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University of Alberta

A Qualitative Evaluation of the Seniors ALIVE Program

by

Rosanne Marie Buijs

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of Master of Science

Centre for Health Promotion Studies

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *A Qualitative Evaluation of the Seniors ALIVE Program* submitted by Rosanne Marie Buijs in partial fulfilment of the requirements for the degree of Master of Science.

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Date approved by Thesis Committee

Abstract

This study used interviews with four informant groups to qualitatively evaluate the Seniors ALIVE Program. This was a ten month health promotion program for low income seniors. A combination of exercise classes, health corners and newsletters was offered in the seniors' own apartment buildings. The purpose of the study was to discover program impacts, factors influencing participation and to clarify the links between program interventions and impacts by exploring the experiences of program participants.

Strong staff-participant relationships, participants feeling comfortable in the program, along with encouragement of participant autonomy, fun, and social interactions were all important mechanisms of program function. How the program related to the determinants of health and contributed to successful aging is explored. Factors found to influence program participation supported Pender's (1996) Revised Health Promotion Model. The most common impact identified by participants was "feeling better". Program goals of increasing participant independence and quality of life were realized.

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Chapter One: Introduction

Introduction

Can individuals exert personal control over their own health? Although not all of the determinants of health are amenable to personal control, personal health practices are among the determinants of health that individuals are able to influence. McKenzie and Smeltzer (1997) note that the underlying assumption of health promotion programs is that positive changes in health status can occur through the adoption of healthy behaviours and lifestyles. In fact, Rootman and Goodstadt (1996) indicate that there is substantial research evidence that health promotion does contribute to improved health.

Health promoting behaviours are practised individually but they can be taught and encouraged in formal health promotion programs. These programs usually have one or more pre-planned, purposeful activities, referred to as interventions, that are designed to improve the health of program participants. FallCreek, Warner-Reitz, and Mettler (1986) note that health promotion programs should be based on a needs assessment of the target population and should include such elements as goals, objectives, a curriculum, and a budget. This thesis is a qualitative evaluation of a health promotion program for seniors, the Seniors ALIVE Program. This was a program to promote Active Living In Vulnerable Elders (ALIVE).

Purpose

The purpose of this study is to discover how the Seniors ALIVE Program impacted program participants and to understand how and why these impacts occurred. The evaluation will assess program effectiveness by looking at process and short term

outcomes. Swanson and Chapman (1994) note that most program evaluation research has studied only program outcome measures. The clarification of the links between program inputs or interventions and program outputs or impacts is an area of program evaluation that still remains to be explored (Stachtchenko & Jenicek, 1990; Swanson & Chapman, 1994). These links have been called program causal processes or mechanisms (Stachtchenko & Jenicek, 1990). An understanding of these links should answer the questions of how and why a program works. This relatively unknown and as yet mysterious area where these links occur has been called a "black box"(Swanson & Chapman, 1994). The relationship of this "black box" to the rest of the Seniors ALIVE Program is illustrated in Figure 1.1. This qualitative evaluation will attempt to explain what happened in the "back box" of the Seniors ALIVE Program by clarifying the links between program inputs and program outputs.

Research Questions

The following are the research questions guiding this study:

1. How did the Seniors ALIVE Program work? What worked well and what did not? Why?
2. What influenced seniors' participation in the Seniors ALIVE Program?
3. How did the Seniors ALIVE Program impact the seniors who attended?
4. Did the Seniors ALIVE Program contribute to independence and quality of life for seniors? If so, how?

Objectives

1. To explore the experiences of participants in the Seniors ALIVE Program.
2. To determine factors influencing participation in the Seniors ALIVE Program.
3. To determine the impact of the Seniors ALIVE Program on program participants including independence and quality of life.
4. To provide a qualitative evaluation that can be used to enrich the quantitative evaluation of the Seniors ALIVE Program.

Background

Seniors are an important target population for health promotion research. This population is expected to increase in both numbers and in age over the next forty years (Statistics Canada, 1997). Since seniors are more likely to have health problems than any other age group (Penning & Chappell, 1993), it is anticipated that there will be more seniors coping with poor health and as a result making increasing demands on the health care system. As the numbers and age of seniors increase, it is becoming more and more urgent to find ways to maintain or improve their health. If this can be done, seniors' independence and quality of life may be maintained, and the anticipated strain on health care utilization and funding could be relieved.

Establishing healthy aging as a priority was a key recommendation of the "Broda Report", a report that reviewed long term care in Alberta (Alberta Health & Wellness, 1999). In this report the vision of future long-term health care in Alberta includes a lifelong focus on effective strategies to stay healthy and to live independently. Both the

Society for the Retired and Semi-Retired and the Seniors Advisory Council of Alberta had identified a need for health promotion programs targeting well seniors (Seniors Advisory Council for Alberta, 1992; Society for the Retired and Semi-Retired, 1992). The Seniors ALIVE Program illustrates the vision and recommendations of the "Broda Report" report and filled an identified need for a seniors' health promotion program.

The Seniors Research Study

The Seniors ALIVE Program was part of the third phase of a long term seniors research study. The different phases of the research study are outlined in Table 1.1. The first phase was a study of health status, attitudes, and health promotion practices of seniors living in subsidized housing. From this initial study, two models of health promotion were developed and used to develop a health promotion program. The second phase was a pilot study to evaluate the health promotion program developed from the first phase. The third phase was a randomized controlled trial to test a second health promotion program, called the Seniors ALIVE Program that was developed from the pilot study of the second phase.

The Seniors ALIVE Program

The Senors ALIVE Program was the second health promotion program developed from the long term seniors research study described earlier in this chapter. The goal of this ten-month program was to promote independent living and to enhance quality of life for seniors. Seniors living in subsidized housing were the target population. The majority of program participants were women living alone. Females are particularly at risk for poor health because there are more females than males in the lower socioeconomic

class and in older age groups. The program was offered in seniors' own apartment buildings. Most of the staff delivering this program were supervised senior university students from the health professions of pharmacy, nutrition, nursing, and physical education. The combination of exercise classes, health corners and newsletters provided three interventions in one program. Rootman and Goodstadt (1996) have noted that when more than one health promotion approach is used, more substantial outcomes are likely to be reached than if only one approach is used. Figure 1.1 is a diagram showing the three Seniors ALIVE interventions, the "black box"and the expected outcomes of the program.

Table 1.1

The Seniors Research Study

Phase of Research Study	**Content of Phase**	**Result of Phase**
Phase 1	Study of Health Status Attitudes Health Practices	2 Models of Health Promotion Development of Health Promotion Program # 1
Phase 2	Pilot Study of Health Promotion Program #1	Development of Health Promotion Program #2 - **The Seniors ALIVE Program**
Phase 3	Randomized Controlled Trial of Health Promotion Program #2 - The Seniors ALIVE Program	Quantitative Evaluation of The Seniors ALIVE Program **Qualitative Evaluation of the Seniors ALIVE Program**

The exercise class. The exercise class was a one hour weight training program offered twice a week. The classes were usually held in a common room in the apartment building. The leader described and modelled all the exercises. Staff leading exercise classes were largely senior undergraduate physical education and nursing students. All staff were instructed and supervised by the study coordinator who had attended a Fit for Your Life workshop. The program, based on the Fit for Your Life strategies, included a warm up, strength training for all major muscle groups, brief cardiovascular exercise, and a cool down. One to three pound hand-held weights and resistance bands were used for the strength training. There was an emphasis on all participants working at their own individual pace. At each of the seven sites, the program was adapted as required to accommodate the needs of each particular group of participants as well as the needs of individual participants.

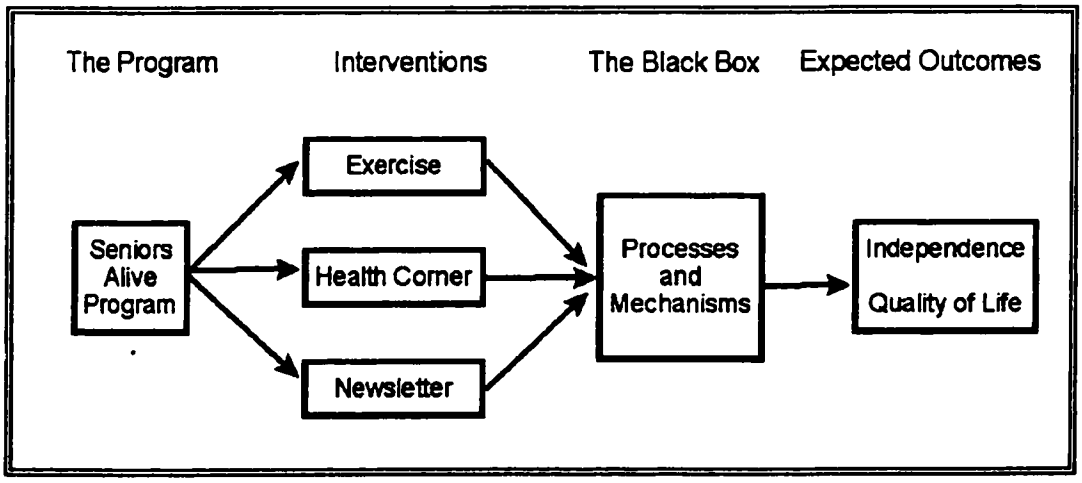

Figure 1.1 Seniors ALIVE Program.

The health corner. A second intervention was a two-hour weekly or biweekly drop-in health corner offering an opportunity for individual health consultation with a student nurse. Students were supervised by a registered nurse. Seniors could ask the nurse any health related questions and the nurse also checked their blood pressure and pulse. After each visit to the health corner seniors left with green piece of paper approximately 3 inchcs by 5 inches recording their most recent blood pressure and pulse. Health corners were usually held in a common room in the apartment building. Furniture was arranged to provide a "waiting area" and a table and chairs for the nurse and her client. Sometimes there was also a table for health related pamphlets. Participants would wait their turn to see the nurse in the "waiting area" if the nurse was busy when they arrived. On some occasions pharmacy and nutrition students were also available for consultation by the seniors.

The newsletter. The third intervention was a newsletter with sections for healthy low cost recipes, exercise information such as featuring one particular kind of stretching, various health topics, such as sleep or bladder health, and a section reminding participants of their involvement in the Seniors ALIVE Program with encouraging comments about their progress. The author of all the articles was the study coordinator. There were seven newsletters issued during the ten months of the program. They were written in English and professionally printed with a large font. A grade six or seven level reading level was used. The first issue was a two page double sided newsletter printed on high quality white paper with black ink and red ink was used for the first page headline. Subsequent issues used

black type on coloured paper. The newsletters were slipped under the apartment door of each registered program participant.

The Quantitative Evaluation. Other researchers are presently conducting a quantitative evaluation of the Seniors ALIVE Program. How this evaluation fits within the broader seniors research study is outlined in Table 1.1. Although there are plans to link the quantitative and qualitative evaluations when both are completed, at the moment they are separate, independent evaluations.

The quantitative evaluation was designed using three repeated measures with two groups: intervention and control. Seven buildings were randomized to the intervention group and eight buildings to the control group. The sample was stratified on the basis of building size. Within selected buildings, seniors were recruited through the use of information sessions and sign up lists presented at tenant meetings. At the beginning of the study there were 129 seniors in the intervention group, but 10 months later, at the end of the study, this number had decreased to 102 seniors. Outcome measures were obtained before the intervention began, at approximately four months into the program and after ten months when the intervention was completed. Figure 1.2 shows the approximate times of data collection for the quantitative and qualitative evaluations in relation to the Seniors ALIVE Program.

The data collected for analysis by the quantitative study includes:

1. Demographic data
2. Health status measurements including perceived health status, blood pressure, body mass index, and grip strength

3. Assessments of functional health, social health, and mental health
4. Quality of life and loneliness measures
5. Health care use

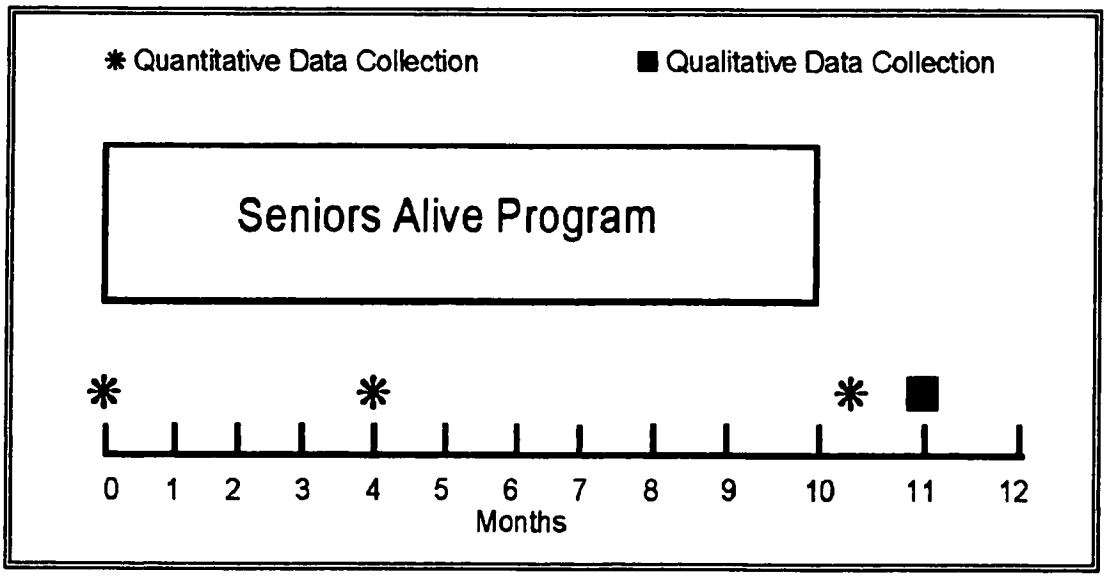

Figure 1.2 Data collection for quantitative and qualitative evaluations.

Qualitative Program Evaluation

The use of qualitative methods for this evaluation is appropriate for several reasons. First, Wister and Gutman (1994) have suggested that since gerontology and health promotion have both contributed to knowledge of health promotion for seniors their differing methodological perspectives, the one quantitative and the other qualitative, are both appropriate and needed to make gains in the knowledge of health promotion for seniors.

Second, qualitative methods are especially helpful in describing individual outcomes and evaluating prevention programs (Patton, 1990). Qualitative evaluations can

provide insight to explain how and why a program works (Swanson & Chapman, 1994). The purpose of this evaluation is both to describe individual outcomes of a prevention program and to explain how and why the Seniors ALIVE Program worked. The method of choice for both these purposes is qualitative.

Third, qualitative methods add depth and rich descriptive detail to quantitative studies. They can elaborate, clarify and identify how the various parts fit together as a whole. They are useful to add meaningful detail that helps make sense of, and interpret, quantitative results (Yoddumnern-Attig, Attig, & Boonchalaksi, 1989). Since there is already a quantitative evaluation of the Seniors ALIVE Program, a qualitative evaluation of the same program will be very useful to enhance and enrich the quantitative evaluation by providing another viewpoint of the same program.

Qualitative methods are suitable for extending knowledge in the area of health promotion for seniors. It is the method of choice for evaluating prevention programs and for understanding how and why programs work. It can also be used to elaborate and triangulate the findings of the quantitative program evaluation.

Definition of Terms

Functional health - the ability to perform the tasks of daily living, an ability not necessarily dependent on physical health.

Health promotion - "the process of enabling people to increase control over and to improve their health" (World Health Organization, 1986, p. 426). This term

includes specific strategies of disease prevention and health promotion that either increase length of life, functional independence, and /or quality of life.

Health promotion program - one or more planned, purposeful interventions designed to improve the health of participants usually presented by staff and having goals, objectives, and expected outcomes. Although some programs may have only one intervention, in this thesis, the term program will always mean that there is a combination of more than one planned, purposeful interventions designed to improve health.

Independence -the ability to manage self-care and maintain a familiar lifestyle (Seniors Directorate, 1992b).

Intervention - planned activity or set of activities to which target populations will be exposed and that lead to the achievement of program outcomes (McKenzie & Smeltzer, 1997).

Program Withdrawers - those who initially signed up for the Seniors ALIVE Program but later asked to be withdrawn from the program.

Partial Program Withdrawers - those who initially signed up for the Seniors ALIVE Program and attended both the health corner and the exercise classes. They later decided not to attend further exercise classes but continued to attend the health corners.

Quality of life - A multidimensional concept referring to overall life satisfaction and total well being including behavioural competence and psychological well-

being (Ory, Cox, Gift, & Abeles, 1994). Major factors affecting quality of life are functional independence and autonomy (Williams, 1994).

Seniors - those individuals 65 years of age and older. In this paper, the term senior is used interchangeably with the terms elderly, the aged, and older adults.

Successful aging - the adaptation level of individuals measured against a specific environment and its demands. It involves a balance between security and autonomy (Baltes, 1994).

Triangulation - the use of two or more methods to examine the same phenomenon (Morse & Field, 1995)

Summary

Poor health is costly both in human and financial terms. The number of seniors in our population is increasing. Since poor health increases with age, there is an urgent need to find ways to keep the rapidly increasing numbers of seniors as healthy as possible. Health promotion programs like the Seniors ALIVE Program can help seniors adopt healthy behaviours and lifestyles. The Seniors ALIVE Program had three components: an exercise class, a health corner, and a newsletter. This program used health information, health counselling, blood pressure screening, and exercise to promote the health of seniors in low income housing.

It is important to evaluate initiatives like the Seniors ALIVE Program to find out whether, and how, they influence the health of seniors. This information can be used to improve future health promotion programs for seniors by ensuring the most effective use

of limited resources. The Seniors ALIVE Program is being evaluated by two different methods, one quantitative and the other qualitative. This thesis is the qualitative evaluation of the Seniors ALIVE Program.

This first chapter provides background information for the qualitative evaluation including the research questions, the relationship of the qualitative evaluation to the total seniors research study, and a description of the Seniors ALIVE Program. The next chapter contains a literature review focussing on seniors' health promotion programs and the evaluation of these programs. The methods used in this study are described in chapter three. Chapter four discusses the analysis of the data. The last chapter presents a discussion of the findings, including suggestions for further research.

Chapter Two: Literature Review

Introduction

The literature review presented in this chapter begins by describing seniors, the population of interest in the Seniors ALIVE Program. Next, health promotion and seniors is explored. Health promotion programs for seniors are described as well as some of the benefits of physical activity for seniors. Various factors influencing seniors' participation in these programs and impacts of seniors' health promotion programs are discussed. The evaluation of seniors' health promotion programs is considered. Finally, several theoretical models relevant to the interpretation of the findings of this study are presented.

Seniors and Population Health

Numbers

In 1995 there were an estimated 3.6 million people aged 65 years or older living in Canada. Seniors are one of the fastest growing groups in our population. It is predicted that by the year 2016 six million Canadians will be aged 65 years or older and that by the year 2041 there will be ten million. Between 1981 and 1995, the number of seniors increased by 50%. In the same time period, the age group 25 to 44 years increased by 33%, the age group 45 to 64 years increased by 32%, the age group under age 15 increased by 8 % while the age group 15 to 24 years declined by 18% (Statistics Canada, 1997).

Many of the seniors in Canada are women. In 1995, although 51% of those aged 55 to 64 years were women, they comprised 58% of all those aged 65 and over. There are

even more women represented in the oldest age groups. For example in 1995 women were 60% of those aged 75 to 84 and 70% of those aged 85 and older (Statistics Canada, 1997).

The combination of low mortality rates and low birth rates has contributed to a demographic transition where the proportion of seniors compared to non-seniors is increasing (Statistics Canada, 1993). In 1995 seniors made up 12% of the total population. In 2016 seniors are expected to make up16% of the population while in 2041 this number is expected to rise to 23% (Statistics Canada, 1997). Life expectancy for seniors has risen. The average life expectancy in the period between 1921-1941 was about 78 years but by 1991 the average life expectancy had risen to 83 years (Statistics Canada, 1997). This means that there are increasing numbers of seniors in the oldest age groups.

Consistent with these national and international trends (Statistics Canada, 1993), the population of Alberta seniors is also aging (Seniors Directorate, 1992a). In the future, it is predicted that geriatricians will be more in demand than pediatricians and long term care institutions will be as important as emergency units (Statistics Canada, 1993). If these trends continue and the predictions are accurate, we can expect that seniors will increase in numbers, that they will make up a larger percentage of our population and that there will be more seniors in the oldest age groups than there are today.

Health

Seniors are a group particularly at risk for poor health. Income, social status, social support networks and biology are some of the determinants of health (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994) that are

particularly relevant to seniors. Although over the last 20 years the average income for Canadian seniors has increased, many still remain poor (National Forum on Health, 1997). Higher incomes and social status are related to better health (Lauder, 1993). Those with higher incomes have more choices available to them as well as being better able to afford the necessities of life (National Forum on Health, 1997; Reutter, 1995). Women have a disproportionate representation among seniors and among the poor (Markson, 1995). In a society that values productivity, seniors also face the pervasive discrimination of agism (Hendricks, 1995) and the resulting decrease in social status. Death of friends or partner, decreased mobility and transportation problems can limit their ability to interact with social support networks resulting in social isolation. Seniors also face the inevitable challenges of biological aging. Indeed seniors are more likely than any other age group to have physical disabilities, chronic illnesses and activity limitations (Craig & Timmings, 1994; National Forum on Health, 1997; Penning & Chappell, 1993). Seniors have more health problems and less resources to meet them than non-seniors (Rakowski, 1986).

Chronic Disease

While the majority of seniors are able to function well in spite of chronic disease, others are severely disabled. Of the 3.4 million community dwelling Canadians 65 years or older, 22% have high care needs and require assistance with daily living because of long term health problems (Keating, Fast, Frederick, Cranswick, & Perrier, 1999).

Since the number of seniors is expected to increase considerably in the next few decades, it can be expected that the number of seniors requiring assistance will also increase. The possibility of a pandemic of disability (Hughes, 1997) among the growing

numbers of seniors concerns many. The problem is not the increasing numbers of seniors themselves but the expected impact of the increase of poor health on the health care system (O'Brien Cousins, 1998). Besides influencing the amount and type of health care required, poor health can affect seniors' abilities to live independently. If the health status of this group can be improved, predictions of strains on the health care system may be averted.

Even though many circumstances affecting the health of seniors cannot be changed, there are some things that seniors can do to improve their health. How can seniors from the group who require assistance be shifted to the group who can manage their own care independently? How can the effects of chronic disease be minimized and healthy aging facilitated? These are important and urgent questions.

Health Promotion and Seniors

Health promoting behaviours are especially important for seniors because they have the potential to prevent or ameliorate acute and chronic illness as well as slow the aging process (Crowell Kee, 1984). Heidrich (1998) reviewed 42 studies of comprehensive health promotion programs offering more than one intervention for community dwelling seniors that were published in peer reviewed journals since 1980. She has grouped studies only with others that are similar, so although she reviewed 42 studies, it should be noted that the number of studies upon which each comparison or conclusion is made is generally very small. Four of these studies examined the relationship between

personal health practices and health outcomes in old age. Table 2.1 summarizes these studies.

Table 2.1

Studies Examining the Relationship of Health Practices and Outcomes

Researchers	Variables	Sample	Findings
Branch & Jette (1984)	Relationship of 5 health practices and mortality	Data from Massachusetts Health Panel Study Interviewed in 1974, 1976, & 1980	Men had no significant predictors of mortality For women the only predictor of mortality was never smoking
Strawbridge, Camacho, Cohen & Kaplan (1993)	Predictors of change in functional health	356 seniors over 6 years	The number of positive health practices was related to increased functional health.
Breslow & Enstrom (1980)	Number of health practices and mortality	6,928 adults all age groups 1965-1974	The number of health practices had an inverse relationship with mortality for all ages but was weaker in older ages.
Kaplan, Seeman, Cohen, Knudsen & Guralnik (1987)	Examined 17 year mortality in 3 age cohorts	38-49 yrs. 50-59 yrs. 60-74yrs.	Smoking and physical activity were related to mortality in all age groups.

