds that "wellness is a process" and therefore the role of the professional is to facilitate what

a group or individual "establishes wellness or quality of life to be to them."

B. EMERGING ISSUES

Program Organization and Process

Program organization and process is the most typical theme in this setting. Leadership roles and responsibilities are not clearly delineated, resulting in overt confusion and conflict between one senior and a professional leader. These individuals hold differing perspectives; the professional supports cooperative decision making and senior involvement, while the senior leader wants no professional interference and wants to maintain the status quo. This tension between the designated leaders is not identified as an issue by the participants. Seniors value both leaders' contribution to the program and feel they are involved.

The designated leader started the program and views herself as the leader. She feels "we really don't need the Department of Public Health" and that the professional involved "has taken over" and "is not really needed." Her view of the Health Department's role is "to provide flu shots and equipment." She stated that "the seniors ran the discussion up until when the professional 'took it over' and clearly indicates a preference for controlling the program independently without professional interference. Tension was obvious and was expressed in this statement "I'm not sure where I fit in and what I'm supposed to do."

The professional views the situation quite differently, perceiving her role as a "facilitator" who therefore "looks to the senior participants for the decisions". She would like to see them more involved

in the program e.g. taking blood pressures, participating more as volunteers within the program and involving themselves in out reach projects.

The senior participants did not voice an opinion about the existing power struggle and strongly valued both leaders contribution to the program. To them the senior leader "runs exercises and massage" and the professional acts as a resource and is involved in the discussion section. They had taken on the role of selecting and organizing topics with encouragement from the professional. There was no expression of concern by seniors about their lack of involvement in other components of the program.

Social Interaction and Support

Although seniors gave many reasons why they attend Program D it is clear that social support and social interaction are of primary importance to the group. Professionals agree and observations support this perspective. Seniors tend to arrive early and stay for the refreshments after exercises. Both periods were busy with chatter. The discussion, though not personal per se, does allow for seniors to talk about issues for which they need support e.g. housing.

The significance of the social element of the program to seniors was apparent by their comments; "a lot come in to chat", or "for the companionship", "the sociability", and "the interaction with people." Another senior pointed out how this support network is significant; "Seniors shouldn't be alone. At least this is a thing where everybody shows up and if some one doesn't show up for a couple of times someone

phones." A professional stated this is a place "they can get together and have a nice chat. Somewhere they are really welcome".

Community Issues

Housing. The housing crisis was a very significant issue in the Vancouver area while this research was conducted. This local community was affected as housing prices sky-rocketed leaving seniors concerned about large tax increases and the lack of housing alternatives, should they choose to sell their homes. The view held by the senior leader and professional differed from the participants. They perceived housing as a non-issue to this group. Seniors described the crisis as "a traumatic thing" and stated they were "frightened." They said they were "angry" about the "increase in taxes". They spoke about wanting to keep their "own homes and that (they) almost felt pressured to sell." Also they expressed concerns about "lack of housing alternatives." Some of them were "very worried about moving. Where would we go?" Some said they "don't want to leave the area and if they had rental apartments they would be all right." Others stated they "wouldn't subject themselves to renting as that's too uncertain." The senior leader felt housing wasn't an issue at all saying "I'm sick of listening to it. It's not an issue for this group." Interestingly she stated she felt housing was only brought up as an a issue because the professional was interested. The professional appeared to agree with this senior, stating that as "most owned their own homes, housing has never been an issue." However, it was apparent that individual senior participants did hold fears about the housing crisis and appreciated discussing it.

Community Involvement. Although announcements were made about some community activities such as trips with other seniors wellness programs and involvement with the "Seniors In Action Day"; volunteering, out reach and community involvement were not encouraged through the program.

Seniors agreed, saying "we are not really encouraged" though one senior said "one time we were asked to help out with flu shots and a fun run but otherwise we are not encouraged." The professional believed "this group was ready for some out reach activities" saying "they really wanted a project to do". However, this was not stated by any of the interviewees.

Attendance

Program D is attended primarily for "social" reasons, by "active" people all of whom are women.

Although various reasons for attendance were stated- "they enjoy the activity and exercise", "the discussion makes it very interesting", "it's an opportunity to get out", and "it's close and convenient"- the need for "social support" and "sociability" were the ones most valued.

The seniors and professional believe that men don't come because "they do not want to be involved in a program full of women, because they feel overpowered, threatened and intimidated." Also "another aspect is that socially, men have depended on women and for them, when they are retired or widowed, to come out in a group, is really a monumental task."

Seniors and the professional viewed attendance similarly. The professional added that she felt "the isolated person will never attend these groups unless the group is healthy enough to reach out" to them.

C. SUMMARY

Program D is located in an urban community center and has been operating for one year. Though the program is predominantly lifestyle in focus (blood pressure checks, massage, exercise, refreshments and health related discussions), community issues (housing, environmental hazards) are discussed. Social components are well integrated into programming. Though conflict was apparent over leadership roles between one senior (who started the program) and a professional (who believes seniors in the program should be given greater opportunity to participate in program planning and implementation), participants were satisfied with the leadership and program content.

V. PROGRAM E

A. DESCRIPTION

Program E, the first health promotion program for seniors in Vancouver started at a downtown community center in 1984. The local area is a diverse self-contained community which has a population of about 37,000 (Canada Census, 1986) people of which 23% are seniors. This area contains a mix of low to high income families and single residents. Although this community comprises a variety of ethnic groups, 77% are English. French, German, Polish, Chinese, Spanish and Hungarian make up 12% of the population. This ethnic mix is replicated at Program E. 91%

of residents rent, and 99% live in apartments. One of the important changes over the last few years has been the demolition of more and more low cost accommodation.

The wellness project developed out of the area's Seniors Network. Seniors and Vancouver Health Department staff organized a Health Fair in June 1982 to promote self-care for seniors. After the fair many seniors expressed an interest to continue with a program. Three wellness workshops funded by the Health Promotion Directorate, Health and Welfare Canada, were conducted by a wellness consultant between April 1983 and April 1984. A number of individual seniors who attended these workshops became wellness volunteers and with the assistance of Vancouver Health Department staff, the program began.

Program E remains a co-sponsored endeavor between the Seniors Network and the Vancouver Health Department. A community center provides space. Program E had no funded positions. A wellness coordinator, a nurse and a coordinator of volunteers, paid by the Vancouver Health Department, assist with the ongoing development and running of the program. A number of wellness volunteers maintain the weekly functioning of the drop-in and are involved in program planning through a monthly combined Volunteer/Advisory Committee Meeting. Appointed Network Volunteers, one community center staff member and three Health Department professionals also attend these meetings.

The program is a "a community program of self-help and support by seniors for seniors 55 years and up who are Seniors Network members. The average number of attenders is 55 people, of whom approximately 15 are men. It operates Wednesdays 1:00 p.m. - 4:00 p.m, all year except for August.

Program components include: blood pressure checks, one-to-one hands on relaxation (shoulder and foot), community resource information, refreshments, activity table, exercise, weekly speaker section, peer counselling and consultation from occupational therapy, physiotherapy, nutrition, pharmacy and nursing on a rotating basis. Special events take place throughout the year.

The following official definition of Program E was developed by the professionals and volunteers; "wellness is the maximization of a person's physical, emotional, social and spiritual well-being both through individual effort and community action."

B. EMERGING ISSUES

Program Organization and Process

Program organization and process is the most typical theme of this program and addresses issues of senior/professional leadership, namely whether seniors utilize their own skills and resources and who is involved in the running and decision making process of the program. Although seniors are encouraged to be involved, the only mechanism existing for this is to be a wellness volunteer. This entitles seniors to participate in running the program and attendance at the monthly Volunteer Meetings. Here, the majority of the decisions affecting programming are made. The meetings are attended by senior volunteers (both of Program E and the local Seniors Network) and a small number of professionals from the Vancouver Health Department and the community center. Discussion occurs and decisions are made about program "philosophy, goals, changes, speakers" and issues to do with the ongoing running of Program E. Only

the senior volunteers and the professionals attend these meetings. The other participants have minimal input into program design and implementation, except through the occasional "brainstorming session".

Senior participants and volunteers view one senior and one professional as the primary leaders, but the other volunteers are also acknowledged for their leadership role. Planning meetings are generally run by professionals. One senior volunteer (regarded as the senior leader) was asked continually for her opinion and the other wellness volunteers were encouraged by professionals to share their views and participate in the decision making process. Although volunteers and professionals alike believe attenders have input into the program, senior participants interviewed did not perceive this, saying, "although we do make a comment occasionally, we don't give input because we are not volunteers."

Professionals stated they "would like to see more input from seniors" and "need more volunteers" to expand the program. Professionals noticed that at volunteer meetings "people try to refer decisions" to them, but the professionals try to take responsibility only for "those things that are rather urgent or something of a medical nature", and otherwise attempt to turn issues and decisions back to the group.

Attendance

Program E is attended by "all kinds" of seniors, predominantly "women." They come for multiple reasons, primarily for "social contact" and "support." "Men" and "people who don't get out in the community" are seen as the non-attenders. However, it is also clear that some of the

attenders do not have any other community involvement except for this program. Seniors and professionals share the same perspectives on attendance issues.

The "all kinds" of people include: seniors who are "mainly women because they live longer"; individuals "settled in this area"; those who have "chronic illness"; or suffered "losses of partners" and "are smart enough to attend (because) they have always been looking out for themselves." This program also "reaches a lot of people not involved in other things."

Although "blood pressure" is viewed by many as a major drawing card especially for the men, many come for the "speaker" section, or "because they see this as a link to the community they don't otherwise have." The primary reason for attendance however, is "companionship" and the "support that happens when people get together."

Seniors and professionals agreed that it is "old people who don't want to help themselves and can't get out and get involved with any body or any thing" that don't attend. Men were viewed as non-attenders because they are "afraid to be amongst so many women", where "women are in charge" and that they either "tend to withdraw and isolate" or are "involved in other things."

Community Issues

Community Involvement. Program E's philosophy encourages seniors to participate in the community and partake in "community action". However, the focus on these concerns is "limited" to minimal volunteer involvement, the writing of an occasional letter to government about seniors' issues

and announcements during the program to participants. On occasion senior volunteers have spoken to local politicians about seniors issues. If community action is deemed necessary, this program's perspective is represented by the local Seniors Network.

The general participants hear about community concerns, meetings and events through the occasional announcement ("Seniors in Action Day", "Environmental Action Conferences" and "Housing Forums"). Seniors are "not pressured" to partake in community action and this they are "pleased about." Beyond "the one-on-one peer support" that the volunteers and professionals offer participants, "this program tends to link itself as part of the Network" when community action is necessary, as professionals and senior volunteers "feel the larger number speaks volumes in comparison." "On occasion we (professionals and volunteers) have written letters or a statement", about seniors issues.

Housing. A "housing crisis" existed, which affected this program's residents, while this research was conducted. Housing was viewed as a major issue by both seniors and professionals, who felt "helpless" and without "alternatives."

Housing was discussed by speakers and through announcements; also seniors could talk on a one-to-one basis with peer counsellor volunteers. "Anxiety" was apparent about the fear of "buildings being demolished" and the "stress of seniors being evicted not only from their homes but from their community." "Enormous rental raises" and the shift from rental accommodation to "unaffordable" condominiums left seniors with the belief

that there were "no alternatives." They felt "discouraged", "harassed" and "helpless."

Professionals and senior volunteers also expressed their impotence with this matter with statements such as, "I feel harassed, everyone wants housing and I can't tell them anything" and "it seems as though all of these groups have to get together but this has been going on for years and they have lost their enthusiasm." A pervasive feeling of helplessness was apparent during this period.

Out Reach. Out reach emerged as a theme during the interview (data collection) phase and was viewed as an issue only by professionals and senior volunteers. They envision expansion of the existing program into other areas of the local community, although financial support and manpower are viewed as restricting this vision. Out reach was not discussed by participants.

Social Interaction and Support

Social interaction and support are of primary concern to the seniors of Program E. Seniors, volunteers and professionals alike acknowledge this. Even though some seniors "sit and stare while waiting for blood pressures" or may not "make significant relationships" with others in the program, all have an opportunity to interact with other seniors and receive support in a social setting.

Seniors commented that they attend Program E "as much for the socialization and support as anything else." Some stated "we've made new friends". Others said "you've got someone to talk to every week about

what ever is concerning you, like housing and finances" and that it is an "outlet when you can talk about your troubles and, once you're through you know that the senior volunteers keep an eye on you." Professionals agree that seniors "can talk with people they feel are supportive" and even if "they don't make friends they do establish significant relationships." All comments clearly indicate the importance of social interaction and support in this program.

C. SUMMARY

Program E, located in the downtown core, has been in operation for six years. Program components are primarily lifestyle in focus, however senior peer counsellors also address community issues such as housing, finances and social isolation on a one to one basis with seniors. The majority of social interaction occurs while seniors and senior volunteers are engaged in a program activity. Informal socialization between members is limited. The seating arrangements are not conducive to social interaction between members. On occasion, program leaders (professionals and senior volunteers) advocate political, economic and structural changes they believe would enhance seniors position in society. Though volunteer seniors are deeply involved in program planning and implementation this is limited for participants.

CHAPTER 4

PROGRAM FOCUS AND FACTORS CONTRIBUTING TO PROGRAM COMPOSITION

This chapter presents a cross analysis and interpretation of data pertaining to program component focus and factors contributing to program composition.

It is claimed that wellness/health promotion programs have tended to focus primarily on individual behavioural factors such as; personal health attitudes, management of chronic illness, diet, exercise, stress management, personal support systems and personal community awareness and participation. Minimal focus has been placed on those political, economic and organizational factors which keep seniors impoverished, socially isolated and disadvantaged (Health Services & Promotion Branch, 1986; Minkler & Pasick, 1986). The section below, **PROGRAM COMPONENT FOCUS,** presents data that supports this claim. Also the similarities and variations of program focus among the programs studied are presented..

Then the section, **FACTORS CONTRIBUTING TO PROGRAM COMPOSITION,** discusses those elements **(Program Organization and Process, Program Attendance Patterns and Rationale)** that best explain program make up. The similarities and variations of these factors among the programs studied are presented.

I. PROGRAM FOCUS

In order to promote health and implement a wellness/health promotion approach, Health Promotion Programs for Seniors incorporate a number of activities or components. For the convenience of this research these all fall into two core areas; **Individual behavioural change components** and **Underlying community change components.**

Tables 2 and 3 are schematic representation of the components in each program studied. This section analyzes the extent to which Individual behavioural change and Underlying community change components are included in the programs studied. In particular, it establishes that the components across all programs are predominantly focused on individual behavioural change. It also presents the similarities and variations of program components among the programs.

TABLE 2
INDIVIDUAL BEHAVIOURAL CHANGE COMPONENTS

	PROGRAMS				
	A	B	C	D	E
PERSONAL SUPPORT SYSTEMS e.g. social activity, luncheon, refreshment break, summer trips	X	X	X	X	X
EXERCISE e.g. yoga, modified aerobics, dance	X	X	X	X	X
PERSONAL HEALTH ATTITUDES e.g. health related discussion	X	X	X	X	X
NUTRITION e.g. health related discussion, weight checks	X	X	X	X	X
STRESS MANAGEMENT e.g. massage, relaxation, coping skill development	X	X		X	X
SELF MANAGEMENT OF CHRONIC HEALTH CONDITIONS e.g. through health related sharing and discussion, blood pressure monitoring, weight checks	X	X	X	X	X
PERSONAL SENSE OF PURPOSE e.g. volunteering, participation in decision making, community projects	X	X	X	X	X
PERSONAL ENVIRONMENTAL AWARENESS AND PARTICIPATION e.g. summer trips, discussion of environmental awareness, community projects, volunteering	X	X		X	X

TABLE 3
ENVIRONMENTAL AND COMMUNITY CHANGE COMPONENTS

	PROGRAMS				
	A	B	C	D	E
COMMUNITY PROBLEMS e.g. housing, out reach transportation	X	X		X	X
COMMUNITY SUPPORT e.g. information sharing and referral		X			X
SOCIAL ISSUES e.g. ageism		X			X
ORGANIZATIONAL CONTROL	X	X	X	X	X
POLITICAL ACTION e.g. seniors issues					X
ECONOMIC e.g. poverty, program funding					X
ENVIRONMENTAL HAZARDS e.g. crime, architectural barriers, environmental concerns				X	X

A. INDIVIDUAL BEHAVIOURAL CHANGE COMPONENTS

'Individual behavioural change components' are defined to include programming that focuses upon personal health attitudes, self-management of chronic conditions, nutrition, exercise, stress management, personal sense of purpose, personal support systems and personal environmental awareness and participation.

The **welcoming, friendly environment** of each program provide attending seniors with a personal support system. All but Program C provide **refreshments** or a **luncheon** component which allows time for social interaction and support amongst members, volunteers and professionals.

Exercise, run by senior volunteers (with the exception of Program A) is an integral part of all the programs. A positive image of senior involvement in exercise is presented which helps to dispel **ageist** beliefs commonly held by professionals and seniors about exercise and aging.

Blood pressure monitoring, and **health related discussion** which speak to personal health attitudes, nutrition, stress management and self management of chronic conditions are addressed by all the programs. Specific **stress management** techniques are offered by all but one program (Program C) in the form of **massage** and **relaxation exercises** (Programs B, D, E) or **coping skill development** (Program A).

Senior volunteer positions, which are available in all programs, provide an avenue for seniors to draw upon their own resources and engage in meaningful activity for others, thereby addressing personal sense of meaning.

Some particular variations in programming are noteworthy. The more established programs, such as Program E and Program B, use a broader array of activities to address individual support systems and personal environmental awareness and participation. In particular Program E is the only one to offer information, support and referral through the provision of **peer counselling** and available brochures. Peer counselling is a specialized form of social support which denotes intervention from a volunteer who is a non-professional. Rather than being formally trained in counselling, peers offer support through the depth of their experience and an ability to empathize and problem-solve which this tends to produce.

Program E is the only one to offer a **luncheon** program. Here, a social context for eating is provided for those seniors who may have

apathy towards food, thereby addressing not only social support but an underlying environmental cause of poor nutrition in the senior population. Both Program E and B conduct **projects** and organize **summer trips** which provide opportunity for the development of personal support systems and encourage personal environmental awareness and participation.
Two smaller programs (Program A and D) use **interactive discussion groups** to address issues of personal support, personal sense of purpose, personal health issues, and personal environmental awareness and participation. Here, the professionals act as facilitators encouraging and supporting the participation of all members in collective decision making and discussion of health related topics of interests. Program A further employs participatory discussion to share ideas on stress management and self management of chronic illness.

Senior involvement in community-based volunteer work which addresses personal sense of purpose and personal environmental awareness and participation is encouraged by Programs A, B and E.

B. UNDERLYING ENVIRONMENTAL AND COMMUNITY CHANGE COMPONENTS

'Underlying environmental and community change components' can be addressed when programs include a focus on those political, economic and organizational factors that affect promotion of immediate individual behavioural change components for example through the availability of community supports, self-help groups, out reach services, information networks, and by addressing social and economic factors such as social isolation, poverty, environmental hazards and ageism.

All except Program C combine a focus on individual health behaviour with broader efforts aimed at helping seniors bring about changes in their environment. It is interesting to note that this is the only program that does not service a particular community. It is located in the downtown business core and the majority of it's members travel from other local areas of Vancouver. Three possibilities to explain why community issues are not addressed include; these are viewed as unimportant, they are addressed by other services within the seniors center, and professional dominance hinders senior involvement to such a degree that these issues do not emerge.

Those programs which do address community issues differ markedly in how much effort and on which elements, they focus. Some concentrate more on immediate community problems, while others focus on broader economic and social issues such as social isolation, poverty and ageism. Most focus on these issues through discussion rather than group or community action.

The **housing crisis** was an immediate community issue in certain localities at the time of the research, and became a focus for Program A, D and E. Affordable multiple resident dwellings and apartments were being demolished and replaced by expensive duplex and quadruplex condominiums leaving many seniors concerned about tax and rental increases, eviction, and lack of affordable alternatives. Two programs (A and D) shared ideas on methods and avenues for community action through group discussion. None of these programs took group action, though seniors were encouraged to do so by the professionals who led the discussions. Program E on the other hand, has, on occasion, responded to social and economic issues affecting seniors, but usually it links itself to a Seniors Network when

community action is necessary. Program E, peer counselors provide information and referral on a one-to-one basis for seniors concerned about specific housing issues, however the focus is on individual adaptation rather than community change.

