Health Determinants: Take II

Marie Carlson, MA
Alberta Centre for Well-Being

In the spring of 1997, we asked readers, “What do you need to be healthy?” This was WellSpring’s first introduction of the concept “Determinants of Health” and marked a shift in Alberta Centre for Well-Being’s thinking about physical activity, Active Living and health.

“Health Determinants” is the generic term given to the full range of personal, social, economic and environmental factors known to have a bearing on health. These factors, most of which fall outside the health care sector, do not act in isolation; their complex interactions have a significant impact on the health status of individuals and populations. Between four and twelve determinants in the literature, depending on the source. Health Canada’s Population Health Promotion (PHP) model is frequently cited, and researchers agree that the following list of health determinants (see page 3) is a well-documented starting point.

This issue of WellSpring emphasizes important implications of health determinants for physical activity and Active Living.

Our Research Corner focuses on the influence of income, one of the most challenging determinants, for physical activity participation of Albertans. Of interest to practitioners, Tish D’yle-Baker reflects on the usefulness of the health-determinants concept for fitness leaders and program developers. At the organizational level, Rick Turnbull, shows how the Canadian Intramural Recreation Association strives to make policy and practical links between intramurals, recreation and determinants of health. Emma Smith explores the challenges of biological-based barriers and affirms the benefits of being active, despite limiting conditions or disabilities. Sandy O’Brien Cousins identifies the physical activity patterns and health status of North American minority groups. Highlighting gender and culture, Sandy suggests that the redefinition of active traditions may be the key to promoting healthy Active Living within diverse population groups in contemporary times. Last, our Snapshots highlight exemplary provincial and national research projects that tackle the influence of health determinants in the workplace, for low-income women, families living on welfare, and for recreation programs, facilities and services country-wide.

“Health Determinants” is a challenging concept to incorporate into traditional thinking and practice around physical activity and Active Living where the behavioral approach is especially entrenched. Evidence-based and community driven, however, this perspective reflects the new way of doing business in health promotion. Ideally, by working across the many determinants or by simply adding one or more (beyond personal health practices and coping skills) to our professional practice, we improve the chances of creating and sustaining a physically active way of life for all.

Check the Implications for Practice boxes throughout this issue to get you started thinking about health determinants where you work, volunteer and play.

Marie Carlson is the Education Coordinator at the ACFWB. She would like to hear how you’re incorporating these ideas into your work. Contact Marie at (780) 427-7816, toll-free at 1-800-661-4551, or by e-mail: marie.carlson@ualberta.ca

References:

Suggested readings:

continued on page 3
A New Way of Doing Business

Judith Moodie

In 2001, the first year of the 21st century, the Alberta Centre for WellSpring (ACFW) released a new name, a new logo, and a revitalized approach to serving Active Living and health promotion practitioners and organizations in Alberta. Established in 1989, the ACFW has become a major player in the field of Active Living in Canada. We are currently in the process of re-creating some aspects of the Centre to better position our work for the future.

For the next few years, the Centre will continue to be guided by two key documents. A Framework for Action, written after the 1995 Conference of Federal-Provincial/Territorial Ministers, addresses the need to reduce physical inactivity of Canadians. The 1995 conference resulted in the formation of the Alberta Active Living Task Force, made up of representatives of five Alberta health ministries, the medical community, universities and colleges, schools, the private sector, and others. The Task Force document Alberta Active Living Strategy resulted in the initiation of major ACFW projects in the areas of older adults physical activity and workplace active living, supported by the Alberta Sport, Parks, Recreation and Wildlife Foundation.

The Centre projects and initiatives will be also guided by the goal that organizations and practitioners will understand and operate from a health-determinants perspective. This is a very progressive goal; one in keeping with best practices in population health and health promotion. We anticipate that ACFW leadership will facilitate understanding of the interrelated factors that impact health. Our hope is that physical activity as a personal health practice will become possible for all Albertans as more barriers are reduced.

