HEALTH CARE PROFESSIONALS' PERCEPTIONS OF HEALTH PROMOTION

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ABSTRACT

The concept of health promotion is an alternative and emerging orientation. Here the belief is that all people have strengths and are capable of determining their own needs, finding their own answers, and solving their own problems. Most health care professionals have been educated in the medical model of health. In this model, the health care professional, especially the physician, plays an active part as an expert on disease; the patient or client has essentially a passive role, and the disease rather than the person is the focus. The role of health care professionals in health promotion is an important one and will continue to expand with the new focus of the province of Alberta's health system. The focus of that system, and other health systems in Canada and abroad, is increasingly upon health promotion rather than disease treatment.

The purpose of this study was to determine the perceptions of a variety of health care professionals working in the community and in the hospital setting relating to health promotion. The study takes a non-experimental approach utilizing a descriptive design. All professional staff including registered nurses, occupational therapists, recreational therapists, physiotherapists, respiratory therapists, social workers, dental workers, nutritionists, speech-language pathologists, and physicians working in Palliser Health Authority were asked to participate in the survey. Two hundred and thirteen staff responded to a questionnaire designed to reflect their perceptions on the importance of health promotion, determinants of health, principles of health promotion, and skills and knowledge of health promotion. Staff were also asked to identify health promotion activities occurring at their work site, possible barriers to health promotion, and what was

needed regarding training and support.

Some of the major findings include:

1) Staff perceive health promotion to be an important part of their job. However staff working in the community perceive health promotion to be more important than those working in the hospital. Physicians were the least positive about questions pertaining to the importance of health promotion.

2) Staff perceive that the purpose of health promotion is to strengthen peoples' control over their health, but responses also indicate uncertainty concerning how control is to be defined and effected.

3) When asked to identify health promotion activities at their work site, the majority of staff pointed to the provision of information to individuals and groups. Community development was listed by very few staff.

4) When staff were asked to identify barriers to health promotion they identified the following in the order: lack of resources, old attitudes about health and health promotion, lack of support from the organization and doctors, lack of knowledge/ education, and lack of communication between health care workers.

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CHAPTER ONE

BACKGROUND TO THE STUDY

Alberta has been actively involved in a process of health system reform since 1992. This reform was preceded by an extended period of provincial review and inquiry. The Rainbow Report: Our Vision For Health (Government of Alberta, 1989) by the Premier's Commission on Future Health Care for Albertans, provided a foundation for many of the subsequent changes implemented by the government of Alberta. The report provided six directions for change within the health system, one of which was increased funding for health promotion and disease prevention programs. This particular recommendation of the report was adopted as the government of Alberta defined a new direction for health policy and its management.

Partners from all facets of Alberta's health system worked to prepare a set of health goals, objectives, and strategies for Alberta which was published in February, 1992 (Government of Alberta, 1993). In the nine health goals produced, there was evidence of a new orientation, a discernible shift in emphasis away from cure toward prevention of disease and disability. The health goals, objectives and priorities provided a context for decision making which aimed at improving the

health of Albertans. Communities were asked to be more involved in decision making and health became the responsibility of not only health care providers and government, but individuals, families and communities. McClellan, writing in the Government of Alberta document (1993), Health Goals for Alberta: Progress Report points out:

> There is more to good health than health care - families, communities, environments, good information and healthy behaviours are all critical. We cannot improve the health of Albertans by focusing solely on the health service delivery system. Alberta's health goals reflect the many important influences on health. They highlight ways to improve health and to prevent disease and injury (p. 1).

The idea of motivating individual and community responsibility is the key to health promotion strategies. Government policy was not only supportive of increasing health promotion and disease prevention programs but provided clear direction in the health goals.

Rationale For The Study

The new health goals signalled the beginning of many changes within the health care system in Alberta. In 1994, 17 health regions were formed with each health region administered by one board rather than individual Hospital and Health Unit boards as in the past. Organizations were restructured as the new health boards began the mammoth task involved with health care reform. In Palliser Health

Authority (Regional Health Authority Two), in accordance with the new focus on health rather than illness, a new division called Community Development and Health Promotion was incorporated into the organizational structure.

This new direction toward health promotion and preventive community services had implications for many people working in the health care field. Health promotion is a philosophy which includes the belief that all people have strengths and are capable of determining their own need, finding their own answers, and solving their own problems (Hartrick, Lindsey, & Hills, 1994). Patients and clients are considered to be equal partners in the relationship with the professionals and are recognized not only as individuals, but also as part of a group, family or community. Most health care professionals have been educated in the medical model of health. In this model, the health care professional, especially the physician, plays an active part as an expert on disease; the patient or client has a passive role, and the disease rather than people is the focus. Skelton (1993) describes it as the "older view that the professional knows best" (p.417). As a result of the new orientation, health care professionals are being asked to adapt and commit to a new way of thinking about health. However, there is fear by health care professionals working in hospitals that a new focus on disease prevention and health promotion will result in job loss at acute care facilities. Conversely, staff working within the community fear that the acute care facilities will retain control of the health care system and find a way to incorporate preventive and community services under their mandate.

Individuals and communities are being told that they have to assume greater responsibility for health but have not been provided with the knowledge and support necessary to make these changes. Rapid changes coupled with poor communication resulting from the breakdown of former structures, have increased mistrust between staff and community members. There is confusion as to how hospital staff, community staff, and community members can work together to improve health and to prevent disease and injury as outlined in the health goals for Alberta. Health reform according to Kotani and Goldblatt (1994) is not just an exercise in fiscal restraint, but represents a much larger agenda to create and sustain health. However, among staff there is suspicion that the new focus on prevention simply provides a rationale for cutting costs within the acute care system. The belief is that the changes do not indicate true health care reform, but simply health care restructuring at the expense of health care providers.

Compounding the confusion over changes in existing structures and belief systems is the lack of conceptual clarity regarding the term health promotion. I questioned the name Community Development and Health Promotion that was given to the new division within Palliser Health Authority as I have always believed that community development was a component of health promotion and not a separate concept. In the literature there is also a lack of conceptual clarity regarding the term health promotion. Terms such as health education, health promotion, health maintenance or protection, disease prevention, and community development appear to have different meanings for different authors. For example, health

education and health promotion are often, but not always, used interchangeably. There is confusion concerning disease prevention and health promotion and a variety of opinions about the role of disease prevention in relation to health promotion.

What then does health promotion mean to individual health care professionals? Is there discrepancy among health care workers as to the meaning of health promotion? Most health care professionals are familiar with the effect of lifestyle practices relating to smoking, nutrition, exercise, and stress on health. However, do they have an understanding of the powerful links among prosperity, income distribution, and health, and of the important role of education and economic development in fostering health? How do these perceptions affect how health care professionals incorporate health promotion into their practice?

As Regional Health Promotion Coordinator, one of my responsibilities will be staff education. The pressure is on for a shift by health care professionals from the traditional role which focused on individuals and disease, to one which focuses on healthy people and environments. If health promotion holds different meanings for different staff, then communication involving needed changes to the health care system will also have different meaning. Health care professionals will need additional education and support to assume their expanding role; however, before educational programs can be initiated, it is important to determine what meaning health care professionals give to health promotion. Education should be consistent with the principles of health promotion, and it should offer staff opportunities for

reflection on their meaning of health promotion and their current forms of practice. Strategies to teach health promotion need to be formulated on the concerns and needs identified by the staff.

Purpose Of The Study

The purpose of this descriptive study was to determine the perceptions of health care professionals working in community and in hospital, relating to health promotion. The data obtained were used to draw conclusions and to make recommendations as to possible need for further education and training of health care professionals in relation to health promotion. The specific objectives of the study were to:

1. Identify the perceptions of health care professionals according to the following four categories: importance of health promotion, knowledge of determinants of health, knowledge of principles of health promotion, and skills and knowledge required for health promotion.
2. Identify differences among the various health care professionals regarding perceptions of health promotion.
3. Identify the types of health promotion activities incorporated into the various areas of practice.
4. Identify the perceived barriers to health promotion.
5. Identify support needed to increase health promotion practice.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this chapter is to review concepts associated with health promotion and discuss the role of various health care professionals involved with the practice of health promotion.

Health Promotion in Canada

A consciously defined health promotion movement only emerged in Canada in the 1970s. Its emergence was signalled by the release in 1974 of a document titled A New Perspective on the Health of Canadians by Marc Lalonde, then Minister of National Health and Welfare. The Lalonde report recognized four equally weighted influences: human biology, lifestyle, environment, and health care organization as the key to improving the health of Canadians. By focusing on risk and lifestyle, the responsibility for change was moved away from the medical profession and government back to the individual. Altering peoples' health practices, such as alcohol and tobacco use, eating and exercise habits, and encouraging the use of safety devices, became the focus. The Health Promotion Directorate was established in 1978 to develop and implement health promotion strategies that the

Lalonde report had identified as a means for improving the health of the population (Rootman, 1992).

The movement in Canada in fact parallelled international developments as "Health for all by the year 2000" became the official target for all World Health Organization Member States. This meant that health was to be brought within reach of all people in all countries. Health for all implied the removal of obstacles to health such as malnutrition, ignorance, contaminated drinking water, and unhygienic housing, as well as the solution of purely medical problems such as lack of medical facilities and equipment (Mahler, 1981). It was a holistic concept which asked for collaboration among agriculture, industry, education, housing, and communications, not just medicine and public health .

Epp (1986) furthered these concepts in his landmark document Achieving Health For All: A Framework For Health Promotion.

> Health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services and coordinating healthy public policy. Moreover, it means creating environments conducive to health in which people are better able to take care of themselves and to offer each other support in solving and managing collective health problems (p.12).

Epp introduced the idea that achieving healthful states was both a personal and

societal responsibility. Epp's framework was presented at the First International Health Promotion Conference in Ottawa in 1986 (King, 1994). The Conference called on the World Health Organization and other international organizations to advocate the promotion of health and to support countries in setting up programmes for health promotion. Participants at the conference drew up a Charter for Health Promotion which represents the health promotion strategies and approaches needed to achieve WHO's goal of health for all by the year 2000. This charter, which became known as the Ottawa Charter for Health Promotion, was published by the World Health Organization, Health and Welfare Canada, and the Public Health Association. It advised that "the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health, requires a secure foundation in these basic prerequisites" (p.1). Action for health promotion focused on building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorientating health services. Building on this view, health promotion was defined as "the process of enabling individuals or communities to gain control over and to improve their health" (Ottawa Charter For Health Promotion, 1986, p.1).

Views of Health

At one time, health was defined simply as the absence of disease. That definition was expanded by the World Health Organization in 1947 to recognize

health as a state of complete physical, mental, and social well-being. This state of well being is influenced by factors such as lifestyle, human biology and physical environment, as well as social, economic and cultural environment (Epp, 1986). In 1986, the World Health Organization further refined the definition to include:

> The extent to which an individual or group must be able to identify and to realize aspirations, to satisfy needs, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (p. 3).

This definition recognizes the importance of the multifactorial nature of health and the necessity of community involvement. However, there are several critics of the WHO definition. Some authors contend that although the WHO definition addresses the complexity of health, it merely represents an ideal rather than an achievable goal (Pender, 1987; Rootman & Raeburn,1994). Others, such as Tones (1986), believe that the definition of wellness or wellbeing is problematic and that it is easier to recognize a deviation from normal bodily or mental functioning than to agree on a definition of "wellbeing."

Dunn (1973) uses the term "high level wellness" and defines it in terms of an individual's potential, or what he or she is capable of doing within his or her own

limitations. It requires that individuals maintain a continuum of balance between internal and external factors and be motivated to reach their optimal level of wellness. In optimum health, individuals function at a high level amid a constantly changing environment. Within each individual, there is the potential for moving toward a personal level of wellness (Dunn, 1973). This is a concept similar to one which was outlined by John Travis. He defined wellness as an active process involving varying degrees of levels (cited in Moore & Williamson, 1984). The definition by Travis would include any movement toward wellness on the health continuum and would include the critically ill. This is in opposition to the view of wellness maintaining a basically static form. Brubaker (1983) defines health promotion as health care directed toward high-level wellness but believes health promotion can occur only after a stable state of health without active disease has been achieved. Accepting any movement upward on the health continuum as health promotion is rejected, as consequently, most health care would be considered health promotion.

To address the promotion of health, it becomes essential to know what health is and how its achievement will be measured. The definition of health becomes especially critical when discussing the role of health promotion in acute care settings.

Determinants of Health

Health does not exist in isolation but is influenced by environmental, social,

and economic factors that are related to each other (Mahler, 1981). Several government documents have recently been developed which further define these factors. Nurturing Health: A New Understanding of What Makes People Healthy, a document produced by the Premier's Council on Health, Well-being and Social Justice in 1993 includes the following as influencing our health:

> "the strength of the economy, a fair distribution of wealth, a stable income, meaningful work, positive conditions in our schools and workplaces, supportive family and friends, a healthy childhood, a clean and safe physical environment and the ability to handle stress" (p.6).