The social support available to those who attend these programs is not necessarily accessible to many isolated seniors who need support to venture out, or who live too far away and have no means of transportation. **Out reach**, which is seen as one means of addressing this problem, is only conducted by one program. Two senior volunteers from Program B conduct exercises and relaxation in a seniors building in their local area. Seniors at Program A tried unsuccessfully to acquire funding for this purpose. Though initially enthusiastic to investigate the needs of isolated seniors in their area, this group gave up after they were blocked by professionals who did not agree they needed the assistance of a paid coordinator. Program E spoke about wanting to provide out reach to another part of their community but stated they needed funding and additional manpower to implement this successfully.

The only program to address **economic factors** that effect the promotion of individual behaviour change is Program E. Peer counselors discussed these issues on both a one to one and at the group level. Also, senior volunteers have been known to participate in **community action** through letters and direct dialogue with local politicians.

Potentially, senior participation in formal and informal organizational structures provides a mechanism to address **ageism**. Ageism is a presumption held by many professionals that older people have less to offer as they age. In fact, all the advisory boards and committees were

implemented to encourage and support seniors to work in partnership with professionals to encourage seniors to draw on their own resources and eventually take control of programming. Programs differ markedly as to how much **control** professionals relinquish to seniors. Some professionals appear to give only 'lip service' to senior input, while others (professionals involved with Program B) foster and encourage senior input at all levels, to the point that seniors run the program with only minimal professional consultation. Professional versus senior control of health promotion programs will be discussed further in the next section.

C. SUMMARY

Although most of these programs have moved far beyond a disease-oriented focus and consider seniors as physical, psychological and social beings who interact with their environments, they still focus heavily on the isolated individual as the target of change efforts. The underlying environmental and community change factors such as poverty, poor housing, poor transportation, negative societal attitudes and status and role change, although acknowledged are only superficially addressed.

II. FACTORS CONTRIBUTING TO PROGRAM COMPOSITION

In the process of examining health promotion programs for seniors, themes emerged which shed light on how these programs are organized and managed, and on the patterns and rationale for attendance. This section discusses four emerging issues presented in Chapter 3 (wellness/health promotion approach, organization and process, attendance, and social interaction and support), which are viewed by the researcher as factors

that contribute to program composition. The emerging issues are addressed under the following headings:

Program organization and process (wellness/health promotion approach, organization and process)

Program attendance patterns and rationale (attendance, social interaction and support)

These issues are presented in order of the frequency with which they emerged from cross-program comparison.

A. PROGRAM ORGANIZATION AND PROCESS

The way Wellness/Health Promotion Programs are developed, organized and managed most significantly influences program composition. The organizational structures of programs are expected to be based on a wellness/health promotion approach which highly values process in the form of seniors' participation, seniors' empowerment and partnership between seniors and professionals. Three structural levels among programs provide this opportunity: as a **general participant** in general planning meetings; as a **volunteer staff member** in formal and informal committees; and as a **member of a seniors advisory board.** This section shows how the program composition and variation among the programs studied are influenced by:

1) the application of a wellness/health promotion approach;

2) varying degrees of structure within the programs;

3) the roles of seniors and professionals;

4) funding;

5) and the historical development of wellness/ health promotion programs for seniors in Vancouver.

Application of a Wellness/Health Promotion Approach

Seniors' participation, seniors' empowerment and partnership between seniors and professionals are identified as elements of the organization and process of wellness/health promotion programs in 'A Framework for Health Promotion: Older Adults' a draft document' which "sets out the framework and mandate of The Health Departments wellness activities" (Vancouver Health Department, 1988). These notions are incorporated into the objectives of this document which follow:

"OBJECTIVES: It is necessary to mobilize and coordinate community resources, (including Health Department resources), to accomplish the objectives of:

1) dispelling the myths commonly associated with aging;

2) enabling older adults to develop and/ or maintain physical, mental and social well-being and autonomy;and

3) encouraging and supporting older adults to draw upon their own resources and take control of their own health promotion programming.

In this approach older people are participants in a dialogue with the health professional who presents ideas for consideration. The community group and the professional exchange their views on health, allowing them to learn from each other while valuing their separate experiences and knowledge. By including older people as partners in the planning, development and implementation of programs, the process also provides opportunities for meaningful activity which increases the older

person's sense of control, their feelings of effectiveness and their contacts with other people."

However, in order for this approach to be implemented seniors must be actively involved at all planning and staffing levels. The value and implementation of senior participation in volunteer staff, committee and advisory board positions will be discussed later in this section (Varying Degrees of Structure). Here, the participation of general senior members is discussed.

Program B, is the only program which has a system whereby general participants, uninvolved in volunteer or committee activities, have the opportunity to give regular input about program focus and organization. This occurs at general planning sessions held, when necessary, during weekly announcement periods. One senior put this well, "different seniors form a group of people who run the speaker section or what ever other activities we have. So they put the plans before the group and see what they think."

Three programs have general member participation which is limited to one program component, the speaker or discussion section. Program E involves participants in brainstorming discussion topics however, this is limited to a yearly occurrence. Programs A and D use group decision making to formulate agendas for upcoming discussion groups. In a very informal atmosphere, both seniors and professionals present ideas for consideration, and consolidate planning.

A number of seniors interviewed indicated they were not given adequate opportunity to participate in program planning and decision

making unless involved at the volunteer level. The following comments support this perspective:

- "We make suggestions to professionals like what topics we want to talk about, but as far as running the group we don't have any say "(Program A). Similar comments are made about Program E.

-"I don't know who gets them(the speakers), I never get asked." (Program C). In this program, no mechanism exists for input about programming by senior members at all.

-"Although we do pass a comment occasionally, we don't get asked (for input) because we are not volunteers." (Program E).

Finally, one other response should be noted. Some seniors were reluctant and lacked motivation to participate in the decision making process. Comments such as; "some seniors lack the commitment" (Program A, B, E), to "we are supposed to make decisions but we only have so much energy and we don't want to give that much time" (Program A), articulate this point of view.

Although professionals claim to support senior direction and control of wellness/health promotion programs, the present lack of organizational structures (with the exception of Program B), limits this process particularly at the general participant level.

Varying Degrees of Structure

The extent to which seniors are valued and participate at the **volunteer staff, committee and advisory board member levels**, differs among programs. Table 4 is a schematic representation of the levels of structure among programs.

TABLE 4
VARYING DEGREES OF PROGRAM STRUCTURE

	PROGRAMS				
	A	B	C	D	E
Participant planning meetings	health topics only	X		health topics only	1x/ year
Volunteer staff meetings		X			X
Program Planning meetings - Professionals and Seniors		X	X		X
Seniors Advisory Board meetings		X			X

Of the five programs, Program E has the greatest degree of structure. At the time of the study, this program was characterized by clear formalized positions and lines of authority. These include: monthly meetings which regularly include senior volunteers, Seniors Network representatives, Health Department staff (wellness coordinator, volunteer services coordinator), and community center program coordinator; a written agenda and minutes; and office space which is slightly more formal than other programs. The strengths of such a structure are that all groups associated with the program can be responsive to emerging program issues as all facets of program planning and implementation are addressed within this group. Senior participation is highly valued. A limitation however, is that general participants are not visibly involved in program planning and decision making and few new faces have joined the senior volunteer ranks since this program's inception six years ago..

Program C's organizational structure is similar to Program A, but on a smaller scale. The Wellness Committee (senior center program coordinator, wellness coordinator and three senior volunteers) meet on an ad hoc basis and conduct all program planning and decision making. The same strengths and limitations apply as with Program E with the additional limitation that input from senior volunteers was observed to be undervalued by professionals.

In terms of structure, committee and volunteer staff members in Program B shun the notion of hierarchies and appear to avoid behaviours which may infer formality or bureaucracy. All seniors who attend are involved in some capacity in the ongoing planning, decision making and staffing of program activities. Seniors refer to the structure as "democratic" viewing the senior leader and professionals as "spark plugs" in the process. One senior stated this well: "There is a leader you know, but the leader we can not call a leader in the sense of saying, you do this and that. The leader keeps everything in order and keeps a link between one thing and another." The strengths of such a structure are that Program B is able to be responsive to the emerging needs of seniors in their community. The corresponding limitations of such a loose structure might include some disorganization.

Programs A and D could be described as lying between the Program E and Program B in terms of their organizational structure. Seniors, in partnership with professionals, are highly involved in planning the speaker section of these programs. No other organizational structure exists in Program D, so there is no forum for senior or professional participation in other aspects of program development and implementation.

In Program A, other structures do exist but permit limited input from seniors. For example, a Seniors' Advisory Committee was formed to act as a consulting body on seniors' needs in this community, but this body (predominantly professionals) does not permit seniors who are regarded as experts to participate. Also a Professional Committee of the community center in which this program is housed, was instrumental in vetoing a proposal for senior out reach programming developed by seniors in the program. Overall the lack of participatory organizational structure in Programs A and D limits senior participation in program planning and decision making and curtails any responsiveness to emerging seniors issues.

The Roles of Seniors and Professionals

In a wellness/health promotion approach, professionals hold up a mirror to the group so that seniors can see their health issues and decide which ones they want to address. Seniors become partners with professionals in the decision making process and, further, play a role in the planning, development and implementation of programs. In order for this process to work effectively, regular and open communication must be maintained between general participants, front line volunteer staff and those responsible for planning and organization. Mechanisms for program recipient feedback are essential if seniors issues are to be adequately identified and addressed (see Table 4, p. 105).

Program B is the only program which provides opportunity for regular open communication about all aspects of programming between the general participants and those responsible for planning. Professionals function

as "facilitators and advocates, and stay out of the way so they (the seniors) can run their own show." Here, seniors use professionals primarily as resources and consultants. The seniors function in two roles, as volunteer staff and as participants. It should be noted that one senior is a paid member of the Seniors Network with which this program is affiliated. The majority of seniors is involved in the running of the program in some way, whether that be "organizing exercise, massage, talks or other jobs like registration, or putting out the chairs and preparing refreshments." Those not involved in this way are given the opportunity to participate in program planning.

Two of the smaller programs (A and D) have regular open communication between professionals and participants, but only in respect to decision making about the speaker/discussion section.

Program A had no designated volunteer positions though some seniors organize chair set-up, sign-in sheets and refreshments on a regular basis. One community center staff organizes the exercise instructor, and the wellness coordinator conducts blood pressure checks and facilitates the speaker/discussion section. The latter professional had encouraged the seniors to conduct exercises themselves, as some members in the group had the skills, however the community center staff stepped in and organized it for them. This highlights the different approaches that professionals involved with this program hold.

Program D have three senior volunteers who conduct exercise, massage and blood pressure checks. Neither professional nor senior-participants had input into these sections of the program, though the seniors are encouraged by the professional to organize speakers. Senior and

professional leadership roles and responsibilities are not clearly delineated here and this results in role conflict and confusion between the professional and one senior volunteer.

Program E and C receive limited input from participants unless seniors make individual comments. In the case of Program E, however, front line volunteers work with professionals on program planning and organization. Also two members of the seniors network, by whom this program is sponsored, attend these meetings. Some fifteen senior volunteers run all program activities. Senior participants on occasion make comments about programming on a one-to-one basis to the senior volunteers. Approximately once a year, senior participants are involved in brainstorming ideas about programming. One professional is viewed as a leader and attends all planning sessions. She commented that "people try to refer decisions to us (the professionals) but we attempt to turn issues and decisions back to the group."

Program C has four senior volunteers whose roles are to run exercise, blood pressure checks and man the registration desk. No attempts are made to ask for more volunteers to participate, yet at one Wellness Committee Meeting this suggestion was made by a senior volunteer and on a number of occasions the volunteers indicated they may not continue much longer. The professionals are autocratic. They run all meetings and tend to make the decisions about programming with minimal input from the senior volunteers who attend yet these professionals advocate for increased senior leadership.

Program Funding

This section discusses how people in each program perceive funding questions and how funding is seen to influence program composition.

In general seniors at each center have limited knowledge of funding issues. Only one or two senior volunteers were able to articulate the funding needs and problems for their program. However, a number of seniors, though they knew nothing about this area, stated they could "use more funds for program expansion (Program A and E)." It was the professionals who demonstrated the most intimate knowledge of funding concerns related to their programs.

Table 5 is a schematic representation of the program funding sources for space, manpower, equipment and miscellaneous costs.

TABLE 5
THE PROGRAM FUNDING SOURCES -
SPACE, EQUIPMENT, MISCELLANEOUS SUPPLIES, MANPOWER

	PROGRAMS				
	A	B	C	D	E
SPACE	CC	HD	SC	CC	CC
EQUIPMENT	CC	HD	SC	CC	CC/ SP
MISCELLANEOUS SUPPLIES e.g. refreshments	SP	SP	SC	SP	SP
PROFESSIONAL STAFF	CC/ HD	HD	HD/ SC	HD/ CC	HD/ CC
VOLUNTEERS	SP	SP/ SN	SP	SP	SP/ SN

CC - Community Centre
SC - Seniors Centre
HD - Health Department
SN - Seniors Network
SP - Senior Participants

Several community organizations supply free space, use of equipment, and staff hours but the primary funding source is the Vancouver Health Department which supplies space, equipment (Program B) and staff (wellness coordinators) to all programs; a volunteer coordinator and a nurse for Program B; and a volunteer and a nurse for Program E. Three programs run out of local community centers. In the case of Program A, space is free and a community center staff member allocates time to the program because his position involves senior program planning. Program C, which operates from a seniors center, is one of many seniors' programs for which the responsibility lies with the center's program coordinator.

Most program components are run by senior volunteers. Participants pay for the ongoing costs of refreshments through contributions. Program E is the only program to have carried out fund raising activities, which they do yearly, to purchase equipment unavailable from the community center.

Like most voluntary groups, these programs are dependent on the good will of their host and sponsoring organizations. Funding and manpower for program expansion e.g. out reach services, is seriously constrained. Often seed money is available from federal and provincial sources but this is usually time limited. One program (A) which applied for such funds was refused, leaving the group frustrated and not understanding why they did not successfully meet the stipulated criteria.

Although federal and provincial governments view health promotion as a legitimate component of the health care system, this study confirms the notion that without funding to accompany rhetoric, program development and expansion is limited.

Historical Development of Wellness/Health Promotion

As noted in Chapter 3, program components among the five programs studied vary little and focus predominantly on the individual and their lifestyle. The historical development of wellness/health promotion programs for seniors in Vancouver, heavily influences program composition.

All the programs studied are modelled in some way, on Program E, the first seniors wellness program in Vancouver. This program was developed and coordinated by a wellness consultant and began with a health fair sponsored by the federal government. Excited at the possibility of

developing an ongoing self-care program for seniors, this professional worked with a seniors network society, in proposing a wellness project to the Health Promotion Directorate of Health and Welfare, Canada. The project was funded in 1983 and was based somewhat on the Wallingford Wellness Project in Seattle, Washington and the Growing Younger Program in Boise, Idaho. It is important to note that both these programs focus primarily on individual behavioural change (Dychtwald, 1986).

A weekly program which developed into the existing program (E) began with the following components; blood pressure checks, health nurse consultation, exercise and a health related presentation. Although two of the programs studied, claim to be based on data gathered by a community developer and a seniors needs assessment, these programs started with identical components to those of the first health drop-in.

Program composition among all the programs studied have changed little in the last six years since the inception of Program E, clearly identifying the strong influence of historical factors on present program composition.

SUMMARY

As has been shown program composition is influenced by multiple historical, theoretical and organizational factors. Each program has combined these elements in various ways. A wellness/health promotion approach is reflected to varying degrees depending on how thoroughly seniors and professionals embrace the underlying principles of health promotion as outlined by the health department (Martin, Robertson & Altman, 1988). Only one program (B) carries this out in a significant

manner. The degree of organizational structure has been shown to reflect a continuum where limitation or facilitation of senior participation, direction and control exists. Organizational safeguards which ensure senior involvement at the participant member level are limited, fundamentally, to one program. Role variation of both seniors and professionals has influenced program makeup in varying ways from program to program dependant on how a health promotion approach is adopted. Only one program has fostered seniors in playing a role in program planning and implementation at all levels. The impact of the historical development on these wellness/health promotion programs for seniors appears to maintain a focus on individual behavioural change. Finally, inadequate funding of health promotion activities severely limits program expansion. The differences and similarities among programs highlight how the program organization and process heavily influence program composition.

B. PROGRAM ATTENDANCE RATIONALE AND PATTERNS

Social interaction and support are identified by seniors and professionals as the primary reasons for seniors' attendance at wellness/health promotion programs. However, the number of social components varies greatly from program to program. Also, the attendance patterns between men and women differ markedly. In this section it is shown how the rationale for program attendance and the differing attendance patterns between men and women influence program composition in varying ways among the programs studied.

Program Attendance Rationale

Loneliness and isolation are key issues for the senior population. Approximately 10% of seniors living in the local areas studied are not living in families, and 45% live alone (Canada Census, 1986). Based on discussion with seniors and professionals from all the programs studied, the consensus was that social interaction and support is a key element to health and well-being, and the prime reason for attendance. This need influences program composition in different ways.

At Programs A, B and D seniors arrive early to chat among themselves before scheduled activities begin. Yet at Program E, senior volunteers prevent entry into the wellness space until 1:00 p.m. As Program E provides no seating for those lining up outside, this is viewed as nonconducive to social interaction. One senior mentioned that a number of members are "dissatisfied with this arrangement." Also this program's seating plan (chairs in rows) does not lend itself to socialization once the program is in process. In contrast, Program B conducts many activities (registering, waiting for massages and blood pressure checks) in small groups and the seating arrangements (in small groups) are very conducive to social interaction.

Program A and D offers a refreshment break following exercise. This allows seniors to mingle and chat for approximately fifteen minutes prior to the health-related discussion component.

Program B, is the only program to offer a lunch component. Here seniors sit together for approximately half an hour and "shoot the breeze" while eating, prior to the discussion section. One senior leader

mentioned "many people who stay for this live alone and appreciate the opportunity to eat with others."

All programs have senior volunteers who offer differing degrees of social support to those who attend. Seniors from all programs commented that these individuals create a "friendly, welcoming environment" that is conducive to social interaction. For example, at Program C, seniors and professionals believe that if the exercise instructor was to leave, attendance would drop markedly. This senior takes the first fifteen minutes to chat with participants prior to commencing exercises. At this program, no other provision for social interaction is made. Program E is the only program to provide peer counsellors, who offer support, information and referral on issues of bereavement, housing, finances, and minor physical health difficulties. A number of seniors who attend Program E commented that the presence of these individuals to talk with about problems has impacted on their lives in very significant ways.

Although social factors have had an influence on program composition to some degree in some of the programs studied, most programs have paid little attention to the importance of activities that address the social needs of seniors.

Program Attendance Patterns

According to 1986 census data, women and men are still approximately equal in number, up to age 50. However, between 65 and 74, there are only 77 men to every 100 women; then between ages 75 and 84, the ratio drops to 50 men per 100 women; and among those aged 85 and older, there are only 44 men per 100 women. As wellness/health promotion programs for seniors

predominantly address the 65 to 84 age group, where the ratio is 63 men per 100 women, it would be anticipated that program composition among the programs studied, would reflect the needs of both gender groups. This is not the case and a number of factors contribute to this.

Firstly, it should be noted that the numbers of males attending these programs is extremely low. Among the programs studied there are 3 males per 10 females and one program (D) has no male participants at all. Apparently, a male did attend Program D once, but did not return because there were no other men. The primary reasons given for the low male attendance are; "men are too shy," "more reclusive," and "feel intimidated by large quantities of women." Many seniors believe "we haven't got the pattern of activities men want." However, a number of men mentioned that they do enjoy "the break in routine" and the "opportunity to chat" that program attendance provides. The component most attended by males is blood pressure checks. Occasionally, men attend the discussion section and, in the case of Program E, men do meet with peer counsellors, though it is felt that more men would use this service if one of the counsellors was male. Program A, is the only program where the men participate in all program components.