The process of positioning the Centre for the future has included communicating with our stakeholders on a number of matters. Our Executive Management Group and Advisory Board, the Alberta Sport, Parks, Recreation and Wildlife Foundation and Alberta Community Development, our staff, and other valued partners have been surveyed for their various viewpoints. An exciting piece of the positioning process is the development of a new corporate look. This will include re-designing all of our print and electronic materials to be consistent, distinctive and effective. WellSpring, one of the Centre’s flagship, and our premier means of educating and communicating, will also be updated.

You may have already been surveyed about WellSpring as part of this evaluation. We are very pleased with the excellent response, and we thank all of you who participated in this important piece of the process. We want to understand our readers’ needs and preferences, assess WellSpring’s production process, and increase circulation to a wider audience. Accountability and cost effectiveness are important to us, so a cost-benefit analysis was also completed. WellSpring’s new look will reflect the wishes of our readers and these other factors.

As well as a superb new paper version, we will provide access to WellSpring articles on our web site. Watch for these changes in the spring of 2001. We will be interested in your opinion of the new look of WellSpring, and invite you to send comments and suggestions to us at any time at well.being@ualberta.ca or by telephone at (780) 427-6949 or 1-800-661-4551.

Thank you to all of you faithful WellSpring readers, committee members and writers, who have supported the Alberta Centre for WellBeing over the years. We hope that you will find WellSpring even more informative in the future, and will consider it a necessary part of your continued professional development.

FROM THE RESOURCE LIBRARY

Tracy Chalmers Kitagawa
Resource Coordinator

Excellent information on the determinants of health can be found within the population health section of Health Canada’s website (www.hc-sc.gc.ca/hppb/phdd). The key determinants are outlined in detail and a selection of downloadable recommended resources is provided. Building a Healthy Future and An Annotated Bibliography on Indicators for the Determinants of Health are just two of the documents accessible by clicking on “Resources.” The health determinants section of the Canadian Health Network (www.canadian-health-network.ca) also cites numerous documents as well as organizations that are involved with research, programs and public policy.

However, for more in-depth information on physical activity as a health determinant and the relationship between physical activity and other determinants, I recommend the following resources.

- Eight of the leading health and social determinants of health, Social Science and Medicine, 47, 287-301.

Implications for Practice

Healthy Child Development

How can you build on a person’s positive childhood experiences to enhance their current physical activity participation levels? What did that person once like to do? Can they do it now, or can it be adapted to suit their present circumstances (abilities, settings, etc.)?

WellSpring

Winter 2000 Volume 11 Number 3
Determinants, Take II …continued from page 1

Twelve Determinants of Health

A social support network means having family, friends and community resources available to provide both encouragement and help in accessing resources. To increase their health, people need to be in contact with others. Communities give people a sense of belonging, plus opportunities to give and receive help.

Education and Lifelong Learning
People spend a great part of their lives being educated. A person's employment history and benefits received has a major impact on the resources available to them during retirement. Environmental and underemployment are both associated with poorer health, as is work-related stress or stress.

Social Environments
The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. If it is reflected in the institutions, organizations and informal giving that people create to share resources and build attachments to others.

Physical Environments
Physical environments include both the natural (the outdoor) and built or “man-made” environments (large communities, etc.). Factors in each of these settings such as pollution of air, water or soil, crowding, road design, and safety features are important influences on health. Environments where we live, work and play should be free of hazards and toxins, and be health promoting.

Biological and Genetic Endowment
The basic biology and organic makeup of the human body is a fundamental determinant of health. Genetic endowment are the physical qualities or traits and pre-dispositions toward certain diseases or conditions that are inherited through ones genes. An individual’s genetic endowment along with the biological differences between the sexes influences health on an individual and population basis.

Personal Health Practices and Coping Skills
Personal health practices include the things we do to prevent disease and optimize good health such as a nutritious diet, exercise, and avoidance of harmful substances. Cognitive coping skills we deal with stress such as the pressures of life, personal relationships, and health conditions. Environments and opportunities that promote positive personal health practices and coping skills allow us to make healthy choices and assist us in dealing with the pressures of life.

Healthly Child Development
The promotion of health and well-being for life has its roots in early childhood. The effect of prenatal and early childhood conditions and experiences on subsequent health, well-being, coping skills and competence is powerful. Habits and patterns established early on contribute to later health status, making this an important area of public health intervention and a positive supportive environment for a child’s growth and development.