Most of these studies supported the relationship between certain health practices and mortality in the elderly. Although Heidrich (1998) notes that some important health behaviours such as screening, immunization and stress reduction are missing from these

studies, she also points out their strength because they used longitudinal designs and probability samples.

The research in this area is far from exhaustive. Heidrich (1998) raises other questions yet to be answered. Which health practice or combinations of them affect mortality? Who might benefit the most from adopting healthy practices? Is it the changes in health behaviours adopted in old age that affect mortality or is it the result of a life long healthy lifestyle that affects mortality?

Programs

The majority of health care use and costs occurs during old age. The literature supports the potential benefits of health promoting behaviours for seniors. In spite of this the number of programs addressing seniors and health promotion is small in comparison to those for other age groups (Heidrich, 1998; Pascucci, 1992).

There are several explanations to account for why there has not been more emphasis on health promotion and seniors. Societal beliefs and attitudes about old age can have a strong influence on the development of health promotion programs for seniors (Minkler & Checkoway,1988). Heidrich (1998) has described some of these beliefs. For example, some people may think that it is too late in life for seniors to benefit from health promotion programs. Another belief is that learning new behaviours is too difficult for seniors. Beliefs such as these can influence political priorities and social policies which determine the distribution of program funding (Minkler & Checkoway, 1988) and as a result the numbers and kinds of programs available.

The content of health promotion programs for seniors usually involves one or more of the following: self-examination skills, smoking cessation, accident prevention, vision care, healthy nutrition, good mental health, medication safety, exercise classes, alcohol use, stress management, weight management, diabetes management and screening programs (Rakowski, 1986). Most of the health promotion programs for seniors that have been developed are unique. Their uniqueness stems from using different combinations of content, settings and methods. Programs can be delivered to individual seniors or to groups of various sizes. Although most programs are delivered in person, sometimes they use telephone interventions (Haber, Looney, Babola, Hinman, & Utsey, 2000) or printed materials (Belcher, 1990).

Benefits

One of the activities suggested for seniors' health promotion programs is physical activity. There is evidence that the benefits of exercise intervention programs for seniors are similar to those for non-seniors (Carethers, 1992). Physical activity for seniors is the one health promoting behaviour most likely to influence health. An immediate benefit of physical activity is increased physical, social, and emotional well being (O'Brien Cousins, 1998).

Many long term benefits have been pointed out by O'Brien Cousins (1998), such as:

- prevention and control of heart disease
- control of obesity, cholesterol, depression, hypertension, and diabetes
- improvement of balance, joint mobility, muscular strength, and body image

- heightened immune response
- bone health

These physical benefits can have positive effects on mobility, mental health, and ultimately on functional health and independence.

Recreational physical activity can also provide fun, enjoyment, companionship, and a sense of accomplishment. Besides giving the positive physiological benefits noted above, it can be a diversion from daily routines and stresses. Some of the more noticeable perceived benefits of exercising are improvements in sleep, energy level, mood, and generally feeling good (Myers, et al., 1999).

Participation

Although the overall participation of seniors in health promoting behaviours is higher than that of other age groups (see Table 2.2), it has been noted that seniors with the most health problems, who are actually the most likely to benefit from these programs, are the least likely to attend (Durham, et al., 1991; Heidrich, 1998; O'Brien Cousins, 1998). It is important to understand why this happens since programs will be most cost effective if they attract individuals who are the most likely to benefit (Higgins, 1986). Some seniors never participate at all. Others begin to participate, then discontinue. Non adherence, attrition, withdrawing and dropping out are some terms that have been used to describe this phenomenon.

The facilitators and barriers that influence seniors' participation in health promotion programs are numerous and complex. The motivation for health promotion

action is not always a logical reason directly related to health or even a single reason (Pascucci, 1992). Although factors influencing seniors' participation in health promotion programs are to some extent program specific and senior specific some of the more common factors are considered below. These range from broad societal influences to very specific personal influences.

Participation in health promotion programs is difficult to maintain. Myers (1999) says that health and fitness clubs have an annual average attrition rate of about 35% but 50% is not uncommon. She also notes that although some people may initially be considered withdrawers from an exercise program, longer term follow up indicates that some of these same people may eventually rejoin an exercise program or begin exercising on their own. This suggests that it is important to have very clear, consistent guidelines for the definition of a program withdrawer.

Social Influences

Ageism. All seniors have to deal with ageism. Ageism is a form of stereotyping and discrimination against people because they are old. This attitude is very pervasive. The elderly are seen as a burden. When aging is seen mainly as a medical problem, this encourages a distorted view that all the elderly are sick and dependent and to be pitied (Crowell Kee, 1984). In spite of the fact that not all the problems of aging are medical, ageism highlights the physical and mental decline associated with aging. We tend to discount those with poor health, especially the elderly. All the elderly tend to get lumped together as having poor health (Hendricks, 1995).

Ageism can have a very negative effect on health. It can result in a decrease of social status and power for seniors. The stereotypes of old age embodied in ageism can affect what seniors themselves think they are capable of and hence are ready to try (Minkler & Checkoway, 1988; Phillips, 1988). This can influence their willingness to participate in health promotion programs.

Encouragement. Physicians are a respected source of health advice. They can play an important role in encouraging health promoting lifestyles in their patients (Connell, Davies, Rosenberg, & Fisher, 1988; Durham, et al., 1991; Kerse, Flicker, Jolley, Arroll, & Young, 1999). The ability of doctors to promote physical activity in sedentary people was demonstrated in one study where doctors wrote prescriptions for exercise (Swinburn, Walter, Arroll, Tilyard, & Russell, 1998). Physicians have great authority with their patients and their voice has a greater impact than that of families. The Canadian Medical Association passed a resolution in 1991 urging all physicians to encourage patients of all ages to participate in an active lifestyle (Baer, 1997).

Other sources of support and encouragement for healthful living can be family members, friends (Annesi, 1996), or fitness groups. Self-monitoring by keeping a log or journal charting progress over time can also offer encouragement (Butler, 1999).

Program Factors

In a study looking at perceived incentives and barriers to participation in health promotion activities the following factors were identified as important to more than half of the sample of 756 people aged 55 and older (Connell, et al., 1988). Delivering the program in a location close to the residence of the subjects was important. Many seniors

face transportation problems because they no longer drive themselves or they have difficulties with mobility that make long trips difficult. Delivering the program in a familiar location was preferable to an unfamiliar location. Day time gatherings were preferred to evening gatherings. Cost was an important consideration since many seniors have reduced incomes. Having a group leader who is expert in the area was important to some seniors. How and when the invitation to participate in health promotion programs is issued can have an influence on participation. For example, at the time of retirement from the workforce seniors may be particularly open to learning ways to keep themselves healthy for the rest of their lives (Phillips, 1988).

Psychological techniques. Annesi (1996) has translated research findings in the area of exercise adherence into practical applications for exercise leaders. He says that exercise leaders can influence positive changes in a participant's motivation level, which is an important factor associated with exercise adherence. Some of the ways this can be done are: assessing participants' motivation level, setting goals, using contracts to encourage commitment, and encouraging participants to keep track of their own progress toward their goals. The exercise leader can provide such things as regular progress feedback and education. Encouraging group support and enjoyment as well as recognizing effort are other ways leaders can motivate participants. Specific methods to deal with any discomfort can be taught, such as dissociation, imagery, relaxation, positive self-talk, and/or self reinforcement. These techniques can all help to increase participants' motivation to continue their exercise programs.

Participant factors

Birth cohort. Attitudes about health promoting activity can affect participation in health promotion programs. The age stratification model suggests that the experiences of certain historical events affect a birth cohort member's attitudes and behaviours (Passuth & Bengtson, 1988). Since seniors of today are in the same birth cohort it is likely that some of their attitudes and behaviours will be similar because they have been influenced by some of the same events. For example, the seniors of today share a common history characterized by many technological changes. Most lived through a childhood without antibiotics, two world wars, the great depression, changes in women's roles, the introduction of the automobile, television, and computers (Markson, 1995).

An analysis of data from Canada's 1990 Health Promotion Survey by Penning and Chappell (1993) indicates that the good health habits practised by seniors are likely to reflect traditional, well established views of disease prevention. For example, compared to non-seniors, seniors are less likely to smoke, drink, or skip breakfast. Compared to younger adults, a greater proportion of adults 50 years and older engage in frequent exercise and have regular blood pressure checks. But in comparing the same groups, a greater proportion of older adults say they never exercise. Younger adults are more likely to reflect the newer health promotion thinking on individual responsibility for health and environmental pollution. Seniors are not as likely as non-seniors to use the health promotion practices of breast self-examination and avoiding prescription drugs. Older adults are less likely than younger adults to feel that changes in their personal health behaviours or environmental conditions will improve their health. Age also is related to

education, income, occupation and family status, all of which can have an effect on health issues (Penning & Chappell, 1993). Seniors generally have less formal education and lower incomes, than non-seniors (Statistics Canada, 1997). Many seniors are retired (Statistics Canada, 1997) and many live alone particularly women (Markson, 1995).

One group of studies reviewed by Heidrich (1998) examined health promotion behaviours by age group. Table 2.2 presents a summary of the findings of these studies. Heidrich's (1998) conclusion based on these studies was that they were consistent with previous research. Older adults are as likely or more likely to use positive health practices as non-seniors. These studies extended previous research by including social, cognitive and affective health promotion strategies.

Table 2.2

Heidrich's Review of Relationships Between Age and Health Behaviours

Researchers	Findings
Prochaska, Leventhal, Leventhal, & Keller (1985)	Frequency of 14 of 21 health behaviours significantly increased from young adulthood to old age
Bausell (1986)	Compared with young adults, the elderly are more compliant with 9 of 20 health behaviours, especially diet, blood pressure checks and home safety but they are less likely to do vigorous exercise or visit the dentist.
Walker, Volkan, Sechrist, & Pender (1988)	Seniors had significantly more frequent health promoting behaviour for the total Health Promoting Lifestyle Profile (HPLP) and for the subscales of nutrition, health responsibility and stress management than younger adults.

Heidrich (1998) points out some gaps still remain in this research. These studies were not designed to provide any information about respondents' changes in health promotion activities over time because they were all cross-sectional. The health strategies studied were not related to any health outcomes or mortality. Comparison of these studies is difficult because each study used different measures to assess the health behaviours. Health status of respondents was not examined. Another area that was not examined was the relationship between changes in health status and frequency of health behaviours.

Health status. Heidrich's (1998) review of three studies dealing with seniors' participation in health promotion programs suggests that seniors with poor health are the least likely to attend health promotion programs. Table 2.3 shows the findings of these studies. One explanation for this might be that if health is seen as a resource for living (World Health Organization, 1986), seniors with poor health are lacking this resource or energy to help them participate in health promotion programs and adopt new behaviours (Rakowski, 1986). Sometimes other life challenges may have higher priorities than health promotion (Frenn, 1996). Another interpretation of this could be that people who attend health promotion programs are healthier because of their involvement in the program. The program improves their health (Hawranik, 1995).

Reasons given by participants of one study for not being interested in health promotion programs were that their health was already under good control, that their health was in poor condition or that they had limited mobility (Connell, et al., 1988). This seems to indicate that there may be a certain range of average health that is required

before health promotion programs are of interest. Those at the extremes of good and bad health may not be as interested in participating as those in the middle range.

Table 2.3

Heidrich's Review of Seniors' Participation in Health Promotion Programs

Researchers	Findings
Buchner & Pearson (1989)	Participants were significantly more likely to be white, better educated and have higher incomes than non-participants.
Durham, Beresford, Diehr, Grembowski, Hecht, & Patrick (1991)	Increased participation in health promotion activities was related to younger age and physician involvement. Lower participation was found only for those 74 and older especially if they had multiple chronic illnesses.
Watkins & Kligman (1993)	Lowest attendance was related to lower income, living alone, having fewer social contacts and having health problems.

Social Involvement. Mental health is one factor that can influence a senior's ability to be involved in social interactions (Buchner & Pearson, 1989; Chappell, 1995). Many health promotion programs for seniors involve social interactions with others in group settings. Anything that influences a senior's ability to be involved in social situations could have an influence on their ability to participate in programs with a social component. Depression which is more prevalent among seniors than non-seniors (Ruffing-Rahal, 1991) is a mental illness that can affect motivation for social involvement.

Social support strategies, such as fostering group cohesion and encouraging buddy systems, can enhance exercise program adherence (Spink & Carron, 1992 as cited in

Myers, 1999). Staff telephone contact with absent participants may promote adherence (Hillsdon & Thorogood, 1996 as cited in Myers, 1999).

Incentives. Positive incentives are anticipated interactions with the environment that have some attraction to the person. This attraction increases the likelihood that behaviours toward that interaction will occur (Veroff & Veroff, 1980 as cited in Pascucci, 1992). Some positive incentives identified for seniors to participate in health promotion programs are "feeling good" (Pascucci, 1992), having a health and fitness benefit (Dishman, 1981 as cited in Pascucci, 1992), socialization (Pascucci, 1992) and fun (Weiss, 1985 as cited in Pascucci, 1992).

Self-efficacy. Expectations of self-efficacy affect adoption and adherence to exercise programs (Dishman, 1994 as cited in Myers, 1999). It plays an important role until exercise behaviour becomes routine or when an exercise routine is disrupted (McAuley, Lox, & Duncan, 1993 as cited in Myers, 1999). Exercise leaders can enhance participant's self-efficacy through realistic goal setting and positive feed back. Another important role for exercise leaders is to help exercise participants correctly interpret such sensations as sweating, rapid breathing and muscle soreness (Ewart, Stewart, Gillian, & Kelemen, 1986 as cited in Myers, 1999). Leadership style and program pacing can affect participants' self-efficacy. Particularly in groups with mixed abilities, exercise leaders must observe carefully for self-pacing (O'Brien Cousins & Burgess, 1992 as cited in Myers, 1999). Past experiences with exercise can also influence self-efficacy (O'Brien Cousins, 1998).

Personal Attitudes. Beliefs and attitudes can have an influence on participation in health promotion programs. For example some seniors may believe that a program is inappropriate or unappealing, that people should take care of their own health, or that dwelling on health creates anxiety (Connell, et al., 1988). Fear of injury (Elward & Larson, 1992) and erroneous beliefs about physical activity (Stephens & Craig, 1990) may limit participation in health promotion programs. Reasons that have been given for not participating in health promotion programs include being too busy with other activities, receiving health information from other sources, being too old, travelling, and lacking interest because they did not feel that participation would result in improved overall health or alleviate a current health problem.

Haber, et al. (2000) looked at why seniors did not continue exercising after the completion of a seven week health promotion program. Seniors said that they discontinued exercising because of physical reasons, such as a leg, hip, knee, or ankle bothering them, because allergies were acting up, or because of feeling tired lately. Motivational reasons for discontinuation were that it was hard to make exercise a habit, that they did not like doing it anymore, that it was not fun, that they were not motivated, that they couldn't remember, or that they were too busy.

On the other hand seniors have given reasons why they do participate in health promotion programs. They said they could learn new information and that participation could improve their health (Connell, et al., 1988). A new awareness of healthy behaviours influences some seniors to participate in health promotion efforts (Frenn, 1996) Other reasons given for participation are camaraderie, fun, to get out of the house, to meet

people, to keep active and healthy, to help with arthritis, to lose weight, to reduce pain, to control high blood pressure, to feel better, to reduce stiffness, to improve appetite, for a sore back, for bones, for diabetes, for joints, to keep limber, to keep moving, or to delay the aging process (Myers, et al.,1999).

Correlates, patterns and predictors. Research in the area of correlates, patterns and predictors of health behaviours in old age can also provide information about participation in health promotion programs. Heidrich (1998) reviewed seventeen of these studies. A number of these studies had theoretical frameworks. Some of the variables included in these studies were internal locus of control, health seeking behaviours, social support and self-esteem. Six of these studies used the same instrument, the health promotion lifestyle profile (HPLP). This instrument is used to assesses the frequency of health promoting behaviour in the areas of self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management. Since a number of these studies looked at the same correlates and predictors, it is possible to say that these studies give some evidence that internal locus of control and better perceived health are related to HPLP. But confidence in these results is limited because some of the samples used were small, nonrepresentative, and biassed (Heidrich, 1998).

Heidrich (1998) points out that one study (Bergman-Evans & Walker, 1996), looking at older women's use of clinical preventive services, found very low participation in the use of preventive services. This is surprising because the others have found that older adults do practice health promoting habits such as eating sensibly and checking their blood pressure (Haber, 1999). This raises questions about the possibility of different

participation rates for seniors in clinical disease prevention behaviours and lifestyle behaviours (Heidrich, 1998).

Most of the studies of correlates, patterns and predictors of health behaviours in old age reviewed by Heidrich (1998) suggest that female gender, adequate income, and higher education are positively correlated with many health promotion activities. Heidrich (1998) concludes that they support the presence of health behaviours and a health promotion lifestyle in old age. The inclusion of diverse samples in these studies is beginning to increase the ability to generalize this finding. However, in general, they rely on non-random samples with few comparisons among different cultural, socioeconomic or at-risk groups. The reliance on self-report used in these studies is one of their limitations. Other work to be done in this area of research is to study the relationship of these health behaviours to health outcomes (Heidrich, 1998).

Significance

Some of the factors thought to influence seniors' participation in health promotion programs have been described. These range from broad societal influences to very specific individual influences. The amount and type of participation in these programs plays an important role in determining their cost/effective. The most effective program interventions will not be cost effective if seniors do not participate in them. Some of these influences can be manipulated to increase program attendance while others cannot. This is useful for program evaluations because it shows where efforts to increase program attendance can be focussed. Knowledge of even the factors that cannot be manipulated is useful because it contributes to a better understanding of seniors and some of their unique

life challenges. This understanding can influence how program leaders relate to seniors attending health promotion programs and also to those who return to a program after an absence.

Evaluating Seniors' Health Promotion Programs

Program evaluation is the use of social research procedures to systematically determine the effectiveness of social programs. Program evaluations can demonstrate the worth of a program, compare different types of programs, provide a cost-benefit analysis, or provide in-depth information about program functioning (Rossi, Freeman, & Lipsey, 1999). Program evaluation is critical to the long term survival of programs. Some evidence of a program's cost effectiveness is usually required for continued funding (Fallcreek, et al., 1986; Higgins, 1986).

Process evaluations provide information about program quality, participant involvement in the program and the different characteristics of participants and non-participants (Higgins, 1986). Few program evaluations have tried to clarify the complex relationships linking interventions and outcomes although this would be very useful (Stachtchenko & Jenicek 1990).

Impact evaluations try to discover if a program is having an impact on the participants. They provide short term measures of program effectiveness. Outcome evaluations are usually more long term and seek to show an association between program activities and changes in long term indicators such as health care utilization (Higgins, 1986).

Program Health Outcomes, Volunteer Samples

Four studies examining the outcome of seniors' community health promotion programs were reviewed by Heidrich (1998). These studies all used volunteer samples and control groups, similar to the Seniors ALIVE Program.

One study of attenders and non-attenders of a monthly wellness program compared health behaviours of these two groups six months after the program. Attenders were more likely to say that they had changed their health behaviours in 4 of 6 areas than non-attenders (Barbaro & Noyes, 1984).

Another study compared three models of health care delivery, a physician oriented model, a patient education model with written materials and a health promotion model where patients could refer themselves to a nurse who practised health promotion based care. Only the health promotion group showed any changes in the number of health promotion practices. In this group there was an increase between 3 to 4 times in the number of health promotion activities (Belcher, 1990).

Another study of a program with two-hour health promotion sessions delivered over 11 weeks showed that health promotion participants scored higher than nonparticipants on their perceived ability to do self-care tasks, use seat belts, change diet, exercise, and reduce stress. However, there were no differences between the two groups in health perceptions, health status, physician use, or in variables related to quality of life (Benson, et al., 1989).

The last study in this group consisted of two-hour classes delivered over 13 weeks. Results of this study indicated that participants had more confidence than the controls in

performing health skills, more attempts at lifestyle changes, and more confidence in talking with physicians. There were no significant differences in self-reported health status or health care usage (Nelson, et al., 1984).

Why some health behaviours are affected and others are not, is not examined by these studies. One limitation of these studies is that they rely on self-report. Heidrich (1998) notes that these studies do not examine what aspect of the program is responsible for changes in health behaviours or perceptions. She speculates that possible critical components could be the content of the program, the person delivering the program, the exposure or number of classes, or the context of the program in relation to overall health care delivery.

Program Health Outcomes, Randomized Trials

Another group of studies examining the impact of seniors' community health promotion programs on health outcomes reviewed by Heidrich (1998) used randomized trials with control and experimental groups. The findings of these studies are summarized in Table 2.4. Heidrich (1998) concludes that the four studies included in this group offer some limited support for the impact of health promotion programs. There does seem to be some change in reported health behaviours after participation in a structured program of health promotion.

Heidrich (1998) raises some questions about these studies. Whether or not these changes result in better health status is not clear. The duration of these studies from 1 to 2 years is very short to detect changes in morbidity. There is not a clear indication of a positive impact on health outcomes although there is some indication of a decrease in the

use of health services. However, it does not necessarily follow that decreases in health service use is related to better physical health. The large sample sizes required to detect small effects in these programs means that it is possible that changes that were detected may not be of practical or clinical significance. These studies do not indicate which aspects of health promotion programs were of the most benefit in terms of health outcomes. What Heidrich (1998) concludes is that health promotion activities can be used by older adults and these efforts result in some self-reported behaviour changes that persist for at least 1 to 2 years.

Issues in Evaluating Seniors' Programs

Program evaluations are not often straight-forward but those involving the evaluation of health promotion programs for seniors are especially difficult (Rakowski, 1986). The efficacy of interventions with seniors is hard to demonstrate because of an aging body and the shorter life expectancy during which to measure changes (Arnold, Kane, & Kane, 1986). There are confounding factors of multiple illnesses and habits and attitudes of a lifetime to be overcome. Illnesses or disabilities unrelated to the target condition may dilute or block the effects of an intervention making evaluation of the intervention, difficult (Rakowski, 1986).

The cost/benefits of health promotion programs for seniors is difficult to evaluate for several reasons. Rakowski (1986) suggests, for example, that the small size of the programs, the difficulty with replication of programs, the complex multiple variables and the possible biases of self-selection are some of these reasons. What is required to demonstrate cost effectiveness of health promotion programs for seniors are lowered

mortality, illness reduction, improvements in quality of life, behavioural change, productivity and functional independence (Rakowski, 1986).

Table 2.4

Heidrich's Review of Program Outcomes, Randomized Controlled Trials

Researchers	Findings
Vickery, Golaszerski, Wright, & Kalmer (1988)	There was no difference in overall health care use between groups but there was a decrease in the number of high service users in the experimental group which resulted in overall cost savings for that group.
Mayer, Jermanovich, Wright, Adler, Drew, & Williams (1994)	The experimental group scored significantly higher than the control group in frequency of aerobic exercise and other exercise and had decreases in dietary fat and caffeine intake. Health care use and status was not reported.
Williams, Drew, Wright, Seidman, McGan, & Boulen (1996)	Attendance at a health promotion program was not associated with any specific health risks, illnesses or social-psychological factors. Although attendance had no measurable effect on physical health there were increases in scores on a coping index.
Fries, Bloch, Harrington, Richardson, & Beck (1993)	There were significant reductions in health risks for experimental groups which suggests better physical health outcomes for the health promotion groups.

Self report. Heidrich (1998) mentions reliance on self report as one of the limitations of some quantitative health promotion program evaluations that she reviewed. Self-report may not always be a reliable indication of actual behaviour but these studies

assume that self-report is the same as actual behaviour. One study tried to handle this limitation by getting corroboration by family members for seniors' self-reported information (Haber, et al., 2000). However they found that there may have been some reluctance by family members to contradict what the seniors had said. Self report is also susceptible to the effects of any factors that raise or lower people's spirits. Examples of factors influencing subjective indicators like self report are the weather, family harmony, occupational prospects, housing conditions, falling in love or bad news (Hunt, 1988). While self report is an important data source in qualitative studies, in quantitative studies these difficulties reconciling self reports with actual behaviour is troublesome.