Also of interest, was Program C, where men come for blood pressure checks and then play ping-pong on a table set up just around the corner from the open area where the program takes place.

A number of men in Program B participate as volunteers in the organization and staffing of the program. It is interesting that the senior leader is male and a third of those who attend are also male and

yet no program components have been added or changed to address men's needs specifically.

Program E had one male volunteer involved; however he has relocated. None of the other programs have men in positions of influence, and even in the case of Program B where men are involved in program planning, men's activity needs and attendance have not been addressed.

SUMMARY

Although social factors are identified as the primary reason for program attendance, on the whole components which address social interaction and support are given limited recognition and support. Although some programs have established new components which foster socialization and provide support mechanisms to senior participants, others continue without recognizing the significance of this identified need. Program composition does not to appear reflect the needs of both gender groups at the present time. However, as there are greater numbers of women attending these programs, it may be valid to focus on the identified needs of women. However, as men's attendance patterns are felt to be influenced by a lack of appropriate activities and the intimidating number of women, it may be important to explore men's health promotion needs further.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this chapter is to link the theoretical concepts emerging from the findings of this ethnographic research on health promotion programs for seniors with existing theory and literature. The research questions are addressed, the limitations of this project are discussed and the implications for future research are outlined. Finally, practical recommendations for future program focus and organization are discussed.

I. THEORETICAL IMPLICATIONS OF THE STUDY

This study explores the concept of health promotion as it relates to the program focus and organization of five health promotion programs for seniors in the city of Vancouver, British Columbia. In this study a health promotion program is defined as that which incorporates "any combination of health education and related organizational, political and economic interventions designed to facilitate behavioural and environmental changes conducive to health" (Green, 1980). Furthermore, a health promotion program is one that enables people "to increase control over and to improve their health" (World Health Organization, 1986).

Because health promotion is a multifaceted strategy it is not surprising that many theoretical concepts emerged as the data and analytic categories were developed and reviewed. **Individual behaviour change** and **Environmental and community change components** were used as analytic categories as received support from the data and literature on health promotion. Personal autonomy and control which were identified in

documentary data were made reference to by seniors and coordinators. As the study progressed **victim blaming, empowerment** and **learned helplessness** emerged as relevant concepts to the research data. Also, because the promotion of senior involvement in program process and organization is articulated as an objective of these health promotion programs, and because organizational goals are a facet of organizational behaviour, **organization theory** is relevant to this study.

A. RESEARCH QUESTIONS

The research questions posed by this study are restated, followed by a brief description of the findings, which are then linked to pertinent theory and literature. As there are multiple levels of influence on health promotion programs these are divided into three including; **macro-level** influences within the larger society, **meso-level** influences at the organizational level, and **micro-level** influences at the individual level. Questions 1 and 2 are discussed together and address how macro and micro-level influences impact on health promotion program focus. Question 3 discusses the impact of macro, meso and micro-level influences on program organization and composition.

QUESTION 1: What is the focus of the program components?

QUESTION 2: Does the profile of program components vary among health promotion programs?

Details of the focus and variation of program components are described in chapters three and four. All programs offer a broad range of activities which have been classified under the analytic categories of **Individual Behavioural** and underlying **Environmental and Community Change**

Components. All five programs concentrate predominantly on **Individual Behavioural Change Components** which focus upon personal support systems, exercise, personal health attitudes, nutrition, stress management, self management of chronic health conditions, personal sense of purpose and personal environmental awareness and participation. Little variation exists among programs in respect to the activities offered to address these specific components although a broader array of activities is offered by the two larger and older programs.

Minimal focus is placed on the underlying **Environmental and Community Change Components** which address those political, economic and organizational factors that affect the promotion of immediate individual behavioural change. Although all five programs provide mechanisms for senior volunteers to participate in program planning and decision making, there is marked variation in 'real' involvement by seniors among programs. Organizational factors are discussed when question 3 is addressed. Fundamentally, programming which addresses environmental factors is limited to one-to-one and/or group discussion which results in minimal action for change. One program wrote a proposal to acquire funding for **out-reach activities** however this was vetoed by professionals. Senior volunteers from another program support their sponsors to take **political action** in the form of letter writing and discussion with politicians, when relevant seniors' issues arise. However, rarely do they take this action themselves. Two programs address **ageism** by encouraging professionals and non-professionals to visit their programs and see how seniors function, however, they appear to be preaching to the converted. Clearly, such underlying **causes of stress** for seniors in these communities as social

isolation, housing, ageism, transportation and poverty, though acknowledged, are given only superficial attention.

The literature on health promotion claims programs focus predominantly on individual behaviour change efforts (Minkler & Pasick, 1986; Labonte, 1988; Smith, 1988). Many authors have expressed concern that although rhetoric legitimizes the idea of developing health promotion programs within a wider context, the programs remain narrow in focus and thereby implicitly support the stance of individual responsibility for lifestyle. Though the theoretical basis of the programs studied is "a socioecological model of health which recognizes the interrelationship between social and environmental factors and defines health as encompassing the physical, mental, social and personal domains," (Martin, Robertson & Altman, 1988) the social and environmental factors are given little recognition and effort.

This focus on the individual without an equal emphasis on the sociostructural bases of health has led to much criticism of health promotion by authors who believe the proponents of individually-oriented behaviour change strategies support a **victim-blaming** ideology (Becker, 1986; Crawford, 1979; Epstein, 1985; Guidotti,1989; Kickbusch, 1989; Minkler & Pasick, 1986; Tesh, 1981).

Ryan (1970), applied this process to North American social problems in his book "Blaming the Victim". In brief, the steps involved in blaming the victim are; (a) identifying a social problem; (b) studying those most immediately affected by this problem and identifying how they are different from the rest of the population; (c) defining the differences as the cause of the social problem; and (d) assigning bureaucrats to develop

"humanitarian action programs" that will "correct the differences" (Ryan, 1970, p. 7). If these steps are applied to the high cost of illness care, the victim blamed is the individual suffering from a chronic illness or the aging process. Using Ryan's model, the following scenario is an example of how individuals can be blamed for their health problems: (a) A social problem which is recognized as requiring attention in our society today, is the high cost of illness care; (b) Those individuals identified as most immediately affected by ill health are people who smoke, lack regular exercise, have poor nutritional habits and do not manage their stress effectively; (c) It is primarily those individuals who do not practice responsible health and lifestyle strategies who become ill and require illness care; (d) Therefore, the provision of lifestyle-oriented health promotion programming could potentially alleviate this societal problem.

Ryan noted that present-day victim blaming is very different from the "open prejudice and reactionary tactics" of earlier times, as now it is "cloaked in kindness and concern, and bears the trappings of statistical furbelows of scientism (and) is obscured by a perfumed haze of humanitarianism" (2, p. 7). Health promotion targeted to the individual fits this scenario form many individuals. While basic efforts at problem solving the possible underlying causes of ill health require major sociostructural, political and economic arrangements, the victim blaming ideology encourages far more narrow strategies which in turn develop more limited individually-oriented programs and policies.

In agreement with this perspective, Crawford (1979, p. 256), states that those who advocate individually-oriented programs support victim blaming which

> "serves as a legitimization for the retrenchment from rights and entitlements in relation to the social causation of disease and it functions as a colossal masquerade. The complexities of social causation are only beginning to be explored. The ideology of individual responsibility, however, inhibits that understanding and substitutes instead an unrealistic behavioural model. It both ignores what is known about human behaviour and minimizes the importance of evidence about the environmental assault on health. It instructs people to be individually responsible at a time when they are becoming less capable as individuals of controlling their total health environment. Although environmental factors are often recognized as "also relevant," the implication is that little can be done about an ineluctable, technological, and industrial society. What must be questioned is both the effectiveness and the political uses of a focus on life-styles and on changing individual behaviour without changing social structure and processes."

The individual-responsibility rationale for health can be viewed as greatly benefiting the medical system, certain political parties and industry. This perspective which is often reinforced by the media, redefines illness into an individual problem which effectively isolates it from its social context. As such, the need to address environmental and community health considerations is essentially eliminated, leaving these interest groups free from the responsibility of making health enhancing

changes. When theorists, programmers and academics limit the determinants of ill health to individual responsibility and individual lifestyle, they can be viewed as allying themselves with the self-interested biomedical, political and industry position.(Minkler & Pasick, 1986; Estes, Fox, Mahoney, 1986; Kickbusch, 1989) If this is done to the virtual exclusion of environmental influences the victim may have little or no information and therefore maybe powerless to influence change except indirectly through action (Epstein, 1985).

As noted minimal environmental and community action for change has been taken by the programs under study. In one case when out reach programming was an objective, seniors were pushed back to the individual behaviour change stance by professionals. The professionals' action undermined and negated the positive action made by the seniors in attempting to address socially isolated seniors in their community. This kind of narrow, introspective approach to health promotion discourages concern for community and societal well-being (Becker, 1986).

What is suggested is that lifestyle change efforts remain secondary or at most equal to environmental approaches, and that approaches solely related to individual behaviour change may yield marginal improvements in the social causes of health. Although this study does not provide direct evidence for this stance, it must be noted that where environmental and community action was attempted gains were minimal. One is tempted to believe that this is an outcome from employing a health promotion approach which primarily focuses on individual behaviour change.

In response to the critics of an individually-oriented approach there are those who contend that few health promotion programs do focus

exclusively on individual behavioural change, and further that programs which address individual health and behaviour must eventually address system-change and the issue of conflicting ideologies about health and health promotion (Green, 1984, 1986; Green and McAlister, 1986).

Green's position is partially supported by workplace health promotion literature (U.S. Department of Health and Human Services, 1987; Walsh, 1988) which suggests that the introduction of health promotion activities in specific worksites led to health enhancing system-changes. The programs presently studied can not make this claim and as yet have not addressed the issue of conflicting ideologies.

Also, Green's perspective does not acknowledge the impact of the language and models used and how these implicitly suggest certain types of approaches over others. Green (1984) pointed this out himself when he suggested it was perhaps regrettable that the predominance of contributions to the literature are from psychology. "Even in large scale community interventions such as the Stanford three-community studies, the behavioral science contributions to planning the interventions have been made largely by psychologists. The result is that the behavioral change interventions have tended to emphasize the individual, and have been most useful in patient education. This concentration of behavioral science applications is sometimes at the expense of action on needed change in the organizational, institutional, environmental, and economic conditions shaping behavior (Green, 1980, p. 217)."

The use of terms such as 'Lifestyles' and 'Individual Responsibility' also inadvertently serve to focus attention on changing the individual rather than changing the underlying community and

environmental problems which maintain and reinforce unhealthy behaviour (Minkler & Pasick, 1986; Health Education Unit, 1986).

Widespread change through multiple mechanisms at all levels of society appears essential if the victim blaming implicitly encouraged through the misuse of health promotion rhetoric, language and narrow models is to be avoided. Even if professionals working in the health promotion arena are successful in incorporating environmental influences into programming, education at the micro, meso and macro-level will be necessary to reverse the present impact arising from the individual behaviour change stance. This focus on individual responsibility for health must be accompanied by an equal emphasis on the community and environmental factors which heavily influence individual health practices. If health care programmers, politicians, industry and the media continue to perpetuate a victim blaming ideology it is feared society will remain blind to the large-scale causal factors of the health problems it seeks to address (Epstein,1985; Becker,1986; Crawford, 1979; Kickbusch, 1989).

Question 3 addresses those **organizational influences** which impact on program process and composition.

QUESTION 3: What factors best contribute to explain program composition and variation?

The composition and hence variation among the programs studied were most influenced by organizational factors including:

1) the way a health promotion approach is applied,
2) the structure of the program organization,
3) program control,
4) program funding and

5) the impact of historical development on programming.

As already noted the health promotion approach formally adopted by the programs in this study is a socioecological model of health (Martin, Robertson & Altman, 1988). The degree to which pertinent individual and environmental components are reflected in program process and composition is dependent on how much professionals and seniors adopt and incorporate its underlying principles. These principles include **senior participation, senior empowerment** and **partnership** between seniors and professionals in program planning, organization and process. If seniors' issues are to be identified and addressed, it would be anticipated that seniors be given the opportunity to be active participants in program planning and decision making, at all **organizational levels.** This would require appropriate mechanisms be in place for regular and open communication between general participants, front line volunteer staff and those specifically involved in planning and organization. Also those operating costs and manpower issues which affect program composition would be viewed as pertinent organizational factors.

Across programs the findings were not reflective of this ideal scenario. Only one program (Program B) adopted and incorporated the principles of the **socioecological model** to any significant degree. This program was the only one that had mechanisms in place for regular open communication and decision making about program planning between the planners and the remaining participants. In this program seniors planned, managed and organized the program while professionals functioned as facilitators, advocates and consultants.

All five programs studied had seniors running program activities, however, two programs had no designated senior volunteers involved in program planning and decision making. Of the three programs that had seniors involved in committees and on boards, in two of these cases professionals clearly undervalued seniors' input by either monopolizing or completely preventing seniors' involvement in discussion and decision making processes.

In three of the five programs professionals and seniors complained that inadequate **funding** and/or staffing limited program expansion. In one program where funding was pursued by seniors, professionals interfered with the process and monies were not forthcoming. In one other program senior volunteers conducted annual fund raising activities to purchase equipment. However, seniors and professionals in most programs did not venture beyond discussion to pursue solutions to staffing and funding concerns.

Also, the impact on programming of **historical factors** can not be underestimated. Although a socioecological model had been adopted since 1986, all these programs were modelled to some degree on a program which began in 1984. This program was developed by a health promotion consultant who employed an individual lifestyle-oriented health promotion approach. As noted program components vary little among programs, and they predominantly address individual behaviour change which fits with this behavioural model.

Organizational factors that contribute to health promotion process and composition are multifaceted and influenced greatly by macro, meso and micro-level influences and practices.

Since the 1980's an expanded definition of health promotion has been added to federal health rhetoric which identifies both individual behaviour and environmental influences as determinants of health. In consequence, **national strategies** for health promotion now identify a commitment to reorient health services and their resources so as to address broader level health issues (Epp, 1986). However, major health policy in the form of legislation and funding for health services, continues to emphasize a costly acute care crisis approach based on biomedical ideology which is dominated by the medical establishment (Estes, Fox & Mahoney, 1986).

This paradox is an example of how health policy and hence practice often result from a process of negotiation between conflicting ideologies. The introduction of health promotion ideology, while biomedical ideology is strongly entrenched in present health policy, has led to both intended and unintended consequences. On the one hand, federal health policy advocates community-based health promotion to improve the health status of a growing population of seniors and to reduce health care costs. Yet, it openly supports biomedical approaches and practices by subsidizing the in-place, high-tech medical system and fee-for-service care. As such, when health promotion programs do exist they tend to adopt a clinical lifestyle focus or operate without adequate funding (Estes, Fox & Mahoney, 1986; Health Services and Promotion Branch, 1986; Kickbusch, 1989; Marshall, 1987; McKnight, 1978, 1987).

This failure to support health promotion with policies and funding that consolidate its ideals can only be expected to lead to ideological and practice differences within health promotion programs themselves.

Although this study does not address these issues directly the data does identify that ideological differences exist and these differences appear to influence program process and composition. These differences appear to stem from the attempt by professionals and seniors to combine two different health promotion approaches. All five programs studied have based their program content on a clinical behavioural approach yet they attempt to organize program process using a socioecological approach. With a clinical behavioural approach "the primary challenge (is) to assist people in taking responsibility for their total health" by adopting health enhancing lifestyle practices (Nelson, 1984). This approach focuses on modification of behaviour at the individual level and the professional is viewed as the program planner, leader and clinical expert. In contrast the socioecological approach refocuses attention, away from strictly individual factors and processes, and towards environmental determinants of health and group empowerment. This approach requires the direct involvement of individuals who identify health needs and participate in any necessary action to create health enhancing changes. Professionals are not viewed as experts and leaders, but rather they function as facilitators, advocates and resources in this process (Martin, Robertson & Altman, 1986; Mcleroy, Bibeau, Steckler & Glanz, 1988; Nelson,1984; Kickbusch,1989).

The impact on program process and composition from these ideological differences, which stem from forces within the larger social system are further compounded by those which stem from organizational influences.

None of the seniors health promotion programs studied is free-standing. Rather, as with many community health promotion programs for

seniors, the programs are all conducted within or sponsored by some type of community organization or agency. If the organizational structures, missions and goals of the host and sponsoring organizations are incompatible with health promotion ideology it is likely this will impact on program process and composition. For example, the structure of most organizations is based on a hierarchical design established to create control of people. On the other hand, the structure of progressive health promotion programs is based on people acting through consent. This difference is critical because many health promotion goals can only be fulfilled through consent, and these are often the goals that will be impossible to achieve through a hierarchical system designed to control (Fried, 1980; Labonte, 1989; Mcknight,1987; Mcleroy, Bibeau, Steckler & Glanz, 1988; Ottoson & Green, 1987; Goodman & Steckler, 1987; Kouzes & Mico, 1979; Shortell, Kaluzny & Associates, 1988).

Though data were not gathered specifically from all the organizations in this study, there were numerous examples that suggest ideological incompatibility in organizational behaviour between the health promotion programs and their host and sponsoring organizations. These issues seriously impact on program process and ultimately affect program composition. For example, the interference by professionals from one host organization essentially blocked a proposal which was to lead to the development of a seniors out reach program. These professionals believed that seniors should take responsibility for this program themselves, while the seniors believed they needed the help of a paid coordinator. In another example professionals blocked seniors from participating on a

Seniors Advisory Board as they believed professionals should identify seniors needs within their community, not the seniors.

If these ideological conflicts are not given adequate attention through appropriate organizational processes, at worst, they could lead to program termination. At best, organizational influences need to be addressed so that these health promotion programs can survive to become integrated parts of host and sponsoring organizations (Goodman & Steckler, 1987).

Finally, **micro-level** influences on program process and composition cannot be overlooked. Both seniors and professionals hold health promotion perspectives based on a lifetime of history within a particular society. Individuals are affected by such factors as age, sex, occupational background, education, economic status, values and beliefs. Collectively, social values, federal policies and the practices of the health system, industry and the media also have a tremendous impact on individuals' perspectives.

Hence, professionals may advocate for senior **empowerment** yet be heavily influenced by those clinical methods which historically placed them in **control** of program process and composition. These clinical methods assume that seniors require assistance to manage health promotion programming which lead professionals to make choices for them. This encourages psychological dependency and **helpless behaviour** on the part of seniors which diminishes their sense of control and empowerment and in turn, their impact on programming

For example, social interaction and support are identified by all seniors as the primary reasons for program attendance yet few programs

legitimate this social health need by developing pertinent program activities. In a number of programs seniors come early and leave late or talk quietly amongst themselves while scheduled activities are in operation. Only one program legitimated this concern through the addition of new social activities. This program also provides a forum for all seniors to identify their needs and participate in program development.

Conversely, seniors may know that they have the knowledge and skills to take control of their own health promotion programming and be adversely affected by a societal presumption that they have little to offer as they age. Ageism may have a negative impact on seniors sense of self worth and encourage an over-reliance on professionals to make the decisions for them. Consequently, seniors may refrain from actively participating in the process of program planning, decision making and organization (Easterbrook, 1978; Clark, 1969; Gaventa, 1980; Seligman, 1975; Maier & Seligman, 1976; Labonte, 1989; Schultz, 1980).

For example, in one of the programs studied, seniors were encouraged by one professional (wellness coordinator) to conduct exercises themselves as she felt they had the skills to do so. The seniors decided to each take a turn in running the exercises with each others support. However, another professional (from the host organization) believed a professional should run the program, and hence organized a fitness instructor to run this program component. The seniors readily backed off from running the program themselves, stating they felt the professional had more expertise.

In summary, although most of the health promotion programs studied focus primarily on individual behaviour change, those programs where efforts are made to give seniors control of program process and

organization were less likely to ignore those social, organizational, economic and political factors that keep seniors socially isolated, disempowered, impoverished and undervalued in society. When an ecological approach is applied health promotion programs can more effectively address pertinent needs of seniors and are more likely to recognize the impact of multiple micro, meso, and macro-level influences on the health promotion programs themselves.