Health Services
Health services help to take care of an individual’s mind and body. Some examples are counseling services, clinics and hospitals. The health care system is concerned with the maintenance and enhancement of health, as well as treatment and rehabilitation. Health services that promote and maintain health and prevent disease can influence the overall health of a community.

Gender
Gender refers to the array of socially constructed identities, personal qualities and traits, attitudes, behaviors, values, relative power and influence that society accords to these sexes on a differential basis, with differing results. Gender roles are learned, reinforced and reproduced throughout the lifespan, but also by other institutions and cultural values. “Gendered” norms influence the health system’s priorities and priorities. Any health issue is a function of gender-based social statuses or roles. For example, until recently, researchers knew more about causes and treatments for heart disease in men than for women, which are less researched and understood.

Culture
Peoples’ customs, traditions, and the beliefs of their family and community all affect their health. Some persons or groups may face additional health risks due to an environment which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of natural attributes and roles. For example, those who are not white and those who are not American (Black, Asian, Latina, etc.). Once health disparities are identified, we can see that the health of an individual and the community at large is no longer the subject of major debate. Those adults who are regularly active have better health than those who are not (IOM, 1980; Public Health Service, 1996). Hence, physical inactivity has been designated as the fifth major risk factor (RF) and one that has been shown to be among the most prevalent in many communities. As a result, many have endeavored to promote the value of exercise for individuals and societies. It is important to note that the role of the health professional in promoting exercise is not to promote a single behavior, but to provide the environment and resources that support a healthy lifestyle.

Implications for Practice

Employment and Working Conditions
List ways to help make your workplace more “family friendly” as well as physically active. Plan seasonal active living outings for staff such as skating or soccer that include children; or schedule a weekly “walking meeting” with colleagues at the office.

The Relationship of Health Determinants to Exercise Practitioners

Physicians, nurses, and epidemiologists often talk about health determinants because of the influence they have on the outcome of an individual’s health. Traditionally these determinants have been labeled as genetic, environmental, health care access and availability, and behavior. These health determinants do provide useful guidelines for quantifying and identifying health status for these health care professionals. The impact that some of these determinants may have been changed or modified over a lifetime through educational programs and policy initiatives.

Health determinants, however, are not likely to be altered by thinking that comes to mind for the practicing exercise leaders or specialists. This may be due to the fact that people focus on physical activity outcomes. Subsequently, the above health determinants may not be as useful in terms of guidelines, but they do have some application to the exercise practitioners’ overall achievement of goals.

The trick to understanding the importance of health determinants for practice is to go outside the conventional and study what we are currently doing, i.e., counseling, motivating, testing, leading exercise groups, and training. These individuals engaging in physical activity. Certainly, we can immediately identify exercise behavior as being very important, however, the other factors may not be as obvious. It may be that we need to conceptualize the health determinants, according to objectives and how they impact the broader scope of what we do.

Let’s start with the inclusion of the Health Objectives for the Nation (1990) because they reveal the bigger picture of how determinants may relate to exercise participation’s role now and possibly in the future. For example, these objectives include the specific terms of: risk factor, utilization of appropriate clinical and screening services, access and availability, public and professional awareness, and health status.

Risk Factor
If we start with what we know, then we can state that the relationship between physical activity status and health status is no longer the subject of major debate. Those adults who are regularly active have better health than those who are not (IOM, 1980; Public Health Service, 1996). Hence, physical inactivity has been designated as the fifth major risk factor (RF) and one that has been shown to be the most common and the most prevalent in many communities. As a result, many have endeavored to promote the value of exercise for individuals and societies. It is important to note that the role of the health professional in promoting exercise is not to promote a single behavior, but to provide the environment and resources that support a healthy lifestyle.

Of course, we have known for a decade or two that physical activity positively influences the other CHD risk factors and enhances physical fitness by improving heart function, blood pressure, body mass index and body fat, and blood lipids. Recently researchers (Blair et al., 1992, 1995) have stated that moderate amounts and moderate intensities of any type of activity are all that is needed to improve clinical status and lower risk of mortality.