Although in the past health care has focused on individuals with, or at risk of, specific diseases, population health address all of the factors that determine health in an entire population. Strategies For Population Health Investing in the Health of Canadians, which was developed for the Meeting of the Ministers of Health in 1994, lists the following nine determinants of health:

- income and social status
- social support networks
- education
- employment and working conditions
- physical environments
- biology and genetic endowment
- personal health practices and coping skills

- healthy child development
- health services.

Healthy lifestyles and availability of health services are often associated with health. However, actions to improve the health of Canadians must take into account all of the above factors. The health care system cannot work in isolation; intersectoral collaboration is the key to addressing social and economic inequity.

Clarification of Concepts

Terms such as health education, health promotion, disease prevention, and health maintenance are often used in the literature; however, the meanings of these terms are not precise and often overlap. These terms could have different meanings to various staff depending on their level of education and work background.

Health Promotion and Health Education

There is a tendency in the literature to interpret and refer to health education and health promotion as one and the same concept. Gott and O'Brien (1990) state "health education is part of, but not the sum of, health promotion" (p.137). Health promotion also includes preventive activities such as screening and immunization, health protection, and action to reduce social and economic inequities. The ultimate goal of health promotion is to improve people's health. The confusion between health promotion and health education appears to arise as a result of the different meanings attached to definitions and perceptions of health education.

Tones (1986) defines health education as "any activity which promotes health related learning, i.e. some relatively permanent change in an individual's capabilities or dispositions" (p.6). He describes three approaches to health education, only one of which is considered synonymous with what is commonly described as health promotion. The first approach, often labelled as traditional education, focuses on the individual and attempts to persuade her or him to adopt a particular lifestyle so as to prevent disease. This approach is consistent with the medical model of preventive medicine. A second approach to education has as its primary goal the facilitation of decision making regardless of the nature of the decision which may be made. With this approach, health professionals provide the information to clients with the understanding that it is then the client's choice whether or not changes will be made.

There are many critics of the above two approaches as outlined by Tones. Down (1990) believes the effectiveness of such approaches is unclear except in acute medical situations. For example, patient education is found to dramatically improve the outcome of surgery and wound treatment, but statistics are much less promising concerning long- term lifestyle changes. Smith (1990) acknowledges the interplay of values and choices associated with the change process and therefore agrees that health teaching or distributing informational pamphlets cannot be equated with health promotion. Some of the confusion stems from earlier approaches to health promotion which focused on "lifestyles", an approach that sought to decrease rising health care cost by targeting unhealthy individual

behaviours for change. This approach is based on two assumptions. One is that the individual has a great deal of influence over his or her personal decisions and the other is that changes in personal behaviour can significantly affect health outcomes (Minkler, 1989). While a lifestyles approach to health promotion has scored some successes, poverty, underemployment, and pollution are playing a growing role in the health problems of society. Freedom of choice can be limited by adverse social and economic conditions. Lifestyles cannot be viewed in isolation from social, economic, industrial, and political structures as the evidence suggests that the social and material circumstances of people's lives rather than their health knowledge and attitudes exert the major influence on their health behaviour (Blackburn, 1994; Labonte, 1987). Caraher (1993) suggests that nursing practice which stems from a perception that health and illness are within the realm of individual responsibility and behaviour, becomes in the end a weapon to blame people and this creates victims.

It is the third approach to health education discussed by Tones, which he terms the "radical" model, that is synonymous with the concept of health promotion. This approach addresses the social issues underlying disadvantage and ill health. Labonte (1987) calls this approach to health education "popular education". This particular term originated in the 1950s with the efforts of Brazilian educator Paulo Freire who espoused a philosophy of liberating or critical pedagogy. Here the teacher is no longer just the-one-who-teaches, but one who is [himself] taught during dialogue with students (Freire, 1970). Unlike traditional education, to which

Freire attributes maintenance of oppression, the purpose of education should be human liberation where participants gain control over their lives in their community and larger society. Smith (1990) agrees that it is the relationship of the professional with the client/patient that is the foundation for health promotion. It is the client's values, goals, or hopes that determine the direction for health promotion activities.

The philosophy of "popular education", sometimes referred to as "empowerment education", substantially extends health education. Health education assumes that individuals can make healthy decisions with enough information, skill, and reinforcement while Freire assumes that knowledge does not come from experts inculcating their information (Wallerstein & Bernstein,1988). Popular education's emphasis is on strengthening communities and creating healthier social and physical environments. Health education in the future will place more emphasis on values clarification and the core of practice will be helping people learn how to learn. Health education has to work on many levels including governmental, organizational, and individual (Clark, 1992). This belief is reinforced by the Regional Programme in Health Education and Lifestyles (WHO, 1981, cited in Tones), which lists three main lines of development for health education as part of health promotion:

> Raising individual competence and knowledge about health and illness, about the body and its functions, about prevention and coping; raising competency and knowledge to use the health care system and to understand its functioning; raising awareness about social, political

and environmental factors that influence health (p.4).

Health Maintenance/Protection and Disease Prevention

One of the greatest areas of debate involves health promotion and disease prevention. Further confusion arises with the addition of terms such as health maintenance or protection. Health maintenance behaviours, according to Tripp and Stachowiak (1992), "prevent illness, reduce the risk of illness, screen for early identification and treatment of illness, and enable neutral, stable, or balanced health to exist " (p.157).

Pender (1987) describes prevention as health-protecting behaviour because its purpose is to defend an individual or group against specific illness or injury which impedes optimum health. Health protection is defined as primary, secondary or tertiary prevention preventing specific illness or disability. Primary prevention, such as immunization programs, consists of activities directed toward decreasing the probability of specific illness in individuals, families, and communities. Secondary prevention emphasizes early diagnosis and intervention to halt the disease process. Hearing screening tests conducted on preschool children are considered secondary prevention strategies. Rehabilitation is the goal of tertiary prevention and consists of restoring the individual to an optimum level of functioning within the constraints of the disability.

The meaning of health promotion overlaps considerably with the meaning of prevention. That is, a common perception of health promotion is that it involves the identification and elimination of risk factors, thus promoting the absence of disease.

Moore and Williamson (1984) include both health promotion and specific protection from disease in primary prevention strategies. Tones (1986) defines health promotion "as any activity which seeks either to promote positive health or to prevent disease at primary, secondary, or tertiary levels" (p.6). Gott and O'Brien (1990) also include disease prevention in their definition, indicating that health promotion includes traditional preventive activities such as screening and immunization, health protection (safer living and working environments), but also includes actions to reduce social and economic inequities.

Brubaker (1983) believes that many authors feel the need to include both of the terms health promotion and disease prevention in statements about ways to improve health; however the two terms are not synonymous. Some definitions of health promotion exclude programs whose main target is the reduction of specific risk factors and those involved with disease management and rehabilitation. Authors connected with the wellness movement appear to support the differentiation of behaviours that promote health and those that prevent disease. Prevention is viewed as a disease-related concept while health promotion is viewed as a health-related concept. Pender (1987) states "health promotion seeks to expand positive potential for health, while prevention or health protection seeks to thwart the occurrence of pathogenic insults to health and well being" (p.5). Health promotion is not disease specific or health problem specific but oriented toward growth to enhance health and improve quality of life. Prevention and health protection can be used interchangeably but not health promotion and prevention. Labonte (1995) also

advises that health be separated from disease. Health promotion is as concerned with experiences such as happiness and contentment as with physical functioning. However, Taylor (cited in Brubaker, 1983) does not advocate such a clear distinction between health and disease. He states that health care directed toward improved nutrition, exercise, avoidance of substance abuse, and stress management, in addition to helping prevent and treat disease, also leads to a happier and healthier life.

Stachtchenko (1990) believes that the main difference between disease prevention and health promotion seems to be one of focus. For example, health promotion focuses on the population at large, while disease prevention focuses on groups at high risk. Health promotion focuses on promoting health rather than simply avoiding illness. McBride (1994) believes that the two approaches are complementary and a combination of approaches may be used depending on the specific objectives of the program.

Some of the confusion between health promotion and disease prevention stems from health promotion's emphasis on lifestyle modification. Many programs labelled as health promotion focus on the reduction of health risks for disease prevention such as smoking cessation, reducing misuse of alcohol and drugs, and improving nutrition, exercise, fitness, and stress control. In the 1980s health promotion became concerned not only with enabling the development of life skills, self concept, and social skills but also with environmental interventions. The focus moved away from disease to the social and economic factors which affect health.

Community Development

As the focus shifts from an individual to a broader environmental perspective, health becomes the concern and the responsibility of the collective, an issue for all sectors and not just the health sector. A distinction needs to be made between community-based and community-development programming. Labonte (1993) defines community development as "the process of organizing and or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/social change, and gaining increased self reliance and decision making power as a result of their activities" (p.237). This is in contrast to the traditional approach to planning health promotion or community based programming where professional staff and administrators defined the problems and solutions.

Community development calls for a different approach, one that involves a search for common ground among multiple interest groups (Schwab et al; 1992). The word "empowerment" is used frequently when discussing community development. Health promotion and community development literature view empowerment as giving power to users over decisions and sometimes taking it away from providers (Labonte, 1995; Skelton, 1993). The outcomes of community development should be relations with and between institutions and community groups that are more equitable in their power sharing. Community development attempts to support community groups in solving concerns as they define them. The essence of community development is creating partnerships about the determinants

of health. Problems and solutions are seen through the eyes of those most directly affected. This differs from community-based programming where the professional or agency defines the health problem, develops strategies to solve problems, and then involves the community to assist in solving the problem and assume ongoing responsibility for the program.

Practice Of Health Promotion

Many disciplines and professions include health promotion activities as part of their practice. Green (1995) believes that "they have taken up health promotion positions with little formal preparation on the theory, research or practice of health promotion" (p.7). The question of who should be involved with health promotion in Alberta will be determined by individual health authorities. In Palliser Health Authority, the expectation from senior administrative staff is that all health care workers should practise health promotion. When discussing the role of the nurse in health promotion, Gott and O'Brien (1990) hold that the type and scale of health promotion activity is likely to be different for different branches of nursing. This would seem true for other types of health professionals as well. Perceptions of health promotion become important when attempting to determine who is presently involved with health promotion and in what capacity.

The concepts of health promotion, prevention and wellness, have been extensively addressed in the community literature. Public health nursing provides services towards individuals , families, and community groups, and has traditionally

seen its major role in the areas of health promotion and disease prevention (Chalmers & Kristajanson, 1989). Public health nurses have frequent opportunities for family and community intervention.

Historically, care provided in hospitals has been disease oriented and individually focused. For many health professionals, the work with patients or clients is short term and crises led (Gott & O'Brien, 1990). Although little has been written about health promotional strategies for hospitalized patients, current literature suggests that hospitals can take a more active role in health promotion. "Since hospitalization may be the patient's first encounter with health care professionals, the attitudes and action of hospital nurses have the potential to influence the futuristic health care practices of these patients" (Flynn & Giffin, 1984, p. 239). Practical nursing skills such as counselling, education, and managing can be taught from a health promotion perspective (Gott & O'Brien, 1990; King, 1994). McBride (1994) discusses the concept of health promoting hospitals where the focus becomes health rather than disease. Letts, Fraser, Finlayson, and Walls (1993) in the document For the Health of It! Occupational therapy within a Health Promotion Framework, challenge occupational therapists to go beyond the way they traditionally work with clients to include the larger community. "Occupational therapists need to be involved in the process that links the individual with the community: the art of health promotion" (p.11). The belief that health is more than a disease free state is essential when incorporating health promotion in acute care practice.

There is little research on perceptions of health promotion by health care professionals, and most of the available literature pertains to the role of nursing only. In one survey conducted by the Canadian Hospital Association, (cited in Ashdown, 1990) health promotion activities identified included patient teaching, referrals to community agencies, staff development programs, occupational health programs for staff, and policies restricting smoking in the hospital. Perceived obstacles for hospitals becoming more involved in health promotion were identified as lack of funding, lack of adequate staffing, and lack of leadership. Whyte and Berland (1993) looked at the role of hospital nurses in health promotion, and noted considerable enthusiasm for health promotion in the acute care setting. However, the enthusiasm was tempered by a host of barriers to carrying out health promotion activities such as time constraints and staff shortages.

McBride (1994) found that although a majority of nurses working in the hospital felt they should be involved in health promotion, there was a lack of coherent health promotion strategies within acute care settings. Nurses appeared to define their health promotion role as one based on the empowerment of patients, but there was also evidence of a controlling relationship with patients. Physicians surveyed by Coulter and Schofield (1991) had a very positive attitude to prevention but it was viewed from an individual doctor initiated care. There was far less commitment to identifying need for prevention in the whole of the population.

The greatest benefit to health would appear to come from a seamless approach to health promotion, with hospitals and primary care working in

partnership (McBride, 1994). In order for this to occur there must be consistency among staff of the Palliser Health Authority regarding meaning and definition of the terms related to health promotion. It becomes essential to explore the perceptions of health promotion between both hospital staff and those working in the community setting before priorities can be established and an effective educational program developed. The focus of health promotion programs will vary depending on perceptions of importance and knowledge and skills. There is therefore a need, as McBride (1994) advocates, to compare professions in order to examine issues of consistency and continuity between professional groups and their interaction with patients in relation to health promotion activity.