Sample selection. There are many difficulties obtaining samples of seniors research participants for both random and purposive sampling. For example, poverty, which is more common in old age, may result in seniors having fewer telephones, which is one way of obtaining random samples. The increasing numbers of seniors residing in institutions also removes some seniors from availability for random sampling (Rowles & Reinharz, 1988). A common source of research participants is senior centres of various kinds. Seniors who attend senior centres may differ significantly from seniors who do not join or attend these types of organizations. For example, they are likely to be more socially active than other seniors. Another source of research participants is health clinics or health fairs. Heidrich (1998) points out that these persons may be more interested in their health and lifestyle modifications than other seniors. When research participants come from these groups, the ability to generalize results of research findings to other seniors is limited.

Comparisons. The use of different interventions, outcomes, and measurement instruments used in the evaluation of seniors' health promotion programs makes it very difficult to compare these programs. For example, Heidrich (1998) notes how difficult it was to make comparisons and draw conclusions because many of the studies were so different.

Outcome measures. There is general agreement in the literature that it is not realistic to measure health promotion program outcomes for seniors in terms of disease prevention as is common for non-seniors. Meaningful outcomes of these programs should be measured in terms of functional health. Slowing the aging process, minimizing the pace of deterioration, and emphasizing well-being in spite of some limitations improves functional health (Crowell Kee, 1984; Haber, 1999; Heidrich, 1998; Lauder, 1993; Minkler & Checkoway, 1988; Penning & Chappell, 1993; Rakowski, 1986). When functional health is maintained or improved, it contributes to independence, which is coveted by seniors (Gatz, 1995; Haber, 1999; Minkler & Pasick, 1986). Maintaining maximum functional independence is one of the major essential components of quality of life (Williams, 1994). These kinds of outcomes are not limited to one domain but encompass physical, mental, social and spiritual domains. Terms, such as well-being, autonomy, independence, lifestyle impact, sense of meaning and self-care, have been included in the goals of health promotion programs for seniors (Alford & Futrell, 1992; Craig, 1995; Craig & Timmings, 1994; Crowell Kee, 1984; Gatz, 1995; Haber, 1999; Heidrich, 1998; Lauder, 1993; Minkler & Checkoway, 1988; Minkler & Pasick, 1986; Penning & Chappell, 1993; Rakowski, 1986).

Theories

Theories help to summarize and integrate the knowledge gained by past research. They describe and explain how and why observed phenomena are related. They lead to the development of predictions and interventions (Marshall, 1999). It is useful to consider research findings in relation to relevant theories because it is one way of connecting new research to previous research. Several theories and models of aging and health promotion are relevant for the interpretation of the findings of this study.

The social theories of aging were used to consider how different processes of aging might affect participation in the Seniors ALIVE Program. The model of selective optimization with compensation (Baltes, 1994) was used to help determine if and how the Seniors ALIVE Program contributed to successful aging. Annesi's (1996) discussion of exercise adherence outlines several key models and theories. Exercise was an important component of the Seniors ALIVE Program. Factors influencing exercise participation in the Seniors ALIVE Program will be compared with those outlined by Annesi (1996). Pender's (1996) revised health promotion model is relevant to look at motivation and the factors that encourage or discourage participation in the program. The population health promotion model (Hamilton & Bhatti, 1996) was used to examine how the Seniors ALIVE Program related to the determinants of health. These theories and models are described below.

Social Theories of Aging

Fry (1992) has reviewed six social theories of aging. These social theories of aging offer explanations for understanding the social needs and social integration patterns of

seniors as they adapt to aging. These theories offer quite different and sometimes contrary explanations for achieving successful aging. Considered together, they offer a range of explanations about how people adapt to aging. Because seniors are heterogeneous in their adaptations to aging, it is likely that no single theory would be able to account for all the diverse adaptations of seniors to aging. Hence the utility of considering these theories as a group.

Some seniors respond to aging by disengaging from society as is described by the disengagement theory (Cummings & Henry, 1961). This involves a desire for and acceptance of withdrawal from active life. There is a mutual withdrawal of the elderly from society and society from the elderly. The exact time and form of disengagement varies from person to person but the result is decreased social interaction and loosening of social ties. Replacing the elderly who are no longer as useful or dependable ensures the optimal functioning of society. When disengagement is complete there is a sense of psychological well-being for the elderly (Fry, 1992).

A second way seniors age is outlined in the abandonment theory (Burgess, 1960). The negative aspects of the aging process are explained in this theory. All seniors will ultimately experience increasing levels of abandonment and social isolation. There is a loss of social status with social and economic deprivation in old age. One of the implications of this theory is the importance of groups and supportive group leaders in helping the elderly cope with abandonment (Fry, 1992).

Although the activity theory has not been associated with one particular author Fry (1992) suggests that this theory is best exemplified by the work of Maddox (1968). The

key to successful aging suggested by the activity theory is in the elderly person's motivation to stay physically and mentally active. Activity is seen as essential to the well-being of the elderly. The only differences seen between the aged and the middle aged is the biological and health problems experienced by the aged. These two groups are seen to have the same psychological and social needs (Fry, 1992).

The role theory has emerged from several studies of aging over the past three decades. It is a fourth type of response to aging. Successful aging according to this theory involves the ability of seniors to carry out the social roles appropriate to old age. In order for this to happen, there has to be a relinquishing of the social roles and relationships of adulthood and the acceptance of those associated with old age. This theory suggests that the loss of significant roles plays an important part in the loss of life satisfaction (Fry, 1992).

A fifth type of aging adaptation is describe in the continuity theory (Rosow, 1963). The continuity theory suggests that seniors use continuity with past life experiences as an adaptive strategy for dealing with the changes of aging. The continuity in behaviours across a person's lifespan is emphasized in this theory (Fry, 1992).

The last method Fry (1992) describes for adapting to aging is expressed in the socioenvironmental theory (Naumann & Hafner, 1985). The socioenvironmental theory of aging sees successful aging as a function of both the social resources available in the environment and the personal resources of the aging individual. Individuals age differently because of different individual resources and different capacities for disengagement,

activity, or role continuity. In making decisions about engagement, seniors weigh their abilities and resources against the expectations of others in their environment (Fry, 1992).

These theories suggest six different ways seniors might adapt to aging. They could disengage from society, become socially isolated through abandonment, remain active, change their social roles, continue past behaviours or weigh their abilities and resources against the expectations of others in their environments. These different perspectives will be used to account for different social involvement patterns of seniors noted in the Seniors ALIVE Program. Implications for future health promotion programs will be drawn from these social theories of aging.

Model of Selective Optimization with Compensation

Baltes (1994) has used the Model of Selective Optimization with Compensation (SOC) to explain successful aging. It is based on three phenomena of aging. First, there is an increase in negative balance between gains and losses in aging. Second there are reserves that can be activated but there are limits to the reserves. Third, there is more disease associated with aging. The three processes of the model are selection, compensation and optimization. Selection encourages restriction to fewer domains of functioning. Compensation can be used when specific capacities or skills lost or reduced. This might involve learning new skills to compensate for deficiencies. Optimization involves using the strategies of practice and training.

Theories of Exercise Participation

Annesi (1996) discusses some diverse theoretical models that shed light on many factors affecting exercise participation. Table 2.5 shows these theoretical models and the

factors derived from these models that specifically affect exercise participation. Because seniors are such a diverse group, it is important to consider a variety of factors that might influence their participation in health promotion programs. These theoretical models, based on previous research, provide a sound basis for the design of strategies to increase program participation.

Table 2.5

Factors Affecting Exercise Participation Derived from Theoretical Models

Theoretical Model	Factors that Affect Exercise Participation
Exercise Behaviour Model (Noland & Feldman, 1984)	Individual's analysis of costs vs. benefits
Theory of Reasoned Action (Ajzen & Fishbein, 1980)	Individual's expectations for success Social support
Theory of Interpersonal Behaviour (Triandis, 1977)	Formation of habit Intent to exercise Conditions encouraging or discouraging exercise
Self-efficacy Theory (Bandura, 1986)	Individual's judgement of ability to do exercise
Transtheoretical Model (Prochaska & Marcus, 1994)	Stages of readiness

Note. Adapted from Annesi, J. (1996). Enhancing exercise motivation. Los Angeles: Leisure Publications.

Pender's Revised Health Promotion Model

Pender's (1996) revised health promotion model suggests that prior related behaviour and personal factors are both important individual characteristics and experiences that influence the adoption of health promoting behaviour. Figure 2.1 shows a

diagram of the model. The personal factors involved are biological, psychological and sociocultural. These personal factors are proposed as directly influencing both behaviour-specific cognitions and affect as well as health promoting behaviour. However some of these personal factors cannot be changed and they are not usually incorporated in health promotion intervention programs. The behaviour-specific cognitions and affect category that make up prior related behaviour is considered to be very important in motivation for health promoting behaviour and is an important place for health promotion interventions. The variables in this category are perceived benefits of action, perceived barriers to action, perceived self-efficacy, activity-related affect (or the affect associated with the behaviour), interpersonal influences, and situational influences. The behavioural outcome consists of a commitment to a plan of action, overcoming immediate competing demands, and preferences, and finally the health promoting behaviour (Pender, 1996).

This model assumes that people seek to be as healthy as possible and that people can assess their own competencies. People strive for a balance between change and stability. They value growth and they seek to regulate their own behaviour. There is interaction between people and their environment and they can transform each other. Health professionals are part of the interpersonal environment that can influence people over their lifespan. Self-initiated changes in the person-environment interactive patterns are considered essential for behaviour change. These assumptions of Pender's revised health promotion model highlight the active role of the individual in adopting health behaviours (Pender, 1996). Factors affecting participation in the Seniors ALIVE Program will be compared with those found to be important in Pender's revised health promotion

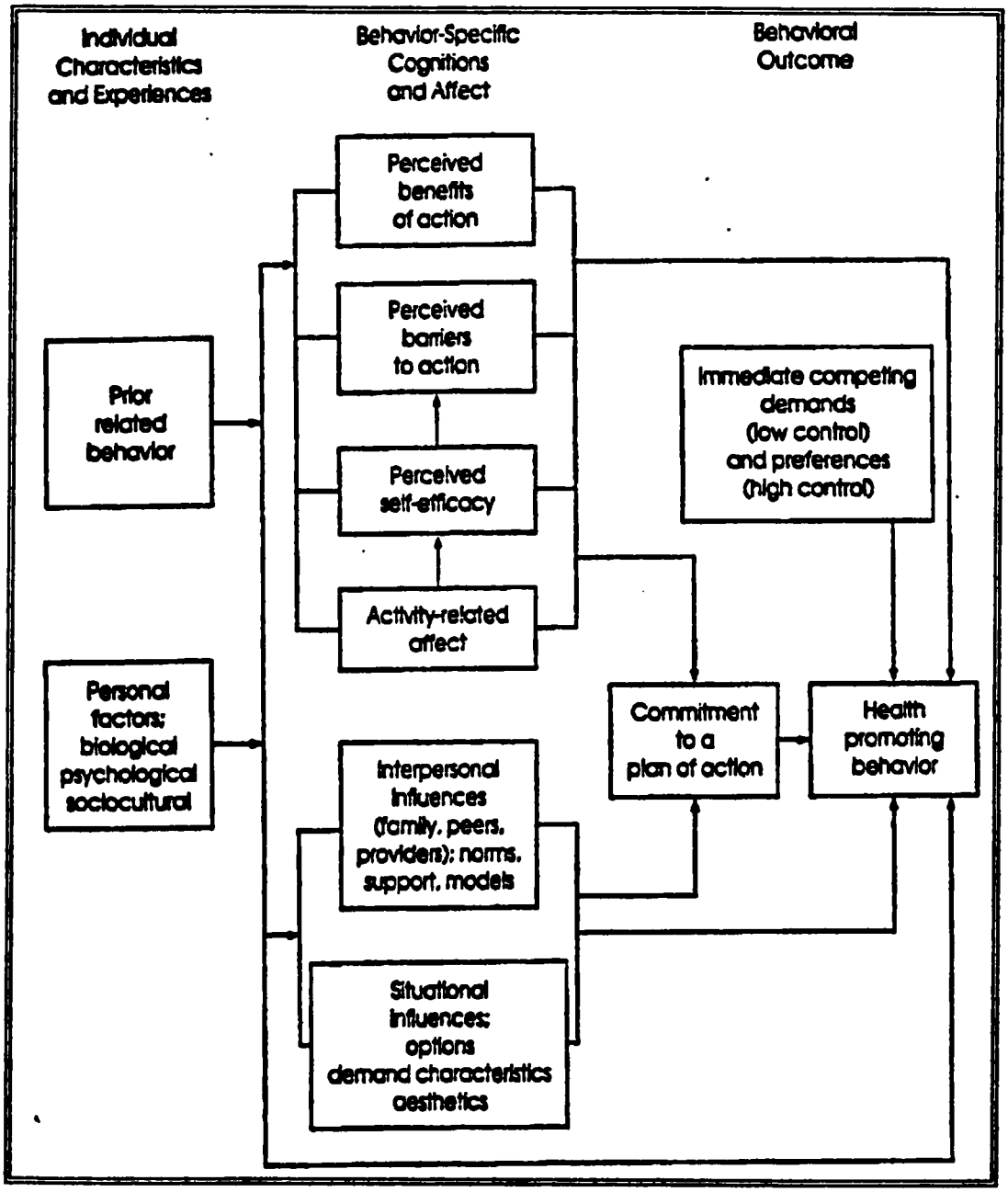

Figure 2.1: Pender's Revised Health Promotion Model

model. Implications for increasing program participation will also be made based on this health promotion model.

Population Health Promotion Model

Hamilton and Bhatti (1996) have proposed a model that integrates population health and health promotion. It describes the following health determinants that programs can influence: income and social status, social support networks, education, working conditions, physical environments, biology and genetics, personal health practices and coping skills, healthy child development, and health services. The action strategies that can be used are strengthening community action, building healthy public policy, creating supportive environments, developing personal skills, and reorienting health services. The levels at which actions can be taken are individual, family, community, sector/system, and society. The Seniors ALIVE Program will be examined to see which of the determinants of health, action strategies, and levels of action discussed in the population health promotion model were present. This should give a good picture of how the Seniors ALIVE Program fits within the broad area of health promotion presented in this model.

Summary

Growth in the numbers of seniors has prompted concern about their impact on future health care use. It is well known that health declines with age. However by using specific health behaviours and coping strategies, as well as general healthy lifestyles, the impact of aging on the health of seniors can be ameliorated. Health promotion programs

for seniors promote the behaviours, strategies and lifestyles that can have positive influences on their health.

The Seniors ALIVE Program and the seniors' health promotion programs reviewed by Heidrich (1998) were similar because they all combined more than one intervention and targeted community dwelling seniors. The literature review shows that most of the research to date has focussed on health behaviours, health promotion participation, and program outcomes for seniors. There is little information about the processes and mechanisms of these programs. The qualitative approach has not been widely used in previous seniors' health promotion program evaluations. The use of qualitative methods has the potential to uncover different information from that provided by quantitative methods. Findings from the qualitative evaluation are likely to provide information that can be used to enhance future health promotion programs. Enhancing programs should ensure that participating seniors receive maximum benefits from their exposure to the health promotion interventions. There is also the potential to decrease the number of program withdrawals if programs can be enhanced.

Chapter Three: Methods

Introduction

In this chapter, the selection of the sample for each informant group is described. Delimitations of the study are given. Next, the different methods used to collect the data are outlined. Ethical considerations of this study are presented. There is a description of methods used for analysis and verification of the analysis. The chapter concludes with a description of methods used to disseminate the findings of the study.

Research Design

Sample

To gain multiple perspectives of the Seniors ALIVE Program, input was sought from four informant groups: program participants, program withdrawers, family members of program participants and program staff.

Program participants. These were seniors who had registered for and attended at least part of the Seniors ALIVE Program. They ranged in age from 60 years to 90 years of age. During the last data collection period of the quantitative study, research assistants interviewed the approximately 90 program participants still registered in the program. They used a prepared script (see Appendix A) and developed a list of program participants who agreed to be contacted about participating in this qualitative study. Seniors were asked to sign a form indicating their agreement to be contacted (see Appendix B). A reminder notice (see Appendix C) and an information letter (see Appendix D) were mailed to each senior on the list. Seniors were contacted by phone approximately one week after

receipt of the letter and asked if they would agree to a personal interview at their apartment. An appointment for an interview was scheduled with those who agreed. In total 26 program participants were interviewed. After the interviews were completed, three of these participants were reclassified as partial program withdrawers who stopped attending the exercise class but still attended the health corners. Table 3.1 shows a breakdown of the buildings, numbers and genders of those who were interviewed. Buildings one and five were among the largest buildings in the intervention group yet they had relatively small numbers of program participants. Building four was among the smaller buildings but it had a relatively large number of program participants for the size of the building. One explanation for this is that this building had a very supportive building manager and a large turn out at the initial information meeting. Building six stands out because it was the only building where more men participated than women. However, this building is unique because there are twice as many male residents as female residents.

For their participation, seniors were offered an incentive, described to them as a small thank you gift, to ensure an adequate sample size. However, more participants agreed to be interviewed than were initially expected. Because of the promised incentive all seniors who agreed to be interviewed were included in the sample. As a result this group was much larger than the number required to reach saturation.

Program withdrawers. These were people who initially asked to be registered in the program but later formally asked to be withdrawn from the program. There were 23 program withdrawers in total. Letters were sent to all 23 program withdrawers inviting them to contact the researcher (see Appendix E). Four letters were undeliverable and

Table 3.1

Building Statistics and Relation to Interviews Completed by Sample Type

Building			Interviews Completed			
Number	Seniors in Building M/F	Number of Program Participants	Participant	With drawer	Partial With drawer	Participant Family Member
1	118 106 F 12 M	12 11 F 1 M	3 3 F 0 M	1 F	1 F 0 M	1
2	48 36 F 12 M	14 14 F 0 M	2 2 F 0M	0	0	0
3	83 74 F 9M	19 19 F 0 M	3 3 F 0 M	0	0	0
4	58 41 F 17 M	31 29 F 2 M	7 7 F 0 M	0	1M 1 F	1
5	93 61 F 32 M	10 10 F 0 M	4 4 F 0 M	0	0	1
6	48 16 F 32 M	10 5 F 5 M	2 0 F 2 M	0	0	1
7	50 44 F 6 M	6 6 F 0 M	2 2 F 0 M	0	0	0
Totals	498 378 F 120 M	102 94 F 8 M	23 21 F 2 M	1 1 F 0 M	3 2 F 1 M	4

M = Male F= Female
Number of seniors in building is approximate

returned to the sender. Of the three phone calls received only one resulted in an interview. This group was smaller than planned because of difficulty in recruiting.

Family members. The initial letter sent to program participants asked participants to check with family members who they saw regularly and who knew they were in the Seniors ALIVE Program to see if they would be willing to be interviewed about the seniors' participation in the program. At the time of the interview the participant was asked if they had a suitable family member willing to be interviewed. Seven participants gave names of family members. From this list of seven, six were contacted and four agreed to be interviewed.

Program staff. A list of 13 staff members was supplied by the quantitative study coordinator. From this list three staff were interviewed individually and three were interviewed in a focus group. Table 3.2 gives a breakdown of the type of interview, the parts of the program and the buildings where the interviewed staff worked. The different buildings, types of program involvement and types of interview were well represented by the program staff interviewed for this evaluation.

Delimitations of the Study

Only program participants who were registered in or had withdrawn from the research part of the program were approached to be recruited for this study. There were some seniors who attended the program but who had not signed up for the research part of the Seniors ALIVE Program. This group was excluded from both the quantitative and the qualitative studies.

Table 3.2
Program Staff, Interview Type, Program and Building Involvement

		Program Involvement		Interview Type	
Staff	Building	Exercise Class	Health Corner	Individual Interview	Focus Group
1	4		X	X	
2	4	X			X
3	3,5		X		X
4	1,2,3,6,7	X			X
5	2,5	X	X	X	
6	1,2,3,4,5,6, 7	X	X	X	

Intervention Program

The intervention program of the Seniors ALIVE Program consisted of exercise classes, health corners and a newsletter. These are described in chapter one.

Data Collection

Interviews. Interviews were conducted with program participants, program withdrawers, relatives of program participants and program staff. Interviewing is an important method of data collection in qualitative research (May, 1989). Guided semi-structured interviews were used (see interview guides in Appendix F and G). This ensured that each type of respondent was asked the same questions but still allowed for unstructured responses.

Three different interview guides were developed for program participants. An initial interview guide was developed, pretested and used for the first 10 interviews (see

Interview Guide Number 1 Appendix F). An early analysis of these first interviews suggested that more specific questions about program impacts should be included. Accordingly, some modifications in the interview guide were made and Interview Guide 2 was used for the next 7 interviews (see Appendix F) Because of ethical considerations of the promised incentive, the number of participants interviewed was not determined by saturation as is common in qualitative research (Morse,1989). At the point of saturation, a shorter interview guide was developed and used for the iast 9 interviews (see Interview Guide Number 3 Appendix F). An interview guide was also developed for each of the other informant groups: program withdrawers, family members and program staff (see Appendix G).

All the interviews took place either at the respondents' residence or at another place of their choice. All the interviews except two were audiotape recorded with the respondents' explicit verbal consent. Notes were also taken during the taped interviews. More detailed notes were taken during the interviews with the two respondents who did not consent to have their interviews taped. All informants were given information letters to read (see Appendix D and H) and consent forms to sign (see Appendix I) before the interviews. All the taped interviews were transcribed and checked for accuracy.

Focus Group. Patton (1987) defines a focus group as an interview with a group of people on a specific topic. The object of focus groups is to have people consider their own views in relation to the views of others. It is an efficient data collection technique and it tends to weed out extreme views (Patton, 1987). Focus groups work best with homogeneous groups. The ideal size is 6-9 people. The purpose of focus groups is to

collect qualitative data from a focussed discussion. Thus focus groups are considered to be helpful in providing information to improve programs and to evaluate them (Krueger, 1994).

Advantages of focus groups include being flexible, low cost and providing results quickly. Disadvantages include the need for a skilled moderator, since focus groups are harder to control than individual interviews. Finding a common meeting time can make it difficult to assemble a group (Krueger, 1994).

A focus group was held with program staff. Due to difficulties in scheduling only 3 staff members attended. The focus group was conducted with the researcher as moderator and a colleague as an assistant using a focus group question guide (see Appendix J). It was audiotape recorded and detailed notes were taken by the focus group assistant. A summary was read at the end of the focus group to check for confirmation of content and completeness of feedback with focus group members as is suggested by Krueger (1994).The taped focus group was transcribed and checked for accuracy.

Fieldnotes. Fieldnotes are written reconstructions of interactions, short conversations or descriptions of events. They are written notes about what the researcher sees, thinks or, hears during the time of collecting and analysing the data. They are necessary for the success of a qualitative study. Fieldnotes should supplement tape recorded interviews (Morse & Field, 1995). Field notes were kept during the time of data collection and analysis.

Observation. The researcher had an opportunity to participate in an exercise class and a health corner as well as to deliver newsletters to several buildings. Although observations from this participation were not used specifically for data collection, it did give the researcher a good background familiarity with the program.

Ethics

Respondents were assured of confidentiality. Sending reminder notes and information letters before speaking to the program participants in person ensured that seniors had enough time completely understand what was being asked of them. It also allowed extra time for them to make their decision. This procedure was very effective in having a quick and informed decision at the time of the initial phone call. For example one senior responded to hearing the researcher's name with the response "Oh yes I know who you are." Informed written consent was obtained before each interview. Respondents were informed that they were free to withdraw from the study at any time. The promise of an incentive was honoured in spite of increasing sample size beyond that required for the study.