Utilization of Appropriate Clinical and/or Screening Services
The fitness industry is now recognized as being linked to the more clinical approach in that exercise practices and the delivery of a single individual. In fact, personal training has become a much sought after service by many individuals for assistance with changing their lifestyle and specifically, exercise behavior.

To the above situation is one of several examples where the utilization of appropriate clinical and/or screening services may be necessary, and many practitioners in the fitness industry conduct on-site testing to determine a client’s readiness for exercise. For example, a young healthy person probably does not need a medical examination before beginning their exercise program, but giving them a PAR-Q and assessing their current fitness level is still warranted. On the other hand, an older person who either has CHD or has risk factors associated with the development of CHD, or an older person who wishes to run a marathon, will need more testing and an individualized program.

Therefore, one needs to consider age, risk factors which may be genetic, current health status and fitness level, and individualized goals and interests.

In addition to the clinical, single person approach, we should also look at the populations at large, dealing with the whole community (Rose, 1992; Ryan, 1996). Ideally, these two approaches should be interactive and mutually supportive. For example, individualized diet counseling given to a client is likely to diffuse among his/her family, friends and work colleagues. Conversely, if a green space and park is developed in a new housing development, it boosted a medical examination before beginning their exercise program, but giving them a PAR-Q and assessing their current fitness level is still warranted. On the other hand, an older person who either has CHD or has risk factors associated with the development of CHD, or an older person who wishes to run a marathon, will need more testing and an individualized program.

Therefore, one needs to consider age, risk factors which may be genetic, current health status and fitness level, and individualized goals and interests.

Of course, these approaches can be made easier when the local government assumes the ideal role in health promotion, which is three-fold. Firstly, it is to protect the public from unbalanced or misleading information. For example, we know that the food and tobacco industry can be very

continued on page 4
Invisible Women: Understanding the Barriers to Physical Activity for Low-Income, Older Adult Women

In this study, eight women, living in the inner city of Edmonton, were interviewed using a semi-structured interview format. Six themes emerged from the discussions: lack of exercise time, not having support, not having control, can’t be bothered, not having confidence, and exercise is too risky as significant barriers to physical activity. The findings suggest further investigation is necessary to identify the relationship between barriers and physical activity participation for low-income, older women. Results from this study can be used to enhance services and programs that are currently being offered.

For more information, contact Tokie M. Khew, M.Sc, at (780) 699-8624.

2000 Alberta Recreation Survey

This spring, Alberta Community Development in cooperation with the Alberta Centre for Well-Being, Alberta Environment, and the cities of Calgary, Edmonton and Red Deer, conducted the 2000 Alberta Recreation Survey. The survey focused on participation of households in selected leisure and recreation activities, changes in recreation behavior patterns, motivations for participation in recreation activities, barriers to participation, volunteer involvement, opinions regarding services supported by various levels of government, and sociocultural and demographic information.

The Alberta Recreation Survey has been conducted every four years since 1981 with questionnaire mail-outs occurring in 1981, 1984, 1988, 1992 and 1996. The 2000 Alberta Recreation Survey is the sixth in the series. Since it has been conducted over 19 years, we have the ability to determine present recreational participation patterns of Albertans as well as assess trends on a longitudinal basis.

For more information on the Alberta Recreation Survey, please contact Janet Fletcher at (780) 415-1164 or e-mail Janet.Fletcher@gov.ab.ca or visit our web site at www.gov.ab.ca/mrd.

Physical Activity Program Standard (PAPS)

Initiated by the ACFWB, this project is developing a comprehensive program standard for the workplace (PAPS) in the workplace. The program standard is based on modified elements of the O.C. Health and Safety Framework and an ecological perspective (i.e. interrelationship of interpersonal, interprofessional and broader system), with the goal of attempting to describe, adopt and maintain personal health behaviours. The PAPS will include an audit tool that this phase of the project will develop in part. The validation of the PAPS will involve both workplace Carers and others interested in workplace physical activity. It is anticipated the use of the PAPS and its audit tool will facilitate understanding and use by employers and practitioners in Alberta workplaces and abroad.

For more information, contact Ron Plotnikoff, ACFWB Research Associate, at (780) 492-0906 or e-mail: ron.plotnikoff@ualberta.ca.