Summary

This chapter included a brief history of health promotion in Canada, a discussion of the terms relating to health promotion, and a review of literature regarding health care professionals' perceptions.

The literature review revealed many different interpretations of the terms associated with health promotion, especially pertaining to the differences between health promotion and health education. It appears evident that there is more to health promotion than health education which consists of simply providing information to patients and clients. However, health education is part of health promotion. I view health promotion on a continuum, with health education on one end addressing personal health practices and health services; community

development is on the opposite end addressing social, environmental, and economic factors.

The differences between health promotion and disease prevention are not quite so clear and perhaps it is the process, or philosophy, or both of health promotion which must be considered. In my view health promotion occurs when patients or clients are respected for their experience and knowledge and actively involved with decisions concerning their health. The emphasize in health promotion should be on people as opposed to programs.

The opportunities for staff to practise health promotion, however, will vary according to individual work site. For example, a nurse on a surgical floor working with very ill patients will be more limited than a nurse working in the community with healthy clients. But health promotion has a place in all of the facilities within the Palliser Health Authority.

The concepts relating to health promotion need to be explored fully by staff and management so that a definition of health promotion can be developed that is consistent within all facilities in the region, and corresponds with the vision and goals of Palliser Health Authority as well as the Alberta Health Goals. Clearly defining a health promotion approach for the staff and management process for planning will create a foundation for health promotion within this region. Health promotion can then be translated into practical terms for the workplace.

CHAPTER THREE

METHODOLOGY

The purpose of this chapter is to describe the research design, outline ethical considerations, describe the sample, and delineate the assumptions.

The Questionnaire

The study was a descriptive study which utilized a questionnaire (Appendix A) to survey health care professionals regarding aspects of their perceptions of health promotion. The methodology chosen allowed the researcher to survey a large sample involving a variety of health professionals from all of the sites within Palliser Health Authority. The instrument was developed by the researcher as an appropriate tool could not be located.

A five-point Likert scale was used to determine the perceptions of health care professionals working in community and in hospital relating to health promotion. The study titled The Role of Hospital Nurses in Health Promotion conducted by Whyte and Berland in 1993 provided a basis for ten of the questions (Appendix B). The remaining 23 questions were developed following a study of the literature. Perceptions of health promotion were catalogued into four categories:

1. Importance of health promotion. Questions 8, 12, 16, 18, 19, 24, 26, 29, and 34 pertain to perceptions regarding the importance of health promotion.
2. Knowledge of determinants of health. Questions 10, 17, 22, 23, 25, 30, 31, and 35 relate to knowledge of determinants of health.
3. Knowledge of health promotion principles. Questions 11, 14, 20, 21, 27, 28, 33, 36, 37, and 39 relate to knowledge of health promotion principals.
4. Skills and knowledge required in the practice of health promotion. Question 9, 13, 15, 32, 38, and 40 pertain to skill and knowledge required in the practice of health promotion.

The instrument is semi-structured in that it contains some open-ended questions requiring written responses. The open-ended questions relate to the type of health promotion activity incorporated in specific areas of practice, perceived barriers to health promotion activity, and the need for further education, training, and support.

The content of the questionnaire was reviewed by the Medical Officer of Health and Vice President, Community Development and Health Promotion for Palliser Health Authority. It was also reviewed by two consultants working within the health care system in another health region. Suggestions, including the deletion and addition of questions, were incorporated. Following review of the second draft of the questionnaire, one of the consultants asked permission to adapt it for use in a class she was teaching on health promotion. Another consultant not directly involved with the health system provided valuable comments on structuring and wording of the

questions.

The questionnaire was pretested on ten instructors at the Medicine Hat College. Two of the instructors have a background in rehabilitation health; while the other eight are nursing instructors. They were asked to check for clarity of the questions, relevancy to the purpose of the research, and to comment on any other aspects of the questionnaire. Suggestions to improve clarity of the questions were incorporated.

Sample

The target population was health care professionals employed by Palliser Health Authority who provided direct care to clients/ patients both in the hospital and in the community. There are six hospitals located within the region and six offices from which community health services are provided. The number of staff within each group varies, with registered nurses comprising the largest professional grouping.

The questionnaire was distributed to as many staff as possible. Delivering the questionnaires in person provided an opportunity to meet staff in all of the locations within Palliser Health Authority. Within seven days a total of 479 questionnaires were distributed to staff in the twelve facilities. The management staff in all areas were very supportive and facilitated the process by scheduling times for meeting with staff or distributing the questionnaire themselves. Without this support it would have been very difficult to access as many staff. As well, many of the unit supervisors encouraged their staff to complete and return the survey which

contributed to a better than expected response rate (n=213, 45%). The total number of staff comprising each grouping of health professionals within Palliser Health Authority (although the study sample is smaller) is shown in Table 1.

Table 1

Health Professionals

OCCUPATION	N
Registered Nurses	472
Recreational Therapists	7
Physiotherapists	11
Respiratory Therapists	15
Social Workers	7
Occupational therapists	11
Dental workers	7
Nutritionists	10
Speech Language Pathologists	11
Physicians	90
TOTAL:	641

A tea bag was attached to every questionnaire that was distributed. This idea was a result of a comment by one of the thesis committee members who had the best return rate using a tea bag as incentive. The comments from staff regarding the tea bag were very positive. Nurses expressed the concern that they are continually being asked to do more. They do not feel that they have a voice in decision making; communication is so poor that often they hear about new initiatives

in the media rather than through their place of work. I believe they saw the offering of the tea bag as a gesture that their responses were valued and appreciated.

Ethical Considerations

The proposal for the study was approved by the Human Subject Research Committee at the University of Lethbridge. Permission to conduct the study within the Palliser Health Authority was obtained through the Human Resources Department.

It was the intention to attend staff meetings of as many of the various groups of professional staff as possible to explain the purpose of the research, how the results would be used, and to obtain support for the project. Unfortunately, because of the volume of staff and the large geographical region, this soon proved to be too time consuming and only approximately 10% of the sample was reached in this manner. Several of the questionnaires were distributed to staff by the researcher while visiting the individual units and facilities within the region. The remaining questionnaires were given to the unit supervisors who placed them in the various units after discussing the purpose of the research with the staff.

The cover letter that accompanied the questionnaire advised staff that results would be tabulated according to professional groupings only and that individuals would not be identified. Questionnaires would be coded to represent the different geographical areas and professional groups, and to differentiate between professionals who work in the hospital and those working in the community. All staff

were informed that their participation was completely voluntary and they had the option not to complete the questionnaire. Those who chose to participate were asked to return the addressed envelope containing the questionnaire to the Palliser Health Authority administration office by February 1, 1996.

The possible return rate from staff working within the hospital was a concern prior to distribution of the questionnaires. Staff morale had decreased over the past year as a result of job loss and uncertainty, and there was concern that staff may not consider health promotion a priority topic. As well, it was suspected that staff working in hospitals may view health promotion as a community health role.

Assumptions

The following assumptions were made concerning this study:

1. There is a difference between staff working in the community and staff working in the hospital regarding perceptions of health promotion.
2. There is a difference in how registered nurses, physicians, and other health care professionals perceive health promotion.
3. There is a difference between staff working in rural areas and those working in urban areas regarding perceptions of health promotion.
4. Staff with baccalaureate degrees and higher educational levels will have a better understanding of health promotion.

Analysis of Data

The data from the questionnaires were computer analysed using the SPSS/PC+ system. Demographic information obtained from the first seven questions was tabulated and summarized. The frequency of answers generated by the participants concerning the Likert type items was used to ascertain perceptions of health promotion. Perceptions of health promotion by health care professionals were identified according to four categories. Statistical methods used to identify patterns of response were mean and standard deviation. To determine if there were statistical differences between perceptions of staff based on facility, profession, education, and geographical location, each item in the four categories was examined using one-way analysis of variance (ANOVA). This procedure was chosen as it allowed for the comparison of the means of three or more groups (Polit & Hungler, 1987).

Similar comments from the open-ended questions were grouped together to form categories. Frequencies were then calculated to describe the occurrence of like statements reported among the sample.

CHAPTER FOUR

RESULTS AND DATA ANALYSIS

The purpose of this study was to determine the perceptions relating to health promotion of health care professionals working in the community and in hospitals. This chapter provides a data analysis from the questionnaire which includes a description of the sample, a discussion of the four categories of questions used to determine perceptions, and a discussion of the open-ended questions. The limitations of the study conclude the chapter.

Description of Sample

Questionnaires (n=479) were distributed to all professional staff who provide direct service to clients/patients in the six hospitals and six community health service offices w..hin Palliser Health Authority. The hospitals were located in Medicine Hat, Brooks, Bassano, Bow Island, Oyen, and Empress. The hospital in Medicine Hat is the largest with 310 acute and continuing care beds. It services the city of Medicine Hat as well as a regional population which includes parts of Saskatchewan. The remaining hospitals are considered small rural facilities. Brooks Health Centre is the largest with 115 acute and continuing care beds; the remaining

four hospitals vary from 10 to 40 beds in total. Community health services are provided on a regional basis and offices are located in Medicine Hat, Bow Island, Brooks, and Oyen.

The sample was divided into three categories of staff for the purpose of analysis. The categories were defined as group one - registered nurses, group two - physicians, and group three which included all other professional staff (physiotherapists, occupational therapists, recreational therapists, speech-language pathologists, respiratory therapists, nutritionists/dieticians, social workers, and dental workers). Registered nurses (n=472, 74%) comprised the largest group in the population. Physicians (n=90, 14%) and the third group (n=79, 12%) made up the remainder.

Two hundred and thirteen questionnaires were returned for a return rate of 45 percent. The response rate from each group was very different with 31% of the registered nurses, 20% of the physicians and 60% of the third group of professionals completing the questionnaire. Of the staff who completed the questionnaire, 146 (69%) were registered nurses, 20 (9%) were physicians, and 47 (22%) were professionals who made up the third group of health care professionals (see Figure 1).

Staff were asked to identify where they worked most frequently. The majority of staff (n=162, 76%) worked in a hospital, in acute or extended care. Fifty one staff (24%) worked in the community (see Figure 2).

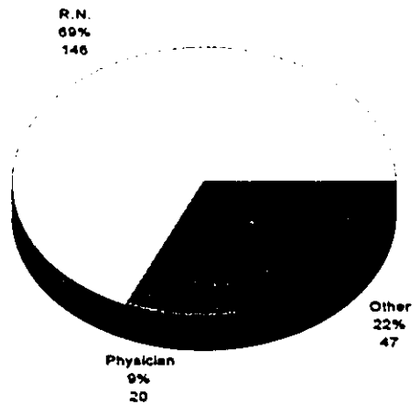

Figure 1: Occupation of Respondents

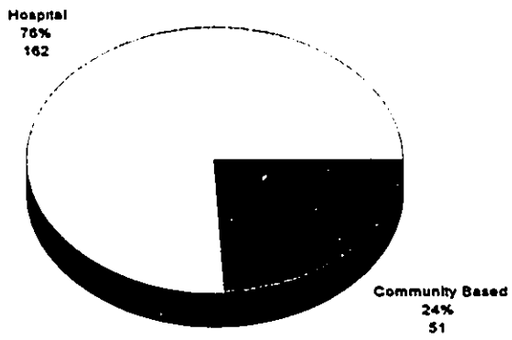

Figure 2: Workplace of Respondents

Of the 213 individuals who completed the questionnaire, 153 (72%) identified themselves as having staff positions, 24 (11%) as team leader/supervisor positions, 14 (7%) as manager/director positions, and 16 (8%) as having other positions. Six respondents did not answer the question asking them to identify their position (see Figure 3).

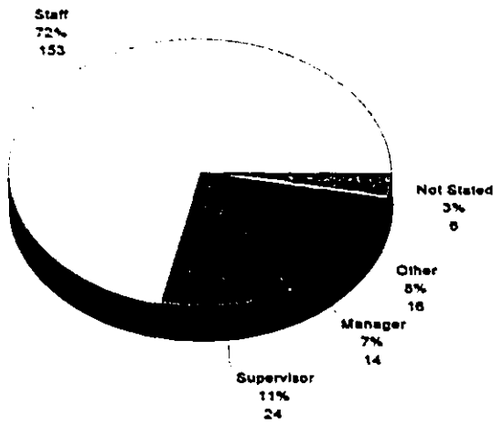

Figure 3: Position of Respondents

Ninety seven (46%) of the health professionals who completed the questionnaire had a professional diploma, 31 (15%) a post diploma certificate, 55 (26%) a baccalaureate degree, 13 (6%) a masters degree, 12 (6%) a doctorate degree, and 5 (2%) indicated 'other' for the question (see Figure 4).