Analysis

Content analysis is the process of identifying, coding and categorizing primary patterns in the data.(Patton, 1990). This process was used to analyse the data. Codes were developed by first dividing two interviews into discrete data bits. Dey (1993) defines "a data bit" as a part of the data that is regarded as a separate unit of meaning for the purpose of the analysis. The research questions were used to decide if the information was important for analysis. Summaries of the data bits were copied onto index cards and

sorted into piles of similar data bits. Once the piles were formed, initial code names were assigned to the piles. The cards were sorted again but this time each data bit was assessed and placed in the most appropriate code category. A code book was developed giving examples of data bits that were included or excluded from each code. Once the data was coded a cut and paste procedure was used to separate the data.

Miles and Huberman (1994) say that check-coding helps to clarify code definitions as well as being a good reliability check. A colleague independently developed codes for one of the interviews and the reliability calculated according to Miles & Huberman (1994) was 93 %. Another colleague independently coded the focus group. This was compared with the researcher coded focus group. When the main categories and any of the sub-categories belonging to that main category were counted as matches, the reliability was 75% calculated according to Miles & Huberman (1994). Riley (1996) says that when agreement is over 70%, discussion of discrepancies can increase agreement to about 90%. Unfortunately there was not an opportunity for this discussion to take place but it seems likely had this been done the reliability would have increased. To ensure internal consistency, the researcher recoded one interview several days after the initial coding as suggested by Miles and Huberman (1994). There was a 90% reliability between the first and second codings.

Data from staff was collected by both individual interviews and by a focus group. Since the program staff were not the main source of data for this study and data provided from this source was very similar to that from individual staff interviews, a decision was made to analyse and report the focus group data together with individual staff data.

However, data obtained from the focus group is specifically identified in the findings as being from focus group staff.

Cross-case analysis is the process of grouping together answers from different people to common questions or analysing different perspectives on central issues (Patton, 1990). Both these procedures were used. Data from participants, the withdrawer, the partial withdrawers, staff and family members was analysed separately. Answers from each informant group were grouped and common patterns identified. Next, the perspectives of the each of the informant groups were combined looking for commonalities, uniqueness, contradictions and patterns.

Methods of Verification

Triangulation is the use of multiple methods to address a single problem. It can increase confidence in the conclusions of a study and strengthen study design by overcoming bias inherent in a single perspective or method (Field & Morse 1985). Each method has its own strengths and weaknesses. The purpose of triangulation is not just to have the combination of data but to interpret and relate the data collected by different methods to each other (Fielding & Fielding, 1990). A single method is vulnerable to error linked to that method (Patton, 1990). Besides providing cross data validity checks, multiple strategies can add to the completeness of understanding the research topic.

The collection of data from four different sources, program participants, program withdrawers, family members and program staff provided a variety of perspectives. Purposive sampling ensured that participants and staff from all the buildings were represented. The relatively large number of interviews makes it less likely that only

extreme points of view are represented. A staff focus group was held to compliment individual staff interviews. The use of more than one theory ensures that different ways of interpreting the data are considered.

Besides using a variety of approaches for triangulation there were several checks of the analysis. Check-coding was used three different times to verify the analysis. These are described in the analysis section of this chapter. Member checks as suggested in Robson (1993) were done with four program participants and two staff members to check credibility of the findings. The combination of these strategies provides for maximum verification of the data and the analysis.

Dissemination

Besides reporting the results of this study in a master's thesis, a report of the findings will be given to the study coordinator of the quantitative study. A summary of the findings will also be mailed to respondents who indicated interest in receiving it.

Summary

A description of the methods and procedures used in this evaluation has been presented in this chapter. Recruitment procedures for each of the four informant groups were outlined. The data collection methods used in this study were individual interviews, a focus group, fieldnotes, and observation. Content cross-case analysis was used to analyse the data and check-coding was used as reliability checks. Methods of triangulation used in this study were multiple informant groups, a large number of participant interviews, and multiple theories to analyse the data.

Chapter Four: Findings

Introduction

This chapter summarizes the main findings of the study. The first section describes how the program functioned including the three interventions of the program as well as the termination of the program and feedback about the program. The second section discusses factors influencing participation in the program including motivation, encouragement and barriers. The third section deals with impacts of the program on program participants, program withdrawers, program staff and family members of program participants. The last section depicts the social relationships involved in the Seniors ALIVE Program. First the main characters, the participants and staff are described and then social relationships in both the building and the program are discussed.

The Program

Participation in Program Components

All of the subjects in the participant group attended at least one exercise class. Only one subject in this group never attended any health corners. Although the majority of the participants said they remembered receiving the newsletter, some were uncertain. The withdrawer and partial withdrawers all attended at least one exercise class and one health corner except for the program withdrawer who did not attend any health corners.

Importance of Components

The majority of program participants thought that the exercise classes were the most important part of the program. Although only a few participants listed the health corner as the most important, some of those who chose the exercises as most important also recognized the health corner as a very close second. The newsletter was not chosen as the most important part of the program by anyone. The withdrawer only attended exercise classes and did not remember getting a newsletter. Of the partial withdrawers two chose the health corner as most important to them and the partial withdrawer who had participated the most in the exercises chose the exercise class as most important. Table 4.1 shows the first choices of participants and partial withdrawers when asked to place program components in order of importance.

Table 4.1

Importance of Program Components First Choices of Participants and Partial Withdrawers

	Participants	Partial Withdrawers
Exercise	15	1
Health Corner	2	2
Newsletter	0	0

Location and Cost

Participants appreciated having the program in their own building because transportation is a problem for many of them. Some of the reasons for this are that they

don't drive, they don't feel safe on the bus, they can't walk very far and they have difficulty getting out in the winter.

Participants also appreciated not having to pay for the program. Besides not having to pay for the program itself, the program also helped seniors financially by providing a service that would otherwise be unaffordable. One participant pointed out that the exercises were as good for her as physiotherapy which she could not afford. She said, "and we're seniors on limited budgets. We can't afford to put out that kind of money for therapy."

The Components

Exercise Classes

Description. Although classes were usually held in a common room or lounge, when the weather was nice, some classes were held outside. Participants helped staff set up the room by moving tables and chairs. Roll call was taken at every class. There were many changes in exercise staff with some sites having as many as three or four instructors over the ten month program. Sometimes the day and time also changed when the instructor changed.

The classes started with a warm up. One instructor took them for a walk up and down the hallways for their warm up. The researcher, who was present for one of these warm up walks, observed the participants having fun, laughing, joking and knocking on apartment doors as they walked along the hallways. This same light hearted fun comes through in one participant's description of a hallway warm up. She said, "One day I led

them and I brought them in here [her apartment] and I told them yeah, say hello to the bird, and this is my kitchen, and then out we went again." Some people could not walk well enough to go on these walks so they just waited for the rest to come back. The exercises, "just involved our whole bodies," one participant noted. One participant described some hand exercises that were done in the classes, "pull your fingers back and press your fingers down and touch your thumbs and open them up one at a time." Another participant demonstrated some of the exercises, moving her head back and forth and side to side and doing a shoulder shrug. One participant reported she even occasionally did some floor exercises when she was asked to describe the exercises she did in the Seniors ALIVE Program.

They used weights and resistance bands for strength training. The bands came in three different strengths. Participants chose the level of resistance that was best for them. The program supplied some of this equipment but did not always have enough for everyone. At one point some of them were using soup cans for weights. Some participants bought their own equipment. The participants seemed quite proud of using the equipment. They said things like, " cause we even - we used weights, two pounds."

The order of the exercises was arranged to prevent fatigue. One participant said, "She sort of mixed them up, so you were doing something for the legs, then you'd go to the upper body, and then you'd go down to the legs again, which by that time your legs had rested."

One instructor would describe how to do the exercises by relating the exercises to common activities. For example, one participant described this as, "we do milk the cow,

we wash the clothes, we played the violin, we swim and we played the piano always, we played the piano lots." Another participant appreciated how this same instructor told them what muscles were being worked and how they should work their muscles. She said,

> She'd tell you exactly what muscle you were exercising . . . and the faster you did it the sooner you got done but that isn't the idea. The idea was . . . you're not to do it in a hurry so that the muscle gets a bit of practice so that was a good thing . . . [It] made good sense.

Participants liked the humour associated with the classes. One participant spoke of the exercise leader saying, "She was comical and it wasn't just exercising." Another participant said, "We'd tell jokes and everything up there." One focus group staff member described the atmosphere of her classes as being like a day camp. She said, "It was like a day camp . . . they would laugh . . . and . . . when they were exercising one would get too close and they'd start giggling."

Attendance. The numbers of people attending the classes varied considerably from site to site and within each site over time. Although participants reported class sizes as large as 20, at one site only one participant attended exercise class two times. The first time the class was cancelled and the second time she and the instructor did the exercises together. There were very few men attending the classes. Some men started attending classes but later left. Participants offered some thoughts about why the men might have left the exercise classes. They thought that the men may have become ill or that "He wasn't doing enough if he went to the classes. If he did it at home he would do more." Another speculated, "Men aren't very good at taking part in things like that. I think they

think that it's too simple. They don't realize that these simple movements are good for you."

People not in the program were curious about the classes. They would sometimes poke their heads in the door to see what was going on. When this happened, staff and participants would encourage them to join them. Sometimes people would just try one class.

Adaptations. There were a number of people who could not do all of the exercises as they were presented. People who had previous hip and knee replacement surgery as well as those with arthritis were among those who could not do all the exercises. There was overwhelming evidence that the instructors encouraged people to work at their own speed and not to over do it. As one participant explained, "they all of them definitely taught us don't do anything that's going to hurt you." There was only one person who presented contrary evidence. This was a program partial withdrawer who said she felt pushed by the instructor to do more than she felt she could. However, there is reason to question the accuracy of this information. This participant's daughter was also interviewed. Without being specifically asked, she indicated that her mother is not always able to distinguish between instructions given to a group and those given specifically to her.

Participants could use weights with just one hand or change how they held them. One participant said, "I couldn't hold them [little barbells] this way to do the exercise so she would let me reverse my hand to do it this way . . . so I was getting benefits out of doing it but a different way." Some people did less repetitions and others sat to do the

exercises instead of standing. If an exercise couldn't be adapted they could just sit and watch the others or they could do a different exercise. Staff also made adaptations to accommodate visual problems. One staff member reported, "One lady could barely see. I would tailor it so that when I talked I explained it more . . . the things that I was doing and go close to her so that she could see." Another strategy used to accommodate widely ranging abilities was to find some other way for them to participate such as one focus group staff member reported, "people with osteoporosis who couldn't exercise . . . could count while the rest of us did [exercises]."

Music. Most of the sites had some music but it was not always consistent. There were times when there was no music. Residents often brought their own tape recorders and sometimes the music as well. One participant said there was difficulty finding the "right music." Another participant said, "I wanted to listen to the music or keep up with the music instead of the speed I was supposed to go." One participant described how some of them made their own music. "Sometimes we . . . sang a tune song . . . that you could keep time with."

Health Corners

Description. The health corners were open to everyone in the building. Seniors not registered in the program and an occasional building staff member attended as well as seniors registered in the program. In most sites, the health corner was a weekly, two-hour drop in time. However, at one site there was an appointment list made in advance of each health corner. Generally they did not have to wait long for their turn. The health corners usually were held in a large common room or lounge type area. One staff member

described how she set up the room for the health corners. She said, "I'd just set up, I'd have tables lined up for the pamphlets and I'd have a separate table for the blood pressure and just chairs for everybody to sit down on."

Health corner staff were university nursing students. During the school year they were volunteers but in the summer months the nursing students were paid. Sometimes they were joined by students from pharmacy and nutrition. There were some staff changes in the health corners but in some places the staff remained the same. There was at least one health corner that changed day but generally the changes in the staff, days, and times of the health corners were not as numerous as in the exercise classes.

The focus was on the seniors and their health. A family member pointed out that at the health corner seniors "felt safe there and asking questions was comfortable for them." There was an informal unrushed atmosphere at the health corners. This atmosphere encouraged communication between staff and seniors. Staff identified an important role of the nurse was to be a listener and sometimes when it wasn't busy they heard other stories unrelated to health. Over time several staff noticed that the seniors became more open with them and shared more of their problems. As one staff member put it, "In the beginning they would hide what was happening to them and then they were able to say well, this is what's going on right now."

Service. The staff at the health corners listened, explained, reassured, gave advice, made referrals to doctors, presented nutrition and medication information, and kept track of blood pressures over time. In some visits a question or problem was completely handled while in other visits questions or problems were continuations from the week before. Staff

used the opportunity to encourage healthy behaviours and also answered questions about the exercise class. The nurse checked blood pressures and pulse, reported them to the seniors, and answered any questions they might have. Examples of the kinds of questions seniors might ask at a health corner were related by a staff member. She said,

> Well sometimes . . . in the very beginning they would ask me well, "What's normal" and they were really interested in that and occasionally they would say well, "I'm taking these medications but is there anything else I can do to help lower my blood pressure?" or just different things like that.

Dealing with medications was an important service offered in the health corners. Seniors asked questions about their own medications as described in the following two examples from program partial withdrawers.

> Well the young nurse used to come . . . and she'd give me the complete low down you know what to take cause I take about nine different pills a day . . . don't take this pill with that pill take these two pills and these on certain days so they don't mix you know.

Another partial withdrawer said,

> I just got a new pill. Does it go with the high blood pressure one? And she would say let me see . . . and she would say yeah it's okay you know so I don't have to go to the doctor because [the nurse] already answered.

The health corner was also used as a resource for participants where they could direct fellow residents about whom they were concerned. For example, in one building there was a resident who was giving her medications to other residents who she thought might benefit from them. This was brought to the attention of the health corner nurse by another participant who became concerned about it. Health corner staff were able to work with all health corner participants in this building, emphasizing the importance of everyone only taking medication prescribed by their own doctor.

One partial withdrawer told another story about how the health corner was used as a resource for participants to direct people with medication problems. She said that one resident had run out of heart medication and that she was not planning to replace it for a few days. This senior realized this might be a dangerous thing to do so she urged her to talk to the health corner nurse about that. She said, "I didn't want to tell her anything but I knew it was wrong you know."

One example of nutrition information given by the health corner was related by a program participant. She said,

> And they told us about margarine which one is good, which one isn't so good . . . and they gave us little hints . . . and they would tell us how to judge like buying meat . . . they would tell you what to look for and stuff - yeah they gave us a lot of good ideas.

The advice given at the health corner was appreciated by this partial withdrawer. She said, "And I found that helpful, you could talk to her and she would have a better idea whether you should see the doctor now or if it was something that could wait."

Attendance. Although some people attended the health corners regularly, every week, others attended with less frequency or only occasionally. Some of those not attending very often were having their blood pressure monitored regularly by their doctors.

Adaptations. Accommodations were made at the health corners in several ways. Pamphlets were enlarged and felt markers were used by one nurse for people with poor vision. One staff member reported that when she had to look up information for a senior, in "a couple of instances I phoned them that night and told them the information because it

was something I felt was very important for them to know." For those seniors unable to come to the health corner, the nurses made occasional "home visits" to their apartments.

Newsletter

Participant descriptions of the exercise classes and the health corner were lively and related with a great deal of enthusiasm. In contrast, participant descriptions of the newsletter expressed a polite, reserved interest. Some of the participants admitted that they had trouble remembering the newsletter. Others did not say so, but it is likely that some of the others also forgot. Of the 20 participants questioned only 12 gave responses indicating they likely did remember it. However one lady was quite interested and showed the researcher that she had saved all the newsletters. In general, they had very few comments about the newsletter. Liking the recipes was mentioned by 5 people. One said it was "good" and another that it was "interesting." One participant mentioned he has trouble with reading because he is legally blind. Another said she was too busy and didn't have time to read it. One lady said it wasn't too interesting for her at that time because she was healthy then. Staff did not get much feedback from the seniors about the newsletters. However, this feedback was not explicitly sought during the program.

Termination

More than half of the participants expressed an unprompted wish for the program to return to their building. A staff member said, "they really didn't want the program to end." One resident reported that her building , "had a meeting to see what the residents want and that [exercise] was on the top of the list . . . so they're hoping that they bring in

. . . an instructor." Two family members also expressed that they wished the program would continue. One of them said, "They should keep it up with more groups, more people on more days."

Emotional reactions to the termination of the program ranged from anger to sorrow, disappointment and sadness. There were some tears. A staff member noted that seniors were "very upset" about the program being finished. One focus group staff member said, "I miss them . . . you get really close." A family member who attended some exercise classes herself noted the reaction to the termination of the program. She said, "some people were regretting that it was only temporary" and also, " they got sad when that finished."

At the end of the program there was some gift giving. One of the instructors gave participants certificates to indicate their completion of the program. Seniors gave some instructors various things including hugs, money, baking and cards. In one building there were two teas held one for the exercise leader and the other for the health corner nurse. One of the participants who organized the teas said, "and some people . . . wanted to be a part of it so bad they just went home and they baked and they made fresh buns you know."

There was also a lack of understanding about the termination of the program by some participants. One participant visited most of the other participants in her building to bring around a thank you card from a staff member. She said, "they just didn't see why it had to stop. . . . It was a research project and some of them don't grasp that that easy." Staff also noted that it was difficult for some of the seniors to understand that the program

was finished. One of them said, "they thought I would always come there . . . yeah they never could really understand." Another staff member said, "some of them . . . even think that we're coming back in the fall."

Follow Up

Most of the instructors left written instructions for the exercises with the participants so they could continue to do exercises on their own. There may have been some differences in the quality of the instructions as one respondent noted one sheet "wasn't very good" while another was "very good."

One participant described her difficulty doing exercises on her own. She said doing exercises in a group is like "I have an appointment. I have to go. I feel I have to go you know and you get it done. I don't fit it in my home program." Another participant did get around to exercising at home. She said, "there is a program on the TV that keeps doing these exercises and I do it in my chair."

In at least 2 of the 7 sites, participants are continuing to meet to do the exercises as a group and one of the participants leads the group. When asked about the new participant leader one respondent said, "she didn't mind doing it and she's younger . . . she can do most well everything." In one building, the participants are thinking of approaching new residents to join their follow up group.

Feedback

Participant Feedback

Every one of the participants interviewed had positive overall comments about the Seniors ALIVE Program. Some sample comments follow:

> "I've enjoyed this [the program] so much that I have no complaints at all."
>
> "I thought that that program was a wonderful thing to have and that more people should have it and that we should have had it earlier."
>
> "I don't think there was anything I didn't like . . . these [exercises] were very easy on the joints and like I said, the same as what they do through the Glenrose [arthritis program] . . . I found it very functional and I think it's a good thing for older people . . . it was basically very good."
>
> "This program was wonderful. It was free and a group thing. It was a fun time."

Although she thought the instructor did "okay," one participant did not see the relevance of describing the exercises as "milking the cow and playing the violin". She thought these descriptive comments were silly and had nothing to do with exercise.

Some specific suggestions from the participants were:

- Have a backup instructor
- Always have music
- There should be privacy for the health corner
- Notices for program should be smaller so they don't take up the whole bulletin board.
- Morning programs were preferred by the majority of participants
- Evaluate sooner because some details were forgotten.

Staff Feedback

Staff thought this was a good program. For example one said, "And overall I just think it was a really great program. I don't know what you would want to do differently." Another said, "There aren't any negative points to it, there are so many benefits for the seniors."

Specific suggestions from the staff included:

- Make sure proposal includes funding to hire regular staff who can continue in the position long term and provide proper equipment
- Spend more time on introductory meetings and one on one contact to make sure seniors understand and stay engaged in the research part of the program
- Consider expanding types of screening offered to include for example blood sugars and cholesterol
- Focus group staff thought there should have been more connection and collaboration between health corner and exercise staff
- Keep regular days and times
- Focus group staff thought that giving certificates at the end would help seniors realize program was finished

Family Member Feedback

Family members noted that the program was something interesting for the seniors to do. It was a social event. One family member actually attended an exercise class and she noted the commitment of the participants. She said, "and I talked to other people too there. I saw how interesting it was for them, how committed they were about that."

Another comment from a family member was "seniors just need to know there's somebody concerned [about their health] other than family members."

Withdrawers Feedback

Each of the partial withdrawers had a comment to make about the program:

"I don't thing they could improve on it. It was fabulous."

"I thought it was really worthwhile."

"Everybody here that I know and the women in here just loved it and they were ready to go upstairs any time you know."

Even the withdrawer said that " . . . I liked going there. . ."

Program Participation

The numbers of participants in the Seniors ALIVE Program are shown in Table 4.2. There were many more females both in the buildings and enrolled in the program than there were males. There was an overall withdrawal rate of about 30% between the beginning and the end of the program.

Table 4.2

Number of Building Residents and Program Participation

Total in Buildings	Initial Program	Final Program	Withdrawers
T 498	T 147	T 102	T 45
M 120	M 12	M 8	M 4
F 378	F 135	F 94	F 41

T = Total M = Male F = Female

Motivation

The most common reasons given by participants for joining the Seniors ALIVE Program are shown in Table 4.3. That they need exercise or that exercise is good were the most common reasons given by participants. Social reasons, for companionship and having something to do were the next most common reason. The following reasons were only reported once: being an alternative to water therapy, wanting to help with research, being more convenient than attending another program, being ready to start an exercise program and worrying that the program might be taken away if it is not used.

Table 4.3

Most Common Participant Reasons for Joining the Seniors ALIVE Program

Motivation Reason	Number of Times Mentioned
Need it	9
Exercise is good	9
Companionship	4
Something to do	3
To feel better	2

One reason for attending the health corners was to check a normal blood pressure and pulse because "down the line you never know." Other reasons given for attending health corners were that it saves long waits in a doctor's office, learning about medication, doctors don't always explain things very well, not trusting the accuracy of blood pressure readings taken by themselves with machines in stores and having a fluctuating blood pressure.

Encouragement

Participants were asked if anyone encouraged them to participate in the program. Six participants identified their doctors as encouraging them to participate either in this program in particular or in exercise in general. Two respondents said their families encouraged them to participate. The exercise leader, the health corner nurse and other participants were also described as having encouraged participation in the program.

Discouragement

Three participants reported situations where they were discouraged from exercising. One lady said her family all looked at her like she was "nuts" when she was exercising. Once they found out how beneficial the exercises were, they didn't say anything about her exercising again. One resident reported that a Seniors ALIVE participant who was no longer attending the program tried to discourage her from attending the program. Another lady who has a membership at a health club said that other residents think "I'm crazy" because she is often going off to the health club to exercise.

Withdrawers and Participation

This group is made up of three partial withdrawers and one withdrawer. They all did at least some exercise classes. The withdrawer however did not ever attend a health corner while the partial withdrawers all attended the health corners and continued to do so even after they did not attend the exercise classes anymore. The reasons given by partial withdrawers for initially joining the program were: for the exercise, to exercise in a group, to get more fit and to get more health information. Two of the partial withdrawers were

cautioned by their doctors not to overdo the exercise. The main reasons for discontinuing the exercise for all the withdrawers were because of pain or fear of pain with exercise.

The one withdrawer initially signed up to help with the research. She said that the exercises, "just didn't suit me. I didn't like the exercises." She said, "I don't really need to go to these heavy exercise - they weren't heavy but they just weren't for me". Table 4.4 shows a comparison of the reasons for joining the program and the reasons for withdrawing from the program for the withdrawers and partial withdrawers. The withdrawer had only one reason for motivation to join and eight reasons for withdrawing.

Table 4.4

Motivation and Withdrawal Reasons for the Withdrawer and Partial Withdrawers

	Withdrawer	Partial Withdrawers
Motivation	Help with research	Exercise
		Group activity
		Get fit
		Health information
Withdrawal reasons	Pain	Pain
	Not understanding pain	Not understanding pain
	Forgot	Doctor caution
	Busy	
	No need for exercise	
	Good health	
	Did not like exercise	
	Exercise is not for me	

Encouraging Others to Participate

Participants were asked what they would say to encourage others to participate in the program. Their responses were that they would tell them: it is convenient, it is good for your health, it is an opportunity for socializing and it is not too strenuous. Also included in the responses were to tell them that they need exercise. Another response stated if they need it they will go. One response was that a return of the program might encourage others to attend. The last response was that a personal visit but without pressure might encourage others to participate.