Workplace Active Living in Alberta: A Needs Assessment

Fifty-seven workplace wellness professionals discussed their perceptions on “workplace Active Living”, the determinants of health in the workplace, and their information needs. The sampled population was drawn from 3 locations: Calgary, Edmonton, and Fort McMurray. A variety of workplaces were represented – provincial and municipal government departments & agencies, regional health authorities, school boards, universities, colleges, unions, and large private industry. Results from this needs assessment are posted on the ACFWB web site www.health-in-the-workplace.ca.

For more information, contact Ron Plotnikoff, ACFWB Research Associate, at (780) 492-0906 or e-mail: ron.plotnikoff@ualberta.ca.

Public Health Infrastructure, Policies, and Practices for the Promotion of Physical Activity in Canada

This is a comprehensive document outlining public health policies and practices for the promotion of physical activity in Canada. Using a multilevel approach, the physical activity delivery system and relevant policies have been identified in twelve communities across three provinces (Quebec, Ontario, & Alberta). The next step will include interviews with the residents of these communities for the purpose of relating their physical activity participation with the existing infrastructure and policies. The ultimate goal of the study is to provide the information required to move towards an integrated physical activity delivery system in Canada.

For more information, contact John Spence, ACFWB Senior Research Associate, at (780) 492-1093 or e-mail: john.spence@ualberta.ca.

The Cost of Healthy Living

This spring, by the Edmonton Social Planning Council (ESPC) entitled The Cost of Healthy Living, used public opinion polling data to construct a basket of goods needed for healthy living for four reference families. Each item in the basket was then exhaustively priced out at local stores or from local available data. In every case, all reasonable methods for reducing costs were taken into account.

The challenge to current public policy comes into focus when the resulting budgets are compared with the incomes for families relying on minimum wage or welfare. The income on welfare requiring $1,471 per year only from welfare, resulting in a monthly deficit of $440. Only the family with two parents working full time at minimum wage was able to reach the healthy budget threshold, and then just barely.

Just about everybody who looks at population health agrees poverty is a major determinant, if not the most important determinant, yet few voices get raised in protest. There must be continual follow and minimum wages. Until health policy advocates join social agencies in demanding a review of current welfare and minimum wage policies, there is little chance of making any headway against poverty. This complete study is available in the latest issue of Tracking the Trends at a cost of $10. For more information, contact the Brian Beech, ESPC Executive Director, at (780) 423-2031.

Exercise Practitioners continued from page 3

Exercise Practitioners continued from page 3

Influen tial in encouraging people to eat unhealthy, to smoke and consume alcohol. Secondly, to pursue economic policies, which at least do not make it harder for people to be healthy. This lifestyle, by, for example, subsidizing the production of saturated fats. And thirdly, to ensure that all public services which the public needs and wants in order to implement accepted health recommendations such as appropriate food labeling, public health facilities, and buses that carry bikes (Rose, 1992).

Access and Availability

In Alberta, we have seen a growth in the public’s concern about health determinants, physical activity and healthy lifestyles. Certainly, there is the community to will. For example, most people know that exercise is good for them. Most inactive people would like to be active. However, if people can’t walk comfortably in their neighborhood in the evening because the street is not adequately lit, or if the drop-in fee to a publicly supported recreational centre in a low income neighbourhood is too costly, then these become access barriers for achieving an active lifestyle. It’s true then, that exercise practitioners are less likely to see the people who need their expertise the most. In reality, our ability to access individuals is sometimes very limited.

Health care professionals also have limited access to their patients. For example, in some rural settings, there is only one physician per 800 people versus the urban centre of 1 in 200. In this issue, and others, results in the health care professions lobbying for change that directly impacts this determinant.

M abe the exercise practitioner should also lobby for the inactive by turning our enthusiasm into public health initiatives. We could become a part of a lobby group that would help to reduce the barriers for the inactive community whether they live in high or low-income neighborhoods, or educated or uneducated. Similarly, we could become involved in policies that are preserving the number of bike and walking paths because this impacts our personal training clients or group walking class.