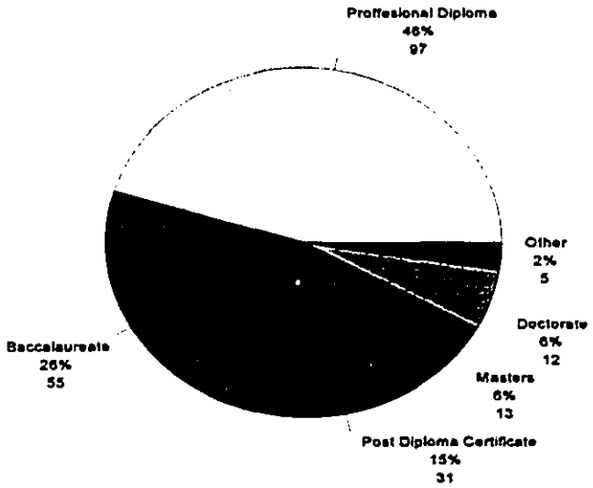

Figure 4: Highest Level of Education

The health professionals were asked how many full time equivalent years they had worked in health. Two respondents did not answer this question. Of the 211 responses, the mean response was 13.8 years with a median of 12, a mode of 20, and standard deviation of 7.94. The number of years ranged from one to thirty five years (see Figure 5).

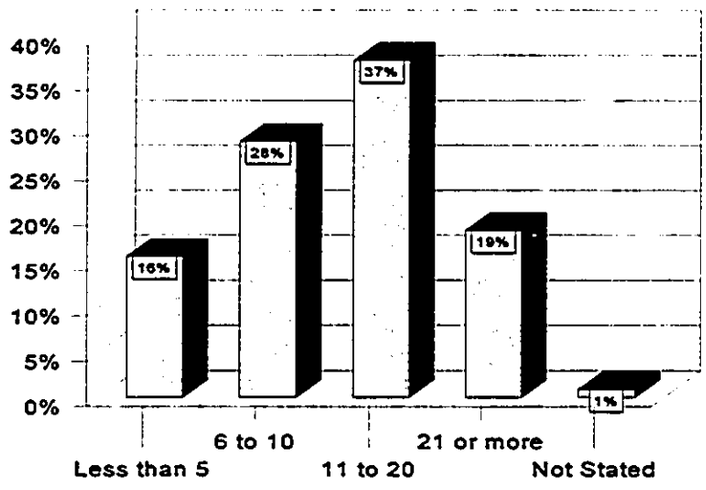

Figure 5: Number of FTE Years Worked In Health Care

Many of the total number of respondents (n=139, 65%) had attended education in-service training pertaining to their work area within the previous three months. Of these, 36 (17%) had attended in-service training within the previous four to six months, and 25 (12%) within the previous seven months to one year. The remainder of the respondents indicated that it had been over one year since their last in-service training. Of the respondents, 108 (51%) indicated that they had taken courses on health promotion since graduating from their last diploma or degree program.

Perceptions of Health Promotion

Perceptions of health promotion were determined using 33 items on a Likert-type scale. The items related to one of four categories which were:

- the importance of health promotion
- knowledge of determinants of health
- knowledge of principles of health promotion
- skills and knowledge required.

For each of the items, respondents were asked to choose a response which indicated the extent to which they agreed or disagreed with the statements. Each statement was followed by a five-point scale on which: 1 is strongly disagree, 2 is disagree, 3 is uncertain, 4 is agree, and 5 is strongly agree.

Category I: Importance of Health Promotion

Nine questions on the survey related to staffs' perception of the importance of health promotion. Frequencies, mean, and standard deviation for each question are shown on Table 2.

Of the total sample, the majority of staff (n= 201, 94%) agreed that health promotion was an important part of their job. Over half (n=120, 56%) claimed that everything they did at the work site could be considered health promotion, although several (n=30, 14%) indicated they were uncertain. Many of the staff (n=139, 66%) agreed that they always incorporate health promotion activities into their practice but thirty one (15%) disagreed and 43 (20%) indicated they were uncertain.

Table 2

Importance of Health Promotion

	QUESTION	N	Ratings (%)					$\bar{x}$	sd
			SD	D	U	A	SA		
8.	Health promotion is an important part of my job.	213	.9	1.9	2.8	43.7	50.7	4.41	.73
12.	Everything I do at the work site can be considered health promotion.	213	2.8	26.8	14.1	41.8	14.6	3.38	1.11
16.	I always incorporate health promotion activities into my practice.	213	.9	13.6	20.2	51.2	14.1	3.64	.92
18.	My workplace supports my efforts in health promotion.	211	.5	13.3	26.1	47.9	12.3	3.58	.89
19.	I model a healthy lifestyle for my patients / clients.	212	.5	10.4	11.3	63.7	14.2	3.81	.82
24.	My knowledge of health promotion primarily comes from my work experience.	213	1.9	29.1	4.7	58.7	5.6	3.37	1.02
26.	Health information is readily available for patients/clients where I work.	211	1.4	13.7	15.2	56.9	12.8	3.66	.92
29.	My workplace models health promotion.	212	.9	17.9	25.9	47.2	8.0	3.43	.91
34.	Learning more about health promotion will help me when working with patients/ clients.	212	.5	3.8	6.6	63.2	25.9	4.10	.71

NOTE: 1 = Strongly Disagree, 5 = Strongly Agree

When asked if their workplace supported them doing health promotion, 127 (60%) staff agreed. However many (n= 55, 26%) indicated they were uncertain. The majority of staff (n=165, 78%) acknowledged that they modelled a healthy lifestyle for patients/clients; the remaining were equally divided between disagreeing and indicating they were uncertain.

When asked to indicate where their knowledge of health promotion came from, 137 staff (64%) agreed that their knowledge primarily comes from their work experience; 66 (31%) disagreed that their knowledge came from work experience.

Health information is readily available for patients/clients where 140 staff (69%) work. The remaining staff were equally divided between disagreeing that health information is available or indicating they were uncertain. Only 117 (54%) conceded that their workplace models health promotion. Fifty five (26%) indicated they were uncertain and 40 (19%) disagreed that their workplace models health promotion.

The last question in this category asked staff whether learning more about health promotion would help them when working with patients/clients. The majority (n=189, 89%) agreed that it would.

The responses to the nine questions relating to importance of health promotion were examined using one-way analysis of variance (ANOVA) to determine if any significant differences existed based on facility (hospital/ community), profession (registered nurse, physician, other), education (diploma, baccalaureate, masters or more), or geographical location (rural/urban). A significance level of .05 was set for this study. Results as shown in Table 3 indicate that significant differences between several of the groups were found when the variables of facility, profession, education , and importance of health promotion were examined.

On the variable of geographical location (urban/rural) there were not any significant differences noted between any of the groups. Significant differences were also not found for question #16 which stated "I always incorporate health promotion activities into my practice".

Table 3

ANOVA for Importance of Health Promotion

	QUESTION	HOSPITAL / COMMUNITY		NURSE / PHYSICIAN / OTHER		EDUCATION	
		F Ratio	P	F Ratio	P	F Ratio	P
8.	Health promotion is an important part of my job.	3.958	.048	4.731	.010	9.045	.000
12.	Everything I do at the work site can be considered health promotion.	3.769	.054	3.725	.026	3.353	.037
18.	My workplace supports my efforts in health promotion.	4.762	.030	.003	.997	.031	.970
19.	I model a healthy lifestyle for my patients/clients.	.374	.542	3.55	.030	6.327	.002
24.	My knowledge of health promotion primarily comes from my work experience.	3.645	.058	.995	.372	3.433	.034
26.	Health information is readily available for patients / clients where I work.	4.793	.030	3.589	.029	.104	.901
29.	My workplace models health promotion.	10.438	.001	.379	.685	1.373	.256
34.	Learning more about health promotion will help me when working with patients / clients.	3.033	.083	8.463	.000	3.50	.032

Results indicate a significant difference (p=.048) between staff working in the hospital (n=162) and those working in the community (n=51) for question 8 which states "Health promotion is an important part of my job". An examination of the means showed that community staff agreed more than hospital staff. A significant difference (p=.01) was also indicated among registered nurses (n=146), physicians (n=20) and the third group (n=47). The means for each group were compared and it was found that registered nurses were most in agreement and physicians were the least in agreement.

On the variable of level of education in question 8, a significant difference (p=.000) was found among staff having a diploma/certificate (n=128), a baccalaureate degree, (n=55) and a graduate degree or more (n=30). An examination of the means showed that staff with a baccalaureate degree demonstrated the most agreement; those with a graduate degree or more the least.

Question 12 asked whether "Everything I do at the worksite can be considered health promotion". Results on the ANOVA indicate a significant difference (p=.026) among registered nurses (n=146), physicians (n=20), and the third group (n=47). When means were examined, the third group was found to agree the most, and physicians the least. When examining the variable of level of education the results indicate a significant difference (p=.037) among staff with a diploma/certificate (n=128), baccalaureate degree (n=55), and those with a graduate degree or higher (n=30). Those with a diploma/certificate agreed the most and those with a graduate degree or more agreed the least when means were examined.

Question 18 sought to determine the perceptions pertaining to support in the workplace for health promotion. The only significant difference found (.030) was between hospital (n=161) and community (n=50) staff. An examination of the means indicate that staff in the community agreed more with the statement "My workplace supports me doing health promotion".

Question 19 stated "I model a healthy lifestyle for my patients/clients." One way analysis of variance found a significant difference (p=.030) among registered

nurses (n=145), physicians (n=20), and the third group (n=47). Following examination of the means, the third group was found to demonstrate the most agreement and physicians the least. There was also a significant difference (p=.002) among groups in the level of education. Staff having baccalaureate degrees (n=55) agreed the most, while those with a graduate degree or more (n=30) agreed the least when means were examined.

Question 24 sought to determine the source of staff's knowledge of health promotion. The only significant difference (p=.002) was found when examining the level of education. An examination of the means indicate that staff having a diploma/certificate (n=128), agreed the most, then those with baccalaureate degrees (n=55), and lastly those with a graduate degree or more (n=30) with the item stating, " My knowledge of health promotion primarily comes from my work experience".

Item 26 stated "Health information is readily available for patients/clients where I work". The results indicate a significant difference (p=.030) between staff working in the hospital (n=160) and those working in the community (n=51). An examination of the means shows that staff working in the community agreed more. There was also a significant difference (p=.029) found among registered nurses (n=145), physicians (n=20) , and the third group (n=46). By comparing the means, it was found that the third group agreed the most with the statement concerning availability of health information, followed by registered nurses, and lastly physicians.

The statement "My workplace models health promotion" resulted in a significant difference (p=.001) only between staff working in the hospital (n=161) and in the community (n=51). An examination of the means for each group showed that staff working in the community agreed more with the statement.

The last item in this category asked staff to rate their response to the statement: "Learning more about health promotion will help me when working with patient/clients." Results indicate a significant difference (p=.000) among registered nurses (n=145), physicians (n=20), and the third group (n=47). An examination of the means show that registered nurses agreed the most, followed by the third group, and lastly physicians. Also a significant difference (p=.032) was noted among staff having a diploma/certificate (n=127), a baccalaureate (n=55), and those with a graduate degree or higher (n=30). A comparison of the mean for each group indicated that staff having a baccalaureate degree were the most in agreement, followed by those with a diploma/certificate, and then those with a graduate degree or more.

Summary Of Category I: Importance of Health Promotion

Significant differences between groups were revealed. It was found that staff working in the community consistently demonstrated more agreement with the items in the category pertaining to importance of health promotion than those working in the hospital.

Five items resulted in significant differences among registered nurses, physicians, and the third group. When profession was analysed, physicians

consistently showed the least agreement of the three groups. Registered Nurses agreed more with two of the items while the third group demonstrated the most agreement with the remaining three items.

Nurses who had a baccalaureate degree agreed most with the items except for question 12 and 24 which stated: "Everything I do at my work site can be considered health promotion" and "My knowledge of health promotion primarily comes from my work experience". For these two items, staff having a diploma/ certificate agreed the most with the statements indicating some differences in how health promotion may be perceived by the two groups. Many of the staff working in the community have a baccalaureate degree as it is a prerequisite for working in public health, although not for working in home care. Staff who had a masters degree or more consistently agreed the least with the items pertaining to importance of health promotion. All of the physicians would be in this group as well as many staff in administrative positions.

It was interesting that there were no significant differences noted between groups in the variable of geographical location (urban/rural).

Category II Knowledge of Determinants of Health

Nine questions on the survey focused upon staffs' knowledge concerning the determinants of health. Frequencies, mean, and standard deviation for each question are shown on Table 4.

The majority of staff (n=176, 83%) agreed people can change their behaviour if they have accurate information. Only 13 (6%) disagreed with the statement while

22 (11%) indicated they were uncertain. However, only 46 staff (21%) conceded people will change their behaviour if they have accurate information; 93 (44%) disagreed and many (n=74, 35%) indicated they were uncertain. Over half of the staff (n=125, 59%) acknowledged that individuals have control over their health. Forty seven (22%) disagreed with the statement and almost an equal number (n=40, 19%) were uncertain.