II. LIMITATIONS OF THE STUDY

1) The people interviewed were not necessarily representative of the whole group of individuals involved in each program, for several reasons:

a) Only one senior who was involved in program planning and organization was interviewed from three programs.

b) Because few men attended these programs and it was felt important by interview to represent both sexes proportionately, in some programs the male perspective may be under-represented.

c) although all coordinators were interviewed, no individuals from host organizations were represented in the sample of professional interviews.

2) Those seniors and professionals involved in program planning and organization may be over-represented as they were asked more questions than senior participants.

3) The more articulate people may be over-represented in the data analysis and presentation, even though participant observation was used in order to reduce this possibility.

4) The data gathered is not necessarily representative of professionals involved with each program, for several reasons:

a) Although all the coordinators adopted a broad perspective that recognized both individual and environmental influences on health, and supported the principle of senior participation, they may not fully adopt the socioecological framework documented by the Health Department which is still in draft form.

b) No data was gathered from professionals in host or sponsoring organizations about these organizations' missions, goals and objectives.

5) Generalization of the findings will be limited for several reasons:

a) Logical argument may provide justification for generalization to all Health Department health promotion programs for seniors in the Vancouver area; however some barriers to this generalizability must be noted. These programs have some variations in terms of professional training and philosophy, senior involvement in program planning and organization, and the number of senior participants, and the involvement from host and sponsoring agencies. The physical location, professional/senior ratio, and community characteristics also vary among groups.

b) Generalizability of data beyond this sample of health promotion programs for seniors in Vancouver is difficult to justify.

6) Replicability of procedures can be viewed as a limitation. However, although only one researcher was involved, the use of multiple data collection procedures, along with triangulation, enhances internal reliability. External reliability is a matter of degree and some

qualitative researchers would argue that nothing can be replicated exactly. However, the detailed description and discussion of both data collection and analysis procedures enhances the potential of this study being replicated.

III. IMPLICATIONS FOR FUTURE RESEARCH

Despite the difficulties with generalizability for many health promotion studies that adopt qualitative methods, further research of this type which specifically explores health promotion program focus and organization, can only add to the lack of research in this area.

Although some authors claim programs continue to focus on individual lifestyle change, too few documented research studies have been conducted to confirm this. Without research that investigates health promotion program focus and the underlying causal factors of program composition, there will be an insufficient quantity of studies to support the need for health promotion programming as envisioned by Epp (1988), Green, (1980) and the World Health Organization (1984, 1986).

In many instances, health promotion program research questions are wide-ranging and complex. Such is the case with the present exploration of organizational influences on program process and composition. More indepth study needs to be undertaken in order to explore the effects of both the internal organizational mechanisms and those external organizational influences on program process and composition.

Despite the difficulties with health promotion research, further studies are essential to provide a firm foundation of information which is readily available to policy makers, health care planners, the media and

the general public if 'real' health promotion is to be assured an integral part of the health care system.

IV. PRACTICAL RECOMMENDATIONS FOR PROGRAM PROCESS AND ORGANIZATION

This study of five health promotion programs for seniors has attempted to capture the existing approach, process, and content of each program. Many issues need resolving if these health promotion programs are to be successful as vehicles for enhancing the quality of life of seniors living in the community. Most of these issues are related to internal and external program influences.

A. INTERNAL INFLUENCES

1) Health Promotion Approach.

Professionals must select a health promotion approach which allows seniors to participate in defining their needs within their community; in particular, an ecological approach would be more effective than a clinical behavioural approach.

2) Involvement by Seniors in Health Promotion Planning and Decision Making.

Seniors must be involved in every level of planning and decision making within programs that are initiated on their behalf. Only then will these programs effectively serve to address those needs identified by seniors. For example, all the seniors interviewed identified social support and social interaction as the primary reasons they attended the programs. However, limited recognition was given to this aspect of their well-being by most programs. Also, professionals expressed concerns that

seniors were not taking leadership roles. However, without appropriate mechanisms for involvement, seniors will not be inspired to exercise control, develop skills and take leadership positions. Only when they become involved, will seniors take ownership of efforts made to improve the conditions of their lives.

3) Involvement by Professionals in Health Promotion Planning and Decision Making.

Professionals must be involved in exploring program approaches which meet seniors' needs rather than those that put a program in place. This requires that professionals should relinquish control of programs and should function more as senior advocates and consultants, where their primary role is to provide knowledge, resources and skills that empower seniors "to run their own show." In conjunction with this role, professionals must be involved in addressing those ideological conflicts which hamper program process with host and sponsoring organizations.

B. EXTERNAL INFLUENCES

1) Conflicting Ideologies between Health Promotion Coordinators and Employers.

Professionals must be empowered within their own organizations if they are to effectively empower seniors. For example, if the professional's health promotion ideology conflicts with their employer's ideology this could impact negatively on the quality and content of health promotion programming for seniors.

2) Conflicting Ideologies between Programs and Host/Sponsoring Organizations.

Professionals must take an organizational role in gaining support for health promotion innovations from upper level management or appropriate personnel of host and sponsoring organizations. This may involve attending management meetings, encouraging management participation on health promotion program boards, and providing staff education, material support and ongoing liaison.

In some cases, however, not all the problems associated with effective health promotion programming will be solved, even given the selection of appropriate approaches, the active involvement of seniors and professionals, and the support of host and sponsoring organizations. Indeed, it may not be practical or possible to build consensus among all those affected. Also, it may take considerable time to develop environmental and organizational support for program goals. Furthermore, many macro-level influences cannot be controlled. Hence, program planners and participants will have to make choices based on priority of needs and the potential for success given the multiplicity of considerations involved.

BIBLIOGRAPHY

Anderson, N. (1923). The hobo. Chicago, IL: University of Chicago Press.

Barbaro, E.L. & Noyes, L.E. (1984). A wellness program for a life care community. Gerontologist, 24, 568-571.

Becker, H.S. (1954). Field methods and techniques: A note on interviewing tactics. Human Organization, 12, (4), 31-32.

Becker, H.S. (1970). Sociological work. Chicago: Aldine.

Becker, H.S., Geer, B., Huges, E.C. & Strauss, A. (1961). Boys in white: Student culture in medical school. Chicago, IL: University of Chicago Press.

Becker, M.H. (1986). The tyranny of health promotion. Public Health reviews, 14, 15-25.

Belloc, N.B. & Breslow, L. (1972). Relationship of physical health status and health practices. Preventive Medicine, 1, 409-421

Bender, C. & Hart, J.P. (1987). A model of health promotion for the rural elderly. The Gerontologist, 2, 139-142.

Berger, P. & Luckman, T. (1967). The social construction of reality. Garden City, NY: Doubleday.

Bogdin, R.C. & Biklen, S.K. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn & Bacon.

Blimensteil, A. (1973). A sociology of good times. In G. Psathas (Ed.), Phenomenological sociology: Issues and applications. New York: John Wiley & Sons.

Blummer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice-Hall.

Brown, V.A. (1982). Toward an epidemiology of health: A basis for planning community health programs. Health Policy, 4, 331-340.

Bronfenbrenner, U. (1976). The experimental ecology of education. Educational Researcher, 5.

Bruyn, S. (1967). The methodology of participant observation. Human Organization, 3, 224-235.

Buchner, M.D. & Pearson, D.C. (1989). Factors associated with participation in a community senior health promotion program: A pilot project. American Journal of Public Health, 79, (6), 775-777.

Burgess, R.C. (1984). In the field: An introduction to field research. London: George Allen & Unwin.

Calaizzi, P. (1978). Psychological research as a phenomenologist views it. In R.S. Valle & M. King (Eds.), Existential phenomenological alternatives for psychology. New York: Oxford University Press.

Catton, W.R. (1966). From animistic to naturalistic sociology. New York: McGraw-Hill.

Charon, J.M. (1985). Symbolic interactionism: An introduction, an interpretation, an integration. New Jersey: Prentice-Hall Inc.

Cox, C. & Monk, A. (1989). Measuring the effectiveness of a health education program for older adults. Educational Gerontology, 15, 9-23.

Clark, M. (1969). Cultural values and dependency in later life. In R. Kalish (Ed.), The dependencies of old age, Ann Arbor, MI: University of Michigan Press.

Crawford, R. (1979). Individual responsibility and health politics in the 1970s. In S. Reverby and D. Rosner (Eds.), Health care in America: Essays in social history, Philadelphia, PA: Temple University Press.

Cronback, L. (1975). Beyond the two disciplines of scientific psychology. American Psychologist, 30 (2).

Davis. A.J. (1973). The phenomenological approach in nursing research. Nursing Research, 20, 186-190.

Denzin, W.K. (1971). The logic of naturalistic inquiry. Social Forces, 50, 168-182.

Draper, R. (1988). The future of health promotion in Canada. Canadian Journal of Public Health, 79, 75-76.

Duncan, D.F. & Gold, R.S. (1986). Reflections: Health promotion - What is it? Health Values, 3, 47-48.

Dunn, M. (1985). Senior wellness services: A concept for the 80s. Health Values, 9, 14-17.

Dubos, R. (1976). Mirage of health. New York: Harper and Row.

Easterbrook, J.A. (1978). The determinants of free will: A psychological analysis of responsible, adjustive behavior. New York: Academic Press.

Epp, J. (1986). Achieving health for all: A framework for health promotion. Ottawa: Ministry of Supply and Services.

Epp, J. (1986). National strategies for health promotion. Canadian Journal of Public Health, 77, 243-247.

Epstein, S. (1985). The Environmental question: Beyond lifestyle change. Health and Medicine, Spring, 3, (2-3).

Estes, C.L. (1983). A message from WGS's president. Generations, Spring, 37.

Estes, C.L., Fox, S. & Mahoney, C.W. (1986). Health care and social policy: Health promotion and the elderly. In K. Dychtwald (Ed.), Wellness and Health promotion for the Elderly, Rockville, MD: Aspen.

Evans, R. (1989). Behaviour and Biology: A wide perspective on the health of Canadians. In The Proceedings of the National Symposium on Health Promotion & Disease Prevention, 31-39. Victoria, British Columbia: Ministry of Health.

Faris, R.E.L. (1967). Chicago sociology, 1920-1932. Chicago: University of Chicago Press.

Fitch, V.L. & Slivinske, L.E. (1988). Maximizing efforts of wellness programs for the elderly. Health and Social Work, Winter, 61-67.

Fraquar, J.W., Fortmann, S.P., Moccoby, N., Wood, P., Haskell, W.L., Taylor, C.B., Flora, J.A. Solomon, D.S., Rogers, T., Adler, E., Breitrose, P., Weiner, L. (1984). The Stanford Five City project: An overview, pp 1154-1165. In Matarazzo et al. (Eds.), Behavioral Health: A Handbook of Enhancement and Disease Prevention. Silver Spring, MD: John Wiley and Sons.

Fried, R. (1980, October). Empowerment vs. delivery of services. Paper presented at the O.P.H.A. Health Promotion Workshop.

Fries, J.F. (1980). Aging, natural death, and the compression of morbidity. New England Journal of Medicine, 303, 130-136.

Fries, J.F. & Crapo, L.M. (1981). Vitality and aging. New York: Freeman.

Fries, J.F. (1983). The compression of morbidity. Milbank Memorial Fund Quarterly, 61, 397-419.

Fries, J.F. (1984). Aging, natural death and the compression of morbidity. Gerontological Perspectives, 1, 5-8.

Fries, J.F., Green, L.W. & Levine, S. (1989). Health promotion and the compression of morbidity. The Lancet, March 4, 481-483.

Gaventa, J. (1980). Power and powerlessness. Chicago, IL: University of Illinois Press.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz (Ed.), The interpretation of cultures. New York: Basic Books.

Gilbert, S. (1986). Health promotion for older Americans. Health Values, 10, 38-46.

Giorgi, A., Fischer, C.L. & Murry, E.L. (1975). Duquesne studies in phenomenological psychology. Pittsburg, PA: Duquesne University Press.

Glaser, B.G. (1964). The constant comparison method of qualitative analysis. Social Problems, 12, 436-445.

Glaser, B.G. (1976). Experts versus laymen. New Brunswich, NJ: Transaction Books.

Glaser, B.G. (1978). Theoretical sensitivity: Advances in the methodology of granded theory. Mill Valley, CA: Sociology Press.

Glaser, B.G. & Strauss, A.L. (1967). The discovery of grounded theory. New York: Aldine Publishing Co.

Gold, R.L. (1958). Roles in sociological field observations. Social Forces, 36, (3), 217-223.

Goodman, R.M. & Steckler, A.B. (1987). The life and death of a health promotion program: An institutionalization case study. International Quarterly of Community Health Education, 8, (1), 5-21.

Gori, G., Ritcher, B. & Yu, W. (1984). Economics and extended longevity: A case study. Preventive Medicine, 106, (4), 623-626.

Green, L.W. (1984). Modifying and Developing health behavior. In L. Breslow, J. Fielding & L. Lave (Eds.), Annual Review of Public Health, 5, Palo Alto, CA: Annual Reviews.

Green, L.W. (1986). Individuals vs systems: An artificial classification that divides and distorts. Health Links, 2, (3), 29-30.

Green, L.W. & McAlister, A.L. (1984). Macro intervention to support health behavior: Some theoretical perspectives and practical reflections. Health Education Quarterly, 11, 323-338.

Green, L.W., Deeds, S.G, Kreuter, M.W. & Partridge, K.B. (1980). Health education planning: A diagnostic approach. Palo Alto, CA: Mayfield Publishing.

Gresham-Kenton, L. & Wisby, M. (1987). Nurse-managed health programs: Problem-oriented approach. Journal of Ambulatory Care Management, 10, (3), 20-29.

Guba, E.G. (1978). Toward a methodology of naturalistic inquiry in educational evaluation. (CSE Monograph Series in Evaluation, 8). Los Angeles, CA: Centre for Study of Evaluation, University of California.

Guidotti, T.L. (1989). Health promotion in perspective. Canadian Journal of Public Health, 80, November/December, 400-405.

Hammersley, M. & Atkinson, P. (1983). Ethnography: Principles in practice. London: Tavistock Publications.

Health and Welfare Canada. (1989/90). Summary report on research priorities and strategies: Developing knowledge for health promotion in Canada. Health Promotion, 28, (3), 6-9.

Guralnik, D.B. (1980). Webster's new world dictionary. New York: New World Dictionaries/Simon and Schuster.

Health Services and Promotion Branch. (1986). Aging: Shifting the emphasis. Ottawa, Ontario: Ministry of Supply and Services.

Higgins, P.G. (1988). Biometric outcomes of geriatric health promotion. Journal of Advanced Nursing, 13, 710-715.

Ho, E.E., Waltz, W., Ramstack, J., Homoki, J., Kligman, E., Meredith, K., Cohen, R. & Meyskens, F. (1987). Health-peers: A delivery model for health promotion among the elderly. Educational Gerontology, 13, 427-436.

Hutt, S.J. & Hutt, C. (1970). Direct observation and measurement of behavior. Springfield, IL: Thomas.

International Conference on Health Promotion. (November, 1986). Ottawa Charter on Health promotion. Ottawa, Ontario, Canada: author.

Jordon-Marsh, M. & Neutra, R. (1985). Relationship of health locus of control to lifestyle change programs. Research in Nursing and Health, 8, 3-11.

Junker, B. (1960). Field work. Chicago, IL: University of Chicago Press.

Kemper, D. (1986). The healthwise program: Growing younger. In K. Dychtwald (Ed.), Wellness and Health Promotion for the Elderly, Rockville, MD: Oregon.

Kickbusch, I. (1986). Health promotion: A global perspective. Canadian Journal of Public Health, 77, 5.

Kickbusch, I. (1988). The concept of health promotion. Innovation, 1, 2-3.

Kickbusch, I. (1989). Self-Care in health promotion. Social Science and Medicine, 29, 125-130.

Kickbush, I. (1989). Back to the future: Moving public health into the '90s. In The Proceedings of the National Symposium on Health Promotion & Disease Prevention, Victoria, British Columbia, Canada: Ministry of Health.

Koch, S. (1964). Psychology and emerging concepts of science as unitary. In T. Wann (Ed.), Behaviorism and phenomenology: Contrasting basis for modern psychology. Chicago: The University of Chicago Press.

Kouzes J.M. & Mico, P.R. (1979). Domain Theory: An introduction to organizational behavior in the human service organizations. The Journal of Applied Behavioral Science, 15, 449-469.

Kluckhohn, F. (1940). The participant-observer techniques in small communities. American Journal of Sociology, 46, 331.

Krout, J.A. (1985). Senior center activities and services: Findings from a national survey. Research on Aging, 7, 455-471.

Krout, J.A., Cutler., S.J., & Coward, R.T. (1990). Correlates of senior center participation: A national analysis. The Gerontologist, 1, 72-79.

Labonte, R. (1989). Community empowerment: The need for political analysis. Canadian Journal of Public Health, 80, March/April, 87/88.

Labonte, R. (1989). Community and professional empowerment. The Canadian Nurse, March, 23-28.

Labonte, R. (1988). Health promotion: From concepts to strategies. Health Management Forum, Autumn, 24-29.

Lofland, J. (1971). Analyzing social settings. Belmont, CA: Wadsworth.

Lalonde, M. (1974). A new perspective on the health of Canadians: A working document. Ottawa, Ontario: Ministry of National Health and Welfare, Government.

Lalonde, B.I.D. & Fallcreek, S.J. (1985). Outcome effectiveness of the Wallingford wellness project: A model health promotion program for the elderly. Journal of Gerontological Social Work, 9, 49-64.

Larson, E.B. (1988). Health promotion and disease prevention in the older adult. Geriatrics, 43, 31-37.

Malinowski, B. (1922). Argonauts of the western pacific. London: Routledge.

Malinowski, B. (1960). A scientific theory of culture and other essays. New York: Oxford University Press.

Marshall, V.M. (1987). Aging in Canada: Social perspectives. Ontario: Fitzhenry and Whiteside.

Martin, S., Robertson, A., & Altman, J. (1988). A framework for health promotion: Older adults. Vancouver, British Columbia: Vancouver Health Department.

Matza, D. (1969). Becoming deviant. Englewood cliffs, NJ: Prentice-Hall.

McDaniel, S.A. (1986). Canada's aging population: Social perspectives. Ontario: Fitzhenry and Whiteside.

McKeown, T. (1976). The role of medicine: Dream, mirage or nemesis? London: The Nufield Provincial Hospitals Trust.

McKnight, J.L. (1978). Politicizing health care. Social Policy, November/December, 36-39.

McKnight, J.L. (1987, November). Regenerating community. Presented before the Canadian Mental Health Association's Search Conference, Canada.

Mcleroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education Quarterly, 15, (4), 351-377.

Mead, G.H. (1934). Mind, self and society from the stand-point of a social behaviorist. Chicago: University of Chicago Press.

Mead, G.H. (1938). The philosophy of the act. Chicago: University of Chicago Press.

Maier, S. & Seligman, M. (1976). Learned helplessness: Theory and Evidence. Journal of Experimental Psychology: *General*, 105, (1), 3-46.

Meeks, S. & Johnson, S. (1988). Health promotion at a senior center: Designing the ideal program. Journal of Gerontological Social Work, 13, (1/2), 21-36.

Meltzer, B.N., Petras, J.W., & Reynolds, L.T. (1975). Symbolic interactionism: Genesis, varieties and criticism. London: Routledge.

Merleau-Ponty, M. (1964). The primacy of perception. Evanston: Northwestern University Press.

Metz, M.H. (1978). Classrooms and corridors: The crisis of authority in desegregated secondary schools. Berkeley, CA: University of California.

Milio, N. (1981). Promoting health through public policy. Philadelphia, PA: F.A. Davis.

Minkler, M. (1983). Blaming the victim: The politics of scapegoating in times of fiscal conservatism. International Journal of Health Services, 13, (1).

Minkler, M. (1985). The nursing home: A neglected setting for health promotion. Family and Community Health, May, 49-64.