Barriers

Participants. The most common reason given by participants for not attending the program themselves were having other priorities. Deteriorating health was reported six times, program factors such as no instructor or no participants and time changes were reported four times and forgetting was reported three times. One respondent described how she forgot to attend the program one day:

> I remember one morning I thought 'oh the nurse is coming this morning.' And I thought well, 'I'll go out and get the Journal and by that time she'll be in'. . . . And then I came in and completely forgot about it and then . . . I dashed over there and she was gone.

Others. Participants identified some reasons why other residents either did not join the program or did not continue to attend the program. The majority of these reasons were poor health and other priorities. Next most common were program factors, social reasons such as not liking the people they would meet there or not being very social in the first place and moving.

Staff perceptions. Staff members identified social factors such as societal attitudes that seniors should be pampered, discouragement from some doctors, negative building social dynamics and not liking a particular instructor as possible barriers to participation. Another factor they identified as a barrier to participation is seniors' lack of knowledge about exercise and health. They also noted the lack of men attending the program.

Staff identified the social aspect of the program as being very important. As one staff member put it, "that whole group thing motivated them . . . not letting the group down". Fun was also identified as being important for participation. One focus group staff member said, "I'd say why did you come and they'd say cause we heard it was fun". Staff encouraged seniors to do exercise in general and attend the classes as well. For example one staff said, "I tried to encourage people when they walked by you know 'Oh come and join us you know it's not that hard anybody can do it'". Another factor that staff identified as encouraging participation was seniors' noticing improvements in themselves. One staff member noted that seniors were "really encouraged" when she pointed out a drop in blood pressure.

One staff member who worked in both health corners and exercise classes thought that there was no significant differences in the health of those who participated in the exercise classes and those who participated only in the health corners. She said,

> For the most part they were probably on par with each other when it came to ailments . . . it's just their outlook . . . I've had some people . . . they felt you know like I can do this, I want to do this . . . I've talked to some other people with the same problem that wouldn't show up [to exercise class] because they thought to themselves 'well no I can't do this, it's too much work, it's too strenuous for me, I can't do it'.

The main reasons participants gave for joining the program were that they perceived some benefits of exercise. Social reasons such as companionship were also mentioned. When asked if anyone encouraged or discouraged their participation, participants most often talked about doctors encouraging their participation either in exercise or in the Seniors ALIVE Program. Barriers most commonly mentioned both for themselves and for others were having other priorities and poor health. Program factors and forgetting were other reasons given for lack of participation. Staff perceptions of what was important for seniors to participate included: the social aspects of the program, having fun, seeing improvements in themselves and a positive attitude that they could do the exercises.

Program Impacts

Twelve participants said that they felt better after participation in this program. This was the most commonly identified impact by participants. Some people specified having more "energy" and another called it "well-being" while others could not be more specific. One participant said, "I felt so good it sort of perked my whole self up because you just sit here you know and do nothing." Another participant said, "You feel more alive, as you say Seniors ALIVE." This overall feeling better was confirmed by both staff and family. One staff member said, "I think people felt better." A family member said that her mother "was just more spontaneous . . . it just contributed to her well-being."

Physical Health

Specific physical changes noted were: loosening of arthritic joints, more flexibility, decreased blood pressure, sleeping better, less pain, weight loss, increased strength, improved breathing, improved circulation, improved muscle tone, improved digestion and being able to move better. Table 4.5 shows the number of times participants reported various physical changes.

Table 4.5

Physical Changes Noticed by Participants After the Seniors ALIVE Program

Change	Number Reported by Participants
More Flexible	4
Moving Better	4
Increased Strength	3
Aches	3
Weight Loss	2
Less Pain	2
Sleeping Better	2
Decreased Blood Pressure	2
Improved Breathing	1
Improved Circulation	1
Improved Muscle Tone	1
Improved Digestion	1

One participant gave an example of a physical impact of the program. Her friend had a sore shoulder "and then with the exercises . . . she can move it much better . . . and it didn't hurt so much . . . she was so proud of that arm."

Three respondents reported aches they did not have before the program and four respondents reported conditions that may have interfered with noticing physical changes such as a thyroid problem and having been very ill recently.

> Staff also noticed physical changes in program participants. One staff member said, I'd have them sitting in the chair and . . . I told them to pretend there's a five dollar bill down there and you know try to reach for it. And she'd reach as far as she could go. And there was this one time that she was able to touch the floor and she ended up screaming really loud . . . and she said 'I can touch the floor' . . . and she was able to see improvements in herself.

Improvements in strength and endurance were also noted by staff. One staff member had taught exercise classes only at the beginning of the program. When she returned later to take the place of the new leader she noticed that the participants were using heavier resistance bands than they had at the beginning of the program, and they didn't seem to be getting as tired as easily because they could do more repetitions and they were able to march a little longer than previously. Another staff member noted that "In the beginning . . . it would take them a good 15 minutes to walk up the one flight of stairs and towards the end it would take them 5."

Staff also noted some physical impacts from the health corner. There was one lady who had a chronic bladder infection. At the health corners she was encouraged to see her doctor. She went to her doctor and was put on medication. Another lady was very itchy. The health corner nurse encouraged her to see her doctor and to keep her blood sugar

under control. She did see her doctor and started testing her blood sugar more frequently and some of her itching was relieved.

The withdrawer noted more pain after participating in the exercise program. She said, "I would come home and I'd limp. I said well this is crazy. I don't need to go to exercise to put hurts in my knees." Partial withdrawers shared a similar physical impact with the withdrawer. They had more pain after exercising. One said about the exercises,"I could do them all [exercises] but I suffered after . . . and I could never find out what I should be doing or what I shouldn't." Another said "I went to it [exercise class] and then I found out I was getting too much."

Continuing Behaviour

One participant walks more now than before the program. Another does exercises at home with a TV program and checks his blood pressure more often. In at least two buildings exercise groups are continuing to meet. Two family members reported noticing increases in the amount of exercise being done by their seniors.

Mental and Social

Two participants reported being happier after attending the program. Being more alert, having more companionship and feeling better mentally were all mentioned by one participant. Some of the participants are really missing the health corner nurse. As one participant reported, "the ones who are really missing [the health corner nurse] now are people who do have . . . to depend on their family or a taxi or something to take them to different things." One participant described the changes she noticed in her building. She said,

> People I think got to know each other a little bit better and saw each other in a different light . . . greeting each other, laughing and joking . . . things used to be . . . laid back, people are a little bit quiet, maybe a bit timid. This [the exercise class] just seemed to bring people out of their shell.

Health corner staff noticed changes in mental and social health as well. For example one staff spoke about a cancer patient who came to the health corners. In the beginning she was very depressed and she would cry almost every week. And toward the end,

> She would come in and she would have a smile on her face and she was much more social also . . she got a brand new hearing aid . . . before she was just, "oh it doesn't really matter, nobody's going to talk to me anyway".

Another example was a man whose wife had died last year. He was very lonely. The manager of the apartment building told a staff member, "he never came out of his apartment but he was at each and every health corner . . . the manager felt that that was a significant thing for him - to come out all the time."

Exercise staff also saw improvements in mental and social health. There was a 96 year old lady who was a little confused. At first she was very reserved and could not keep up with the exercises but, "by the end of one month . . . she was talking to the people, she was really comfortable with that group and she was able to follow the exercise classes a lot better . . . her concentration skills were better."

An exercise staff member noted that, "they left with smiles on their faces . . . And they seemed like they felt better about themselves. It increased their self esteem." Another thought that "their quality of life improved."

Family members saw changes in mental and social health. One family member noted that her mother was experiencing some social problems in her building but through the program she "got a new group of ladies in the building." Having a new social group made a big difference for this senior. Her daughter reported that before the program she was saying things like, " I've got to get out of here, I've got to move . . . and she doesn't talk like that anymore."

Two other family members reported that their seniors seem happier since participating in the program. One said she thought that the program, besides making him more "easy going,"was also a motivation to help him get up before noon. Another family member reported that her mother "seems happier" and is now more motivated to look after her own nutrition. Another family member reported,

> He more questioned things - like if something went wrong with him physically he was like well 'I think I have to go to the doctor and get that checked'. . . He was more aware of certain things that could go wrong.

Knowledge

Some participants identified changes in their knowledge from having participated in the Seniors ALIVE Program. Three participants noted that they learned the benefits of exercise. Two participants said they learned how to do certain exercises. One participant reported learning about high blood pressure and another participant reported learning about healthy recipes.

One impact of the program noted by a focus group staff member was a change in participants' attitudes towards exercise. Societal attitudes have been identified as affecting what seniors think they are capable of doing (Minkler & Checkoway, 1988; Phillips,

1988). Birth cohort also can affect attitudes (Passuth & Bengtson, 1988). The knowledge gained by participating in the exercise classes contributed to changing societal and birth cohort attitudes. The focus group staff member related,

> One of the things I heard frequently at the beginning was a kind of a pride in being too frail to exercise. And I attributed this to their generation . . . Then . . . it was just kind of unfeminine women who did [exercise] . . . they would come and it was almost like daring me to prove that they could exercise . . . so what I found toward the end was that they had dispensed with all that . . . They were just enjoying the exercises to whatever extent that they could.

Independence

One person reported being able to do more activities that together allow her to be more independent. Doing her housework is easier. She said that "Vacuuming . . . was so much easier. It's very difficult when your leg gets extremely stiff. It's not any more." She also finds it easier to walk so she can do more things with her grandchildren.

One staff member thought that the health corners "were able to help them manage their health problems themselves." A family member noted that her mother was able to be more independent socially. Her mother was more willing to do things on her own after she was involved in the program such as using voice mail and a banking machine. She also said that before the program her mother would not deal with government officials on her own but would let her children do that. She recounted that,

> I can't believe the other day she went up to the provincial government . . . She wants her direct deposit to go to her new bank. She did that on her own . . . She actually went into the building to do that on her own. She wouldn't have done that before. . . . She told him [my brother] to stay in the car. She wanted to do it on her own.

Impacts on Staff

Staff noticed some changes in themselves after participating in this program. For example one staff said, "when I first started I was really shy, I'd never taught a seniors' exercise class . . . they gave me a lot more confidence in that area." Another staff was not sure she would like working with seniors or not before the program but now, "I'm actually now looking at going into geriatrics." Another staff member learned a lot about seniors she said' "I thought I had a good understanding of seniors but . . . after finishing the program it's amazing to see how they viewed their lives and how they viewed their health."

Impacts on Family

Two family members mentioned that their parents were more inclined to listen to health advice from medical staff than from family members. One of them expressed it like this, "you know nurses and doctors have a kind of a power that daughters I don't think have." The other complained that her mother never listens to her, "so it's better to listen to somebody else I think and let them reinforce all the things that she needs to do and take care of."

The Social Environment

The social environment of the Seniors ALIVE Program was composed of the people and relationships involved in the program. Program participants and program staff were the main people involved in the program. First they will described. Because the already existing relationships in the social environment of the building had some influence

on the program they will be described. Finally the socialization that took place in the Seniors ALIVE Program will be described.

Program Participants

Compiling information about program participants relevant to their participation in the Seniors ALIVE Program gives an overall picture of what they are like. For example reading is a problem for some of them. This is either because of visual difficulties or because they never did read very well. They don't always tell others that they are having difficulty with reading. One health corner nurse had sent a thank you card for a farewell tea to a particular participant and had asked her to share it with other participants in her building. This participant personally visited other participants to show them the thank you card. She said of another participant,

> Then she just set it [the card] on the chesterfield beside her just quite quickly and I thought well I don't think she could read that . . . And I said to her "Were you able to read that alright"? and she said, "Well I have a problem with my eyes."

In spite of the difficulties some residents have with reading, the most popular way for participants to obtain health information is through reading. The next most popular ways to obtain health information are by asking their doctor, television and lectures. Other methods mentioned were by using the telephone, listening to the radio and through a hospital.

The weather affects how much some of the seniors go outside. In the summer they can get outside more easily than in the winter. One participant spoke about winter weather, "as far as winter goes . . . there's a number of us who don't like to go out

walking in the winter even for an exercise class because there's too much danger of falling."

Remembering is a problem for some of the seniors. The notice posted on the bulletin boards in the building were helpful in reminding people of the next program day and time. Some people also used their calendars to keep track. Residents also reminded each other not to forget about attending the program. One participant suggested that the difficulties some of the participants had in understanding that the program was ending may have been partly because of forgetting what had been explained to them before. One of the organizers of the farewell tea was trying to explain to the seniors the difference between the exercise leader and the health corner nurse who was also the program coordinator. She said "and I explained to them you know . . . because they were quite confused between [the program coordinator] and [the exercise leader] . . . A lot of them had trouble grasping that link they just - they don't remember."

Some of the seniors do not have many friends left. As one senior put it,

> When you get to my age your friends are all gone, I'm the only one left in my family. . . and consequently you get to the point where you have no friends left so the friends in here that you make . . . it's important to me . . . it does a lot for me.

Although friends are important to some of the seniors, the majority of the participants said they would attend an exercise class even if their friends were not there. Only one person said she would not attend if her friends were not there.

Seniors help and look out for each other. They did this by asking the health corner nurse to make a home visit for a senior who could not attend the health corner. As one staff member reported, "They would come and get me and say well she really wants her

blood pressure checked today and can you come?" Seniors would phone people who didn't come to exercise class to see if they just forgot. One staff member said, "you really felt a sense of teamwork when you came to those exercise classes just because if there was one person that didn't show up they would phone . . . to remind them." Staff reported that they also helped each other with the resistance bands because some of the seniors couldn't bend down.

There is a fair amount of movement of people in and out of these buildings. One participant said,

> There's always people moving in and out of here too you know . . . It reminds me of a hotel in this sense . . . They're here for maybe a short term and a long term, well I mean it's sort of like a stopping off point before you go to the next phase you're going to go to. You're going to need long term care you know. But you don't try to think about that.

Participants were asked if they had any particular thoughts just before they went to the program. Half of the fourteen participants who responded to this question wondered who would be at the program. Only 2 of 14 respondents worried about getting too tired or having pain. One person was hoping a certain person did not come because there was a disruptive participant who took it "as a joke." Three people reported other thoughts when getting ready to go to the program. One of them was worried about the class going longer than 30 minutes and the other two expressed a happy anticipation. For example one respondent said,

> I looked forward to going to it . . . you were up there with other people, you were all doing the same exercises . . . you weren't ridiculed because you could only do so much . . . but you got a few laughs out of the whole thing.

Participants were asked if they thought that exercises might be too hard for them. Only 2 of the 14 participants thought the exercises might be too hard for them before they attended a class. The rest had no concerns. One respondent noted that he had been able to observe a class before he attended one as a participant. He said "it looked good to me and . . . I didn't think it would have been too hard for me you see."

Most of the participants had prior experience with both blood pressure checks and exercise behaviour. Only 3 of the 14 participants who responded to this question reported not having previous regular blood pressure checks. The previous checks ranged from once a year to twice a month. The checks were either at their doctor's office or at a store where they checked their own blood pressure. Only 2 of the 14 participants reported no prior exercise behaviour. Most of the others had been quite active in their younger years with participation in sports, yoga, tai chi classes, health clubs and exercise classes. There was visible evidence of an active life style in one apartment where a rebounder was seen in the livingroom. One lady still has a membership at a health club at the local mall. Another respondent still rides a mountain bike. A few reported doing their own exercises at home.

Staff

Most sites experienced more than one exercise instructor and some as many as three or four. When the instructor changed the time and day of the class sometimes had to be changed as well. There were no complaints about the number of different instructors although in a few cases some instructors were preferred over others. When asked about the change in instructors, one respondent replied that it "didn't really matter to me but as long as they knew how to teach us."

Overall participants were very pleased with the program staff. One comment was, "the girls were very very nice girls, really willing to help in any way." Another comment was, "she was very qualified, yes I have been to paid therapy that was worse." Another comment was about a health corner nurse. "I think you could have if you'd had time, could have told her all you life's history you know or ask her when you had problems or anything."

One staff member reported that some of the staff formed "helping relationships" with the seniors. Relationships with the seniors were described by staff as being like a "daughter" or a "granddaughter." One focus group staff member said that the seniors were "my teachers" and also that "I was like their teacher." Relationships were described by staff as being "close" and "attached." One staff member heard seniors express "tender emotions" for some of the younger staff.

Two participants thought that one of their instructors did the exercises too quickly. One of them pointed out that she didn't think that some of the younger instructors realized that "older people don't move as fast as . . . they do." The other participant said she talked to an instructor who she thought was going too fast and she slowed down.

At least one participant did not see eye to eye with an instructor about the value of exercise. The participant had told the instructor she would be missing an exercise class because her housekeeper was coming. The participant said, "And the instructor said . . . exercise is . . . more important than your housework. I said it might be to you, but it's not to me. I'm a very fussy person."

One participant thought that an instructor talked too much during the exercise class. The talking was seen to use up the participants' exercise time. There was one example of a staff-participant interaction that ended up with a participant not returning. A participant related,

> There was this one lady . . . she was sitting where she always used to sit and this one morning she [the instructor] says oh come on let's all get a little closer. And she [the participant] says no I want to sit here. And she [the instructor] says no you have to move. So she [the participant] says move yourself. She [the participant] says I quit . . . and this lady used to go all the time.

One lady thought that the exercise instructor was not very organized because the classes varied in length from 30 minutes to 45 minutes. Two participants mentioned the instructor being late getting the class started. One lady was under the impression the class was only supposed to be 30 minutes long and was impatient to leave after 30 minutes. However, she was likely mistaken because everyone else said the classes were between 50 to 60 minutes.

Social Relationships

The manager. Most of the buildings have a building manager. This person is in a position to be influential with the seniors and facilitates contact with the president of the residents' association in the building. One staff member felt that the managers' attitude toward the Seniors ALIVE Program affected the amount of participation in the program. The buildings with managers most supportive of the program had higher participation rates than in buildings where managers were not as supportive of the program.

Social groups in the building. There is evidence that the buildings have different social groups functioning within them. As one staff member said, "the dynamics are unique

to each building and set the tone in the building." Another staff member noted that there were "about two different groups of people in the building . . . and they didn't like integrating between each group." One of the participants is reported to have told a staff member that,

> The reason that a certain number of people didn't participate in the project was because all the ones that were participating were in a particular faction in the building and I guess there were a lot of dynamics in that building.

Most buildings have social clubs that organize various social activities such as entertainment or pot luck suppers. Although some seniors enjoy and participate in these activities others rarely come out of their apartments. For example one senior said, "we've had other things going on in the lounge and there are so few people some of them never come." Another senior pointed out that "for the amount of people in here there's a lot of them that don't participate in anything." Men particularly were identified as less likely to attend social events in the buildings.

Privacy. One senior explained that in a previous building she had other residents visiting her apartment all the time. She said, "they were there all the time so you never had no time for yourself." In this building she prefers to meet others outside her apartment so she can keep some privacy. In these buildings news travels very fast. As one staff member noted, "everyone seems to know everybody else's business." One example was that right after a person left the health corner the next person already knew about the previous persons' blood pressure reading.

Negative social interactions. Participants from different buildings related stories of negative social interactions. One described it as "back stabbing." Another said, "the group

gets together and they get to gossiping and the first thing you know, you're in trouble." A third senior described it as "a lot of people . . . don't love one another or like one another." The reason for this she thought was,

> They are old you know . . . they're getting a little bit senile maybe . . . one lady's always talking about when she was young . . . and then the next one cannot stand it and they say 'oh you're just a crabby old woman' and then that crabby old woman is so hurt.

Most of the program staff were aware of the negative social interactions. For example it was noted by program staff that one senior "was ostracized" , that there were "little cliques" and that "familiarity breeds contempt."

Socializing in the Seniors ALIVE Program. One staff member thought that the Seniors ALIVE Program "gave them a chance to get to know their neighbours a lot better and gave them an outlet for socializing." Another staff member described the health corners as "a very social time". Another staff member described the program staff as being like "an icebreaker for them to get to know each other." Staff actively encouraged social interactions among participants. One focus group staff said, "I would try and get little interaction things going between them." Another staff member said, "I encouraged the social atmosphere."

Participants enjoyed the social aspects of the program. As one participant put it,

> It was like a meeting point with the other members that were in the Seniors ALIVE . . . we always sort of looked forward to that . . . We'd have our chit chat. I thought that was sort of nice. You got to know the other ones on a first name basis . . . up there [in the exercise class] we seemed to have something in common with one another . . . we were all doing the same thing.

There was a change in the social interactions over time. In describing the health corners one staff member said, "people would come by themselves at first and be hesitant and . . . then I'd see the same two ladies they'd come together and it seemed like they became friends." In the exercise classes one participant thought that people became less self conscious over time and were more relaxed. Another participants' description of changes in an exercise class was, "People weren't so worried about what their neighbour was doing and they could joke and laugh amongst each other - much more fun as time went on."

There were also a few examples of negative social interactions in the Seniors ALIVE Program. For instance in one of the exercise classes at the end of the class the participants gave each other a back massage.

> When we were finished and we all turned and did this massage thing, well she was hurting me. And I told her 'I know you don't mean to hurt me but please don't.' Next time she grabbed me by the neck and wouldn't let go. . . . So they stopped this [the massage] . . . And I stopped being her friend I'll tell you.

One of the staff members presented evidence that the negative interactions in the building can affect seniors social participation. She said,

> Some of the ladies said oh well I don't like that person and if I go to the exercises I have to see that person . . . if there's one person they don't like they won't go out. They won't go into the same area.

The amount of socializing that took place around the exercise class varied according to individual's needs and other opportunities available in the building for socializing. At least one of the buildings had a regular coffee time not associated with the

exercise class. Sometimes small groups would visit after class and in one building they had coffee together after the class.

There was some evidence that there was socializing around the health corner with other participants. For example one lady said, "so then after your schedule [at the health corner] then you sit for a while and gab." Another stated that "a very friendly group of people was there [at the health corner]."

Summary

In this chapter, information from program withdrawers, program staff and family members of program participants has been used to enhance the description of the Seniors ALIVE Program from the program participants viewpoint. Participation in the program was discussed by considering initial motivation, sources of encouragement, discouragement and barriers to participation. The impacts of this program have been described with examples given from different informant groups. Finally the people and relationships involved in the social environment were considered. The social aspects of the Seniors ALIVE Program were described with examples from both the exercise classes and the health corners.

The following points summarize the major findings of this qualitative evaluation:

- An overwhelming majority of participants and staff loved this program.
- The exercise classes were the most popular with the health corners next and the newsletters third
- Participants were encouraged to decide for themselves how they would participate in the exercises

- Staff established strong bonds with the participants by listening to them and being flexible in the delivery of the program
- Termination of the program was not well received and sometimes not understood by participants
- The most common factors influencing participation reported by participants were perceived benefits, encouragement, social factors and fun. Staff noted seeing improvements in themselves and a positive attitude seemed to be important for participation
- Barriers to participation reported by participants were having other priorities, deteriorating health, program factors, social factors, and forgetting
- The most common impact reported by participants was that they felt better after participating in the program
- There were examples of specific physical, mental, social and behavioural impacts
- A few impacts of the program on participants increased their independence
- Program staff and family members also experienced impacts
- The apartment buildings all had established social environments with both positive and negative aspects that influenced the program
- The social aspects of the program were very significant for many participants

The findings presented in this chapter are discussed and considered in light of the literature review in the next chapter.

Chapter Five: Discussion

Introduction

The objectives of this evaluation are to explore the experiences of program participants, to determine factors influencing participation, to determine the impact of the program, and to provide a qualitative evaluation. Discussion of the findings in this chapter are organized around these objectives. First, the experiences of program participants with supporting evidence from program staff and family members, are used to explore possible mechanisms of program function. To further consider how the program worked, the Seniors ALIVE Program is discussed in relation to Hamilton and Bhatti's (1996) population health promotion model. Second, factors that influenced program participation are compared with those described in the literature including Pender's revised health promotion model. Third, possible explanations for impacts of the program are considered. How the program supported successful aging is explored. Limitations of the study are described. Finally, suggestions are made for future health promotion programs and for future research.

How the Program Worked

Figure 5.1 shows a representation of how the Seniors ALIVE Program worked based on the findings of this study. The interventions of the exercise classes and the health corners appear to be the most important interventions both in terms of participation and impacts on program participants. The newsletter could be considered an adjunct

intervention. It did not appear to have had any direct impacts on program participants by itself but acted indirectly by supporting the other two interventions.