Public and Professional Awareness

This major and independent risk factor designation of physical inactivity gives those of us in the health and fitness industry more credibility to become involved in the larger public health perspective. This status also gives physical activity greater legitimacy to become part of our health care prescription. Hopefully, this will stimulate more advocacies for healthier lifestyles and demonstrate that physical activity is part of health prevention, which is an integral part of public health policy and health promotion. For example, collaborative government initiatives have developed such programs as Active Living and The Vitality Approach, both of which are examples of health education and health promotion tools.

Public awareness of the benefits of physical activity and reduction of risk factors towards chronic diseases should also result in greater professional affiliation for the exercise practitioner as well. These practitioners, who have a designated certification for personnel working in the fitness and lifestyle appraisal industry, should advocate for taking on a greater role in prevention of these diseases.

Health Status

In 1997, the Constitution of the World Health Organization (WHO) made the statement that physical education is the cornerstone of a healthy lifestyle. The subsequent report stated we must recognize that failure to provide physical education (PE) costs more in health care than the investment needed for PE. One dollar invested in PE results in a subsequent $3.20 savings in medical costs (Symposium notes, CESF, Conference, Oct., 2000).

Therefore, exercise practitioners can take pride in what they do as an important factor in preventing and reducing the risk of some diseases. In summary, the theme of RF illustrates the relationship that the exercise practitioner has to some of the health determinants because of the impact that physical inactivity has on an individual’s health and fitness status. However, it may not have highlighted, as well as the other examples did, that an exercise practitioner’s role has legitimacy to be included in the health care profession; or how important it is for us to become activists of the impact that physical inactivity has on the individual, the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in. It is our job, now and in the future, to become health advocates, to educate the community and the environment that we live in.

Dr. T. D. Doyle-Baker is the Clinical Exercise Physiologist and Associate Professor with the Faculty of Kinesiology at the University of Calgary. He recounts essentially describes the situation in reproductive care and Public in Health. He main research area is outcomes of female health in both chronic and catastrophic diseases and sport.

References are available from the ACFWB.
Cross-cultural Studies on Physical Activity, Sport and Aging in North America

Sandra O'Brien Cousins, PhD
Faculty of Physical Education & Recreation, University of Alberta

Of interest to developing countries and communities with both emerging cultural traditions of physical work and active recreation, a new view of aging and physical activity is advocated. The notion is that physical activity is that housework, farming or ranch work, hunting, fishing, gardening, ethnic dancing and walking are all relevant components of a healthy lifestyle (Nelson, 1997). Multiple lifestyle trends tend to be very sedentary: watching television, working at computers, playing cards or bingo, and knitting or sewing for hours at a time are good examples of many of the typical, but less healthy, elderly activity options in the dominant North American culture. Technologically, we are now so advanced that societies must revalue the role that taking the time to be more physically healthy. As a D’Akota elder said, “the old ways are the new ways. We must look at them and learn from each other” (Norriss, 1994, p. 1).

Evidence is apparent that the low activity levels of minority older adults place them at high risk of encountering preventable diseases, experiencing depression and dying prematurely (Padget, 1995; Norris, 1994). While little is known about specific determinants, multiple jeopardy theory claims that aging makes life worse for members of ethnic groups;灰, minority elders have less status to begin with (Babits & Juarez, 1991; M. Iranda, 1991; N. Iranda, 1994). Population data suggest that minority elderly 65+ comprising less than 10% of the population, are an urgent gerontological concern because of rapid population increases in the elderly minority, and the disproportionately greater number of socioeconomic and health-related problems that indicate their quality of life compared to the predominantly white racial group (Allison & Smith, 1990; Kriak; & Hoyman, 1994).

Not surprisingly, less affluent nations have fewer resources to meet the issue of how to spend their leisure-time, as leisure itself might be considered to be a non-issue, a luxury, or an unfortunate condition of unemployment, or even less, cultural meaning altogether. Indeed, concerns about the present health status of emerging nations arises alongside other critical issues of adequate housing, nutrition, education and income (Krause & Wray, 1991). However, for political, moral and social reasons, there is growing interest in the minority and ethnic variations of aging and health status in Canada, the U.S. and the North American territories. The borders reside representations of Asian, Black and Hispanic communities as well as First Nation's peoples. Assembling a Black and Hispanic communities along with the Asian, status in Canada, the U.S. and the ethnic variations of aging and health among the dominant groups. The main concerns related to aging and health problems they face that impair their quality of life and interfere with their physical activity needs according to national guidelines.