Minkler, M., & Pasick, R.J. (1986). Health promotion and the elderly: A critical perspective on the past and the future. In K. Dychtwald (Ed.), Wellness and health promotion for the elderly, Rockville, MD: Aspen.

Mollenill, C. (1987). Health promotion for the elderly: Need for a new perspective. In M.L. Teague (Ed.), Health promotion: Achieving high-level wellness in the later years, Indianapolis, IN: Benchmark Press.

Morris, M. (1977). An excursion into creative sociology. New York: Columbia University Press.

Mullen, K.D. (1986). Wellness: The missing concept in health promotion programming for adults. Health Values, 10, 34-37.

Nelson, N.H. (1984). Be well. Health Promotion Directorate of Health and Welfare Canada.

Nelson, E.C., McHugo, G., Schurr, P., Devito, C., Roberts, E., Simmons, J., & Zubkoff, W. (1984). Medical self-care education for elders: A controlled trial to evaluate impact. American Journal of Public Health, 74, 1357-1362.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, January, 49-63.

O'Neill, M. (1989/90). Healthy public policy: The WHO perspective. Health Promotion, Winter, 6-8, 24.

Ottoson J.M. & Green, L.W. (1987). Reconciling concept and context: Theory of implementation. In W.B. Ward (Ed.), Advances in health education and promotion. Greenwich, CT: JAI Press.

Patton, M.Q. (1980). Qualitative evaluation methods. Beverly Hills, CA: Sage.

Pender, N.J. (1982). Health promotion in nursing practice. Norwalk, CT: Appleton-Century-Crofts, p. 42.

Psathas, G. (1973). Phenomenological sociology: Issues and applications. New York: John Wiley and Sons.

Radowski, W. (1986). Research issues in health promotion programs for the elderly. In K. Dychtwald (Ed.), Wellness and health promotion for the elderly, Rockville MD: Aspen.

Roadburg, A. (1985). Aging: Retirement, leisure and work in Canada. Agincourt, Ontario: Methuen.

Roth, J. (1963). Timetables. Indianapolis: Bobbs-Merrill.

Rist, R. (1978). Blitzkrieg ethnography. Educational Researcher, 9, (2).

Russell, L. (1984). The economics of prevention. Health Policy, 4, (2), 85-100.

Ryan, W. (1970). Blaming the victim. New York: Random House.

Schultz, R. (1980). Aging and control. In Garber & M.E. Seligmen (Eds.), Human helplessness: Theory and applications, New York: Academic Press.

Seidel, J.V., Kjoiseth, R., & Seymour, E. (1988). The ethnograph. Littleton, CO: Qualis Research Associates.

Seidman, E. (1983). Unexamined premises of social problem solving. In E. Seidman (Ed.), Handbook of Social Intervention, Beverly Hills, CA: Sage.

Seligman, M.E. (1975). Helplessness: On depression, development, and death. San Francisco: University of Pennsylvania.

Shortell, S.M., Kaluzny, A.D. & Associates. (1988). Health care management: A text in organization theory and behavior. New York: John Wiley & Sons, Second Edition.

Somers, A.R., Kleinman, L. & Clark, W. (1982). Preventive health services for the elderly: The rugers medical school project. Inquiry, 19, 190-221.

Smith, D.L. (1988). Health promotion for older adults. Health Values, 12, 46-51.

Spiegelburg, H. (1960). The phenomenological movement. The Hague: Martinus Nijhoff, Vol. 2.

Spiegelburg, H. (1970). On human uses of phenomenolgy. In J.F. Smith (Ed.), Phenomenology in perspective. The Hague: Martinus Nijhoff.

Spradley, J.P. (1980). Participant observation. New York: Holt, Rinehart & Winston.

Statistics Canada. (1985). Population projections for Canada, Provinces and Territories; 1984-2006. Catalogue 91-520. Ottawa, Ontario: Supply and Services.

Statistics Canada. (1986). Vancouver Local Areas 1986: 100% data from the Canada Census. City of Vancouver Planning Department, October 1988.

Statistics Canada. (1986). Vancouver Local Areas 1986: 20% data from the Canada Census. City of Vancouver Planning Department, June 1989.

Strauss, A.L. (1970). Discovering new theory from previous theory. In T. Shibulani (Ed.), Human nature and collective theory. Englewood Cliffs, NJ: Prentice-Hall Publishing Co.

Strauss, A.L. (1987). Qualitative analysis for social scientists. New York: Cambridge University Press.

Swartz, H. & Jocobs, J. (1979). Qualitative sociology: A method to madness. New York: The Free Press.

Tesh, S. (1981). Disease causality and politics. Journal of Health Politics, Policy and Law, 6, (3), 369-390.

Thatcher, R.M. (1988). Health promotion for older adults. In I.M. Burnside (Ed.), Nursing and the Aged: A Self-Care Approach, 989, (3rd ed.). New York: McGraw-Hill.

Thatcher, R.M. (1989). Community support: Promoting health and self-care. Nursing Clinics of North America, 24, 725-731.

Thrasher, F. (1927). The gang. Chicago: University of Chicago Press.

Taylor, L. (1983). A cross country highlight of health promotion activities. Health Education, Winter, 8-11.

U.S. Public Health Service and Administration on Aging. (1984). Aging and health promotion: Market research for public health education. Contract No. 282-83-0105. SRA Technologies: U.S. Public Health Service and Administration on Aging.

Vickery, D.M., Kalmer, H., Lowry, D., Constantine, M. & Loren, W. (1983). Effect of self-care education program on medical visits. Journal of the American Medical Association, 250, 2952-2956.

Wade, R.W., Patterson, M.A. & Alford, D.M. (1989). Services for maintaining independence. Journal of Gerontological Nursing, 15, (6), 31-37.

Wax, R. (1971). Doing fieldwork: Warning and advice. Chicago: University of Chicago press.

Walsh, D.C. (1988). Current policies regarding smoking in the workplace. Journal of Industrial Medicine, 13, (1), 10-16.

Wechsler, R. & Minkler, M. (1986). A community-oriented approach to health promotion: The tenderloin senior outreach project. In K. Dychtwald (Ed.), Wellness and Health Promotion for the Elderly, Rockville, MD: Aspen.

Weiler, P.G., Chi, I. & Lubben, J.E. (1989). A statewide preventive health care program for the aged. Public Health Reports, 104, (3), 215-221.

Weiss, L.J., & Sklar, B.W. (1983). An alternative health delivery system for the chronically ill elderly. In S. Simon et al (Ed.), Aging and prevention: New approaches for preventing health and mental health problems in older adults. New York: Haworth Press.

Wells, A. (1978). Contemporary sociological theories. Santa Monica, CA: Goodyear Publishing Co., Inc.

Wiley, N. (1979). The rise and fall of dominating theories in American sociology. In W. Snizek, E. Furherman & M. Miller (Eds.), Contemporary issues in theory and research, a meta sociological perspective. Westport, CT: Greenwood.

Williamson, L., Karp, W.E., Dalphin, K. & Gray, P.N. (1982). The research craft: An introduction to social research methods. Toronto, Ontario: Little, Brown & Co.

Wolcott, H. (1973). The man in the principal's office. New York: Holt, Rinehart & Winston.

Wolf, R.L. (1979). An overview of conceptual and methodological issues in naturalistic evaluation. Paper presented at the meeting of the American Educational Research Association, San Francisco, April.

U.S. Department of Health, Education & Welfare. (1979). Healthy people: The Surgeon-General's report on health promotion and disease. (DHHS Publication No. 79-55071). Washington, DC: Public Health Services.

U.S. Department of Health and Human Services. (1987). National survey of worksite health promotion activities: A summary. U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion.

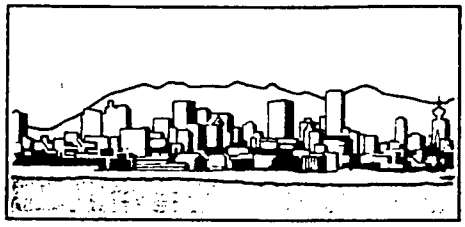
World Health Organization. (1984). Discussion document on the concepts and principles of health promotion. CPHA Health Digest, 8, (6), 101-102.

World Health Organization. (1985). Targets for health for all. Copenhagen: WHO/EUROPE.

World Health Organization. (1986). Health Policy and Health Promotion: Towards a new conception of Public Health. Vienna and Copenhagen: Proceedings of the first Vienna Dialogue on Health Promotion, WHO/EURO and the Austrian Ministry of Health and Environmental Protection. Document RP-12 of the Eurosocial Research and Discussion Papers, European Centre For Social Welfare Training and Research, Vienna.

APPENDIX A

RESEARCH CONSENT FORMS



Vancouver Health Department

North Unit

#200-1651 Commercial Drive, Vancouver, B.C. V5L 3Y3 Telephone: 253-3575

Re: A qualitative research study - Community health promotion programs for seniors: Program components and contributing factors to their composition.

Student investigator: Kim M. Calsaferri
Graduate Student (M.Sc. - Health Promotion)
University of British Columbia

I consent to participate in a study being conducted by Kim Calsaferri of health promotion programs for seniors in the Vancouver area. I understand part of the study will focus on my perspective as a Seniors Wellness Coordinator.

I will participate by: a) assisting the researcher to establish a working relationship with one selected seniors program within my catchment area; b) making available pertinent documents such as program schedules, goals and objectives, minutes from program planning meetings and; c) participating in a semi-structured interview of one hours duration.

If I wish to withdraw from the study I know I can do so at anytime without jeopardy. I understand all information will be strictly confidential, no names are required or will be recorded and that no identifying information will be placed in the final report. I know answers to any questions concerning my participation will be given by the researcher to ensure that I fully understand the process.

I have maintained a copy of this consent form:

Name _____ Signature _____ Health Unit _____

Name _____ Signature _____ Health Unit _____

Name _____ Signature _____ Health Unit _____

Name _____ Signature _____ Health Unit _____

Name _____ Signature _____ Health Unit _____

/ljb
89/4/10

CITY OF VANCOUVER

APPENDIX A
SENIORS CONSENT FORM

RE: A qualitative research study: COMMUNITY HEALTH PROMOTION PROGRAMS FOR SENIORS: PROGRAM COMPONENTS AND CONTRIBUTING FACTORS TO THEIR COMPOSITION.

Student Investigator: Kim Calsaferri
Graduate Student (M.Sc. Health Promotion)
University of British Columbia

I CONSENT to participate in a study being conducted by Kim Calsaferri, of health promotion programs for seniors in the Vancouver area.

I understand part of the study will focus on my perspective as a senior member of one of these programs. I will participate in a semi-structured interview of one half hour's duration.

I know I can withdraw from the study at any time without it jeopardizing my future participation in the health promotion program.

I understand all information will be strictly confidential; no names are required or will be recorded, and that no identifying information will be placed in the final report. I know answers to any questions concerning my participation will be given by the researcher to ensure that I fully understand the process.

I understand I will receive a copy of this signed consent form.

Interviewee's Name: _____

Program: _____

Date: _____ 1989

APPENDIX B

OBSERVATION SCHEDULE

APPENDIX B
OBSERVATION SCHEDULE FEBRUARY - JULY 1989

DATE	TYPE	TIME	PROGRAM	PROTOCOL
Feb 22	Informal	10am-12pm	A	PAOB1
March 1	Formal	10am-12pm	A	PAOB3
May 1	Informal	10am-12pm	B	PBOB1
May 1	Informal	1pm-3pm	C	PCOB1
May 2	Informal	930am-12pm	D	PDOB1
May 3	Informal	1pm-4pm	E	PEOB1
May 6	Focused	11am-12pm	D	PDOB5
May 8	Informal	930am-12pm	B	PBOB2
May 8	Informal	1pm-3pm	C	PCOB2
May 10	Informal	10am-12pm	A	PAOB2
May 10	Informal	1pm-4pm	E	PEOB2
May 15	Focused	1030am-12pm	E	PEOB3
May 16	Formal	930am-12pm	D	PDOB3
May 17	Focused	12pm-1pm	E	PEOB4
May 17	Formal	1pm-4pm	E	PEOB5
May 23	Formal	945am-12pm	D	PDOB4
May 24	Formal	10am-12pm	A	PAOB4
May 24	Formal	1pm-4pm	E	PEOB6
June 7	Focused	1045am-12pm	A	PAOB5
June 12	Formal	930am-12pm	B	PBOB3
June 12	Formal	1pm-3pm	C	PCOB3
June 13	Focused	11am-12pm	D	PDOB6
June 14	Focused	11am-12pm	A	PAOB6
June 19	Formal/Informal	10am-2pm	B	PBOB4
June 19	Focused	3pm-4pm	C	PCOB4
June 26	Formal/Focused	930am-115pm	B	PBOB5
June 26	Focused	130pm-230pm	C	PCOB5
June 28	Focused	11am-12pm	A	PAOB7
July 17	Focused	1030am-1pm	E	PEOB7

Key: P = Program
OB = Observation

APPENDIX C

EXAMPLES OF OBSERVATION PROTOCOLS

APPENDIX C

EXAMPLES OF INFORMAL, FORMAL AND FOCUSED OBSERVATION PROTOCOLS

INFORMAL OBSERVATION PCOB1-Program C, Observation 1

+PCOB1
+Name of researcher:Kim Calsaferri
+Date: May 1/89
+Time: 1:00-3:00 pm
+Subject: Informal

OB: Program C is run out of a seniors centre in the down town core. When I entered the building I noticed a woman sitting behind a table
BR: I wondered if she was a volunteer giving people info on what was happening in the building as there is a hive of activity.
OB: I notice on the sign that there are a number of senior oriented services run out of this building.
I was surprised to bang into a senior from the Program B there. Then I saw (A) the fun and fitness instructor I had met last week at Program C when I asked the Senior's for permission to observe. She is of Scottish decent and recently was at S.F.U. completing her teachers diploma. She is full of energy and enjoys what she does here with the senior's a lot
BR: She told me this when I was here last.
OB: She herself is a senior and is involved as a volunteer here after doing the fun and fitness instructors course. I introduce myself to another woman who sits behind a table with cards on it. Her name is (F).
She is also a senior and a volunteer.
It is more difficult to tell her age as her hair is black.
BR: ?dyed
OB: (F) gives me the schedule for May also I receive a hand out from (M) the coordinator of whole senior's center about special programs.

BR: I meet (M) Friday 22nd April to discuss my coming to the center to observe. He requested this-I suspect he over sees every thing and likes to keep his finger on the pulse of what is happening.

OB: Music is now playing which (A) has put on. Seniors arrive and some go over to the table I asked the Senior Volunteer what happens at the table "this is for BP's". Apparently there is a RN who comes from the health dept to do these and people sign up 1st and are put on a list and when their turn comes up (F) lets them know. There is a scale by the table.

BR: I was told by (F) this is so people can weigh themselves. Records are kept of this in a cardex which (F) organizes.

OB: So far there are 7 people here- all are woman. (A) comes over and chats to me about the senior's strutt-she gives me a hand out on this event and also announces this to the group and gives interested people a pamphlet. This group are dressed in slacks and tops. All are well groomed, the majority wear nylons and shoes. Some wear sneakers Ethnic mix is 3 of Chinese decent and 6 Caucasian- one of these appears to have a German accent.

BR: She's the one who told me to sit down so they could get started with exercises when I came to request to do research.

OB: She share's her concerns about things not starting on time. (A) explains the exercises usually start at 1:15pm. She makes mention this isn't what's on the schedule. Exercises start at 1:15pm. She makes mention the Spanish teacher had lost two people her. The Wellness coordinator arrives and pops over to say hello to me and asks how things are going. People stand in front of chairs which are arranged in rows of approximately 5 and the group begins with arms. One woman hums to the music. (A) sings along. The music is gentle.

Exercises include;
-shoulder raises
-knee bends
(A) reminds people they are gentle exercises and to hold onto the chair if they wish to.
-marching on the spot "to raise your heart. Does anyone have medication and if you do it would be helpful if you would let me know." She points out that one lady has a pace maker, who has now sat down and continues to do the exercises with her feet seated in the chair. (A) asks specific people if they are o.k. One she asks a number of times. Her name is (G) and I notice she has a tremor of some kind and is also one of the older members

BR: This is a guess-late 70's

OB: # 2 is called by (F) for BP. The woman leaves the room and goes off somewhere around the corner. This room although closed off by three walls is open at one end so I can hear ping pong balls and people pop over now and again to look at what is happening. The room itself is on the 3rd floor where seniors programs are held. It has windows down two sides and is approximately 30x15 feet. The table (F) is at is located at the end which is open. The instructor is in the middle of the group at the front.

Two more woman arrive and move to the back and join in.
-ankle rotations
-leg rotations

A man comes up to the table and gets a # for BP.

(A) changes music to 'moon river'
-marching on the spot- some sit- the rest remain standing
-twisting

Another man arrives & then a woman. Only the woman joins in the exercises, the man is here for BP.
-walk in large circle around chairs (I am now in the center). (J) pops over to talk to me and mentions she is only here because the senior's like

her to come by as it makes it more official.

BR: I wonder what this means..

OB: She talks to me about how they had a planning meeting in April.Z I ask when the next one is and if I can attend. She says it will be in June and is usually held after the session. She also talks about how she likes to see the program stop in the summer as believes the volunteers need a break, or they get burnt out, yet often they want to continue. She also said she does to, to do other things.

-fingers and feet in a seated position

Music is very mellow now-piano

(J) makes announcements-Wellness fair at Kerrisdale (a hand out is given out labeled Seniors in Action), she explains that different wellness groups will be there and it will be a chance to see what others are up too. Every one chats about how to get the bus there. (J) apologizes for interrupting the exercises and then leaves.

-arms One of the women mentions this is what she had to do when she had a broken arm.

-fingers

-Itsy bitsy spider

-seated raise arms-arms out and in

-eyes-up and down, side to side

Another woman arrives.

I notice this group looks relatively young-late 50's 60's except for a couple who look to me about 70-80.

Another man arrives for BP.

-stretching arms

-face

It's now 2:00pm (A) finishes the session and thanks the group for coming. She mentions the seniors strutt and gives pamphlets to those that don't have them. Seniors now chat together. Many leave, there are now 7 left. The speaker is here now. It is going to be a talk on 'dementia/senility' by a coordinator of a S.T.A.T. Center. Two men join the group as

they are waiting for BP. The talk continues for about one hour and during that time seniors ask questions about depression, alzheimer's and delirium the topic. At the end one member asks what other talks this coordinator gives and wonders if she could come back again sometime.

The program ends at 3:00pm The tone has been relaxed.

BR: I did notice however how a # of men came but how only two stayed for the talk and none went to the exercises.

OB: This is the end of this observation.