Table 4

Determinants of Health

	QUESTION	N	RATINGS (%) SD	D	U	A	SA	$\bar{x}$	sd
10.	People can change their behavior if they have accurate information.	211	1.4	4.7	10.4	60.2	23.2	3.99	.81
17.	Health promotion and disease prevention mean the same.	210	9	52.4	19	17.1	2.4	2.51	.96
22.	Income and social status are important determinants of health.	212	3.3	13.2	13.7	50	19.8	3.70	1.04
23.	Health professionals are the most appropriate persons to do health promotion.	212	.5	22.6	21.2	45.3	10.4	3.42	.97
25.	People will change their behavior if they have accurate information.	213	4.7	39	34.7	18.3	3.3	2.77	.92
30.	Health education and health promotion mean the same.	210	2.9	45.7	25.2	24.3	1.9	2.77	.92
31.	A formal background in health is necessary to be involved in health promotion.	213	7.5	63.4	14.1	12.7	2.3	2.39	.89
35.	Individuals have control over their health.	212	.9	21.2	18.9	44.3	14.6	3.50	1.01

Few of the staff (n=41, 20%) agreed that health promotion and disease prevention mean the same. Over half (n=129, 61%) disagreed with the statement and 40 (19%) were uncertain. Regarding question 30 stating that health education

and health promotion mean the same, almost an equal number (n=55, 26%) agreed as were uncertain (n=53, 25%). The remaining (n=102, 49%) disagreed, indicating health education and health promotion did not mean the same.

When asked about the importance of income and social status, 148 staff (70%) agreed they were important determinants of health. Thirty five (17%) disagreed and 29 (14%) were uncertain regarding this item. Slightly over half (n=118, 56%) agreed that health professionals are the most appropriate persons to do health promotion. The remaining were almost equally divided between disagreeing (n=49, 23%) with the statement and indicating they were uncertain (n=45, 21%). Yet only 32 staff (15%) acknowledged that a formal background in health is necessary to be involved in health promotion. One hundred fifty one (71%) disagreed and 30 (14%) were uncertain.

The nine responses relating to knowledge of the determinants of health were examined using one-way analysis of variance (ANOVA) to determine if any significant differences existed based on facility (hospital/community), profession (registered nurse, physician, other), education (diploma, baccalaureate, masters or more), or geographical location (rural/urban).

Results as shown in Table 5 indicate the only significant differences were found when examining the variable of education and determinants of health; this occurred for items 17, 23, and 30 only in this category.

Results indicate a significant difference (p=.007) among staff having a diploma/certificate (n=126), a baccalaureate degree (n=54), and those with a

graduate degree or more (n=30) for question 17 which states "Health promotion and disease prevention mean the same". An examination of the means found that staff with a diploma/certificate agreed the most, then those with a baccalaureate degree, and lastly staff with a graduate degree or more.

Results approach significance (p=.051) for question 23 which stated "Health professionals are the most appropriate persons to do health promotion." When means were examined, staff with a graduate degree or more (n=30) were found to agree the most, followed by staff with a diploma/certificate (n=127). Staff with a baccalaureate degree (N=55), agreed the least with the statement.

Question 30 stated "Health education and health promotion mean the same." One way analysis of variance found a significant difference (p=.000) among groups having a diploma/certificate (n=126), baccalaureate degree (n=55), and a graduate degree or more (n=29). When means were examined, those having a diploma/certificate were found to agree the most, followed by those with a baccalaureate degree, and lastly those with a graduate degree or more .

Table 5

ANOVA for Determinants of Health

	QUESTION	EDUCATION	
		F Ratio	P
17.	Health promotion and disease prevention mean the same.	5.051	.007
23.	Health professionals are the most appropriate persons to do health promotion.	3.026	.051
30.	Health education and health promotion mean the same.	12.187	.000

Summary of Category II: Knowledge of Determinants of Health

Very few differences were noted between groups in the category relating to knowledge of determinants of health. The differences were in questions relating to meaning of health promotion and the role of the professional in health promotion.

Staff having a diploma/certificate agreed the most with the two statements relating health promotion and disease prevention, and health promotion and health education. Conversely, it was those having a graduate degree or more who disagreed the most with linking disease prevention and health education to health promotion. Concerning the question asking whether health professionals were the most appropriate persons to do health promotion, staff having a graduate degree or more agreed the most. Again physicians would comprise the majority of this group.

Category III: Knowledge of Principles of Health Promotion

Ten questions on the survey related to staffs' knowledge of the principles of health promotion. Frequencies, mean, and standard deviation for each question are shown on Table 6.

Of the total sample, 173 staff (81%) agreed with the item stating "Professionals assume a leadership role when working with communities". Sixteen (8%) disagreed and 24 (11%) were uncertain. One hundred fifty staff (70%) agreed that people are primarily responsible for solving their own problems while the remainder of the responses were equally divided between disagree and uncertain. The majority (n=196, 92%) agreed that the purpose of health promotion is to

strengthen peoples' control over their health. Although staff believed that the purpose of health promotion is to strengthen peoples' control, only 52 (25%) agreed that the task of defining health problems and needs primarily belongs to those experiencing the problem or need. One hundred sixteen (55%) disagreed with the statement and 44 (21%) were uncertain. Question 28 continued with the issue of control and asked staff to respond to the statement: "One of the core elements of health promotion is empowerment." Again the majority (n=152, 72%) agreed; only 10 (5%) disagreed, but many 49 (23%) were uncertain.

One quarter of the staff (n=53) indicated they were uncertain when asked if the focus of health promotion is individual change; 121 (57%) agreed while 37 (18%) disagreed. However, the majority (n=178, 86%) disagreed with the statement that health promotion primarily involves working with groups of individuals only. Five staff (2%) agreed with the statement and 24 (12%) were uncertain.

Many staff (n=65, 31%) indicated they were uncertain when asked to respond to the statement "One of the core elements of health promotion is personal skill development". Only 130 (62%) agreed and the remainder disagreed. Again many indicated they were uncertain (n=77, 37%) regarding question 37 which states "The focus of health promotion is social change". Only 99 (47%) agreed with the statement.

The last question in the category of principles of health promotion asked whether health professionals can change peoples' lifestyles. The staff were very divided on this question with 88 (42%) agreeing, 78 (37%) disagreeing and 46

(21%) indicating they were uncertain.

Table 6

Principles of Health Promotion

	QUESTION	N	RATINGS (%)					$\bar{x}$	sd
			SD	D	U	A	SA		
11.	Professionals assume a leadership role when working with communities.	213		7.5	11.3	56.3	24.9	3.99	.82
14.	People are primarily responsible for solving their own problems.	213	.9	14.1	14.6	53.1	17.4	3.72	.94
20.	The purpose of health promotion is to strengthen peoples' control over their health.	213	.5	1.9	5.6	68.5	23.5	4.13	.63
21.	The task of defining health problems and needs primarily belongs to those experiencing the problem or need.	212	8.5	46.2	20.8	20.8	3.8	2.65	1.02
27.	The focus of health promotion is individual change.	211	.5	17.1	25.1	49.8	7.6	3.47	.88
28.	One of the core elements of health promotion is empowerment.	211	1.4	3.3	23.2	47.9	24.2	3.90	.85
33.	Health promotion primarily involves working with groups of individuals only.	207	14.0	72.0	11.6	2.4		2.02	.59
36.	One of the core elements of health promotion is personal skill development.	211	.5	7.1	30.8	54	7.6	3.61	.75
37.	The focus of health promotion is social change.	210	.5	15.7	36.7	43.3	3.8	3.34	.80
39.	Health professionals can change peoples lifestyles.	212	7.5	29.2	21.7	38.2	3.3	3.00	1.06

The responses to the ten questions relating to principles of health promotion were examined using one-way analysis of variance (ANOVA) to determine if any significant differences existed based on facility (hospital/community), profession

(registered nurse, physician, other), education (diploma, baccalaureate, masters or more), or geographical location (rural/urban). Results as shown in Table 7 indicate that for six of the items significant differences between groups were found when the variables of facility, profession, education, geographical location and principles of health promotion were examined.

Table 7

ANOVA for Principles of Health Promotion

	QUESTION	HOSPITAL / COMMUNITY		NURSE / PHYSICIAN / OTHER		EDUCATION		URBAN / RURAL	
		F Ratio	P	F Ratio	P	F Ratio	P	F Ratio	P
11.	Professionals assume a leadership role when working with communities.	2.680	.103	.867	.422	.340	.712	6.047	.015
21.	The task of defining health problems and needs primarily belongs to those experiencing the problem or need.	7.190	.008	.199	.820	.295	.745	1.033	.311
28.	One of the core elements of health promotion is empowerment.	4.428	.037	2.170	.177	13.612	.000	.166	.684
36.	One of the core elements of health promotion is personal skill development.	.592	.442	4.793	.009	.108	.898	.508	.477
37.	The focus of health promotion is social change.	.695	.405	3.326	.038	.824	.440	.005	.941
39.	Health professionals can change peoples lifestyles.	1.989	.160	3.076	.048	4.843	.009	.320	.572

Results indicate a significant difference (.015) between staff working in urban (n=180) and rural areas (n=33) regarding the question stating "Professionals assume a leadership role when working with communities." An examination of the means showed that staff in the rural area agreed more with the statement than those in the urban area.

Question 21 stated "The task of defining health problems and needs primarily belongs to those experiencing the problem or need." One way analysis of variance found a significant difference (p=.008) between staff working in the hospital (n=161) and in the community (n=51). Following examination of the means, staff working in the community were found to agree the most.

A significant difference (p=.037) was again found between staff working in the hospital (n=160) and those in the community (n=51) regarding question 28 which states "One of the core elements of health promotion is empowerment." An examination of the means found that staff working in the community agreed more with the statement. There was also a significant difference (p=.000) among staff having a diploma/certificate (n=126), a baccalaureate degree (n=55), and those with a graduate degree or more (n=30). When means were examined it was found that staff with a baccalaureate degree agree the most, followed by those with a graduate degree or more, and finally those with a diploma/certificate.

Question 36 stated "One of the core elements of health promotion is personal skill development." A significant difference (p=.009) was found among registered nurses (n=144), physicians (n=20), and the third group (n=47). An examination of

the means found that the third group agreed the most, followed by physicians, then registered nurses.

Question 37 stated "The focus of health promotion is social change." There was a significant difference (p=.038) again among registered nurses (n=144), physicians (n=19), and the third group (n=47). An examination of the means showed that the third group agreed the most, then registered nurses, and finally physicians.

The last item in this category stated "Health professionals can change peoples' lifestyles." Results on the ANOVA indicate a significant difference (p=.048) among registered nurses (n=145), physicians (n=20), and the third group (n=47). An examination of the means found that physicians agreed the most, then registered nurses, and lastly the third group. There was also a significant difference (p=.009) among staff with a diploma/certificate (n=127), baccalaureate degree (n=55), and those with a graduate degree or more (n=30). When means were examined those with a graduate degree or more agreed the most, followed by those with a diploma/certificate, and lastly those with a baccalaureate degree.

Summary of Category III: Knowledge of Principles of Health Promotion

This was the first category in which a significant difference was found between staff working in an urban area and those in a rural area. Staff in the rural area agreed more with the item stating "Professionals assume a leadership role when working with communities" than those in the urban area.

There were some consistencies found when examining the significant differences among groups. Staff working in the community consistently

demonstrated more agreement with the item relating health promotion to patient/ client control of defining health problems and needs and the one relating it to the issue of empowerment. When examining the variable of profession, physicians showed the least agreement for the item which related the focus of health promotion to social change. The one question where physicians demonstrated the most agreement was the one stating "Health professionals can change peoples' lifestyles." This question also resulted in a significant difference when the variable of education was examined; staff having a graduate degree or more agreed the most. Physicians would comprise most of this group.

Category IV: Skills and Knowledge

Six questions on the survey related to staffs' perception regarding their skills and knowledge. Frequencies, mean, and standard deviation for each question are shown on Table 8.

Of the total sample, 158 staff (74%) agreed they felt they were skilled at implementing health promotion concepts. Only 12 (6%) disagreed with the statement and 42 (20%) were uncertain. A majority of staff (n=176, 83%) agreed they have the ability to advocate for a healthy workplace while 29 (13%) were uncertain. When asked if they have a clear understanding of what health promotion means, 157 (74%) agreed but 42 (20%) were uncertain. Less than two thirds of staff (n=131) agreed they have easy access at their work site to updated resources that help them in their health promotion efforts. Forty six (22%) disagreed and 36 (17%) indicated they were uncertain. Only 58 staff (27%) agreed they felt skilled at

evaluating health promotion programs/activities. Many (n=91, 43%) indicated they were uncertain and 63 (30%) disagreed. A large percentage (n=178, 84%) agreed they have the ability to advocate for a heathy community; however, the remaining staff (n=28, 13%) indicated they were uncertain.