Types of activities preferred

Sex and cultural match among minority elders, and in physical activity involvement emerged in a New Mecado study of 128 Anglo, Indian and Hispanic men and women (66% females aged 20-92) in N. Iranda, Begg, & Page, 1989). The main activities were reported to be sedentary; 79% of participants engaged in reading, 78% visited friends, 77% watched TV, and 74% enjoyed travelling. However, cultural differences were evident. Fishing, hunting and childcare were the least common activities except among Indian males and females who appeared to be equally sharing significant childcare responsibilities. Indian males more often reported farming, hunting, gardening, and working to support themselves than the other social groups. Statistically significant sex differences were found, women more likely than men doing arts and crafts, cooking, housework, thinking, reading, and going to church. Hapicans were significantly more active in attending church than the other. Indian males from the Alameda County study provide support that other females experience activity and its benefits through exercise and that getting “out” while older males experience more formal and regular exercise (Couch, 1995). With regard to “sitting around”, 57% of Indians, 42% of Hispanics and 27% of Anglos reported this pastime. The social order of reported “exercise” activity was, from highest participation to lowest, Indian females (70%), Hapicans (67%), Indian males (63%), Anglo females (59%), Anglo males (56%), and lastly, Hapicans females (43%). Such findings speak to the complexity of activity issues mixed with gender; issues that can’t be understood without more population research.

Regardless of culture, males were more likely to report exercise than females, and Asian elders were the most active, with both males and females being two times more likely to be exercising than white elderly. Black elderly were about 20% more active than white elderly. Luben and his research team (1998) concluded that white elderly women were the lead physically active, especially after age 75. One might conclude that when poverty and income issues are accounted for, the inactivity of minority groups is not as big a concern as it is for the Anglo-Americans. Lamentable is the fact that the physical activity patterns of Native and Aboriginal peoples in North America seem to have been neglected in the research. Notwithstanding the general social apathy for understanding the health problems of Native peoples, there are other issues explaining why the research community is ignorant in this regard: alcoholism, discrimination, education, housing and other social problems are acute; and most telling is the simple fact that research, though needed, has been lacking because less than 5% of that population reach the age of 65 (Norriss, 1994). We do know that native elders are more active than non-native elders, so that their health is “poor” compared to other groups, and 45% of Native elders report having “problems in walking more than two blocks” (Norriss, 1994). If one examines the current lifestyles of North American Indians, those assimilated into mainstream culture have adopted the mainstream lifestyle, while those on reserves have often withdrawn from the hunting, trapping, herding, farming and food gathering activities of their heritage (often due to environmental restrictions). As a consequence, obesity, diabetes, tuberculosis and social depression are rampant. Data assembled by Norris (1994) reports that less than 1% of native elders belong to a fitness or sport organization, less than 3% belong to any kind of self-help or support groups such as Alcoholics Anonymous, or weight management program, and only 6.8% attend a seniors activity centre. Native elderly may have leisure time, but they apparently do not spend it. Hapic health promotion has arguably taken hold in white, middle-class America in both professional and popular realms (Kerr & Ritchie, 1990). If all segments of North American society are to have the opportunity to enjoy a better aging experience, diverse populations need to be studied with a view to implement culturally appropriate programs that will enable them to enhance their health. A “culturally relevant” (Gallegos, 1991), “culturally sensitive” (Thompson, 1993), or “culturally competent” (Tee & Weaver, 1994) approach to increasing Active Living programs requires knowledge and respect for the diversity of beliefs held by a multicultural society.

Focus on family activity

The family is an important socializing agent for physical activity. For cultural reasons, the family unit has meant that an important network for increasing physical activity may be lost. However, the finding of moderate familial aggregation of physical activity to both Anglo- and Mexican-American communities, provides further support for the need for family-based health promotion through increased physical activity at all ages. One has to wonder if the breakdown of the family unit is one of several issues that might be moderated with more intergenerational active recreation.