FORMAL OBSERVATION PCOB3-Program C, Observation 3

+PCOB3
+Name:Kim Calsaferri
+Date: June 12/89
+Time: 1:00-3:00pm
+Subject: Formal

OB: I arrive at 1:05pm and see the table set up. There is a TV set up. 7 senior women sit in lines. (I), a Senior Volunteer arrives & tells 3 seniors sitting next to the coat rack that the RN won't be here today.
FEMALE: (arrives) Hi
(I): No nurse here today- only exercise and lecture.
OB: A young guy sets up the TV and puts on a video. There are 10 senior woman.
MALE: What's on today.
(I): Eye disease. Are you going to come?
MALE: No, my eyes are OK.
OB: The video starts. It is a video from the Red Cross for Seniors- exercise, 1/2 hour. I understand (A) is away right now so the video is being used as a substitute. I notice on the table are two pamphlets from the St. John Ambulance:
1) Healthy Aging
2) Get Ready, Get Smart, Get a Handle On Your Retirement Lifestyle
I notice that 1/2 of these people are regulars. Another woman arrives, it is 1:22pm. She takes a seat and joins in. I notice one woman doesn't join in. Another woman arrives at 1:27pm. There are 13 women now.
One of the woman sings as they do a rowing motion.
FEMALE: Row row row your boat.
OB: They do strengthening and stretching of both legs and arms.
Another woman arrives.
Then the pace increases. Heel, toe, polka.
The woman on video sings. They all laugh.
They now move into a cool down.
I notice a sign on a board:

Wellness Clinic-discussions-your blood pressure taken-musical exercise-guest speakers.
The video finishes at 1:45pm & (R) starts again. 2 more women arrive. 2 leave to go have coffee the others do it all again.
(I): (to me) Come and join in. (She joins the group)
OB: One of the woman who arrives doesn't do it. 2 more women arrive and 1 joins in. (I) goes over to the other and encourages her to join in.
(E): (tells me) Last week we had a lecture on AIDS and one by one all of them left. I don't know why. The 2 men complained. I don't know why but one man was telling us when he started having sex and that it wasn't till late.
OB: Another woman arrives. (I) goes over.
FEMALE: Someone's supposed to come and speak about the eyes.
(I): Join in the exercises.
FEMALE: I can't exercise. (She sits over by the coat rack)
OB: I notice when I look over that she has joined in.
(I): I think that's him. Do you remember his name?
OB: She goes over to him.
SP: I need a screen for slides.
OB: The exercises end at 2:10pm. There are 20 people here.
The talk is called "The Aging Eye"
MALE: My name is (P). I'm an eye doctor in training. I finish in 2 months at VGH.
(P): Please shout out if you have questions.
FEMALE: Can you speak a little louder please.
(P): Do you know what legal blindness is?
OB: Explains same.
Shows a picture of the eye & explains. He mentions clouding of the eye-cataracts.
FEMALE: I have that.
(P): What I'd like to tell you today is what happens to the eye when you

age, the diseases and what you can do.
OB: Another man arrives.
(P): Things that go wrong as you get older.
1)baggie skin-simple surgery-take away extra skin
2)droppy lids- muscle that pulls eye c\open gets weak-can be in one eye or other. Fairly simple surgery.
FEMALE: That's not a squint eye is it?
(P): No and we won't talk about that because it's more in younger people.
3)lid flops out
4)spotsoneye-skin tumour-not dangerous unless left- important to treat and remove.
Things that affect front of eye:
5)white ring- no problem
6)glaucoma- increased pressure in eye, the drainage of fluid out doesn't work- damage to peripheral vision (gradual loss) 2% of population
Rx-drops in eye to decrease pressure
7)Cataract-lens gets cloudy
-don't have to wait now till "ripe"
-90% chance of restoration of vision
-local anesthesia only
-surgery only Rx and lens implant or glasses or
Macular Degeneration: -aging of back of eye
-very common
-50% over age 50 years
-damages spot for fine vision
-build up of white waste products
-doesn't affect side vision
-very little can be done except laser Rx.x
-only 1 type-leaking blood vessels
Diabetes: -increased sugar levels
-effects eyes-damages retina
Detached retina:
-aging, short sightedness, diabetes can cause same
-retina detaches from blood supply
-loose part of vision
-a lot of black spots
-flashing lights
Optic Nerve Damage: -uncommon
MALE: Is there 2 operations. One for dry eyes and wet eyes.

(P): Some of you may have dry eyes
(he explains same). Rx not an
operation but to use tear
replacements. Can be plugged if too
much fluid.
FEMALE: Last time I went to doctor he
only changed one glass.
(P): That's great it didn't cost so much.
FEMALE: What is a lazy eye.
(P): The same as a squint eye, like
cross eye. It's called lazy because
it's not working.
FEMALE:: Is that because you're over
using.
(P): That's a myth. You can't damage
your eye from over use or lack of
light- you just can't see.
MALE: Night glare
(P): Glare can be solved
Do you have cataracts?
MALE: Yes
OB:: Many more questions are asked and
(P) answers.
FEMALE:: Why do you get sleepy when you
read
(P): Probably eye strain.
OB: (I) and I talked at end as I
needed to tell her I wouldn't be there
next week but would see her at
planning meeting. She thought it was
today so hasn't been filled in on
changes.
The session has been very interactive.
(P) was very down to earth and
approachable for questions. The talk
ends at 3:15pm.
This observation has had a very
relaxed tone. This protocol ends.

FOCUSED OBSERVATION PCOB6-Program C, Observation 6.

+PCOB6
+Name:Kim Calsaferri
+Date: June 26/89
+Time: 2:30-3:30pm
+Subject: Focused

OB: I arrive in the room next to the
Wellness Clinic and 5 people are
there. Sen Vol 1, Sen Vol 2, RN, Coord
and Prof (connected to Seniors

Centre staff). We meet in another room off the Wellness Clinic at 2:30pm for the planning meeting for the Wellness Fair in fall. I heard about this meeting from the last planning meeting held on June 19/89.

COORD: We talked about the possibility of a fair when we come back- explains what was discussed at last meeting.

RN: On that day

COORD: We could have films, speakers, games

SEN VOL 1: You mentioned nutrition

COORD: Yes the food wheel. She explains that if it stops meat area- they give out meat recipe. We have a couple of other games we could use and give out some prizes. She mentions two good films-Georgia and Rosia- a comedy about seniors. Mr. Nobody- one done in Toronto about individuals freedoms when they become older. A good film to elicit discussion. "A House Divided"- another good film about elder abuse. There are others about seniors accomplishments

PROF: We could call it Fun and Wellness Day and advertise what will happen.

COORD: We would be able to advertise your programs

PROF: It would be good to start before the school board

SEN VOL 1: How long for

PROF: 10-3, the 2nd Monday, the 11th

(M): (Arrives in) He asks the Sen Vol 2 to give out minutes from the June 19/89 meeting (SEE "Wellness Committee Meeting June 19/89" in the appendices)

COORD: (M) we thought we could hold it 10-3pm on the 11th

PROF: And its going to be called Fun and Wellness- kick off day

SEN VOL 1: Will we put balloons and streamers

(M): I have balloons

COORD: How should we do it

PROF: --BP and counselling in one area -popcorn

COORD: And we could have exercise and the nutrition games

PROF: And why don't we invite Dr. Blatherwick to speak about AIDS
OB: I wonder if she is joking considering last time
OB: They laugh
(M): Suggests the living will
SEN VOL 1: Wouldn't it be better as a topic for the Wellness Clinic
(M): He's a good speaker. Do you want speakers
PROF: It's a kick off
COORD: BP and maybe one of your counsellors could come down.
PROF: You should just advertise yourself
SEN VOL 1: What about the feet
(M): Reflexology
COORD: We need to get people involved
SEN VOL 1: We need to get some of these people here involved
COORD: What about the glee club
PROF: 5 hours, 10-3pm. One room set up for films
COORD: Fun films
SEN VOL 1: I went down to the film festival some are long some are only 10 minutes
COORD: Will you be here (M) to do BPs
RN: Yeah but not all day
COORD: We could slot it in
COORD: If you do it all day your ears really kill you
PROF: So BP
What else do you do
SEN VOL 2: Yes we should get a new weigher
PROF: We could bring up the doctors on a trolley
OB: COORD explains very expensive to fix. The Prof says she'll look into it
PROF: I can but that no problem. By the time you start
(M):
COORD: We'll have some speakers, exercise and counselling, movies and massage. It would be really good to do massage
(M): She stopped though
We could talk to (V)
COORD: We had a physiotherapist come in
SEN VOL 1: There was too much before with massage, exercise, getting mixed with the talks

(M): Exercise- do you want me to approach the reflexologist and massage also
COORD: I don't know how to do that unless we train someone
(M): We can get (V) she's trained
COORD: And then some fun games
(M): Those nutrition games
SEN VOL 2: He's a very good massager
(M): As long as he does it on the back
SEN VOL 1: He did me and it hurt all week
COORD: We don't want a treatment massage we want a relaxation one
(M): Should we divide up the tasks
COORD: (M)'s afraid he'll get stuck
(M): Someone on films from NFB, displays
SEN VOL 1: They're very happy
OB: People discuss this
(M): (To Sen Vol 1) You want to pick up and preview
SEN VOL 1: I don't want to
COORD: I will discuss with you (M) and the Sen Vol 1
It's good if we look at issues and fun
Which means we need a skilled person to answer questions
(M): That's why I said the Sen Vol 1
RN: A social worker
COORD: Yes a social worker
PROF: Maybe someone to speak on resources
(M): I'll take care of demonstration, exercise and you COORD take care of speakers
COORD: Dr. X, LTC and some one from police
SEN VOL 1: Some one from Home Care
COORD: Hard to get someone because they are so busy
RN: Some one from LTC would know
Who would you get (M.B.)
COORD: Some nurse working down here someone from LTC, Health Unit
(M): and (J) from information services
COORD: And I can get (J.W.) to come with popcorn
(M): I missed that
COORD: She makes popcorn with Italian mix

PROF: The best thing is to give out things.
Anything the Health Dept. can give away
SEN VOL 1: The safety people gave out things
(M): We had a barrage of calls after that for things as they said we could give things out
RN: The Health Department give nothing
COORD: We could organize popcorn and a water fountain
PROF: I think that's pretty well organized. Should we have another meeting
COORD: I'm away in August
SEN VOL 1: We need to schedule and advertise in the West Ender
(M): What do you think
PROF: We're going to advertise classes
RN: On TV that is
COORD: (M) can organize that
OB: Discuss exercise as important
COORD: We could have carpet bowling using tins of food
SEN VOL 1: We could have the Food Bank, after all it is a wellness thing
PROF: Very similar to our open day except focusing on Wellness
RN: Have they set the date in August
COORD: How about a meeting the middle of July and August
(M): I'll be away in August
COORD: Middle July
(M): 3rd week
COORD: About noon
(M): Over lunch in the cafeteria. The 17th?
COORD: A little informal meeting
PROF: You'll get speakers and films, we'll get the rest
COORD: Line dancers
SEN VOL 1: If you do line dancing you can't come to this
COORD: Even it you had dancing in one room. And crafts
(M): We don't start that until 3rd week
SEN VOL 1: Last time only one person came. You're supposed to focus on health. How far do you want to go

(M): Your physical well being
SEN VOL 1: Yes
OB: The Sen Vol 1 and (M) appear to be suggesting that wellness shouldn't include crafts. More discussion occurs about when the meeting should happen etc and this meeting closes around 3:30pm
The tone of this meeting was fairly relaxed. (M) looked to COORD a lot for answers. The Coord and Prof ran most of it with occasional input from the Sen Vol 1 and 2.
This protocol ends.

APPENDIX D

INTERVIEW SCHEDULE

APPENDIX D
INTERVIEW SCHEDULE
July - August 1989

DATE	TYPE	SEX	TIME	PROTOCOL
March 13	Sn.Part.	M	12pm-1pm	PAINT1
July 1	Sn.Vol.	F	1030am-12pm	PEINT1
July 4	Sn.Part.	F	11am-12pm	PCINT1
July 5	Sn.Vol.	M	11am-12pm	PBINT1
July 5	Sn.Vol.	F	2pm-3pm	PAINT2
July 5	Sn.Vol.	F	7pm-8pm	PDINT1
July 5	Sn.Part.	F	8pm-845pm	PDINT2
July 10	Sn.Part.	F	10am-1030am	PBINT2
July 10	Sn.Part.	M	1030am-11am	PBINT3
July 10	Sn.Vol.	M	1115am-12am	PBINT4
July 10	Sn.Part.	F	130pm-2pm	PCINT2
July 11	Sn.Part.	M	9am-930am	PAINT3
July 12	Sn.Part.	F	930am-10am	PAINT4
July 12	Sn.Vol.	F	2pm-3pm	PEINT2
July 12	Sn.Part.	F	3pm-330pm	PEINT3
July 17	Sn.Part.	F	930am-10am	POINT3
July 19	Sn.Part.	F	10am-1030am	PAINT5
July 19	Sn.Vol.	M	11am-1145am	POINT4
July 24	Prof.	F	930am-1030am	PBINT6
July 24	Prof.	F	11am-1230pm	PCINT4
July 24	Prof.	F	3pm-415pm	POINT4
July 24	Prof.	F	830am-930am	PEINT6
July 26	Sn.Vol.	F	930am-1015am	PEINT5
July 26	Prof.	F	2pm-315pm	PAINT6
July 31	Sn.Vol.	M	11am-1130am	PBINT5
Aug 1	Sn.Vol.	F	11am-1145am	PCINT3

Key:
Sn.Part. = Senior Participant
Sn.Vol. = Senior Volunteer
Prof. = Professional
P = Program
INT = Interview

APPENDIX E

INTERVIEW QUESTIONS

APPENDIX E
EXAMPLES OF INTERVIEW QUESTIONS

Seniors' Questions-Participants

+Questions for Category 1 Seniors.
+Across Programs
+Date:July 3/89
+Questions:

1: What is the name of this program?
2: What is wellness/health promotion to you?
3: What is a wellness/health promotion program?
4: If you were to describe this program to someone, how would you? How long does the program run?- per year, per week, per session.
4: What are the goals/ philosophy of the program?
5: What is the history of the program? How did it start?
6: How do people find out about the program?
7: Who goes to the program? Who doesn't go? Why do people go?
8: What is the age range of people who go?
9: What is the ethnic mix? Socio-economic range?
10: Who runs the program? Who is in charge?
11: How are decisions made about the program content and activities? Who makes these decisions?
12: How is the program funded? Do people have to pay to attend?
13: What are the strengths of the program? What would you like to change/add?
14: Is community participation/ advocacy encouraged?
15: How would you describe this community?
16: I noticed certain issues are important to you as a group such as _____ could you comment on these.

Seniors' Questions-Volunteers and Program Planners

+Questions for Category 2 Seniors
+Across Programs
+Date:July1/89
+HX-Wellness/Health Promotion Programs:

1: History of Seniors wellness in the city.
2: History of establishment of the Seniors Advisory Committee to Council-City Hall-How are committee members selected-are there other committees/different members -what is the mandate of these committees. Who where the founding members.
5: Funding sources-Advisory Committees,Programs.

6: One stop shop
7: Out reach-mentioned as "an eternal problem". What does this mean?
8: Housing-seems to be a major issue?
9: Toward a Better Age?

+Specific Program:

1: Hx of same
2: What is wellness/health promotion to you?
3: What is a wellness/health promotion program?
4: How would you describe Program ___?
5: How do people find out about this program?
6: How is it funded/do people pay to attend?
7: What are the philosophy and goals of program?
8: Who goes/doesn't go/why more women than men/why do people go?
9: Who runs the program/who are the leaders-in charge/
10: How are decisions made?
11: People go to different programs-why?
12: How involved is this program in community participation/ advocacy?
13: I noticed certain issues are important to the seniors such as _____ could you comment on these?

Professionals' Questions

+Questions for Professionals Across Program
+Date:23July/89
+General Health Promotion for Seniors in Vancouver:

1: What is the history of health promotion/wellness in this city for seniors?
2: Why/ how where the Wellness Coordinator positions established?
3: What is the mandate of these positions?
4: Who are you funded by? Who do you report to? What influence does this have on your decisions?
5: What is health promotion/wellness to you? How would you define it?
6: What is a health Promotion/wellness Program? How does it operate?
7: Is there a framework by which you operate? Is there a philosophy/goals? Could you explain on these?

+Specific Health Promotion Programs.

1: What is the history of the program __? How did it begin? How long has it been in operation?
2: How would you describe this program to some one who hadn't been? What kind of components/activities occur/topics covered?
3: Who goes/why do people go/who doesn't go?
4: Men/women issue?
5: Who runs the program? Is there a leader(s)?
6: How are decisions made about program content/components? Who makes these decisions? Is this an active /passive process?
7: What if any is the philosophy/goals of the program? Is this program meeting perceived goals?
8: How is the program funded?
9: Is community participation/advocacy encouraged? How?
10: How is this program funded?
11: What are the strengths of the program?
12: What if any thing would you like to see changed/added?
13: How would you describe this community that this program in terms of cultural, social, and economic factors?

+The following questions were asked as a result of the observations and the interviews with the seniors. (see in my dairy #2 pg 1&2)

14: Why are you involved/interested in:-housing?
-outreach?
-writing position papers?

APPENDIX F

EXAMPLES OF SENIOR AND PROFESSIONAL INTERVIEW PROTOCOLS

APPENDIX F
EXAMPLE OF SENIOR INTERVIEW PROTOCOL-CATEGORY TWO

+PAINT1-Program A, Interview 1
+Senior Interview-Cat 2
+Name: M
+DATE: July 5th,1989

OB: This interview was organized on Wed, June 28/89 following a focused observation. M was chosen as she is a designated leader and also has been involved with the program since its inception. She also assisted me in pin pointing other people who might be appropriate interviewees considering my criteria

KIM: OK. I suppose the first thing is what is the name that you have for you program? What is the name of it?

M: At the center.

KIM: Yeah.

M: That's Keeping Well.

KIM: It's called Keeping Well

M: Yeah. But we're affiliated with uh Good Age. And the Good Age is uh Program A Community Center, School X and School Y. The 3 groups together are working with the seniors you see and we call ourselves the Good Age. And the Keeping Well Program came out of the Good Age. Do you know what I mean.

KIM: So it's kind of a co-sponsored type of thing is it.

M: No not really uh just some people came to the Good Age meetings and um (S) came along from the Health Unit and um -I put a name in-

KIM: Oh that doesn't matter I won't put use names in, you can use names.

M: And then she came to the community center and brought up the subject of Keeping Well Programs because she had done it at other community centres. And so what started off, what started the Keeping Well Program was the people that were going to the Good Age and they met (S) there. And they came to the community center and we formed the Keeping Well and from there then I started getting hold of

neighbors and knocking on doors and delivering pamphlets and advertising our Keeping Well Program and it expanded.

KIM: OK. So how long has that program been running?

M: Four years now.

KIM: And you were kind of like a founding member, were you-M: Yeah, because I was in with the Good Age

KIM: Where was the Good Age held?

M: We had our open house at School Y. It was (G) from the community center and the 2 um I don't community workers I guess from the community schools that got together and formed the Good Age.

KIM: OK. And how did they get people to come along to that? How did you hear about it?

M: Word of mouth and advertising. They advertised that they were having-going to be holding this open house at School Y. Of course we all were all used to doing community work, volunteer work so we all pitched in.

KIM: OK. Now I know it's called Keeping Well. What is wellness to you. How would you define wellness?

M: Wellness is uh uh a well rounded out person. Um um let me see now. Somebody that's active. Looks have them- and happy a happy person. And uh they like themselves so they look after themselves. And uh from there I guess it just goes on and on and on.

KIM: So what is a wellness program then to you? What does that mean to you?

M: It's more social than anything. I've got to know so many people. And some of my old friends are there too that I contacted old friends to come to this. And then we've met a lot of new ones like the Chinese ladies and that. They're all new to me so uh I met them there. And it's -that's why we start a half an hour- we get there an half an hour early to have a little social before uh you know. A little chat before we get into out exercise.

KIM: OK. So if you were to describe this person to a new person. If you were telling someone about this program how would you describe it to them.

M: I would just tell them to come to uh you know -they want to meet a lot of nice people to come and then I would explain to him the things that we do. We have half an hour of uh light exercise and then we have a little tea break and then we have um somebody come in and talk to us on different subjects. On health, on uh nutrition , um anything um law. We had a doctor that came from the Health Unit and his topic was "How to get the best out of your doctor" and that was very very interesting. Uh investments cause there are some seniors that have a bit of money and so it's uh- I would explain all this to them it's a real variety of things that we do during the year.

KIM: OK. Now how long does the program run. Does it run all year round?

M: Right through we never stop.

KIM: OK so it's a year long thing and does it always run right through.

M: Yeah, the first year that we started uh (S) said look quite a few of the programs um stop for the 2 summer months July and August and she said what do you think. She asked us what do you think. So I spoke up first and I said well seeing it's our first year let's run right through . Cause what I am afraid of is some of them who have been coming and if they stay away for 2 months they just might decide to stay away you know, not come back. And this way if we stay right through, you know they'll keep coming and we won't lose them.

KIM: Sure.

M: And so you know everybody showed up. We always had-even in the summer time we had such a good turn out that we decided to keep going all year.

KIM: So what's the attendance like? How many people usually come?

M: Uh average between um 18 and 20.