The exercise classes provided physical activity adapted to the needs of individual participants. They also provided education about exercise and opportunities for social interaction and support. The health corners provided health screening, various kinds of health information as well as opportunities for social interaction and support. They were also used as a resource for participants to refer other seniors about whom they were concerned.

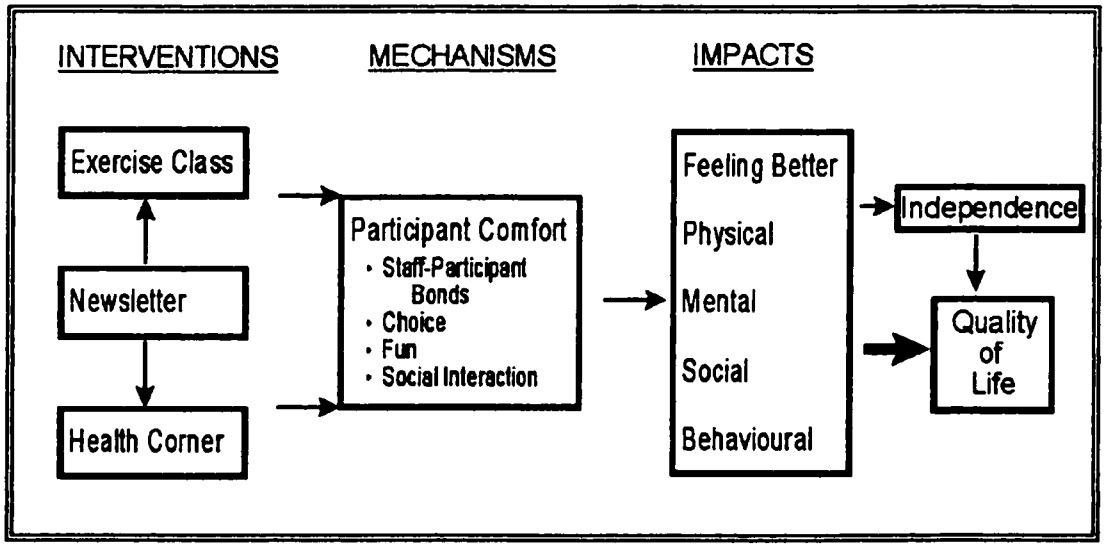

Figure 5.1. How the Seniors ALIVE Program worked

Mechanisms of Program Action

Staff-participant relationships. The strength of the relationships established between the program staff and the participants was very evident. These relationships developed over time. Staff described participants as becoming more open with them about

their problems as time progressed which probably corresponds to the development of trust over time.

Staff talked about participants in a way that demonstrated caring and empathy for the seniors. Examples of staff caring for seniors were when staff adjusted the program to fit participant needs such as arriving early before the class to chat, phoning information before the next scheduled health corner and making an occasional home visit.

Participants were very positive about program staff. Generally, they really liked the "girls." Some of the participants mentioned particular staff by name. This stands out as significant because seniors in general had a hard time remembering specific details of the program. For example one senior who forgot she received newsletters still remembered the name of the health corner nurse and there was a softness that came into her voice as she spoke her name.

There was evidence that the bonds were mutual and reciprocal. For example there was mutual gift giving at the termination of the program. One staff member described herself as being both the teacher of the seniors and the student of the seniors. Relationships with the seniors were described by staff as being like that of a daughter or granddaughter. Staff's readiness and ability to listen to the seniors and to be flexible in program delivery likely contributed to the development of the strong relationships between staff and participants.

Listening. Program staff noted that listening to the seniors was an important part of their job. One of the exercise leaders would arrive half an hour early for class so she would have a chance to interact with the seniors before her class. There is evidence that

their listening was of a very high quality. For example one participant said that she felt she could have told the staff member her "whole life's history."

Flexibility. The ability of the program staff to be flexible was an important element of the program. For example one of the focus group staff members recounted the time one of the participants died. She said "there were times where we didn't [do all the exercises] because there was talk because someone died." In the health corners this flexibility was seen by the willingness of the nurses to occasionally go to the seniors apartments when the seniors could not come to the nurse. The encouragement of exercise adaptations for individual seniors also demonstrated flexibility. This is very important especially in a seniors physical activity program because of the wide variations in physical abilities as people age.

Choice. Autonomy is the freedom to act and to make independent choices. A personal sense of control is highly correlated with good mental health (Zautra, Reich, & Newsom, 1995). Autonomy was encouraged throughout the program. Seniors were not pressured to participate in this program at any level. This included their decision to join the program in the first place and to later withdraw from the program. Seniors chose the amount of their participation in the program both the number of classes to attend and the amount and type of exercises they did within each class. Providing as many opportunities for autonomy as possible is important for seniors since many of them experience an increasing loss of autonomy because of the aging process.

Fun. Both participants and staff talked about the enjoyment and fun experienced in the program. For example, one focus group staff member said, "I'd say why did you come

and they'd say, 'cause we heard it was fun'." Staff recognized this as an important part of the program. They consciously worked at trying to make it fun for the seniors. Fox, Rejeski and Gauvin (2000), found that there was moderate support for the statement that enjoyment is important in the promotion of physical activity.

Social aspects. The social aspects of the program were very important. The abandonment theory, one of the social theories of aging highlights the social isolation experienced by some seniors (Fry, 1992). There is no doubt that some of the seniors in the program buildings were very lonely. One of the participants remarked about some of the other residents in her building, "They're so lonely." The importance of the social aspects of the program may be greater for some seniors than for others because they all experience different degrees of loneliness or abandonment. The opportunities for social interactions provided by the Seniors ALIVE Program were very significant in alleviating the social isolation experienced by some of the seniors.

There were different levels of social impacts. Impacts were noted in individual participant interactions, staff-participant relationships and the social environment of the building. The program and the resulting increased social interactions decreased the boredom experienced by some of the seniors. It gave them something to look forward to and was a social event for them. One of the focus group staff members described her role in the exercise class as being "entertainment" for the seniors. A focus group staff mentioned another function of the program was to work as an "icebreaker" that led to increases in the amount and depth of social interactions among program participants.

Comfort. Individuals perform more competently in environments where they feel compatible, related and safe. The environment is one of the situational influences in the health promotion model that is thought to influence participation in health promotion programs (Pender, 1996) . The term used to describe this optimum environment in the Seniors ALIVE Program was "comfort". Both staff and family members talked about the program being comfortable for the seniors. For example, one focus group exercise instructor said, "If they felt comfortable they came." Although seniors did not identify comfort themselves as important for their participation in a program, they did talk a lot about fun and enjoyment. It seems likely that comfort would be a prerequisite for fun and enjoyment to occur. Identifying specifically what makes seniors feel physically and mentally comfortable and uncomfortable could lead to some insights about program enhancement and participation.

Many of the strategies used by program staff to encourage participation helped to make the participants comfortable. This included making eye contact, listening to the seniors, forming strong staff-participant relationships, encouraging adaptations of exercises, being flexible in program delivery to meet seniors' individual needs, allowing choice in amount and type of participation, encouraging enjoyment and fun, using motivational strategies such as pointing out improvements, recognizing effort, encouraging the social aspects of the program, and allowing seniors to observe classes before they signed up for the program.

The interventions of the program resulted in participants generally feeling better as well as specific physical, mental, social and behavioural impacts. The majority of the

impacts positively influenced quality of life and a few also influenced independence. This is reflected in Figure 5.1 by the different thicknesses of the lines leading to independence and quality of life.

Population Health Promotion Model

Hamilton and Bhatti's (1996) population health promotion model is useful in considering the determinants of health and the Seniors ALIVE Program. Figure 5.2 illustrates and summarizes the various levels of action, the action strategies and the determinants of health affected by the Seniors ALIVE Program that will be described below. The darkest sections on each face of the cube represent the aspects of the population health promotion model demonstrated in the Seniors ALIVE Program.

Levels of Action

The Seniors ALIVE Program acted mainly at the individual program participant level but there were also some impacts on the social community of the seniors' apartment building, the program staff and the families of program participants. Figure 5.3 shows the relative relationships of the program impacts to the program.

The program had an impact on the social environment of the buildings. In some of the buildings the program acted as an ice breaker and helped seniors get to know each other better. The main program impacts were positive in increasing the number and depth of social interactions and contributed to creating supportive social environments. However, there were also some negative effects because of the increased exposure of people who did not "love one another." It is important that program staff be aware that

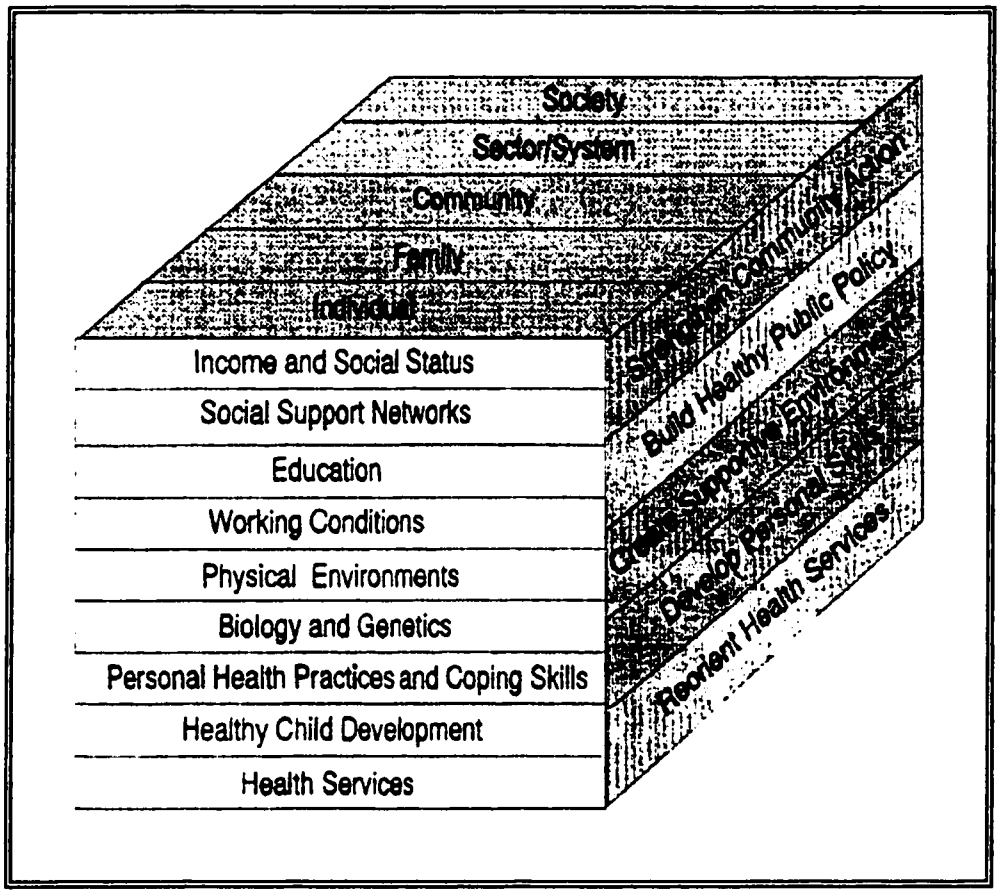

Figure 5.2. The Seniors ALIVE Program and the Population Health Promotion Model

the existing social environment likely has both positive and negative aspects and of the possible effects of both these aspects on the program.

Two of the family members of program participants indicated they felt that their family member became less dependent on them after participating in the program. These families of program participants are members of the "sandwich generation", squeezed between the demands of their own growing families and the demands of caring for their

aging parents. For these families the increased independence of their senior family members appears to be significant in relieving some of their care giving concerns.

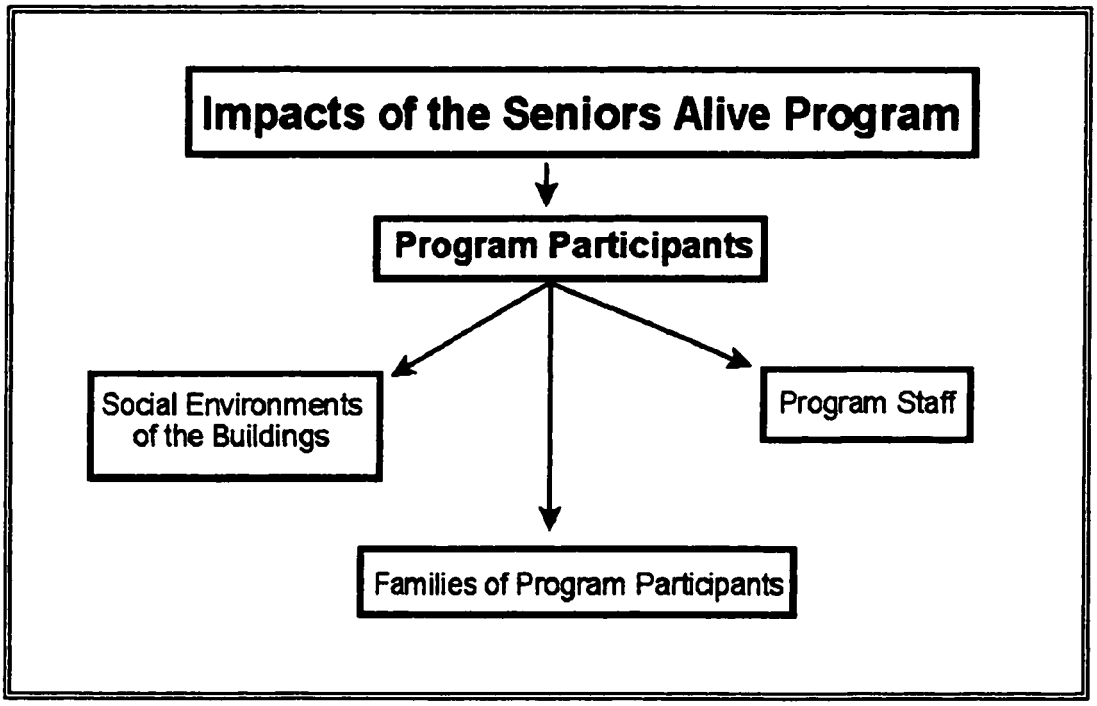

Figure 5.3. Levels of program impacts and their relationships

Health Promotion Action Strategies

The action strategies used by the Seniors ALIVE Program were to develop a supportive environments and to develop personal skills. Having the program in their own building and at no cost were important ways of making the program physically and financially accessible for low income seniors. The combination of interventions offered in this convenient format contributed to making a supportive environment for seniors to look after their own health. Because of the program, seniors were making more independent health care decisions, paying more attention to their health and participating in regular

physical exercise. Seniors learned how to do appropriate exercises and some also developed skills to lead exercise classes for the other seniors after the program terminated.

The program also strengthened community action. Experiencing the program helped seniors learn the benefits of regular exercise. As a group, some seniors have used this knowledge to set priorities and make decisions on issues affecting their health. In at least one building the seniors tenants' association has told the apartment manager that continuing exercise classes in their building is a priority. It is at the "top of their list."

Determinants of Health

The determinants of health influenced by the program were social support networks, personal health practices and coping skills. The newsletter and health corners provided health education and information that could be applied to developing personal health practices and coping skills. Regular exercise is one way of coping with or moderating the many changes associated with aging.

The location of the program in their own buildings made health services more accessible to seniors. Because there was no cost for the program everyone who wanted to participate was able to do so. Income was not a barrier to participation in this program. The exercise classes encouraged the personal health practice of physical activity as well as provided opportunities for increasing social support networks. Seniors' perception of their social status was affected by the program challenging some of the assumptions of ageism so that seniors learned that they were not too frail to exercise. Some seniors adopted a new role of "exerciser." Being able to contribute to the program in various ways such as

helping set up the chairs and physically assisting each other provided opportunities for seniors to feel useful.

Program Participation

Attendance

There is evidence that at least in some sites there was difficulty in maintaining the numbers of people attending the exercise classes. There were several reasons for this. First, seniors are more likely than adults of younger ages to experience declining health. Poor health is an important barrier to program attendance. Second, the increases in mortality with age will also affect attendance. In fact two participants died during the program. Third, the lack of a continuous routine because of the changes in time and day also affected attendance in the programs. Most of the staff were university students whose schedules changed every three months. There was difficulty finding replacement students every time the schedules changed. Fourth, moving was also identified as a reason for withdrawing from the program. As one participant pointed out many seniors eventually move on to lodges or nursing homes. Fifth, remembering was another problem. Memory losses are more common in old age. Some of them simply forgot to attend.

Logistics

The findings of this study are consistent with that of Connell et al (1988) who found that location, cost, day time of gatherings and an expert leader were important for seniors' participation in health promotion activities. Participants in the Seniors ALIVE Program appreciated the location in their own building. They described their

transportation difficulties that would make it hard for them to participate in a program that was more distant. The majority preferred morning, day time programs. Cost was mentioned as a consideration for some. One participant said she would not participate unless there was a qualified instructor.

Incentives

The positive incentives of feeling good, socialization (Pascucci, 1992), having a health benefit (Dishman, 1981 as cited in Pascucci, 1992) and fun (Weiss, 1985 as cited in Pascucci, 1992) were all given as reasons for participation in the Seniors ALIVE Program.

Social Involvement

Participants described a group of seniors who rarely participate in any social activities. Another way that prior behaviour might influence participation is suggested by the continuity theory of aging. This theory says that people do not change their behaviours very much over time (Fry, 1992). Participation in both the health corner and the exercise classes required some social interaction. It could be that participation in health promotion programs is also influenced by interest in social interactions. Perhaps seniors who do not participate in social activities never did participate in social activities even in their younger years. Their present behaviour of little social interaction could just be a continuation of earlier behaviour patterns.

This health promotion program was based on the assumption of an activity theory of aging which suggests that successful aging is a result of the elderly's motivation to stay physically and mentally active. But it seems that there may be some seniors who may want to stay physically and mentally active but do not want a lot of social interaction. The social

involvement required to participate in the program could have been a barrier for seniors who rarely participate in any social programs in their building. A program without a large social focus such as encouraging individual exercises at home might appeal to this group. A more individual health promotion program could be set up by doing individual exercises at home but being able to record their exercise time in the group exercise room to both help them feel a part of the program and provide some motivation to continue their individual exercises.

Another group of seniors could be dealing with aging by withdrawing from social activities as suggested by the disengagement theory (Fry,1992). Carstensen, Graff, Levenson and Gottman (1996) suggest that one of the critical factors that brings about a decrease in social interaction in old age, is the awareness of mortality. There is an anticipation of endings and a move from future oriented goals to becoming more present focussed. If this is the case, it seems unlikely that these seniors would be very interested in working to improve their long term health since health is a future oriented goal.

Perceived Benefits

The reasons why participants said they joined the program were expressed in different ways but all noted some benefits for themselves except for two people who said that they joined to help with the research. It is interesting to note that one of these people was the withdrawer and that was the only reason she gave for joining the program. The other person who gave helping with research as the initial reason for joining said of the exercise "it felt so good." She obviously attended classes enough to experience some benefits so although her initial motivation may have been to help, later she did experience

benefits herself. This is consistent with the health promotion model which suggests that perceiving benefits of health promotion behaviour is one of the necessary cognitions before the behaviour is performed (Pender, 1996).

The transtheoretical model (Prochaska & Marcus, 1994 as cited in Annesi, 1996), one of the models discussed by Annesi (1996) suggests that the different stages of readiness to participate in exercise can account for an individual's participation in exercise behaviour. There was only one example of a participant who stated he joined the program because he had been thinking about it for a long time and was ready to do some exercise.

Prior Related Behaviour

In the Seniors ALIVE Program, 11 of 14 participants had regular blood pressure checks before the program and 12 of 14 participants had previously engaged in exercise, sports or an active lifestyle. This would seem to support Pender's (1996) health promotion model which suggests that prior related behaviour is a good predictor of health behaviour. One of the ways prior behaviour is thought to influence future behaviour is by relying on the memory of the affect associated with preforming the behaviour. The positive affect which was encouraged in the Seniors ALIVE Program should support the future performance of this behaviour by program participants.

Self-Efficacy

Self-efficacy is the estimation of one's ability to perform a health behaviour. Only 2 of 14 participants were concerned that they might not be able to do the exercises before the first class. The findings are consistent with the literature that says that self-efficacy can affect adoption and adherence to exercise programs (Dishman, 1994 as cited in Myers,

1999) and that past experiences with exercise can influence self-efficacy (O'Brien Cousins, 1998). Greater expectations of efficacy correspond with more positive activity related affect (Pender, 1996).

Activity Related Affect

The feeling state or activity related affect associated with the performance of a health behaviour is likely to influence if it is repeated or not. The health promotion model suggests that positive feeling states of fun and enjoyment make it more likely that a health behaviour will be repeated than if the feeling state is one of disgust or unpleasantness (Pender,1996). Some of these same techniques that affect activity related affect have been identified by Annesi (1996) as influencing participants' motivation to participate in exercise. For example he has pointed out that exercise leaders can provide progress feedback, participant education, recognize effort and encourage group support and enjoyment.

The exercise leaders in the Seniors ALIVE Program encouraged positive feelings towards exercise behaviour by giving the participants positive feedback, making the classes fun and adapting the exercises so that they were able to be successful in the performance of them. One of the instructors in particular would give the class feedback about their progress. For example she would say, "Looks like you're having an easier time using weights, yeah and they feel really good about themselves and it would just encourage them to just keep on going."

Another instructor mentioned teaching the participants how the exercises were connected to their daily lives. She would say things like this muscle we are exercising is

used for things like opening door knobs. Effort was recognized by the instructor who gave certificates at the end of the class. She said she gave the certificates as proof that "they can be proud of something . . . they can say 'I was a part of something'."

One of the instructors encouraged group support and fun by getting the ladies to give themselves a clap at the end of the class. She explained, a "big clap, you know, just to show them, you know, you did a really good job today. Keep it up." Most of the instructors made a real effort to make the classes fun and promote enjoyment through the use of humour and encouraging social interactions with other participants. Having a positive feeling state for exercise should make it more likely that program participants will engage in exercise behaviour in the future.

Interpersonal Influences

The socioenvironmental theory of aging suggests that seniors weigh their individual and social resources against the expectations of others in their environment (Fry, 1992). The influence of others encouraging or discouraging participation in the Seniors ALIVE Program is one way that participants assessed the expectations of others in their environment.

Physicians were important in encouraging participants to exercise. Out of 16 participants, six seniors said their physicians supported their participation in exercise in general or in the Seniors ALIVE Program in particular. The fact that physicians have greater authority with their patients than their families (Baer, 1997) was similar to the suggestion by two family members that seniors listen to health professionals more than they listen to their families. Two of 16 participants mentioned families as encouraging their

participation in the program. Program staff, the building manager and other participants were each mentioned as having encouraged participation once. Only 6 of 16 participants said that no one encouraged their participation in exercise or this program. This seems to supports the literature in this area (Baer, 1997; Connell, et al., 1988; Durham, et al., 1991; Pender, 1996; Swinburn et al., 1998) about the importance of various interpersonal influences in predispositions to engage in health promoting behaviours.

It is likely if participants can be encouraged to participate through interpersonal influences they can also be discouraged to participate by these same interpersonal influences. There was one former participant who actively discouraged other residents from participating. The lady who related this story did not particularly like the lady who was discouraging her so she did not listen to her. But it is possible that some others may have listened to her. The reason why this lady was discouraging other seniors from participating is not certain but it seems possible that she had a problem that was not addressed by the program. Ensuring and encouraging an easy, anonymous method of getting feedback from program participants during the program might help with the identification of problems before they become too serious.

Knowledge

Some seniors seemed to lack knowledge about their health condition and how exercise might affect it. For example the withdrawer said she did not know why she had more "hurts" in her knees after exercises. Another partial withdrawer was experiencing pain with exercise and approached the exercise leader to try and determine what exercises she might omit or adapt. She indicated that this was an unpleasant interaction and the

leader was not able to help her in spite of her request. Her interest in seeking out more information about the exercises and how they might affect her is a good example of the kind of information that other seniors who experience pain with exercise may also want to know.