Table 8

Skills and Knowledge

	Question	N	RATINGS (%)					$\bar{x}$	sd
			S.D.	D	U	A	S.A.		
9.	I feel I am skilled at implementing health promotion concepts.	212	.5	5.2	19.8	59.9	14.6	3.83	.75
13.	I have the ability to advocate for a healthy workplace.	213		3.8	13.6	59.2	23.5	4.02	.72
15.	I have a clear understanding of what health promotion means.	211		5.7	19.9	56.4	18	3.87	.77
32.	I have easy access at my work site to updated resources that help me in my health promotion efforts.	213	.9	20.7	16.9	50.2	11.3	3.50	.97
38.	I feel I am skilled at evaluating health promotion programs/ activities.	212	2.4	27.4	42.9	25.5	1.9	2.97	.84
40.	I have the ability to advocate for a healthy community.	211		2.4	13.3	64.9	19.4	4.01	.65

The six questions relating to importance of health promotion were examined using one-way analysis of variance (ANOVA) to determine if any significant differences existed based on location (hospital/community), profession (registered nurse, physician, third group), education (diploma/certificate, baccalaureate,

masters or more), or geographical location (urban/rural).

Results as shown in Table 9 indicate the only significant differences among groups was found when examining the variable of education and skills and knowledge, but only for two of the items in this category.

Table 9

ANOVA for Skills and Knowledge

QUESTION		EDUCATION	
		F Ratio	P
13.	I have the ability to advocate for a healthy workplace.	3.505	.032
40.	I have the ability to advocate for a healthy community.	6.180	.002

Results indicate a significant difference (p=.032) among staff having a diploma/certificate (n=128), a baccalaureate degree (n=55), and staff with a graduate degree or more (n=30) for question 13 which states "I have the ability to advocate for a healthy workplace." An examination of the means found that staff with a baccalaureate degree demonstrated the most agreement; those with a graduate degree or more the least.

Question 40 stated "I have the ability to advocate for a healthy community." One way analysis of variance found a significant difference (p=.002) among staff having a diploma/certificate (n=127), a baccalaureate degree (n=55), and staff with a graduate degree or more (n=29). When means were examined, staff with a baccalaureate degree were found to agree the most and those with diploma/ certificate the least.

Summary of Category IV: Skills and Knowledge

Significant differences between groups were revealed when education was examined. Staff with a baccalaureate degree consistently demonstrated the most agreement with the two items in this category.

Open-ended Questions

Questions 41, 42, and 43 were open-ended, and asked respondents to identify the health promotion activities incorporated in their area of practice, the perceived barriers to health promotion, and what, if anything, was needed to increase health promotion activities in their area of work. Question 44 asked respondent to choose and rank the areas in which they would like to increase their ability from a list of provided topics. The final question on the survey provided an opportunity for comments of any kind.

Health Promotion Activities

Question 41 asked respondents to list some of the health promotion activities incorporated into their area of practice. A high percentage of staff (n=54, 25%) did not answer this question while 4 (2%) indicated that there were no health promotion activities incorporated into their area of practice. From the responses that were provided, four main activities were identified. The health promotion activities identified were: provision of information, community development, professional development, and provision of services. Single responses were summarized into a category labelled "other". The total frequency and percentage for each theme are

shown in Table 10. Frequencies and percentages according to the variables of facility (hospital/community), occupation (registered nurse, physician, other), education (diploma/certificate, baccalaureate, graduate degree or more), and geographical location (urban/rural), are shown in Appendix C.

Table 10

Health Promotion Activities

Activity	Number	Percentage
Provision of information to individuals or groups.	134	63%
Professional development	27	13%
Provision of Services	18	8%
Community Development	7	3%
Other	14	6%
Absence of health promotion activities	4	2%
Not stated	54	25%

Of the total population, the majority of staff (n=134, 63%) identified providing information to individuals or groups as the health promotion activities incorporated into their area of practice. Some of the topics listed under providing information were smoking, nutrition, exercise, wellness, self esteem, discharge information, parenting, breastfeeding, prenatal education, dental health, breast self examination, and injury prevention. Professional development was listed by 27 staff (13%), followed by provide services (n=18, 18%). Only 7 (3%) identified community development as a health promotion activity, and none of these were physicians or professionals who comprised the third group.

Barriers to Health Promotion

Respondents were asked to identify what, if any, were the barriers to health promotion in their area of work. Again 54 staff (25%) did not respond to this question and 3 (1%) indicated that there were no barriers to health promotion. Five themes were generated from the responses which were lack of resources, poor communication between health workers, old attitudes about health and health promotion, lack of support from the organization and doctors, and lack of knowledge/education. The total frequency and percentage for each theme are shown in Table 11.

Table 11

Barriers to Health Promotion

Barriers	Number	Percentage
Lack of Resources (time, staff, materials,)	92	43%
Old Attitudes About Health and Health Promotion.	57	27%
Lack of Support From the Organization and Doctors.	22	10%
Lack of Knowledge/Education	15	7%
Poor Communication Between Health Workers.	13	6%
Other	29	14%
Nothing	3	1%
Not Stated	54	25%

The majority of staff (n=92, 43%) identified lack of resources such as time, staff, and materials as the barriers to health promotion in their area of work. Old attitudes about health and health promotion were identified by 57 (27%) and lack

of support from the organization and doctors was listed by 22 (10%). Interestingly only 15 (7%) identified lack of knowledge/education as a barrier.

Frequencies and percentages according to the variables of facility (hospital/ community), occupation (registered nurse, physician, other), education (diploma / certificate, baccalaureate, graduate degree or more), and geographical location (urban/rural), are shown in Appendix D. Physicians did not identify lack of knowledge/education as a barrier to health promotion.

What Is Needed To Increase Health Promotion

Question 43 asked respondents what, if any, is needed to increase health promotion activities in their area of work. The themes developed from the responses were the same as for the previous question. Barriers to health promotion were rewritten to address what was needed to increase health promotion and included the need to address the lack of resources, better communication, address old attitudes about health promotion, get more support/direction from the organization and doctors, and better training/education. Even fewer staff (n=80, 38%) responded to this question and 4 staff (2%) indicated that nothing was needed to increase health promotion activities. The total frequency and percentage for each theme are shown in Table 12.

Of the respondents who answered this question, 59 (28%) identified a need to address the lack of resources including staff, money, and time. Thirty eight staff (187) identified a need for better training/education and 32 (15%) indicated that old attitudes about health needed to be addressed. Remaining responses were to get more support from the organization and physicians (n=24, 11%) and better

communication and teamwork (n=13, 6%) were needed.

Frequencies and percentages according to the variables of facility (hospital/ community), occupation (registered nurse, physician, other), education (diploma / certificate, baccalaureate, graduate degree or more), and geographical location (urban/rural), are shown in Appendix E.

Table 12

Increase Health Promotion

Activity	Number	Percentage
Address the Lack of Resources (more time, money)	59	28%
Better Training/Education	38	18%
Address Old Attitudes about Health Promotion	32	15%
Get More Support from Organization, Physicians	24	11%
Better Communication More Teamwork Between Health Workers	13	6%
Other	18	8%
Nothing	4	2%
Not Stated	80	38%

Where Can Abilities Be Increased

The last question on the survey, question 44, provided respondents with a list of topics related to health promotion and asked them to choose and rate the areas in which they would like to increase their ability. This information is very difficult to present here as many respondents checked topics but did not rate them, while others neither checked or rated the topics. Even when comparing the topics which had the most responses it is only possible to identify the most highly rated

topic which was health impact and needs assessment.

Limitations of the Study

Sample

The study utilized health care professionals from an accessible population of staff employed within Palliser Health Authority. A random sample was not possible as the employer would not release the names of the staff comprising the professional groups, for reasons of confidentiality. Therefore the staff who responded to the questionnaire may have been predisposed to the topic of the survey. The questionnaires were distributed both by the researcher and by administrative staff and this may have influenced which staff completed the survey. Staff who heard an explanation of the purpose of the study from the researcher may have been more motivated to complete a survey than those who found a survey on their work station left by the unit supervisor. Furthermore, as indicated by question 7, over 50% of the respondents indicated they had taken courses on health promotion since graduating from their last diploma or degree program. This could be an indication that the staff who responded had more of an interest in health promotion and results cannot be generalized to the remaining population. It could also indicate that staff attach many different meanings to the term health promotion. For example, in response to the question about health promotion activities in specific work areas, professional development was identified as an activity.

As there are a variety of professional groups working within Palliser Health Authority, it was necessary to condense several of the professions into one group

which was labelled the third group of health care professionals. This group was made up of recreational therapists, physiotherapists, respiratory therapists, occupational therapists, dental workers, nutritionists, social workers, and speech language pathologists. All of these professions have commonalities in that they work in the health care field, but individual differences could not be explored when they were grouped together. Therefore the possibility exists that there may be significant differences in how, for example, dental workers and respiratory therapists perceive health promotion.

The sample was divided into three groups (nurses, physicians, and the third group of health care professionals) for the purpose of analysis, but there were variations in the size of the groups. There were 146 registered nurses (69%), 20 physicians (9%) and 47 staff (22%) in the third group. The response rate from each group was very different with 31% of the registered nurses, 20% of the physicians, and 60% of the third group of professionals completing the questionnaire. As the response rate from physicians was lower than the other two groups, it may be difficult to generalize the results for this particular group.

Many more staff worked in the hospital (n= 162, 76%) than in the community (n=51, 24%). The majority had a diploma/certificate (n=128, 60%) compared to a baccalaureate degree (n=55, 26%) and a graduate degree or higher (n=30, 14%). This variation is also reflected in the population as well.

Instrument

The questionnaire was designed from information found in the literature.

There may have been some variation in the interpretation of some of the terms used in the instrument, as terms were not defined.

Questions 41, 42, and 43 were open-ended questions asking about health promotion activities practised, barriers to health promotion, and what is needed to increase health promotion activities. Approximately one quarter of the staff did not answers these questions, and some staff provided multiple responses, making interpretation difficult. Question 44 provided staff with a list of topics related to health promotion and then asked them to choose and rank the areas in which they would like to increase their ability. Not only did many staff not answer this question, but many checked then did not rank their answer, making interpretation impossible. Again a large percentage (n=80, 38%) did not respond to this question.

CHAPTER FIVE

DISCUSSION

This chapter presents a discussion of the study, possibilities for further study, recommendations for further education and training, and some conclusions.

Discussion of the Findings

The purpose of the study was to determine the perceptions of health care professionals relating to health promotion. The literature describes the three predominant approaches to health as medical, behavioural, and socio-environmental. The medical approach is disease-based and actions involve treating symptoms, eliminating illness, and/or preventing conditions from becoming worse. The behavioural approach is concerned with promoting healthy behaviours, starting early in the life cycle to prevent illness. The socio-environmental approach attempts to create social and physical environments that nurture individual health and wellness. In this last approach, actions are community based and not restricted to health professionals (Labonte 1987). Although there may be a common theme of improving health throughout, there are significant variations in emphasis and philosophy for each of the above approaches. Health promotion as a concept has

evolved over the past 20 years from an early focus on lifestyle and individual behaviour to one which is now largely concerned with social change. This study did not provide for an in-depth analysis of the meaning of health promotion among Palliser Health Authority staff. The purpose was to gain an understanding of the staff's general knowledge of the principles of health promotion as described in the recent literature. It was assumed differences in the perceptions of staff existed based on facility, profession, education, and geographical location.

The results of the analysis suggest some notable differences in perceptions of health promotion among the three different groups of health care professionals, especially regarding the category of importance of health promotion. Differences were found to be statistically significant when the variables of facility (hospital/ community), profession (registered nurse, physician, other), education (diploma, baccalaureate, masters or more), and geographical location (rural/urban) were examined. Staff working in the community were more likely to agree with the items regarding importance of health promotion, knowledge of determinants of health, principles of health promotion, and present skill and knowledge than were staff working in the hospital. On the variable of profession, physicians consistently agreed the least when comparisons were made between registered nurses, physicians, and the third group of health care professionals. Finally, it was usually staff who had a baccalaureate degree, rather than those with a diploma/certificate or masters degree or more who were in the most agreement on the variable of education. These findings are discussed in the following paragraphs.

Importance of Health Promotion

Whyte and Berland (1993), in their study on the role of hospital nurses in health promotion, found that 93 per cent of the participants agreed that health promotion was an important part of their role. The majority of health care professionals working within Palliser Health Authority (94%) also acknowledged the importance of health promotion. However, analysis of the questionnaires showed that the perceptions of the importance of health promotion differed significantly among the various groups. Staff working in the community consistently demonstrated more agreement with the items in the category pertaining to importance of health promotion than those working in the hospital. When the variable of education was examined, staff with a baccalaureate degree generally agreed the most with the items. Many of the staff working in the community have baccalaureate degrees as this is a prerequisite for working in public health. Although a degree is not a prerequisite for working in home care, it is certainly preferred. Consequently many of these nurses would also have a baccalaureate degree.

As discussed by Hanchett (1989), planning by public health nursing focuses on individuals, families, and on the health and wellbeing of the community itself. Since public health nurses have been involved with population-centered practice and work with individuals who are well, they may be more familiar with and supportive of health promotion. Staff in the hospital are working with patients who may be very ill and dependent upon them for their care. Much of their work involves

reducing the effects or the risks of disease. Brubaker (1983) believes health promotion cannot be practised until a stable state of health without active disease has been achieved. If staff also agree with this concept, it could explain the findings that staff working in the community agreed consistently more with the statements concerning the importance of health promotion than those working in the hospital.