KIM: OK and you've got a core group that are pretty consistent?
M: Yeah
KIM: OK, now are there any goals that you have for this program? Do you have any- what are the goals that you try to achieve.
M: What we want, what we want- my goal is to get a seniors room at the community center and we've been fighting the Parks Board for 6 years now. That we've trying to get this room and every year they promise us next year you're going to have your room cause we want to combine the 2 back rooms, we want to knock the wall off, we want to make it one big room. We want to um move the south wall that faces the street. We want to move it 6 feet towards the street, towards the side walk to make the rooms more square because they are long and narrow now. And we want to knock the 2 back rooms we want to knock the middle wall out and make it one great big room and that would be like a seniors- form 9 in the morning to 5 in the afternoon would be strictly seniors. And then- seniors don't go out very much at night so in the evening you know so uh well they have their bridge. But that's a different group but that's still seniors and um they have bridge 3 nights a week and so you know they're finished about 9 o'clock. And so from 9 in the morning until 5 in the afternoon would be strictly seniors that room and then after that they could use it for other things- for exercise, an extra exercise room from the gym and
KIM: So that must be the space issue that's been coming up, because I know that people have talked about space. Is that what that's all about?
M: Yes. Because we're in Snowies Lounge now. But there are a lot of things that we can't do we can't do line dancing on account of the floor. We don't have the proper flooring and we can't get in the gym that has the proper floor. We can't get in the gym

because it's being used all the time so if we had our own room we could have so many more programs for seniors.

KIM: So what's been the problem about getting the space?

M: What the Parks Board I don't know- they keep promising to us and then they set money aside for that space and they turn around and give it to some other community center and we're left. And now they tell us it will be next year before we get our room. So it's 6 years that they've been- so it's kind of frustrating, very very frustrating. I am so frustrated that I want to get that Parks Board out of there, I'm working to have them all voted out of there and get a whole new group in there and then maybe we'd get our new room.

KIM: So how do you work on something like that? How do you work on getting those out and getting new people in?

M: Talk to the seniors. The seniors are the ones that- there are a lot of seniors in area A. And talk to the seniors every chance I get I talk to the seniors. Get those guys out of there. They've been in there too long. Get 'em out.

KIM: So you say the program has been running for what- 4 year?

M: Yeah

KIM: And you've explained how that started. How do people find out about the program? How do people find out about the program?

M: Word of mouth. Neighbors, you know person telling their neighbors and then little brochures that we have out they have a little calendar each month that gives the programs.

KIM: Is that the community center is it?

M: For the community center and uh we can take it like when they have seniors day at Shopper's Drug Mart. We take a few of the calendars there and leave them on the table and people pick them up and

KIM: Do you ever use the newspaper or anything like that?
M: No
KIM: What about the local newspaper?
M: They haven't bothered too much with that. It's just more or less word of mouth and you get your neighbors to come over, you know to come in and attend the meeting you know the gatherings.
KIM: Who goes M? Who are the people that go? What's
M: Active people, active people. The majority of them are between 60, 60 and up I guess we have some in their 80s- up there.
KIM: What about ethnic mix in there?
M: We were really surprised. (S) was really surprised you know, how well they fitted in when the Chinese people started to come and Wes who gives us our instructions now, he's Japanese. We get a long. They really fit in nicely. We've had Greeks in there we've got uh you know. And we have a lot of people that come and visit like our Indian lady from India who just left and uh she was so interesting. KIM: So how did the Chines ladies get involved then?
M: I guess their neighbors told them to come. And they knew about the community center. There's a brochure that goes out twice a year. The spring one and the fall brochures that go out with the programs in there. And goes out in paper X. Everybody gets paper X so they get the programs and they come to the community center.
KIM: So the rest of the group then- I've noticed they're Caucasian. Are most of those people of Canadian background of English or have you got a sense of where people are from?
M: Yeah, well like (B) he's Scottish, you know. Uh (G) uh he's Canadian but his wife is Parisien French and she doesn't come because she's involved with other things, tennis and all this sort of stuff you know. So she doesn't come but um (J)

I believe he's French, he never speaks French but I believe he's French and um they just all fit in.

KIM: So it's kind of a mixed bag.

M: Yeah

KIM: What about as far as people's socioeconomic status? Is it people that are kind of - is it all ranges or is it-

M: I think the majority of people that come there- I would call myself not poor but maybe middle class. If there was such a thing as lower middle class I would say because I'm fixed income. Nearly all of the people in here are on fixed incomes. And uh but some of the others they own their own home and that they're a little better off. So they would be- but I would say the majority -middle class.

KIM: Who runs the program? Who's in charge of and how are the decisions made about what happens.

M: (S) actually- and works with the community center with the staff at the community center uh they have a seniors coordinator. (W) is the seniors coordinator and working together and then they consult us.

KIM: So how-

M: Like they left it up to us today whether to cancel last-next weeks um program on account of the Stanley Park picnic for seniors. It's on next Wednesday- so he left it up to us whether we wanted to cancel that program and go to the picnic and so the ones that aren't going to go the picnic are just going to stay home. Their won't be a program. It was voted that- but he left it up to us to decide.

KIM: Is that what happens around the types of activities that happen here.

M: Yeah. They present them to us and they uh the bus trips and what have you we leave it up to them cause they plan very good- we've never had any problems with the bus trips that they've planned for us. The kind of bus trips - the different places that we go. The majority of people have

been quite satisfied with that.
KIM: And that's through the community center that's not part of the Keeping Well?
M: No that's for all seniors.
KIM: What about in the Keeping Well Program itself? How do you make decisions about the topics and speaker and
M: With (S), we discuss it with (S) and the coordinator.
KIM: How's the program funded? Do you have to pay to go?
M: No that's free.
KIM: OK so that's free.
M: Yeah all you need is your membership which is $1.00.
KIM: Because the space is supplied by the community center, they fund that right?
M: Yeah
KIM: What about the coffee and tea and
M: Well they pay for it
KIM: The community center
M: No no the seniors themselves we've got a little box and they through their monies in their hot $.25 for a cup of coffee or tea and $.25 for a cookie or a slice or what ever we have there you know. And lots of times like I'm with The Chamber of Commerce as well and our meeting s is on a Monday and so we meet the seniors meet every Wednesday so sometimes there will be fruit and cheese and stuff like that left over from the Chamber and I stick it in the fridge and then I bring it to the seniors and always tell them that is was compliments of the Chamber of Commerce. So they benefit that way a little bit.
KIM: That's great. What do you think are the strengths of the program? What are the good things about it? What do you like about it?
M: Pretty well everything that we do there I like.
KIM: OK
M: I can't find any fault with it.
KIM: OK that's great. Is there anything that you would like to add or change about the program?

M: Just the room, I'd like to have a better room for us to meet in so that we could do more programming for the seniors.
KIM: Are the seniors there encouraged to participate in the community through the Keeping Well?
M: Yes because quite a few of our Keeping Well people have volunteered to help out on the Tuesday afternoon when they have the special seniors. You know a bus picks them up from a nursing home and brings them and they do um ceramics and some will go in the kitchen and they'll look after the tea things and they make their own little Christmas decorations and what have you. Stuff like that. They are quite a few of our Keeping Well people who have volunteered to do that and from there they volunteered to go and visit another old senior that's house bound you know.
KIM: Is there any Out Reach from this program? Is that something that is- that you want to do or might want to do?
M: We tried, yes. Well we tried I guess it's still in abeyance there, we tried for a grant from the New Horizon and all we got was a run around so we dropped it for a while. But (S) ants to start it- would like to bring it up again maybe in the fall. We might start working on it maybe in September. And that's - we call that program Out Reach cause we want to reach out- we want to take programs to other parts of the area A. I'm thinking of - I'll use one area as an example, around school Z, using the school as sort of a base. It wouldn't necessarily be in the school but the seniors would meet . It might be at the Legion, we might t get a room there. Or we might find a meeting place, but around there because they are so far away from the community center and even the ones that take the bus they still have a walk up a hill to get to the center and if they come

along street B they still have a hill to climb. You know, that's why some of them stay away because of on account of we are not near a-we're not on a bus line

KIM: So that kind of gets at my next question of who doesn't come?

M: Yes the ones who don't come are people who are who have got in the habit of staying in the habit of staying in their homes and looking at their 4 walls. And they need, those are the ones that need encouragement to get them out. And I figure if we brought a program closer to them so they wouldn't have it wouldn't be such an effort for them then we could start getting them out and then gradually it would expand and they would go out a little further and-

KIM: OK. One thing that came up when I was doing the observations was housing. That's been an issue in your group. Can you talk a little about that.

M: Well I'm involved quite a bit- the Chamber of Commerce is involved with quite a bit with what we call ATTACK right now, with the Assessment and what our seniors are really worried about are how much their taxes have increased this year. And I got involved through the Chamber of Commerce and I keep going to those meetings hoping that we achieve- we're trying to get them to squash this years assessments that are so high for the merchants but- I'm also hoping that through that the residents and some of our seniors you see have their own homes and they might benefit if we can get the assessments squashed for this year. And they would pay the same taxes as they paid last year and reassess for 1990 and forget 1989 because they are going to be so many merchants that are going to have to close their doors and today's their deadline you see.

KIM: So is the concern for the seniors-

M: The seniors, the way - well we're watching Kerrisdale very closely what's happening in Kerrisdale and we're watching it very closely that it doesn't happen here because they are a lot of people who are renting so we're keeping a close watch on what happens and the outcome for Kerrisdale where the seniors are being kicked out of their places and having to go into a different area altogether that's affordable. And so uh- see with us here we're OK cause this is government owned these buildings and these were built - these were opened in 1946 for the veterans.

KIM: But it's a different story for some of the others.

M: But now it's open to the public but veterans still get preference, you know. And so this is owned by the government but there's been talk the last 5, 6 years that uh Central Mortgage is going to sell theses places to developers. And so we're watching that very closely and quite a few of our people that live in the block here belong to the Legion and so we've got the Legion and the DVA behind us that will fight for us.

KIM: OK another thing that came up in your discussion was exercise instructors.

M: Yes

KIM: It sounds like you've quite a few-

M: (Laughs)

KIM: And there's been a few hassles with that. Like it sounds like you're pretty happy with this last one but

M: We were very very happy but I think that the thing is there is 2 ways of looking at it. I like the little girl I don't want to sound like I am against her cause I like her and she was very very good but she may have used us to get her certificate. She had to do so many hours of volunteer work to get her certificate. When she got her certificate and she's stayed on since her certificate maybe a month that she's done exercise with us and she has her own little

business. She's got her little bake shop. She does 2 other seniors groups that she gets paid for. See with us that was free- that was volunteer. Anyway we were very very happy with her except quite a few of our seniors said they wished she would change her music, her tape because the music didn't go with the exercise that she had. And they want to be able to keep time you know. They're not real rambunctious but they want to be able to keep time to the music if they are marching and that. And her music didn't coincide with uh -so the other day I went up to her and I said while we were doing our exercise, I said to her very quietly do you- is that the only tape you have. And she said why are you getting tired of it and I joking- I thought I knew her well enough and I'm laughing when I said to her "It's the shits" (Laughs) And she didn't say anything you see and she finished the program and she finished the exercises and that they told me they wanted to see me in the office and they accused me of -she told them that I had insulted her in front of everybody. So I do not know if her being a business person and she's getting paid for the other 2 senior things . See there are 2 ways of looking at it, maybe she is over sensitive and - but I said it jokingly I was laughing when I said that to her and because I would never insult her. But I thought I knew here well enough to kid with her that way. The other hand maybe she used us to get her certificate and now that she's got her certificate couldn't very well quit as soon as she got her certificate so she went for the month and now she - this is her way out. And so we wrote her a letter and everybody signed it and asked her to come back. And today (W) said that they mailed her the letter and also (H), who works in the office there, who's programmer met her on Friday and he gave her one of the letters that had been signed and that

had been sent to her. He handed her one and she read it and she said she would think it over and let them know. So it's still standing. So we don't know. The other one was very very good but she has a bad back. I think she has arthritis in her back and she had to quit plus her husband just retired and they wanted to do a little bit of traveling cause she was free too. Before (P) we had (H) who uh does- who takes exercises from seniors but a little more advanced, a little more rambunctious -like the younger seniors I would say. She takes lessons on that- she takes a class.

KIM: Do you have a preference whether you have a young person or an older person?

M: It doesn't matter to us. Just as long as they are you know-. Because she's young and they all liked her except for her music (LAUGHS)

KIM: The only other thing I really want to ask you about is-I notice\ that there are very few men in the program. Have you got any idea why that might be/

M: Well men- I'm surprised that those guys come on their own. We have about 10 men all told but they don't all come at once. But we have about 10 men and according to (S) that is really to something because it is mostly women that come out for exercise. Men don't normally come out.

KIM: Why do you think that is?

M: I don't know, I guess maybe they might think it's sissyfied. They go down stairs and lift iron and what have you, you know and use the bicycles and stuff like that, that is more manly. But to exercise and to be with a bunch of women- this is why I'm really surprised you know at the ones who do show up.

KIM: Well I think that's basically it.

OB: Tape clicks off.

KIM: Go ahead and say that.

M: What?

KIM: That social stuff. What you just said. That you think it is more social than anything.
M: Oh yeah,
OB: Tape ends.

APPENDIX F
EXAMPLE OF PROFESSIONAL INTERVIEW PROTOCOL

+PAINT6-Program A, Interview 6
+Professional Interview
+Date:July 26th, 1989

OB: I met with the professional at her office on the 26th July/89. Our interview took approx 90 mins.
KIM: What is health promotion or wellness to you, how would you define it?
PROF: Health promotion to me is really strategies to promote health in the definition that health is a means not and end, that health is a resource for every day living, then health promotion then becomes strategies to support people in their development of their health and increase their sense of control over their actions, over their, I think an example then is health could be housing for example and the housing crisis, because people have a sense that they have no more control, and a health promotion program then with older people to help them feel like they are getting some control over the housing situation by either lobbying government or by letting the community know how the lack of affordable housing or lack of choice in housing is making them, giving them stress so for me health promotion is increasing a personal sense of control over their future and over their well being.
KIM: So that moves me into the next question which is what is a health promotion program to you, what is it about what is it's purpose?
PROF: A health promotion program then is it's purpose then is to have people feel like they're increasing their own sense of control over their life, over their future, over what's happening with them, so if you use that as the base you start by working where they are. I mean if they are going to increase control then they define the issues, they work with you on the

strategies, they are part of, if we expect them to be responsible for health then they have to be responsible for the decisions around their health care, around health and then so if it's specifically about care then they should be involved some where in the decision making and know that it is a much more of a partnership between health professionals and people and also that the health professionals are a resource to people and have something to bring to people but they don't have all the answers, so that the participants or citizens are helped in defining what the issues are and are much more involved in the process.

KIM: As a Wellness Coordinator what kind of frame work do you work from, what is your kind of philosophy, your goals?

PROF: Well I work from a very, 1st of all I don't consider it wellness. Because to me wellness is a very narrow and has become in every day language a very narrow term and it is really starting to focus much more on lifestyle so I don't use that frame work I use a frame work of health promotion whether it's health promotion fro younger or older people it's still back to what I have already defined which is what guides me is that he issues for older people and that they start to look at what they want ah and then the program has a number of different activities. It has the neighbourhood health program but it has the West Side Seniors Advisory Committee, it has the neighbourhood, it comes from where the people are and where they start to define what they see as important for their sense of well being, so the frame work is always back to where older people now the other part of the frame work is to really understand that older people see that for them a sense of involvement or purpose and how they define that is important to their well being, so that that's a

major health issue for them. And the other aspect of it is I just lost my train of thought here.

KIM: Goals.

PROF: The other major issue is that older people be seen as a resource being as they have experienced some skills and we are working with what they have rather than with what we think they need, so those are the kind of driving tenants of health promotion for me.

KIM: I understand that these positions have been in place for some years now, can you give me a thumb nail sketch of the history of how these positions came into being or how the health promotion programs came into being?

PROF: Well they came to be in different ways in different sections of the city because they where the first ah programs developed out of units, so each Health Unit went about it a little differently. Home Support, and the job was primarily community development working with seniors to develop alternate to home maker services or other options, so I was involved in getting Home Sharers developed and meals programs and Day Cares. While I was out there working with older people about these things they where talking to me about what they needed, they wanted more than L.T.C., quite a number of them were younger seniors and they weren't sure what they wanted but they wanted a prevention program, so sort of in the course over the years they did have these two drop ins. They weren't one end Kerrisdale was sort of done by prevention, but it was sort of month to month whether the prevention program would continue and it the one in Health Unit Y was done by L.T.C. and it was the same thing L.T.C. wasn't sure whether there was any value in it, and the mean time the older people are saying there is value and we would like more of these, we need a prevention program of people. They put together some ideas in Health

Unit X, you know we put them to the Prevention Program and they never, they really didn't have any manpower or time for any people, their whole focus in prevention at that time was children and their mothers so they said these are nice ideas but we don't have any staff. The older people where continually getting kin of cheesed off. The few that were involved in the 2 little drop ins wanted them to continue and they were constantly facing the fact that staff were saying we don't know how long we can continue this so as a, working with older people the Director of the Health Unit asked me alright what would the program look like if we had it, what would it look like for older people, and so I went out, he said take some time and do a bit survey about what is in the literature, what's available in the community. So I went and looked at the 2 that we had and then, which I wasn't directly involved in, and then looked at Program E that had started and I never did understand it, some of it was with the Health Department but some of it was with the seniors down in the that area. I interviewed the professional coordinator and her view of Program E and went and looked at the whole Seattle Wallingford stuff and while I liked a lot of the stuff in the whole wellness what I was concerned about continually about it and I was concerned even as I interviewed people what were the older peoples role in this. One of the things at that time the professional coordinator talked about was not being able to get older people to take control of the program. So what I wrote up the program in Health Unit X was I said we had to really look at that but I couldn't understand since I worked with people out here while developing hoe sharers why this, why older people wouldn't be interested in developing their own

neighbourhood health programs. Where was the discrepancy, was it that we just had the bright more active ones out here running Home Sharers and Day Cares and the ones we met in the neighbourhood didn't have the skills or what? So when we wrote up the both of them from Health Unit X one of the big areas we wanted to look at was how do we involve older people, how would we go about that. The whole idea of peer to peer was very important and that life style was one thing but what was the other dynamic and that we would have to look into the literature and go further. we proposed that we would hire some one in Health Unit X who would work with the older people and plan a health program, a preventive program. Still very vague as to what exactly would we do, we wouldn't, I wasn't quite sold on the wellness model that I saw. So they hired at that time a woman and she
came in and she did that, took a long time before she went out in the community and did a whole lit search and some of the areas that we really looked at was the whole thing of role and meaning for older people..

KIM: was she hired into a wellness position?

PROF: Yes she was hired and she was the only non nurse and she was hired that what was felt in the unit what was we didn't need was another nurse, what we needed was a planner or developer, we needed some body that knew some thing we didn't know. We didn't want to replicate what was there. There was some thing missing there but we didn't know what, so she came and she did a lit search and then we held health forums with older people in Health Unit Y and West unit because the unit was the Health Unit X Unit so we had the 2 sections. So we talked a lot to older people and ah what we could see where really involved older people yet at the same time none of the places have been using the people in the real planning,

so. And interestingly enough a lot of the older people didn't see themselves as being involved in that, they would do any thing we asked but they couldn't see themselves planning any thing. So we decided to set up the a Seniors Advisory Committee and out of say a hundred older people about 20 came and started the development of the program and then we wrote the back ground paper on, before we would put a program out there we had to have a frame work to set it in, so that was when we came around and it was almost the beginning of that whole new look at health promotion, so we were coming at it one way and it almost, it's like you think you've got the only view but it's out every where. well then almost simultaneously realized that what we where interested in they were also interested in Ottawa, you know everyone was starting to look at the area of control and involvement. So that was how we started in our area and one of the aspects of Health Unit X was the neighborhood health program but that wasn't the only aspect there was the West Side Seniors Advisory Committee.

KIM: The Seniors Advisory Committee is that connected to any organization?

PROF: No it's just advising 2 areas. It started off by advising Health Unit X and eventually it progressed. The Seniors Advisory Committee is to Health Unit on how would develop programs for older people.

KIM: Is that an ongoing committee?

PROF: Yes it still exists.

KIM: And does that met on an ongoing basis?