Another participant pointed out that she had previously lived in another setting where exercise classes similar to those of the Seniors ALIVE Program were offered. She said that at that time she did not think she needed the exercises and that she did not know that those little exercises could be so helpful. This highlights the importance of emphasizing the benefits of exercise in advertizing exercise programs to seniors.

Health Status

The findings of this study are consistent with Heidrich's (1998) conclusion that those with poor health are least likely to attend health promotion programs. Participants of the Seniors ALIVE Program very often gave the reason of poor or declining health for their own or other participants' not attending exercise classes. There was also some support that some people did not join the Seniors ALIVE Program because their health was too good as was suggested by Connell, et al. (1988). It does seem that seniors whose health could be described as average were the most likely to attend Seniors Alive exercise classes. That is, they were beginning to have some health concerns but not so many that they were overwhelmed by them.

Personal Attitudes

Many of the personal reasons described in the literature for seniors not participating in health promotion programs were also seen in the Seniors ALIVE Program.

For example fear of injury (Elward & Larson, 1992) was evident in the partial withdrawers who were afraid their health problems might get worse with exercise. Being too busy (Connell, et al., 1988), physical reasons such as a leg, hip or knee bothering them and forgetting (Haber et al., 2000) were also reasons given by participants for lack of program attendance.

Perceived Barriers

Barriers are imagined or real blocks or personal costs involved in undertaking a health behaviour. The main reasons for not attending the Seniors ALIVE Program given by participants for both themselves and other were: health problems, other priorities such as doctors appointments or holidays, program time change, forgetting, moving, already doing exercises, difficulty of exercises too easy or too hard, doctors' advice, dislike of social activities and dislike of some people in the program. When these barriers were stronger than the motivation to perform the health promoting behaviour, the participants did not attend the program. The health promotion model proposes that barriers directly block action as well as indirectly decrease commitment to a plan of action (Pender, 1996)

One example of an individual's analysis of costs versus benefits of exercise was the lady who decided that keeping an appointment with her housekeeper was more important than doing exercise at least some of the time.

The factors found to influence program participation in the Seniors ALIVE Program are summarized in Table 5.1 and Table 5.2 by relating them to theoretical models that explain factors affecting health promotion behaviour participation or exercise adherence.

Table 5.1

Variables Explaining Exercise Participation Derived from Theoretical Models and Examples From the Seniors ALIVE Program

Theoretical Model	Relevant Variables	Examples From Seniors ALIVE Program
Theory of Reasoned Action (Ajzen & Fishbein, 1980)	Social norms	Encouragement and discouragement of others
	Expectation of success	12 of 14 thought they could do the exercises
Theory of Interpersonal Behaviour (Triandis, 1977)	Encouraging or discouraging conditions	Incentives
		Interpersonal influences
Transtheoretical Model (Prochaska & Marcus, 1994)	Stages of readiness	Participant was ready to exercise
Self-efficacy Theory (Bandura, 1986)	Judgement of ability to do exercises	12 of 14 confident they could do exercises
Exercise Behaviour Model (Noland & Feldman, 1984)	Analysis of costs vs. benefits	Exercise versus housekeeping
		Withdrawer's motivation to join vs. withdrawal reasons

Program Impacts

Personal Control

The impacts that participants noted after participating in the Seniors ALIVE Program have all been described in the literature (Myers, et al.,1999; O'Brien Cousins, 1998). The most frequently reported impact by participants was that they felt better after

Table 5.2

Variables of Pender's Revised Health Promotion Model and Examples from the Seniors ALIVE Program

Variable	Example From Seniors ALIVE Program
Prior Related Behaviour	11 of 14 had regular blood pressure checks 12 of 14 had previous active lifestyle
Perceived Barriers	Health problems, other priorities, scheduling, forgetting, lack of knowledge
Perceived Benefits	Feeling good, health benefit, socialization
Perceived self-efficacy	12 of 14 thought they could do the exercises
Activity related affect	Positive feedback, fun, humour, social interaction, recognition of effort, adaptation of exercises
Interpersonal Influences	Doctors, family, staff, manager, other participants
Situational Influences	Comfort in program

participation in this program. They often could not be more specific than this. Yet their enthusiasm and enjoyment of the program was quite striking. Because of the inability to be specific about the impacts of the program, the interview guide was revised to ask more specific questions about possible impacts in various domains. (See Appendix F: Interview Guide Number 2) Even with the more specific questions some of the participants still could not be more specific than feeling better. Frequently a reason given by participants for joining the program in the first place was that they knew they needed exercise or that exercise is good for them. The program was an opportunity for them to do something

good for their health. Perhaps the program was a way for them to take control of their health and it was the taking control that resulted in them feeling better. This could explain why they felt better but could not relate it more specifically to any domain. In fact Evans and Stoddart (1990) suggest that the increased sense of control that accompanies the initiation of preventive behaviour may result in positive effects independent of objective assessments of impacts.

Fry (1992) has also pointed out that improved morale and life satisfaction are positively correlated with increased opportunities for choice and responsibility. Mitchell (1996) also reports that research indicates that a sense of personal control results in positive health outcomes for older people. Another explanation for participants not being able to be specific about impacts might be that they do not normally think in terms of program impacts so it was difficult for them to put these impacts into specific words.

Some of the participants indicated that they were told their building had the best response to the program of all the intervention buildings in the study. They reported this with satisfaction and pride. Evans and Stoddart (1990) note that there may be some positive health influences from being associated with a winning team. If this is the case, it might be worthwhile to explore what happens when different buildings participating in the same program are given a chance to compare their participation rates. Another variation could be having the same building compete against itself for different time periods. The competition could foster group cohesiveness as well as provide motivation and possibly some health benefits.

Physical Health

Crowell Kee (1984) suggests that ameliorating chronic illness is one of the possible benefits of health promotion programs for seniors. Two participants spoke about the exercise classes being helpful in keeping their arthritic joints loose and hence decreasing some of the pain and mobility limitations of arthritis. One of these participants had attended an arthritis program at the Glenrose and because of this was very knowledgeable about arthritis and exercise. The other participant said, "This program was wonderful number one for arthritis. You know all the joints working better after a while. At first they are really stiff but then you do this kind of exercise . . . and then [they] work better." On the other hand, one partial withdrawer with arthritis withdrew from the exercise part of the program because of arthritic pain.

The partial withdrawer spoke to his family doctor about his arthritic pain which seemed to be worse with exercise. His doctor gave him general directions to do less of the exercises if he was having pain. This partial withdrawer chose to withdraw completely from the exercise class rather than to attend the classes and participate partially as the first two arthritis participants did. He was afraid of making his arthritis pain worse with exercise while the two other arthritis participants seemed more knowledgeable and confident in managing their arthritis and exercise. The difference in the response of these seniors could also have been because of the differences in the severity of their arthritis. The one who withdrew could have had more severe arthritis than those who continued. Another possible explanation for the withdrawal is that this participant was the only male in his class and his withdrawal may have had more to do with gender issues than arthritis.

Arthritis is a common chronic disease among seniors. It can affect their ability to exercise in significant ways. Other participants also mentioned not being able to do all of the exercises because of their arthritis. It may be worthwhile to explore if more knowledge about exercise and arthritis would make a difference in exercise participation and benefits noted by seniors with arthritis.

Quality of Life

Quality of life is a subjective evaluation of overall life satisfaction and well-being. It includes such broad areas as competence, social relations, the environment, psychological well-being and finding meaning in life. Major factors affecting quality of life are health and ability to function (Williams, 1994). Most of the impacts reported from this program in some way contributed to increased quality of life for the participants. The physical impacts either increased behavioural competence and independence or improved psychological well-being.

Successful aging has been described by using both subjective and objective indicators. The subjective indicators are life satisfaction, personal meaning, personal control and self-efficacy. The objective ones are length of life, cognitive efficacy, biological health, social productivity and mental health (Baltes, 1994). Other suggestions of what is important for successful or healthy aging are activities and relationships, altruism, resilience, drive or ambition, hardiness, global concern and self-actualization (Miller, 1991). Quality of life is included in a definition of successful aging.

The Seniors ALIVE Program gave participants opportunities to experience personal control in the choices they were able to make and to experience self-efficacy by

seeing they were able to do the exercises. Some of the impacts noted affected cognitive efficacy as well as biological and mental health. The program gave seniors the chance to participate in activities and increased their opportunities to form new and deeper relationships. They were also able to practice altruism by assisting one another and the exercise leader in various ways.

Successful aging can also be considered as a process of coping and adapting to the changes of aging. Baltes (1994) has described three processes involved in successful aging: selection, compensation and optimization. The model of selective optimization with compensation suggests that for people to age successfully there should be selection by restriction to fewer domains of functioning. For those seniors who were at the stage of aging that required selection, the Seniors ALIVE Program allowed them to restrict their environment by staying in their own building. They were able to limit their interaction with strangers and not have to worry about transportation. Compensation was used in the program when the exercises were adapted to individuals. They did the ones they could and omitted or adapted the ones they could not do. The reliance on the health corner nurse for health information and advice could have been used by seniors who had decreased capacities to do this for themselves. Optimization was used when participants did regular exercises to increase their strength and physical stamina through repetition and training.

The Seniors ALIVE Program supported successful aging by providing opportunities for experiencing self-efficacy and personal control. Some program impacts improved biological and mental health. Opportunities for participation in activities, altruism and growth of relationships were all present in this program. The processes of

selection, compensation and optimization that facilitate successful aging were all evident in the program.

Future Programs

Although the Seniors ALIVE Program was established for research purposes and will not likely be implemented again, it is important to learn from the evaluation of this program what worked well and what did not work very well so that this knowledge can be applied to similar programs in the future. The following suggestions for future programs are based on this evaluation of the Seniors ALIVE Program.

Advertisement for future programs should emphasize information on benefits of participation because perceived benefits appear to be an important influence on program participation. In the congregate housing environment careful attention to privacy is important since news travels very fast there and lack of privacy could be a barrier to participation for some seniors. Seeking specific anonymous participant feedback during the program may help to identify problems before they are either forgotten or become very serious.

Health promotion programs in seniors congregate housing can be particularly prone to difficulties with attendance. Special efforts to keep attendance numbers up can be taken throughout the program. For example special attention could be given to building managers, family members of residents and doctors of residents before a program is even begun. They should all be well aware of the positive benefits of health promotion programs. Their informal influence in encouraging seniors to participate in the program

can be very valuable both at the beginning of a program and throughout the duration of a program. A procedure for systematically inviting new residents to participate in programs should be in place. Continuity of program scheduling is very important for continued participation. Seniors identified the winter as being the time of year they had the most need for an indoor exercise program. Encouraging a reminder system for those participants who are interested may decrease the number of participants who do not attend because they forget.

Although the majority of participants said they preferred to get information through printed material it seems that many seniors do have difficulty reading either because of language problems, reading ability or visual problems. Supplementing printed materials with audio alone or audio-visual materials is one way that accessibility to the printed materials used in a program could be increased for those seniors with reading problems. Using a variety of information sources would also offer more choices to participants.

Staff should be encouraged to use psychological techniques known to increase adherence to exercise programs by increasing participant motivation such as those suggested by Annesi (1996). The importance of the staff and their ability to form strong relationships with program participants was very evident in this program. Ensuring that staff are capable of interacting in a positive way to encourage the development of strong relationships is likely to also be important to the success of similar programs. Allowing for program flexibility and encouraging participant comfort by providing opportunities for

participant choice, fun and social interactions will provide an optimum environment for future programs.

Besides being able to lead exercises and provide health screening and counselling, staff also have to understand the many issues affecting seniors particularly the ones that influence their participation in health promotion programs. This would include understanding the variety of changes that occur in an aging body, the different ways seniors adapt to the aging process and the influences of the social environment on program participation.

Specific attention should be given to termination of future programs. Follow up activities should be planned before a program is implemented. Frequent reminders and discussion of follow up plans should be given throughout the program. A smooth transition from a program to follow up activities should be encouraged. For example besides just discussing the possibility of doing exercises with a television program, one class could be devoted to actually doing the television exercises. Another example would be to actively recruit participants to lead the exercises during the program and to give them opportunities to practice leading the exercises before the termination of the program.

Limitations of the Study

There were several limitations to this study. First, some of the subjects may not have been comfortable having the interviews tape recorded even when they had given permission to do so. For example one subject who had not been very verbal during the interview while it was being tape recorded became extremely verbal as soon as the tape

recorder was turned off. Her uncomfortableness with the tape recording could have influenced the quality of her responses. Once this was noted, subjects were given the opportunity to have a last word with the tape recorder turned off even if they had agreed to have the interview tape recorded. (See Appendix F, Interview Guide Number 2)

In some subjects difficulties with remembering may have affected some of the responses. Several subjects responded that their memory was not very good when asked to remember specific details of the program.

Siderovski and Siderovski (1992) describe several reactive effects which are threats to the validity of a program evaluation where subjects respond to the experimental conditions as well as to the program. The social desirability effect is when subjects respond favourably in an attempt to please or impress the evaluator. The placebo effect is when subjects respond favourably because of their strong belief in the program rather than to the actual program. The pygmalion effect can occur when the evaluator consciously or unconsciously subtly influences the subjects. All of these effects could have influenced the results of this evaluation.

Most of the subjects interviewed were very enthusiastic and positive about the program. Since the program had actually been terminated at the time when the interviews were conducted, people who liked the program could have been motivated to participate in this evaluation with the hopes of influencing the future continuation of the program. It is possible that subjects who were not as positive about the program did not have the same motivation to volunteer to be interviewed. If this is the case, this less positive view point could be under represented in the sample. Program withdrawers were difficult to recruit so

the sample size of this group is smaller than initially intended. Because of the use of an incentive, there could have been an approval bias from those wanting to get the thank you gift.

The focus group with program staff was difficult to coordinate. In the end only two staff were present at the beginning and a third one came in late after the focus group was half finished. This falls short of the recommended number of members for a focus group which is 6-9 (Krueger,1994).

There is a bias inherent in asking subjects about retrospective perceived changes. In order to minimize this bias, the statement was included that some people notice changes and others do not notice changes (See Appendix F: Interview Guide Number 2) and these changes could be good changes or bad changes. (See Appendix F: Interview Guide Number 3)

The researcher believed in the effectiveness of health promotion programs and continuing social and physical involvement as contributors to successful aging. This bias both during the interviews and during the analysis may have influenced the generalizability of the results. The small sample size and the volunteer, non random sample means that the findings of this study are only pertinent to those who have been interviewed.

Summary

This chapter has discussed the findings of the study. It can best be summarized by answering the original research questions posed in chapter one.

1. **How did the Seniors ALIVE Program work? What worked well and what did not? Why?**

The main interventions of the Seniors ALIVE Program were the exercise classes and the health corners. The newsletter seemed to act as an adjunct intervention supporting the other two interventions. The location of the program in the seniors apartment buildings and at no cost to the seniors was appreciated and probably influenced participation although this was difficult to determine from this study.

Mechanisms of program action that worked well were strong staff-participant bonds, fun, social interaction and encouraging participant autonomy by allowing opportunities for individual choice. One explanation of why they worked well is that they all contributed to participant comfort which is a situational influence that encourages program participation.

The program acted at the individual, family and community levels. It developed supportive environments, developed personal skills and strengthened community action. It influenced the following determinants of health: social support networks, personal health practices and coping skills.

There were some areas where changes in the program might have made it work better. Increased funding for staffing would have made it easier to maintain consistency in program scheduling. It would have also allowed more in person contact with subjects outside of program time both at the advertisement phase of the program and during the program. This may have kept the participants more engaged in the research process and

decreased the number of participants formally withdrawing from the research part of the program.

In some cases better integration of music into the exercise classes may have increased the enjoyment for some seniors. Being able to specifically address concerns of participants with arthritis either by training staff or by referring seniors to experts in arthritis and exercise may have increased participation in the program. Some of the focus group staff who worked in only one of the intervention areas felt that they might have been able to do a better job of encouraging participation in all aspects of the program if they had had a better sense of the overall project.

Termination of the program was difficult for both participants and staff. Because the participants enjoyed the program so much many of them saw the termination as a big loss for them. Staff found termination difficult because they had established close bonds with the seniors and also because in spite of explanations some of the seniors did not seem to be able to understand that the program was going to finish.

2. What influenced seniors' participation in the Seniors ALIVE Program?

Perceived benefits, perceived barriers, prior related behaviour, perceived self-efficacy, activity related affect, interpersonal influences, and situational influences were factors found to influence seniors' participation in the Seniors ALIVE Program. These are the same variables as those in Pender's Revised Health Promotion Model (1996). Some of the variables for the adoption of health promoting behaviour in the theory of reasoned action (Ajzen & Fishbein, 1980), the theory of interpersonal behaviour (Triandis, 1977), the transtheoretical model (Prochaska & Marcus, 1994), the self-efficacy theory (Bandura,

1986), and the exercise behaviour model (Norland & Feldman, 1984) were also noted in the Seniors ALIVE Program.

3. How did the Seniors ALIVE Program impact the seniors who attended?

The most common impact reported by participants was simply feeling better. In some cases there was an inability to further describe this "feeling better." One explanation is that feeling better was a general benefit experienced by taking control of their health through their participation in the program. However participants also noted some specific physical, mental, social and behavioural impacts. In some cases program impacts ameliorated the pain of arthritis.

4. Did the Seniors ALIVE Program contribute to independence and quality of life for seniors? If so how?

The personal control allowed within the program in terms of choosing the type and amount of participation gave participants opportunities to exercise independence in making their own choices. There were a couple of examples of impacts that increased participant independence as well as quality of life. The majority of program impacts contributed to improved quality of life for program participants. The increases in quality of life were a result of generally feeling better and sometimes specifically feeling better physically, mentally and socially. The program supported successful aging by improving physical and mental health, encouraging altruism, facilitating the growth of interpersonal relationships and allowing seniors to use the processes of selection, compensation and optimization that contribute to successful aging and quality of life.

Future Research

Research in the past has focussed mainly on factors that influence participation in seniors' health promotion programs and the impacts of these programs. Knowledge about health promotion programs for seniors could be expanded by looking at the delivery of the program itself.

This evaluation has noted the importance of participant comfort and encouraging participant autonomy, fun and social interaction. One area to study within the program is how program staff are able to make seniors feel comfortable in the program. What techniques do they use? What works best and why? How can seniors' ability to function independently and to use personal control be fostered in health promotion programs? What makes the program fun for participants? How can social interactions best be facilitated?

The question of whether or not seniors are getting the maximum benefits of the program they attend should be asked. For example in this study some of the participants limited their participation in the exercises because of their arthritis. Teaching and counselling specifically about arthritis and exercise might help these participants manage their arthritis and exercise more comfortably and effectively.

Most of the health promotion programs for seniors have a goal of improving functional independence and quality of life. This goal should be expanded to encompass successful aging as well. This means that health promotion programs should be considered in the overall context of seniors lives. Central to this view is an understanding of seniors and the variety of ways that they adapt to the aging process. In order to age successfully

some seniors may have to make choices to limit their participation in health promotion programs. If the long term goal is successful aging, then they should be supported and encouraged to do what is required to age successfully.

The next step would be to translate these concepts into practical guidelines for program staff by developing staff training programs specifically for seniors' health promotion programs. The importance of the staff-participant relationship was noted in this study. Investing in high quality staff training would be well worth while since staff are so important in the delivery of health promotion programs for seniors.

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Appendix A

Script for Research Assistants

Research assistants who interviewed program participants during the last data collection of the quantitative study asked program participants about their interest in participating in the qualitative evaluation of the Seniors ALIVE Program. They used the following script. It was from this list that subjects were recruited for this qualitative evaluation.

Rosanne Buijs (Buys), a graduate student in Health Promotion Studies is evaluating the Seniors ALIVE Program for her master's thesis. It is important to see what was helpful and what was not so we can offer better programs for seniors in the future. She would like to talk to people who were in the Seniors ALIVE Program in your building. I am collecting names of people who agree to be contacted by her. Her study will look at what it as like for you to participate in the Seniors ALIVE Program. She will contact you by phone and set up a time to meet with you. She will be contacting those who are interested within the next couple of months. The time involved should be about one hour. You can participate or not participate in this study. If you choose to participate you are free to withdraw at any time. There will be a thank you gift given at the end of the interview. Can I put your name on the list to be contacted by Rosanne?

Appendix B

Research Recruitment Form

I agree that Rosanne Buijs may contact me about a possible meeting for her evaluation of the Seniors ALIVE Program.

_____

Date Signature

Appendix C

Participant Reminder Notice

Date

Dear _____,

My name is Rosanne Buijs. I am a graduate student at the University of Alberta. I am doing a study of the Seniors ALIVE Program. The last research assistant who interviewed you told me that you would be willing to talk with me. I really appreciate your help and I will be phoning you to set a meeting time within the next week or two. I am enclosing an information letter about my study.

I am talking to lots of different people about the Seniors ALIVE Program. I am talking to people like you who were in the program, people who left the program, program staff and family members of people who were in the program. Do you have any family members who see you regularly? Do they also know that you were in the Seniors ALIVE Program? If you do, would you ask if I could phone them? When I come to talk to you, I will ask if you have a family member who is willing to let me phone them about this. After you tell me it is alright, I will phone them to set up a meeting. Thanks for your help. I look forward to meeting you soon.

Sincerely,

Rosanne Buijs

UNIVERSITY OF ALBERTA

Appendix D

Information Letter for Program Participants and Program Withdrawers

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Date

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis I am doing a study of the Seniors ALIVE Program. I want to talk to people like you who were in the program. I will also be talking to people who ran the program and family members of people who were in the program.

You were already interviewed several times for this program. I am doing a different study. The results of this study will be combined with the results of the first study. This will give a better picture than one study by itself. I will be asking different questions than the first study. I want to know what you thought about the program.

If you are willing, I would like to ask you some questions about the Seniors ALIVE Program. We can meet where it is best for you, either at your apartment or at the University of Alberta. This would be one meeting of up to one and a half hours and one possible follow up meeting or phone call of up to 30 minutes. I would like to tape record our talk so I can listen to it later. Even if you agree to meet with me, you can still change your mind about talking to me at any time. You can also refuse to answer any of the questions. By being in this study you can help make future programs like the Seniors ALIVE Program better. Your help is really important and valued. There will be a small gift as a thank you at the end of the interview. Being in this study involves no known risks for you.

Centre for Health Promotion Studies

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Telephone: (780) 492-4039 • Fax: (780) 492-9579
e-mail: health.promotion@ualberta.ca • www.ualberta.ca/~healthpr

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Your name and anything you say that would identify you will not be available to anyone except the researchers working on this study. The tapes and transcripts will be stored in a safe place and kept for five years after the study is finished and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies, ethics approval will be sought again.

If you have any questions or concerns about the study, you may call me, Rosanne Buijs or my supervisor, Dr. Wilson. If you have any concerns with how the study is being conducted, you may also contact Dr. Madill who is not connected with the study. Phone numbers for these people are given below. Thank you for being part of my study.

Rosanne Buijs 436-0659
Centre for Health Promotion Studies
University of Alberta

My supervisor,
Dr. D. Wilson 492-7385
Department of Public Health Sciences
University of Alberta

Someone unconnected with this study,
Dr. Helen Madill 492-9347
Graduate Programs Coordinator
Centre for Health Promotion Studies
University of Alberta

Sincerely,

Rosanne Buijs

Appendix E

Invitation for Program Withdrawers

My name is Rosanne Buijs. I am a graduate student at the University of Alberta. For my master's thesis, I am doing a follow up study of the Seniors ALIVE Program that was in your building. I am especially interested in talking to people who only attended part of the program. I want to know your thoughts about this program.

Your help is important and valuable. It will help us learn how to make better health programs for seniors. A small gift will be given as a thank you for your help. If you would be willing to talk to me you can phone me at 436-0659.

Appendix F

Interview Guide for Program Participants Number 1

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis I am evaluating the Seniors ALIVE Program. As part of this evaluation, I am talking with program staff and people like you who were in the program. I want to know what you thought about it.