Physicians consistently showed the least agreement of the three professional groups. Staff who had a masters degree or more on the variable of education also consistently agreed the least with the items pertaining to importance of health promotion. All of the physicians would be in the group having a masters degree or more. This would seem to support the findings of Coulter and Schofield (1991) who found that despite enthusiasm for their role in preventive health care, general practitioners have not yet embraced the model of prevention which is being encouraged. The focus of physicians continues to be on the treatment of disease.

Staff having a diploma/certificate agreed the most with the items stating "Everything I do at the worksite can be considered health promotion" and "My knowledge of health promotion primarily comes from my work experience". Staff having a diploma/certificate would make up the majority of staff working in the hospital, and include many working in home care. Both of these settings are concerned with the treatment of illness. Although home care nurses work in the community, their responsibilities are similar to staff working in the hospital. The researcher suggests this finding may indicate a perception by staff in these areas that health promotion is related to a medical approach to health promotion where

disease is the focus.

Only slightly more than half of the staff agree that their workplace models health promotion and 26% were uncertain. Staff in the community agreed more that their workplace modelled health promotion. This finding needs to be explored further to determine why a large number of staff do not feel that their workplace reflects health promotion. The majority agreed that learning more about health promotion would help them when working with patient/clients but the process and philosophy of health promotion must be incorporated into policies and decisions affecting staff as well as patients/clients. If staff do not believe their work environment models or promotes, how does this affect their ability to effectively promote health among patients/clients?

Knowledge of Determinants of Health

Down (1990) believes that the effectiveness of education is clear only when pertaining to acute medical situations. Concerning chronic conditions requiring long term lifestyle change, she indicates that information alone is not enough. Many staff appear to understand that information alone is not enough as less than half agreed people will change their behaviour if they have accurate information. However, the majority of staff agreed that people can change their behaviour if they have accurate information. These apparently contradictory perceptions need to be explored further. Do health care professionals perceive clients/patients as unable to understand or comply with information provided? Is the manner in which the information is conveyed a factor?

Over half of the staff agreed that individuals have control over their health. This would indicate a lack of understanding of the social and economic factors impacting on health. Yet 70% agreed that income and social status were important determinants of health. This could be interpreted to mean that staff believe people have control over the choices they make, including the ones affecting income and social status. This lack of understanding of the broad determinants of health was again reflected in the question asking whether health professionals are the most appropriate persons to do health promotion. Slightly more then half of the staff agreed that health professionals were the most appropriate persons. Do health care professionals perceive that since health promotion concerns health, they have the expertise? An understanding of the broad determinants of health as outlined by the Premier's Council on Health, Well-being and Social Justice (1993) should reflect that health professionals are only one of many who should be involved with health promotion. The health sector cannot act alone because most of the determinants of health such as income and social status, social support networks, education, employment and working conditions and physical environment, fall outside its realm. Intersectoral planning is needed to address these types of issues.

Few of the staff agreed that health promotion and disease prevention mean the same thing. This was surprising in view of the literature linking the two together. Perhaps it is as Brubaker (1983) suggests; since the terms health promotion and disease prevention are both included in statements about improving the health of the population, staff do not see them as synonymous. This however does not mean

that staff can clearly differentiate between the two terms. Staff with a diploma/ certificate agreed the most strongly that health promotion and disease prevention mean the same. The majority of staff with these qualifications are working in the hospital and in home care where the focus is more on disease and treatment rather than in the community where the focus is on wellness.

Approximately half of the staff disagreed that health promotion and health education mean the same, and 25% were uncertain. Again this was surprising because of the literature linking the two. It suggests that staff perceive health promotion to mean more than the provision of information or handing out of pamphlets. Those having a diploma/certificate were again found to agree the most that health promotion and health education were the same.

Although the majority of staff do not agree that health promotion and health education are the same, when asked to list some of the health promotion activities incorporated into their area of practice, 134 staff (63%) stated they provide information to individuals or groups. Therefore, the question arises whether staff understand the difference, but only have opportunities to incorporate health education which as Gott and O'Brien (1990) note, is not the same as, but is part of, health promotion.

Knowledge of Principles of Health Promotion

Health promotion is defined as " the process of enabling people to increase control over, and to improve their health (World Health Organization, 1986). The majority of questions in this category pertained to empowerment or control. Many staff agreed with the question stating "Professionals assume a leadership role when

working with communities". Labonte (1995) believes that health promotion rejects professional dominance and seeks instead to create equal partnerships. It was interesting to note that the only significant difference in the questionnaire regarding the variable of geographical location was located in the above question. In rural areas hospitals are viewed as an integral part of the community. Health care professionals are usually very visible in rural communities. These factors may help to explain why staff in the rural areas agreed more than staff in the urban areas that professionals assume a leadership role when working with communities. The majority of staff agreed that the purpose of health promotion is to strengthen peoples control over their health and that one of the core elements of health promotion is empowerment. Yet only 25% agreed that the task of defining health problems and needs primarily belongs to those experiencing the problem or need. When researching the attitudes, beliefs and practices of hospital nurses, McBride (1994) also found evidence of a controlling relationship with patients even though nurses defined their health promotion role as one based on the empowerment of patients.

What then does empowerment mean to professionals? Skelton (1993) facetiously characterized it as "about getting you to come round to a way of behaving that I, the expert, knew in advance was good for you, whilst encouraging you to think that changing your behaviour was your idea in the first place" (p.417). Or it could be a matter of understanding the principles and not willing to give up control. Skelton (1993) believes that existing powerful groups are not readily going

to hand over resource, information or the responsibility to make decisions to the less powerful without incentives to do so. On a less cynical note, these findings may reflect that staff in the hospital are working with ill patients who they may believe are not well enough during the acute phase of their illness to identify their needs.

Many staff also indicated that they were uncertain that a core element of health promotion is personal skill development. However, on this question the other group of health care providers agreed the most that this was in fact the case. The reasons for this remain unclear. The development of personal skills was one of the key strategies outlined by the Ottawa Charter for Health Promotion in 1986 as part of the action for health promotion.

Finally, 37% of staff were uncertain that the focus of health promotion is social change. As well, many staff either agreed or were uncertain that health professionals can change peoples' lifestyles. This indicates that many staff believe health promotion is linked to the medical or behavioural approach. The third group of health care professionals agreed the most that the focus of health promotion is social change; physicians agreed the least. Physicians agreed the most that health professionals can change peoples' lifestyles. This is not surprising as it would be expected that most physicians follow the medical approach.

Skills and Knowledge

Seventy four percent of staff agreed they were skilled at implementing health promotion and that they have a clear understanding of what health promotion means. However the research findings indicate that there are many staff who are

not knowledgeable about the determinants of health or the principles of health promotion. Staff may believe they are skilled at what they personally perceive to be health promotion, but it is arguable that the concepts of health promotion should and must be consistent throughout Palliser Health Authority. Information which is not consistent, may become contradictory, thus creating problems rather than solutions.

While a major component of current health care reform is the emphasis on accountability, only 25% of staff agreed they are skilled at evaluating health promotion programs/activities. It has always been necessary to evaluate programming, but the challenge is to develop effective process and outcome measurement for health promotion programs.

Staff having a baccalaureate degree agreed the most with the statements asking about ability to advocate for a healthy workplace and a healthy community. Perhaps this again indicates familiarity with the health of individuals, groups, and the community as a result of their work or education.

Open-ended Questions

Question 41 attempted to further clarify staffs' perceptions of health promotion by asking about health promotion activities in specific areas of practice. The activity that was listed the most often was that of providing information to individuals or groups. This seems to indicate that the medical model, where the professional is the expert, is still very predominant. Another activity that was rated quite high was professional development. This needs to be explored further to

determine what is meant by professional development and how it relates to health promotion. Community development was described by very few staff. However, the importance of community development lies in its potential to address the socio-economic factors which impact on health. The findings correlate with that of Gott and O'Brien (1990) who found that nurses' health promotion activities were individual and lifestyle-focused with few opportunities to contribute to health promotion at the community or societal level. They also support the findings of the study done by the Canadian Hospital Association (cited in Ashdown, 1990) which identified health promotion activities conducted in hospitals as programs to teach patients about risks associated with lifestyle behaviours.

Both staff participating in this research project and the study conducted by Whyte and Berland (1993) identified lack of time as a barrier to health promotion. If health promotion is to be viewed as a process and philosophy rather than a program, then the means of incorporating it into everyday duties must be explored. Staff appeared to be receptive to a new way of thinking as they identified old attitudes about health and health promotion and lack of knowledge/education as barriers to health promotion. Lack of support from the organization and from physicians was also identified as a barrier to health promotion. This response requires further clarification to determine why there is a perception of lack of support. How does this correlate with the perceived lack of communication between health care workers which was also identified as a barrier? What, specifically, do staff require/desire in terms of support?

When asked what was needed to increase health promotion activities in their areas of work, staff rephrased the responses they gave in response to the question pertaining to barriers to health promotion. They identified that lack of resources needed to be addressed as well as old attitudes about health promotion. Staff required better training/education, more support from the organization and physicians, and better communication and teamwork between health workers.

For the second to last question, a list of topics identified in the document Health Promotion: Training and Support by the Ontario Prevention Clearing House (1994) as skills required for the practice of health promotion were listed. Respondents were then asked to check and rate their responses. Because many staff did not respond to this question, while others checked but did not rate their responses, results were very difficult to interpret. Twelve categories were possibly too many to rate, perhaps fewer categories should have been provided, or respondents asked to just check applicable categories.

Possibilities For Further Study

This study was conducted in order to determine the perceptions of various health care professionals pertaining to health promotion. Some colleagues believe that very little health promotion can occur in the acute care setting; that it is only something that happens in the community. I understand health promotion to be an orientation and a process, not a specific program. Therefore, all health care professionals have a role to play in health promotion. I do agree that the practice

of health promotion will vary according to health care setting. Staff working with very ill patients in the hospital for example, may have little opportunity to work with communities to address social and economic factors which impact on health. They can, however, reflect principles of health promotion by involving patients in decisions concerning their care and they can look at quality of life issues. The role of all health care professionals needs to be explored further, in order to understand how health promotion can be incorporated into the various levels of care and work settings within the Palliser Health Authority.

The staff working in Palliser Health Authority have observed many changes since regionalization, and their thoughts and feelings need to be acknowledged. During the process of conducting the survey, my knowledge of staff and the health services provided within our region certainly increased. When travelling to the various facilities to distribute the questionnaire, I had the opportunity to meet with a variety of staff. I developed a great respect for the staff from the rural areas who must now travel up to two hours to Medicine Hat for meetings because of regionalization. I was able to discuss the differences between nursing in larger hospitals and small rural hospitals with the staff in both of these areas. Support services are not available in smaller hospitals and nurses must be prepared for a wide range of medical emergencies. These nurses expressed concern that their counterparts in larger centres do not always understand their situation. I gained a new understanding of the pride staff have in small rural hospitals and the fear that they will be closed because they are not believed to be cost effective. Concerns

expressed in the large regional hospital were about the level of acuity of the patients now being cared for. The units are filled to capacity with very sick people but as positions have been eliminated, there are fewer staff to take care of them. Consequently the stress level among some staff is very high. Staff working in the community expressed concern that because their numbers are small, they would lose their identity and be taken over by the larger hospitals.

We have heard many discussions pertaining to health care reform over the past three years. Many would argue that what is occurring is not health care reform but simply health care restructuring. The results of the study indicate that many staff are uncertain about the philosophy behind health promotion and do not believe they have support for this new direction in health care. Results also indicate that they are very much aware that one of the barriers to health promotion is old attitudes about health.

In my view, staff are very receptive to learning more about health promotion but learning must be based on their knowledge and experience, and the needs at their specific work site. Discussions about the concept of health promotion including the determinants of health and principles of health promotion must occur at all levels of staff. Some suggestions for follow up to this study include:

1) The meaning of health promotion as well as staffs' attitudes about health promotion need to be explored further. The meaning of health promotion and its relation to disease prevention needs to be discussed. Many staff agreed that health promotion and disease prevention were not the same but do they

have a clear understanding of the meaning of both terms? Common definitions should be developed for use within the region. Focus group discussions may be a feasible mechanism to facilitate such dialogue.

2) Health promotion needs to begin at the staff level. Staff should be provided with opportunities to talk about the changes they have experienced over the past three years and how health care reform has affected them.

3) Wellness at the worksite needs to be explored further with staff. Why do staff feel that their workplaces does not model health promotion?

4) Old attitudes about health need to be explored at both the staff and the community level. How can staff and community contribute more to the strategies for health promotion?

5) The type of education and training required by staff needs to be explored in greater detail.