PROF: Monthly, but it, just to go back that was set up as part of the health promotion program then we also recognized that to reach a lot of people in the community we needed a similar kind of program to the Be Well program a more neighbourhood program. And what (A) did and by this time I was completely out of it, (A) went to

where there were programs at Health Unit Y there was one that eventually became the Live Wires and one in Kerrisdale already. So those had been there before any one had thought about what and they were very much developed on health drop ins where you came and got your blood pressure so it was very much on the clinical model. And she just worked and built on those. Then I left Health Unit X and came here, there was a vacancy for a wellness person or health, wellness person here. I came to that position and when I here it was agreed with (J) that it would not be wellness it would be same, it had been set up the program in Burrard similar to other programs around the clinical health wellness model and he and I agreed we would not call it wellness but it would be health promotion and that since I was starting with nothing much I would do health promotion similarly to what we had already developed in Health Unit X because that's where I was coming from.

KIM: As related to

PROF: The background.(this is the frame work) So he agreed to the back ground paper, so he agreed in having to expand into having the seniors, bring on seniors from another area onto the Seniors Advisory Committee, so that was what we have done.

KIM: Your difference between wellness and health promotion, is that you see wellness as more of a clinical thing

PROF: Clinical thing, yes.

KIM: And you see health promotion as

PROF: The big difference is I see wellness, the clinical model as still being professionally decided and controlled and I see the health promotion model as really working at least with the frame work that you're involving older people in the decisions and it's works some places and it doesn't work in other places. But you always recognize that older people have been really WELL TRAINED into having been passive receivers of

care. But the model that drives the health promotion model is to at least be expecting that older people can make decisions. In the clinical wellness model we are still expecting some where or we are making an assumption that older people A) need to be taught about life style, or B) need to have come to us for counseling or screening and we have decided that that's the program they should have and even if we only decided it ten years ago we still decided it, so the assumptions are different and so the assumption that I work on is that all five of the programs I'm involved in look different because they come from what the older people want. So that Program X, they want blood pressures and the seniors take them there. Now in Program A they never have them because they never did want them. In Program Y they have them once a month because they want to do that. And then some times there are people who don't want blood pressure so there is no blood pressure, so the program comes much more from the people, the participants and looks more like them, so that the five are different. I'm starting one at Z and it will look like they are in Z. Now the reality you are always dealing with is one of our problems that we are continually plagued with is some of the assumptions that I had at the beginning is that out of the groups would come the leaders and that eventually they would run the whole program, they would facilitate, they would take the blood pressures and I would be their resource on the telephone. well it's only worked (she laughs) at Mt Pleasant. Which is fascinating, with the seniors with the less education, but they facilitate, but it's just really the people that are there and because, when I'm really studying it now it's also because of the setting that they are in. They are in a neighbourhood house that expects that these people all can

contribute. So besides just the seniors there is a setting of belief or expectation that older people have skills and older people contribute and they sit on their board and they run the finances and they make decisions about what their program looks like and so it all leads into that the Keeping Well Program their. I haven't been there in 5 months. And (Je) who is one of the leaders and (K) phone me and they phone me if they think there is anything that I can get them, like a resource person. They think they might the fire men to come and talk to them well do I know his number or I some times phone them because there is nutrition neighbors or some thing, but they run their whole program. Ah they sometimes lead their own exercises, some times they draw on the program there who will help them with their exercises. Over on the other end of it is Program A which we started from nothing in the community center and they will almost do every thing but they won't do the facilitating. They will if I'm going to be away and they will do it for a while but then they want me to do the facilitating and so facilitators have not just emerged out. We are interesting in Program A now we have no exercise person, it's just sitting and I have said to them I can't come up with an exercise person, they have to find the exercise person and ah the community person eventually helped them and they found an exercise person who one of the people spoke not nicely to her i guess and she quit, though I had a feeling she was on a volunteer basis for eight weeks. She was getting her fitness ticket so she agreed to do it, but maybe after eight weeks she decided she had too much to do. Any how they haven't got an exercise person and they keep looking for some one I say as a group and there's three women in the group who could lead the exercises, but they all hesitate but I'm just waiting to see

how they are going to resolve this. They want exercise, they'll pay for it they've said, one of them (H) maybe she'll try this Wednesday, she's terribly shy and maybe with time she'll take it on. But she used to teach exercise and now when she's older she feels she just too shy to exercise. Well we are just leaving it now but the seniors are now saying they'll help her with the exercises if only she will lead it. Because they really like the group and they really like the exercises and they know it's really important but previously we have found them or you know exercises but have found people through Red Cross to give them exercises but I thought this time they have to solve it them selves because they have not emerged the same as Program Y.

KIM: So how would you if you where to describe that group, to someone who hadn't been coming how would you describe it?

PROF: Well I just feel it's very, they have a nice social network when you consider how none of them knew one another, when you consider when we started there where three seniors and over r the years it has built up and they come back as they describe it, what they come back for is one another. Their friendships that they have made there which is an important part of the whole health promotion as older people tell me one of their health issues is friendships, that support, social support. I think it has really been worked that way ah there was a friendly open and welcoming and that they do follow up and walk home with one another and they do support one another and care about on another, so they have created a kind of a caring group, ah and I like the fact that there are different kinds of people in the group, there's Chinese, Japanese, any ones welcome and a woman came from India and they just open up and people feel immediately at home so I think it's

open and excepting and they care a lot about one another and they have created a little community there but the part that is kind of confusing me or making me wonder is they don't take on, like they would like line dancing but they can't seem to go beyond and create line dancing. Now I am beginning to think myself that it's because the whole environment is in the community center and that there is an expectation in a community center that the programs will be provided because other wise they are all very capable and 2 or 3 of they now have gone to nutrition neighbours which, and have been working on it, nutrition neighbours. At one point they wanted to do out reach and they organized a group to put together a proposal for New Horizons for out reach, a half time out reach person where the person could work with them to put on fairs and put on, go to McDonalds and put on coffee parties and talk to the seniors in the street and find out, one of the things that's a problem in area A is none of their programs are over subscribed they are all under subscribed for the amount of seniors that live in the neighbourhood. So they wanted to find out why. In the middle of their process came along a group of professionals ah, the teacher from the community school, a couple of the staff at the community center and they all said they didn't need a programmer, that they could do it themselves, that they were all capable seniors and why didn't they just run the out reach program themselves and go ahead. And kind of got in the middle of this with New Horizons and New Horizons every body agreed that the seniors should do it themselves. Now the seniors never agreed, they have always sen the need, they don't want to take on that kind of responsibility, they want to work with some one to do the out reach. So they all quit and they don't have an out reach program there because the

seniors there got so fed up with the different professionals at New Horizons that every time they put a proposal in New Horizons changed the rules and kept cutting them back and finally about five of them just took it and gave it to New Horizons and said keep it, so they're interesting people, they make you think about what it is about women and men who are fairly middle class and have much better education than our people over on the East side and yet they don't seem to take the leadership role that you would expect would happen, so

KIM: Are you the leader there?

PROF: I'd suggest that (M) is probably the leader there, and she does try and some of them are coming like (D) and there are 2 or 3 of them who worked more like (L) who has a severe case of arthritis if any one they would probably say (M) is the leader, but ah sometimes you would be hard pushed to know that, however

KIM: How are the decisions made in that group then about what happens?

PROF: I met with them on a regular basis and like they decided that this summer they wouldn't have a group discussion, they really wanted to have exercise, they didn't want to close they decided they would stay open, all summer and that they wanted to ah be pretty flexible have some exercise and they planned a picnic which they've had and organized themselves and other times they just want to sit around and talk so some times I go over and they just sit around and talk and other times they do their own thing. So they decided this summer they will do their own thing and be completely unscheduled by, but by the end of the summer we will me t again and we will usually set up what they want to discuss for the next 2 months, 2 or 3 months. Now in the spring some where in February March they decided that they really wanted to look at eh whole thing of attitude, depression, humour, so we set up about three months and

part of that group it is not a laid on schedule so you're generally looking at attitudes but if one week we go over and get into humour and want to know some thing more then that goes on the next week. So there is no schedule it comes from what they are wanting but they will make up that schedule for, well we have been at it for three years so we go through different cycles. Prior to that cycle on attitudes they did quite a lot on, they where concerned about heart attacks and how you manage that, blood pressure so we did a lot of work around more what signs do you look for, do you need to be on medications for hyper tension and why so they were looking at much more specific information around the body, that was last fall. Then sometimes what happens, we have a doctor who will come and answer questions about the body and so they schedule her in when she, they are asked would they like to have her and they agree and it's a mutual arrangement between them and

KIM: Would you see that there are any goals for that group? Is there a philosophy by which they operate?

PROF: Ah The philosophy I think is really more around involving other people. They had a hard time getting people in that center to the center so one of their major interests when they started was to really involve older people. Their other goal would be (the tape ends and I turn it over and mention we are addressing goals). So their 2 goals are really to continue and they are really interested in reaching older people and involving them. the other area is to have a center for themselves in the community center either to have a room or a club house or to have some thing where they can have a focal point because they, that lounge they are in is not, and they have had the Parks Board down they have talked to them. One of the things that's happened to them is they

have been spun around by Parks Board a number of times. they've had all year kind of an on going disagreement with the staff there in that the coordinator felt that they needed nothing, they didn't need a seniors programmer. So they've been at the board and they have been arguing those things but they have been working on this too, one is to get more of a focus in area A and in that neighbourhood for seniors. They have had the Parks Board staff in, they've had the Parks Board politicians in, they've met with them they've talked with them, there is $65,000 in their bank account at area A but they can't seem to get, this is like working with an immorphous, everybody moves around them, which is very exhausting for, you now it's not like the housing issue that can crystalize and they can get very angry over it, they get it all organized and then they get so much red tape that eventually they start to loose steam and then they think why are we fighting the Parks Board why don't we just enjoy ourselves. So it kind of goes in tides, but the goal would be to have more of a center there and they have a general interest in out reach but they have had a lot interference by professionals who have really if you looked at it felt that they didn't know any thing.

KIM: Professionals like who?

PROF: Like I say the teacher from the community school, the coordinator at the community center, you see at the community center they relate to a couple of the community schools, and they kind of have a triangle and they do a lot of work with the youth and so they tried to set up in the community schools, there is one the Greek Program that I'm involved with but they have , they developed a, and this is kind of interesting they developed a group of professionals to look at the issues around older people in area A and

they never asked any older people and part of my thing is they have been so difficult some of the professionals that I have just let them do their thing and I haven't, I tried at one point to change their view of how older people work but the 2 school teachers and the coordinators were so negative, they knew in fact what was needed for older people and it became such a political mess that I just receded and stayed with the seniors because they were so negative. I mean they do a continual model, they all knew what the older people wanted and what they needed was not a grant what they needed was to do the out reach themselves and nobody needed to take government money for this and this was really the prevailing view of 4 or 5 of the professionals. (K) from the Elders Network tried to tell them differently and they just, so they took the steam right out of them and the other reality for the seniors at area A is if you are at Program C you have to raise the money to keep that place going and at area A you don't have to, they'll always have space there. So it's not the same kind of focus, there isn't the same kind of fund raising. Ah at Program X the seniors get very active because Program X is another one that's not government reliant. They have the United Way helps and they are always fund raising, the seniors are very active and have to work collectively to keep that house going. But in area A the center is there but it is always controlled by professionals. They can't even get right now space to do their line dancing in the gym because the gym is all booked up. There is a continual argument to get them, the staff to understand how the seniors have some say and they should be heard, so that's part of the problem at Program A.

KIM: What do you see as the strengths of the program?

PROF: At Program A? (I say yes) I think

the major strength is that it is, it demonstrates that older people in many ways can run their own program and its a great net work developer. I mean for a lot of people who are very isolated at Program A, they come in there and they make friends. There is a number of those people over the years their spouses have died and the group has really supported them and they'll come back and tell you that they have no other kind of support. So I would say that friendship is probably the primary, where as at Program X a lot of is it is involvement and purpose. At Program A probably the most successful part of it is the friendships they have made. You would only see that if you tracked it, I mean those people as I say started out with three and then there was five and they it built on, and now they have quite a large core group to met, new ones come back and forth. They get a lot of support from on another for a number of them has serious arthritis and osteoarthritis. there are four or five of them who are care givers who come there, it's not formalized, but that's the way they like it. they sit and talk about it when they feel like talking about it. Last week they where talking about how being older is not fun, and they feel very comfortable about talking about it. Two people there have been in and out of hospital for depression and now they talk about coming there regularly, one woman was sent over maybe by a care team, hasn't been back into hospital for two years, so it's really much more the social support with that group.

KIM: What would you see as things you would like to change or add if any thing?

PROF: Well I don't know if I need to change or add it, it's not my job, my job is to follow what they want and if I had, what I would hope for is they still take on more leadership and go on and run it themselves. But it's

not my job to decide what the group is all about that is their job. My job is to follow what they want and sometimes too, to work in partnership and to throw some suggestions out but lots of times you throw out suggestions and they don't bother because that's not what they are interested in. I'm not in control of that group but I have a strong role as far as the facilitator goes.

KIM: Who doesn't go there?

PROF: Well that's a question mark that we have not had a lot of people come and never come back. We have had people come who go on to other things and we will see them, you know I can think of some women, you know no body chases them, there's no body phoning them down. We have had people come onto he group who will then go off to come on to our Advisory Committee or get interested in some where else or we have a number of women who then start to volunteer who come there times but volunteer in Program A. Some times it's just an entry point for them in Program A, but there are a lot of people in Program A who are not going any where and nobody knows what that is about or whether those people as the literature might tell you have a lot of resources have cars come and go to Brock House have a lot of resources. Then there are a lot of people who nobody ever sees and they are question mark in any of our neighborhoods about who are the isolated. Some I think and I would of if I could have pushed it would have liked to see them do, because what their out reach was looking at was really to go into the Safeway and ask that question of older people in the neighbourhood, what would they like to see in programs. Whether the people in area A just don't see themselves going to community centres, I don't know. Now we do have on of the neighborhood houses which is just across the street and it's a, it draws on all the seniors

housing there, so who doesn't go I'm not sure. We have not really survey it and know. I think that as I say when we started Program A we had three or four seniors going, they just couldn't get seniors to come to Program A at all so over the two or three years we have probably had about 100 come in there and we have a regulars, every week you'll notice there are some come and there some aren't there so they feel they don't have to be there every week, but they see it as a resource for themselves and some times they come every week when things aren't maybe going so well or well, you also have people who have left because of frailness and have just gone on, we have several men, and we have had people move away, but I would think that it has been one of the more successful programs at Program A.

KIM: Why do you think that there are so many more women than men?

PROF: In all of them? (I say yes). Oh because two thirds of the people over 65 are women, but I think that's the easy answer like 66% of the population are women. So i think that's one of the demographics, is one of them. But I think the other thing that interests me is, and it interests me at Program A we have more men than we do at most centres, I think that men are not that socially integrated. Like men will come if they have a woman to bring them often, well at Program A that's not the way as the men who come on their own. I don't know if men see exercise and socialization as their thing. I don't know and yet the men that do come to Program A really enjoy themselves, and a number of them are married and their wives don't come, but they just like to come and, one is an ex teacher, you keep wondering why he comes, he plays tennis, he cycles, he's married, he goes to Paris on a regular basis as his wife is French, but he comes every week and he just likes to come. He gets something from the group he's not getting from some

where else. Whether , well I don't know, but one of the things about men, the other thing is often the groups are made up of all women just who that's who comes out or that's who's there. In almost all of the groups except the neighbourhood house are new groups and they started with three or four women and then three or four more women come, now at Program A that's how we started but we started with three women and one man and we have always had a man in that group and we have always has men in that group because I think they come through the door and they don't see a man they don't come back. I haven't looked at it extensively. the other thing is it may be just to do with males and females, males will come on our advisory committees, males are very involved in the housing up in area B, but males are not very involved in the health drop ins or the neighbourhood health programs they just don't come.

KIM: Another issue that seems to have emerged is housing, do you want to comment on that?

PROF: Housing across the West side even though it's more focused in area B is a great concern whether it's in Program A where they feel every day if you have a house a Realtor comes to your door. Almost every day they have Realtors asking them to sell their houses ah and then there's all theat whole they don't' know if they sell their house where would they go, could, you know I have lived in this house for 60 years and they feel a bit harassed in area A and area F they are all in apartments they are suffering the same way as Program J. What a lot of those people have done is gone up to area J forums and they have taken interest and talked to (R) from, and used Program J as their resource. Now where housing isn't and issue is in Program X because they are already in subsidized housing or

already in low I mean poor housing, they have in some ways thought this was their lot I guess. So housing is a concern on the west side period, there are the 2 aspects of it. If you sell your house there are very few alternates for you. You can buy some condominiums but there is not a lot of them and a lot of them are very expensive. You may sell your house for $400,000 but you are still looking at $200,000 and some thousand to buy a condominium and for people that age they just think the whole things ridiculous, they can't seem to, you know housing is continually there. they feel there whole neighbourhood changing in area A so that, and many of the people in the area at the Program A group are people who have lived in that neighborhood for 50 or 60 years and went to school there and so they see now all these new yuppie condominiums as they call them that don't have fences and people don't neighbor and both husband and wife work and some of them do not have children so they see there whole neighbourhood and often they are closed inward so they are not like housing where you , they feel there is no neighbors any more and they , there is some resentment at the size of the housing, but mostly there is kind of they see their whole area changing and that change is bothering them. But in area A you can not replace your house and another thing is a lot of older people like to rent at 75 they don't see buying any thing because they say at the most I have got 25 years and at the least I have got a year so why would I buy any thing and there is the whole values around leaving money for your children and their house is often their estate, particularly in area A. It is an issue at Program A they talk about it a lot. But there is an area A planning committee and a number of our seniors are active in that, have on behalf of the group have come to the

group and we have talked about the Program A Planning Group.

KIM: Is there any thing else you want to say?

PROF: No I don't but I think the Health Promotion Program is more than the neighbourhood programs. I think that the neighbourhood programs have 2 or 3 purposes. One is they are a place where seniors can come back onto he community, so if you are new to the neighbourhood, so if you are newly bereaved or are newly retired it is a place to come into the community or if you've lost your best friends you can easily come into a program and get to know people and make new friends in the program and it has a purpose of showing other programs what could be a program so that ah it makes staff people around there is has worked some places but not others to recognize there are other ways of relating to seniors than just laying on programs and so that it can demonstrate other kinds of principles. It's also a place where a number, the other purpose is for older people to take on other kinds of projects so in Program A it would have been the out reach project if it had worked. In area J they did put together a big out reach project and did get funded for that and in area X they have the Neighbourhood project and an Out Reach Project so that it's not just the program itself but identifying issues that they want to be involved in and taking it and getting some funds and some staff to work with them on any development project so, but that's only one aspect of the Health Promotion we also have as I say the West Side Advisory who have done some work with housing and they have also done so work on a dialogue with L.T.C. ah telling L.T.C. staff how the fell about receiving service and how they could try and influence L.T.C. about this relationship and service delivery and those right off the top of my head. And the other big thing of

course is trying to influence professionals who relate to older people to see them rather than diseases and problems is to see older people as people with potential and skills.

KIM: Are the seniors concerned about that issue?

PROF: Well they talk about it. they talk a lot about the whole Dr who doesn't listen to them and that's where they will focus in and they also will talk about the whole thing with age and they talk about that aging is not fun. But then I'm not sure any of us have understood how we have learned how to be passive receivers of advise and care, I think we have been conditioned to be dependant so I don't think older people are any different than all of us. they do talk about it about the bag clerks who don't pay attention to them. But when you ask about ageism directly they will say there is no such thing, but if you ask about attitudes they will talk about it. Maybe when you say where are the seniors that don't come well they are the ones who don't want to be treated that way. So when you look at Lauds power you have got three choices, you can give up- you can not come, or you can fight with it. And I think a lot of the seniors don't come and when you interview the seniors out side you find that the seniors don't come because they are not stupid or they have given up. And we have got that documented at area J where the seniors have said we just won't go back to that center because we just won't put up with that, we won't have her talk to us like that, they feel that they are important enough.

OB: This inter view took approx 1 and a half hours. It flowed very easily and I felt that she was very frank and open. The tone was relaxed.