With your permission, I would like to tape record our talk. You can change your mind about talking with me at any time just by telling me you don't want to continue. You can refuse to answer any question. By being in this study you can help to make other programs like this better. Your help is really important. Being in this study involves no known risks for you.

No one except the researchers working on this study will know your name or be able to identify you by what you say. The tapes and transcripts will be stored in a safe place for 5 years after the study is completed and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies it will go through another ethics approval.

Do you have any questions about the study? Before we begin the interview I have an information letter for you to read and a consent form for you to sign.

Background

1. How did you find out about the Seniors ALIVE Program?

2. There were 3 parts to the program, the exercise classes, the health corners and the newsletter.

   Exercise Class

   Did you use the exercise classes? If so how often? (Probe attendance pattern)

   Can you tell me what it was like? (room, # of participants, type of exercises, music)

   Health Corner

   Did you use the health corner? If so how often? (Probe attendance pattern)

   Can you tell me what the health corner was like? What did you do there?

   Newsletter

   Did you receive the newsletter? What kinds of things were in the newsletter?

The Program Components (only ask about the components they used - if only used one skip this question)

3. I have three cards. One card says the exercise classes, another card says the health corner and the last card says the newsletter. I am going to give you these cards. If we could only keep one, which one should we keep? If we could keep two, which two should we keep? That means this one is last. (Put cards out the way they gave them to you) Is this the order of importance that you would put them in? Can you say why you put them this way?

What Worked and What Didn't

4. If I was going to start a program like the Seniors ALIVE Program somewhere else, what advice would you give me?

Withdrawal or Discontinuation

5. Did you ever not go to the program when you could have? If so, what was the reason you did not go?

Participation in General/Barriers

6. Some people in your building joined the Seniors ALIVE Program and some did not.
   Why do you think some people join and some don't?
   What made you join the Seniors ALIVE Program in the first place?
   Is that the same reason why you kept going?
   What made it hard for you to be involved?

Benefits

7. If I wanted to tell someone else reasons why they should attend the Seniors ALIVE Program what should I say?

Affect

8. Here are some things that might go through the mind of someone getting ready for a program.
   This is going to be fun.
   I wonder who will be there today?
   I hope (so and so) won't be there.
   I hope this won't hurt too much.
   Maybe I'll get too tired.

Do you agree with any of these? Did you think of other things before getting ready for the Seniors ALIVE Program?

Situational

9. If the same program was offered at a nearby building instead of your apartment building, do you think you would go? How important is it to you that it is offered in your own building?

Interpersonal

10. Was there anyone like family, friends, program staff or doctors who encouraged or discouraged you to attend the program? What did they do? Did any of your friends go to the Seniors ALIVE Program? Would you go even if your friends did not go?

Commitment to Plan

11. How did you keep track of when to go? Did you do anything special to make sure you got to the program? Probe: calendar, go with friend, see notice.

Self-efficacy (skip if did not attend exercise class)

12. Before a first exercise class, some people think that the exercises might be too hard and they won't be able to do them. Did you ever worry about that? Why did you think you could or couldn't do it?

Prior Behaviour

13. In your younger years did you play sports or do other exercise? If you did, what did you do and how much? Did you ever do an exercise class before?

14. Before joining the Seniors ALIVE Program how often did you have blood pressure checks? (Probe regular?)

15. Before joining the Seniors ALIVE Program where would you find out information about how to stay healthy?

Competing Demands

16. Was there ever any thing that happened at the last minute so you didn't go to the Seniors ALIVE Program when you had planned to go? What things came up to change your plans?

Impact

17. Is there any health information you know now that you didn't know before the program? Where did you learn it?

18. Now that you have been involved in the Seniors ALIVE Program, do you do anything differently than before? (Probe: exercise, walking, health habits)

Independence

19. Can you think back to before you joined the program? Think about how well you were able to do things for yourself like shopping, taking a bath, getting up and down from chairs or opening jars. Now are you able to do things like that for yourself, worse, just the same or better than before you went to the program?

Quality of Life

20. In general, would you say that you feel worse, just the same or better since beginning the Seniors ALIVE Program?

21. Would you say you are less happy or just the same or happier with your life since you began the program?

22. What is it that makes you feel better or worse? (Probe: sleep, pain) What changed to make you feel better or worse?

Validity Check

23. Do you have a family member who knows about you going to the Seniors ALIVE Program who might be willing to talk to me about it?

Member Check

24. In July or August, I will be contacting a few people that I interviewed to discuss the results of my findings. I am not sure yet if you will be among those I talk to again. In any case you can have a written report of the findings if you give me your name and mailing address. I hope it will be ready in September or October. Thank you for your help. Here is a small gift for you.

Interview Guide for Program Participants
Number 2

1. How did you find out about the Seniors ALIVE Program? Do you think most of the seniors in your building knew about the program?

2. There were 3 parts of the program, the exercise class, the health corner and the newsletter. Which parts of the program did you use?

   _____

   How often? _____
   Which part of the program was most important for you? _____
   The next most important? _____
   And the next? _____

3. Exercise Class
   What time of day is best for you? _____
   Was the number of times a week okay? _____
   Was the amount of time for each class right for you? _____
   What did you think of having it in your building? _____
   Would you go if it was elsewhere? _____
   Were there any staff changes? _____
   Any other staff comments? _____
   # of participants - beginning _____
   - end _____
   -males _____
   Could you do all of the exercises? _____
   Did the staff say anything about you not doing all the exercises? _____
   If you couldn't, did you do anything instead? What? _____
   How did you feel when you couldn't do all the exercises? _____

4. Music
   Used?
   Type
   Type you like

5. Socializing
   -before _____
   -after _____
   Disruptions (time, place, staff) _____
   Ending/Follow up

6. Health Corner
   Time of day _____
   How often best _____
   Length of time ok? _____
   Wait time _____
   Pamphlets _____
   Medication _____
   Nutrition _____
   BP _____
   Staff changes _____
   Socializing _____

7. Newsletter
   Delivered _____
   Read _____
   Liked _____
   Other suggestions _____

8. What was the best part of the program?

9. What could have been better about the program?

10. If I was going to start another program like the Seniors ALIVE Program what advice would you have for me?

11. I am interested in finding out why some people joined the program and others didn't. What made you join the Seniors ALIVE Program in the first place? Is that the same reason you continued? Was that the same reason you continued to go? Were there any other reasons to attend the program that you found after you went to the program?

12. In a program that runs over many weeks sometimes people miss going to some of the sessions. If this happened to you, can you tell me the reasons why you missed some of the program? Did anything happen at the last minute to stop you attending?

13. How could more seniors be encouraged to participate?

14. Here are some things that might go through the mind of someone getting ready for a program. I will read some short statements and after each one could you say yes or no if that thought crossed your mind before you went to the program?

I wonder who will be there today?	Yes	No
I hope (so and so) won't be there.	Yes	No
I hope this won't hurt too much.	Yes	No
Maybe I'll get too tired	Yes	No

Did you think of any other things while you were getting ready to go to the program?

15. Was there anyone who encouraged you to attend? If so who? What did they do or say?

16. Was there anyone who discouraged you from attending? If so who? What did they do or say?

17. Some people have trouble remembering when to go to the program. Do you have any ideas about what might help people remember?

18. Before a first exercise class some people think that the exercises might be too hard and they might not be able to do them. Did you ever wonder about that?

19. Did you ever do an exercise class before? Sports or other exercise? How often did you check your blood pressure before the program?

20. There are different ways of getting information such as reading, going to a talk or listening to the TV or radio. Which of these methods do you prefer? Would this be a good way for you to find out health information?

21. In general would you say that now you feel worse, just the same or better since beginning the Seniors ALIVE Program?

22. Some people notice some changes in themselves after participating in a program like the Seniors ALIVE Program and some people do not notice any changes. Do you think that the Seniors ALIVE Program caused any changes in you? If you noticed any changes what were they? Do you think it was because of the program?

23. Is there any health information you know now you did not know before the program? If so what is it and where did you learn it?

24. Now that you have been involved in the Seniors ALIVE Program, do you do anything different than before? (Exercise, health habits, BP checks) If so what?

25. Can you think back to before you joined the program? Think about how well you were able to do things for yourself like shopping, taking a bath, getting up and down from chairs or opening jars. Now are you able to do things like that for yourself worse, just the same or better than before you went to the program?

26. Have you noticed any difference in

Stiffness	Yes	No
Strength	Yes	No
Energy	Yes	No
Sleep	Yes	No
Pain	Yes	No
Happiness	Yes	No
Blood pressure	Yes	No

27. Turn off the tape. Is there anything else you would like to tell me about the program?

28. Do you have a family member I can contact?

Ask either to do a member check to discuss findings or to send a summary report if requested.

Give gift.

Interview Guide for Program Participants
Number Three: Short Form

1. Can you tell me why you decided to sign up for the Seniors ALIVE Program in the first place? (Motivation- health, exercise, convenience, help, social)

2. There were 3 parts of the program, the exercise class, the health corner where the nurse came to check blood pressures and the newsletters. Can you tell me what parts of the program you were involved in? How much did you attend each part?

3. I am trying to understand what the program was like from your point of view. Can you tell me what you thought about the program? (what worked well what did not work quite as well) Is there anything that bugged you?

4. Facilitators/Barriers. To be cost effective, programs like the Seniors ALIVE Program have to be well attended. Because of this it is important to understand what makes some people attend and other people not attend or quit once they have started. People have said that things like cost, location, music, the instructor, their doctor's opinion or their ability to do the exercises can either help or hinder their participation. What factors do you think influenced your participation?

5. Some people notice some changes in themselves after attending a program like the Seniors ALIVE Program and some people don't. The changes could be either good or bad changes. Did you notice any changes in yourself since attending the program? (Probe physical, mental, social, health knowledge, health habits, independence, quality of life.)

6. Is there anything else I should know for an evaluation of this program that I forgot to ask?

Thank you for your help. Here is a gift in appreciation for your help.

Appendix G

Interview Guides

Interview Guide for Family Members

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis, I am evaluating the Seniors ALIVE Program. As part of this evaluation, I am interviewing family members of people who were in this program. I want to know your impressions of this program.

With your permission, I would like to tape record our interview. You can change your mind about talking with me at any time just by telling me you changed your mind. You can refuse to answer any question. By being in this study you can help to make other programs like this better. Your help is really important. Being in this study involves no known risks for you.

No one except the researchers working on this study will know your name or be able to identify you by what you say. The tapes and transcripts will be stored in a safe place and kept for five years after the study is completed and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies, it will go through another ethics approval.

Do you have any questions about the study? Before we begin the interview I have an information letter for you to read and a consent form for you to sign.

Name_____ (your family member) participated in the Seniors ALIVE Program that was offered in his/her apartment building.

1. What has your family member told you about this program?

2. Last summer, before your family member began this program how would you describe him/her?

3. Today, would your description of him/her be the same as last summer before the program or have you noticed any changes?

4. If you noticed any changes what were they?

Interview Guide for Individual Program Staff

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis, I am evaluating the Seniors ALIVE Program. As a part of this evaluation, I am interviewing program staff. I want to know your impressions of this program.

With your permission, I would like to tape record this interview. You can change your mind about participating at any time just by telling me you changed your mind. You have the right to refuse to answer any question. Your participation in the evaluation of the Seniors ALIVE Program will provide information that can be used to improve other health promotion programs for seniors. Your help is really important. Being in this study involves no known risks for you.

No one except the researchers working on this study will know your name or be able to identify you by what you say. The tapes and transcripts will be stored in a safe place and kept for five years after the study is completed and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies it will go through another ethics approval.

Do you have any questions about the study? Before we begin the interview I have an information letter for you to read and a consent form for you to sign.

Background

1. Can you tell me what work you did in the Seniors ALIVE Program? How long did you do this work?

Program Components (only if they were aware of the three components)

2. The Seniors ALIVE Program had three components. These were the exercise classes, the health corners and the newsletter. Which of these components did you participate in? If you were involved in more than one of these components, which do you think is the most important and why?

What Worked and What Didn't

3. If I was going to set up a similar program what should I do the same as the Seniors ALIVE Program? What should I do differently?

Participation

4. What seemed to you to be important for seniors to be able to participate in the program? Did you do or say anything to encourage them to return the next time? Are you aware of anything that made their participation difficult?

Interpersonal

5. Is there anything that stands out about the social atmosphere of where you worked? Did the seniors stay around to talk with each other or you after the program? Did they leave immediately? Did this change over time? Did you notice any friction between participants?

Impact

6. The Seniors ALIVE Program has been running for some time. I am interested in the period of time between the beginning of the program and the end of the program. Can you think for a few minutes about the first time you met the program participants. Now think about the last time you saw them. Are the individual program participants different in any way between now and then? What about the group as a whole? What about yourself?

7. How do you think program participants will respond (or have responded) to the termination of this program?

Member Check

8. Thank you for your help. Here is a small gift as a thank you for your help. In July or August I will be contacting a few people to discuss the results of my findings. I am not sure yet if you will be among those I contact again in person. In any case you can have a written report of my findings if you give me your name and mailing address. I hope the written report will be ready in September or October.

Interview Guide Program Withdrawers

1. Can you tell me why you decided to sign up for the Seniors ALIVE Program in the first place? (Motivation - health , exercise, convenience, help, social)

2. There were three parts of the program, the exercise class, the health corners where the nurse came to check blood pressures and the newsletter. Can you tell me what parts of the program you were involved in? How much did you attend each part?

3. Can you tell me why you withdrew from the program?

4. Can you tell me what you thought of the part of the program you did attend? I am trying to understand what the program was like from your point of view. (Likes/Dislikes)

5. Was there anything that could have been changed in the program so that you would have continued to attend the program?

6. Some people notice some changes in themselves after attending a program like the Seniors ALIVE Program and some people don't. The changes could be either good or bad changes. Did you notice any changes in yourself since attending the program? (Probe physical, mental, social, health knowledge, health habits, independence, quality of life)

Thank you. Here is a gift in appreciation for your help.

Appendix H

Information Letters

UNIVERSITY OF ALBERTA

Information Letter for Family Members

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Date

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis, I am evaluating the Seniors ALIVE Program. I want to interview people who were in the program, people who ran the program and people like you who are a family member of someone who was in the program.

If you are willing, I would like to ask you some questions about your family member. By answering my questions, you will provide valuable information to help us understand more about how the Seniors ALIVE Program worked. This can be used to make future programs like the Seniors ALIVE Program better. Your help is really important. There will be a small gift as a thank you at the end of the interview.

This would involve one meeting and take about 30 minutes. We could meet where you prefer, either at your residence or at the University of Alberta. I would like to tape record our talk so I can listen to it later. Even if you agree to meet with me, you can change your mind at any time. You can refuse to answer particular questions. Being in this study involves no known risks for you.

Centre for Health Promotion Studies

5-10 University Extension Centre • 8303 - 112 Street • University of Alberta • Edmonton • Canada • T6G 2T4
Telephone: (780) 492-4039 • Fax: (780) 492-9579
e-mail: health.promotion@ualberta.ca • www.ualberta.ca/~healthpr

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Your name and anything you say that would identify you will not be available to anyone except the researchers working on this study. The tapes and transcripts will be stored in a safe place for five years after the study is finished and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies ethics approval will be sought again.

If you have any questions or concerns about the study, you may call me, Rosanne Buijs or my supervisor, Dr. Wilson. If you have any concerns with how the study is being conducted, you may also contact Dr. Madill who is not connected with the study. Phone numbers for these people are given below. Thank you for being part of my study.

Rosanne Buijs 436-0659
Centre for Health Promotion Studies
University of Alberta

My supervisor:
Dr. D. Wilson
Department of Public Health Sciences
University of Alberta
492-7385

Someone unconnected to this study:
Dr. Helen Madill
Graduate Programs Coordinator
Centre for Health Promotion Studies
492-9347

Sincerely,

Rosanne Buijs

Information Letter for Program Staff

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Date

My name is Rosanne Buijs. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis, I am evaluating the Seniors ALIVE Program. I am interviewing program participants, program staff and family members of program participants. Your impressions of this program are valuable both in understanding how this program worked and in designing effective health promotion programs for seniors in the future. Your help is really important and valued. There will be a small gift as a thank you at the end of the focus group.

If you are willing, I would like to invite you to participate in one focus group interview for 6 to 10 program staff at the University of Alberta. This will take about 2 hours. The group will be instructed to respect and maintain confidentiality by not sharing the information given during the focus group with other persons. The date and time of the focus group will be arranged for the convenience of the majority of participating staff. I would like to tape record the focus group as well as take notes. Should there be difficulties arranging a focus group, a single one hour individual interview will be held instead. If individual interviews are used, there will also be one possible follow up meeting or phone call of up to 30 minutes to discuss the results of my evaluation. Even if you do agree to participate, you can change your mind about participating at any time by telling me you don't want to continue. If you decide not to participate in this study, it will not affect your job with the Seniors ALIVE Program. You can decline to answer individual questions. Being in this study involves no known risks for you.

Centre for Health Promotion Studies

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Telephone: (780) 492-4039 • Fax: (780) 492-9579
e-mail: health.promotion@ualberta.ca • www.ualberta.ca/~healthpr

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Your name and anything you say that would identify you will not be available to anyone except the researchers working on this study. The tapes and transcripts will be stored in a safe place and kept for five years after the study is completed and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported.

If this information is used in any further studies ethics approval will be sought again. If you have any questions or concerns about the study, you may call me, Rosanne Buijs or my supervisor, Dr. Wilson. If you have any concerns with how the study is being conducted, you may also contact Dr. Madill who is not connected with the study. Phone numbers for these people are given below.

If you have any questions or concerns you may call me:

Rosanne Buijs 436-0659
Centre for Health Promotion Studies
University of Alberta

My supervisor:
Dr. D. Wilson 492-7385
Department of Public Health Sciences
University of Alberta

Someone unconnected with this study:
Dr. Helen Madill 492-9347
Graduate Programs Coordinator

Thank you for being part of my study.

Sincerely,

Rosanne Buijs

Appendix I

Consent Forms

Consent Form for Seniors

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Principal Investigator: Rosanne Buijs
Graduate Student
Centre for Health Promotion Studies
University of Alberta, Edmonton AB
Phone: 436-0659

Co-Investigators:
Doug Wilson M.D. FRCPC
Professor
Department of Public Health Sciences
University of Alberta
Edmonton Alberta
Phone: 492-7385

Janet Ross Kerr Ph.D.
Professor
Faculty of Nursing
University of Alberta
Edmonton Alberta
Phone: 492-6253

The Study
The purpose of this study is evaluate the Seniors ALIVE Program. You were an important part of this program. What you tell us can help us learn more about how the program worked. We will use this to make better health promotion programs for seniors. Those who want to be in the study will be asked to answer some questions about the program. If you agree, we would like to tape record this session. There are no known risks to you if you are in this study.

Voluntary Participation
You do not have to be in this study if you do not want to be. Even if you do agree to be in this study, you can drop out at any time by telling me that you wish to drop out.

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Procedure
Information that you give me will be stored in a locked cabinet. Only people working on this study will see the information. Your name or anything that might let others know what you said will be taken away. If this information is used again, in another study, an ethics committee will approve it again. If you have any questions about this study at any time you can call any of the phone numbers at the top of this form.

Consent: I, _____ (Print Name)

agree that the above study has been described fully to me. Any questions have been answered to my satisfaction. If, at any time questions or concerns about this study arise, I can contact the people at the above numbers. I have been assured that the records of this study will be kept confidential. I have been told that my name will not be linked with the information that I share. I understand that I am free to drop out of this study at any time. Also I have been given a copy of this form to keep. I agree to take part in this study.

_____ _____
(Signature of Participant) (Date)

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

If you write your name and address below, a summary of the research findings from this study will be sent to you.

_____
(Name)

_____
(Address)

_____

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
(Signature of Investigator or Designee) (Date)

Consent Form for Program Staff

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

Principal Investigator(s): Rosanne Buijs
Graduate Student
Centre for Health Promotion Studies
University of Alberta
Edmonton Alberta
436-0659

Co-Investigator(s):

Dr. Doug Wilson
Public Health Sciences
University of Alberta
Edmonton Alberta
492-7385

Dr. Janet Ross Kerr
Faculty of Nursing
University of Alberta
Edmonton Alberta
492-6253

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read the copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and if you work at the Seniors ALIVE Program refusal to participate will not affect your job.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you understand who will have access to your records?	Yes	No

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____
Signature of Research Participant Date Witness

_____ _____
Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

If you would like a summary of the results of this study please print your name and mailing address below and one will be sent to you.

_____
Name

_____
Address

Consent Form for Family Members

Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

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Edmonton Alberta
492-6253

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read the copy of the attached Information Sheet?	Yes	No
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Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.	Yes	No
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Project Title: A Qualitative Evaluation of the Seniors ALIVE Program

This study was explained to me by: _____

I agree to take part in this study.

_____ _____ _____

Signature of Research Participant Date Witness

_____ _____

Printed Name Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____

Signature of Investigator or Designee Date

If you would like a summary of the results of this study please print your name and mailing address below and one will be sent to you.

_____

Name

_____

Address

Appendix J

Focus Group Interview Questions for Program Staff

Good afternoon and welcome to our session. Thank you for taking the time to join our discussion about the Seniors ALIVE Program. My name is Rosanne Buijs and this is _____ my assistant. I am a graduate student in Health Promotion Studies at the University of Alberta. For my master's thesis, I am evaluating the Seniors ALIVE Program. As a part of this evaluation, I am interviewing program staff. I want to know your impressions of this program.

With your permission, I would like to tape record and take notes during this focus group. You can change your mind about participating at any time just by telling me you don't want to continue. You have the right to refuse to answer any question. Your thoughts and perceptions are really valuable. Your participation in the evaluation of the Seniors ALIVE Program will provide information that can be used to improve other health promotion programs for seniors. Being in this study involves no known risks for you.

No one except the researchers working on this study will know your name or be able to identify you by what you say. The tapes and transcripts will be stored in a safe place and kept for five years after the study is completed and then they will be destroyed. All the information will be confidential except when ethics and/or the law require it to be reported. If this information is used in any further studies it will go through another ethics approval.

Do you have any questions about the study? Before we go any further, I have information letters for you to read and consent forms for you to sign.

This afternoon we will be discussing your experiences and your opinions about the Seniors ALIVE Program. There are no right or wrong answers but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said.

Ground Rules

Before we go further, let me share some ground rules. Please speak loudly. Only one person should talk at a time. We are tape recording this session because we don't want to miss any of your comments. If several are talking at the same time, the tape will get garbled and we will miss your comments. We will use first names today but later in our reports no names will be attached to the comments. Keep in mind that we are just as interested in negative comments as in positive comments. Sometimes the negative comments are the most helpful. I ask you to please respect and maintain confidentiality by not sharing the information given during this focus group with other persons.

Our session will last about 2 hours. There are name cards on the table in front of you to help us remember each other's names.

Introduction

1. Let's find out some more about each other by going around the room one at a time. Tell us your name and what you did in the Seniors ALIVE Program and for how long.

2. What did you think of the Seniors ALIVE Program?

Participation

3. Some things make it easy for seniors to participate in health promotion programs. They facilitate the senior's participation.
   a) Can you think of things that made it easy for the seniors to participate in the Seniors ALIVE Program?

4. Some things make it difficult for seniors to participate in health promotion programs. They are barriers to participation.
   a) Can you think of things that made it hard for the seniors to participate in the Seniors ALIVE Program?

Impact

5. The Seniors ALIVE Program has been running for some time. I am interested in the period of time between the beginning of the program and the end of the program. Can you think for a few minutes about the first time you met the program participants. Now think about the last time you saw them. Is anything different between now and then?

6. Have you noticed any changes in yourself?

7. How have/will program participants will respond to the termination of this program?

Closure (final position)

8. All things considered, what was the most important aspect of the Seniors ALIVE Program?

9. Assistant moderator will give a summary of answers to main questions. Is this an adequate summary? (Type of member check)

10. Repeat overview of purpose of study. (Allow about 10 minutes before the end)

11. Have we missed anything?