If Palliser Health Authority is committed to moving the focus of the health care system from an emphasis on disease to one with an emphasis on health and wellness, it needs to begin with education and support for staff as identified in this study. If staff are to promote health and wellness among patients/clients, families, and the community; they must perceive their workplace to be a health promoting environment. The definition of health promotion must be consistent throughout the region as the definition will influence the scope of programs and policies that are put into place. Otherwise we will speak the words about this new and emerging orientation called health promotion, but action will continue to be missing.

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APPENDIX A

COVER LETTER AND QUESTIONNAIRE

January, 1996

Dear Colleague:

The term "health promotion" is used frequently when discussing changes needed to be made to the Health Care System in order to improve the health of populations. I am conducting a study of various health care professionals working in the community and in the hospital to gain an understanding of your perceptions relating to health promotion.

I know you are busy, but invite you to participate in this research study by completing the attached questionnaire. You may refuse to participate simply by not completing the supplied questionnaire.

In this study you will be asked questions pertaining to factors affecting health, principles of health promotion, importance of health promotion, and your present skills and knowledge in the area. Perceptions will then be identified according to these categories. You will also be asked if there are barriers to health promotion activities at your work site and what your needs are in regards to further education, training, and support. The information will be used to develop educational programs as well as identify the type of support needed at all levels in the Palliser Health Authority.

Individual responses will be kept confidential and the information on the questionnaires will be analysed according to professional grouping only. Individual participants will remain anonymous. If you would like a copy of the results following completion of the study, please contact me.

The results of this study will become part of a Master of Education Thesis. Any questions regarding the study should be directed to me or to the following people from the Faculty of Education, University of Lethbridge, 4401 University Drive, Lethbridge, Alberta, T1K 3M4.

Dr. Kas Mazurek (Thesis Supervisor) Phone: 329-2462
Dr. Peter Chow (Chairperson, Human Subjects Research Committee) Phone: 329-2443

PLEASE RETURN THE QUESTIONNAIRE IN THE SELF-ADDRESSED ENVELOPE PROVIDED, (Terry Frey, Community Development And Health Promotion, Palliser Health Authority), **NO LATER THAN FEBRUARY 01, 1996.**

Thank you very much for completing the survey.

Sincerely,

Kathy Farrell
Regional Coordinator, Health Promotion, (M.Ed. Candidate)

HEALTH PROMOTION QUESTIONNAIRE

Please circle one answer for the following questions.

1. What is your occupation?

   1) physiotherapist
   2) occupational therapist
   3) recreational therapist
   4) speech-language pathologist
   5) respiratory therapist
   6) nutritionist/dietician
   7) registered nurse
   8) social worker
   9) dental hygienist/ assistant
   10) physician
   11) other (please specify: _____)

2. Where do you work the most frequently?

   1) acute care
   2) public health
   3) home care
   4) long term care
   5) other
   (Please specify _____)

3. What is your position?

   1) staff
   2) team leader / supervisor
   3) manager / director
   4) other (please specify _____)

4. What is your highest level of education?

   1) professional diploma
   2) post diploma certificate
   3) baccalaureate degree
   4) master's degree
   5) doctorate
   6) other (please specify _____)

5. How many full time equivalent years have you worked in health care?

   _____ years

6. When was the last time you attended any educational in service pertaining to your work area?

   1) within the last three months
   2) within the last four to six months
   3) within the last seven months to one year
   4) over one year ago

7) Have you taken courses on health promotion since graduating from your last diploma or degree program?

   Yes ____ No ____

Please circle the number that indicates your response to the following questions.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
8. Health promotion is an important part of my job.	1	2	3	4	5
9. I am skilled at implementing health promotion concepts.	1	2	3	4	5
10. People can change their behaviour if they have accurate information.	1	2	3	4	5
11. Professionals assume a leadership role when working with communities.	1	2	3	4	5
12. Everything I do at my work site can be considered health promotion.	1	2	3	4	5
13. I have the ability to advocate for a healthy workplace.	1	2	3	4	5
14. People are primarily responsible for solving their own problems.	1	2	3	4	5
15. I have a clear understanding of what health promotion means.	1	2	3	4	5
16. I always incorporate health promotion activities into my practice.	1	2	3	4	5
17. Health promotion and disease prevention mean the same.	1	2	3	4	5
18. My workplace supports my efforts in health promotion.	1	2	3	4	5
19. I model a healthy lifestyle for my patients/ clients.	1	2	3	4	5
20. The purpose of health promotion is to strengthen people's control over their health.	1	2	3	4	5
21. The task of defining health problems and needs primarily belongs to those experiencing the problem or need.	1	2	3	4	5
22. Income and social status are important determinants of health.	1	2	3	4	5

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
23. Health professionals are the most appropriate persons to do health promotion.	1	2	3	4	5
24. My knowledge of health promotion primarily comes from my work experience.	1	2	3	4	5
25. People will change their behaviour if they have accurate information.	1	2	3	4	5
26. Health information is readily available for patients/clients where I work.	1	2	3	4	5
27. The focus of health promotion is individual change.	1	2	3	4	5
28. One of the core elements of health promotion is empowerment.	1	2	3	4	5
29. My workplace models health promotion.	1	2	3	4	5
30. Health education and health promotion mean the same.	1	2	3	4	5
31. A formal background in health is necessary to be involved in health promotion.	1	2	3	4	5
32. I have easy access at my work site to updated resources on health related topics that help me in my health promotion efforts.	1	2	3	4	5
33. Health promotion primarily involves working with groups of individuals only.	1	2	3	4	5
34. Learning more about health promotion will help me when working with patients \ clients.	1	2	3	4	5
35. Individuals have control over their health.	1	2	3	4	5
36. One of the core elements of health promotion is personal skill development.	1	2	3	4	5
37. The focus of health promotion is social change.	1	2	3	4	5

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
38. I am skilled at evaluating health promotion programs/activities.	1	2	3	4	5
39. Health professionals can change people's lifestyles.	1	2	3	4	5
40. I have the ability to advocate for a healthy community.	1	2	3	4	5

41. Please list some of the health promotion activities incorporated into your area of practice.

_____

_____

_____

42. What if any, are the barriers to health promotion in your area of work?

_____

_____

_____

43. What if anything is needed to increase health promotion activities in your area of work?

_____

_____

_____

44. The following is a list of topics related to health promotion. Please choose and rank the areas in which you would like to increase your ability.

___ Self-Assertion	___ Community Analysis	___ Social Marketing
___ Conflict Resolution	___ Policy and Program	___ Community Development
___ Collaboration	Planning	___ Health Impact and Needs
___ Communication	___ Evaluation	Assessment
___ Facilitation	___ Research	___ Other: _____

45. Is there anything else on which you would like to comment?

_____

_____

_____

_____

THANK YOU VERY MUCH FOR COMPLETING THE QUESTIONNAIRE. PLEASE ACCEPT THIS TEA BAG IN APPRECIATION FOR YOUR TIME.

APPENDIX B

TEN QUESTIONS FROM THE ROLE OF

HOSPITAL NURSES IN HEALTH PROMOTION

Questions adapted or taken from "The Role of the Hospital Nurse In Health Promotion":

8. There is easy access to up-dated resources on health-related topics that help me in my health promotion efforts.
14. My hospital is supportive of health promotion activities.
22. I generally model healthful lifestyles for my patients
28. Health promotion is an important part of my role.
43. Learning more about health promotion will help me provide better patient care.
44. My experience as a nurse has taught me about health promotion.
46. Since graduation I have taken courses on health promotion.
47. I am satisfied with my skills in health promotion.
50. Health promotion is an "everyday thing" for nurses.
51. I have the ability to advocate for a healthy hospital.
52. I have the ability to advocate for a healthy community.

APPENDIX C

QUESTION 41

Question 41: Please list some of the health promotion activities incorporated into your area of practice.

	FACILITY				OCCUPATION						EDUCATION						URBAN			
	Hospital		Community		R. N.		Physician		Third		Dip. Cert.		Baccalaureate		Post-Graduate		Urban		Rural	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Provide information to individuals or groups	64	103	61	31	60	87	50	10	79	37	63	80	67	37	57	17	59	107	82	27
Community Development	2	3	8	4	5	7	0	0	0	0	2	3	7	4	0	0	3	5	6	2
Professional Development	12	20	14	7	13	19	0	0	17	8	10	13	24	13	3	1	13	27	9	3
Provide Services	4	7	22	11	9	13	10	2	6	3	7	9	5	3	20	6	9	16	6	2
Other	7	11	6	3	7	10	10	2	4	2	5	7	7	4	10	2	8	13	3	1
Nothing	2	4	0	0	2	3	0	0	2	1	2	3	0	0	3	1	2	3	3	1
Not Stated	26	42	24	12	27	40	35	7	15	7	28	36	18	10	27	8	27	49	15	5
TOTAL:	100	162	100	51	100	146	100	20	100	47	100	128	100	55	100	30	100	180	100	33

APPENDIX D

QUESTION 42

Question 42: What, if any, are the barriers to health promotion in your area of work?

	FACILITY				OCCUPATION						EDUCATION						URBAN			
	Hospital		Community		R. N.		Physician		Third		Dip. Cert.		Baccalaureate		Post-Graduate		Urban		Rural	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Lack of Resources (time, staff, materials, etc.)	41	67	49	25	45	66	15	3	49	23	41	52	58	32	27	8	44	79	39	13
Poor Communication between Health Workers	6	9	8	4	7	10	5	1	4	2	5	7	7	4	7	2	4	8	15	5
Old Attitudes About Health and Health Promotion	30	48	18	9	19	28	40	8	45	21	21	27	31	17	43	13	28	50	21	7
Lack of Support from Organization and Doctors	12	19	6	3	12	17	5	1	9	4	9	12	16	9	3	1	11	20	6	2
Lack of Knowledge/ Education	7	11	8	4	7	10	0	0	11	5	4	5	13	7	10	3	6	10	15	5
Other	15	24	10	5	12	18	15	3	17	8	14	18	15	8	10	3	13	24	15	5
Nothing	1	2	2	1	1	2	5	1	0	0	1	1	0	0	7	2	2	3	0	0
Not Stated	24	39	29	15	26	38	35	7	19	9	32	41	11	6	23	7	27	48	18	6
TOTAL:	100	162	100	51	100	146	100	20	100	47	100	128	100	55	100	30	100	180	100	33

APPENDIX E

QUESTION 43

Question 43: What, if any, is needed to increase health promotion activities in your area of work?

	FACILITY				OCCUPATION						EDUCATION						URBAN			
	Hospital		Community		R. N.		Physician		Third		Dip. Cert.		Baccalaureate		Post-Graduate		Urban		Rural	
	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Address the Lack of Resources (More Time, Money, etc.)	25	41	35	18	27	39	15	3	36	17	26	33	40	22	13	4	28	50	27	9
Better Communication - More Teamwork Between Health Workers	5	8	10	5	6	9	0	0	9	4	4	5	9	5	10	3	7	12	3	1
Address Old Attitudes About Health Promotion	15	25	14	7	12	18	20	4	21	10	13	16	16	9	23	7	14	26	18	6
Get More Support/ Direction From Organization and Doctors	12	19	10	5	10	15	10	2	15	7	10	13	9	5	20	6	11	20	12	4
Better Training/ Education	16	26	24	12	21	31	0	0	15	7	16	20	31	17	3	1	16	28	30	10
Other	9	14	8	4	8	11	10	2	11	5	6	8	13	7	10	3	9	16	6	2
Nothing	2	3	2	1	2	3	5	1	0	0	2	3	0	0	3	1	2	3	3	1
Not Stated	40	64	31	16	40	58	45	9	28	13	45	57	20	11	40	12	41	73	21	7
TOTAL:	100	162	100	51	100	146	100	20	100	47	100	128	100	55	100	30	100	180	100	33

APPENDIX F

ETHICS COMMITTEE APPROVAL

FACULTY OF EDUCATION
HUMAN SUBJECT RESEARCH CHECKLIST

Title of Study: Health Care Professionals' Perception of Health Promotion

Principal Investigator: Kathy Farrell

Instructor (if student): Dr. Kas Mazurek (Committee Member)

1. The proposal contains a clear statement of the nature, intent and duration of the research. ☑
2. The proposal includes adequate information about instrumentation and/or testing procedures to be used. ☑
3. Participants have been apprised of their rights to inquire about the research. ☑
4. If necessary, participants can direct inquiries to a resource person outside the research group. ☑
5. Provision has been made for obtaining the informed consent of all participants, or their parents or guardians (Unless otherwise stated, this should be in writing). ☑
6. There will be no coercion, constraints or undue inducement. ☑
7. All participants and/or their parents or guardians have been informed of their right to withdraw without prejudice at any time. ☑
8. Provision has been made to inform participants of the degree of confidentiality that will be maintained in the study. ☑
9. In cases where participants have essential information withheld and/or are intentionally mislead as part of the research procedure the proposal clearly explains the reason for this. ☐ N/A
10. The research being proposed is not potentially threatening or harmful to any participant. ☑

Committee Decision: ☑ Approve Date: Dec. 12 95

☐ Resubmit Date: _____

Signature of Chairperson: Peter Chow