Focus on women

Evidence is surfacing that women in particular are at risk of being inadequately active, and it is the women’s exercise habits that have the greatest positive effect on their children (Salis et al., 1988). All efforts to improve women’s health by taking steps to insure that females are “culturally competent” (Yee & Weaver, 1994), “culturally sensitive” (Thompson, 1993), or “culturally relevant” (Gallegos, 1991), or “culturally appropriate” (Tee & Weaver, 1994) approaches to increasing Active Living programs requires knowledge and respect for the diversity of beliefs held by a multicultural society.

Focus on education

Evidence is surfacing that women in particular are at risk of being inadequately active, and it is the women’s exercise habits that have the greatest positive effect on their children (Salis et al., 1988). All efforts to improve women’s health by taking steps to insure that females are “culturally competent” (Yee & Weaver, 1994), “culturally sensitive” (Thompson, 1993), or “culturally relevant” (Gallegos, 1991), or “culturally appropriate” (Tee & Weaver, 1994) approaches to increasing Active Living programs requires knowledge and respect for the diversity of beliefs held by a multicultural society.

Focus on education

Evidence is surfacing that women in particular are at risk of being inadequately active, and it is the women’s exercise habits that have the greatest positive effect on their children (Salis et al., 1988). All efforts to improve women’s health by taking steps to insure that females are “culturally competent” (Yee & Weaver, 1994), “culturally sensitive” (Thompson, 1993), or “culturally relevant” (Gallegos, 1991), or “culturally appropriate” (Tee & Weaver, 1994) approaches to increasing Active Living programs requires knowledge and respect for the diversity of beliefs held by a multicultural society.

Focus on education

Evidence is surfacing that women in particular are at risk of being inadequately active, and it is the women’s exercise habits that have the greatest positive effect on their children (Salis et al., 1988). All efforts to improve women’s health by taking steps to insure that females are “culturally competent” (Yee & Weaver, 1994), “culturally sensitive” (Thompson, 1993), or “culturally relevant” (Gallegos, 1991), or “culturally appropriate” (Tee & Weaver, 1994) approaches to increasing Active Living programs requires knowledge and respect for the diversity of beliefs held by a multicultural society.
The church as an activity centre

While supporting spiritual well-being among older people, churches could provide excellent community facilities for health promotion (Kai, 1989). Churches throughout and auditoriums can act as places for community exercise. All religious elders might benefit with better health if the churches of their faith were to support more physically active events. Churches are community-based and geographically placed to reach the population base. Older adults are over-represented in most churches, and have a strong voice in the affairs of the ministry. It is this kind of community-based model, fitting the ethnic traditions it represents, that have been recommended by Krause and Wray (1991).

Restoration of active traditions

Each minority group needs only to explore the cultural history to find the kinds of physical activities that have promoted their physical fitness and sense of pride in the past. The Native American, African, Hispanic, Indian, Chinese, Filipino, Korean, Singapore, Hong Kong, Cambodian and Viet Nam (H'ardia & Kim, 1995). Finally mainstream "while culture" also has a variety of ethnic representatives - British, French, German, Mediterranean, Scandinavian, and Eastern European. Each of these peoples has different ways in which they resolve health issues affecting their group (Gibbs, 1993), and their "old" ways of wellness seem to hold the future for culturally sensitive health promotion.

Ripe for exploration in understanding how beliefs about staying well change the way people are Latin American accounts of humoral pathology and the thermal principle of opposite (Poter, 1984). A theme of "catching ones death of cold" in Northern climates needs to be contrasted with more southern cultures who live in extreme of desert heat and cold. We need to know how elders who physically labour in hot climates reconcile this activity in terms of their health, and who older adults in Northern climates avoid wasting activity even when the climate is cool.

The health of mainstream society would do better to celebrate the unique traditions of various cultural groups, and facilitate or adopt those physical pursuits that promote the health of interested participants. International food fairs could be accompanied by physical opportunities for the general population to experience a range of ethnic activities. For example, the Inuit Games, pow-wows and hundreds of similar events provide opportunities for cultural sharing and restoration of proud traditions. One success story is Tai Chi, a slow-motion Chinese martial art that is spreading from older adults in North America. As one wise aboriginal elder has said, "By walking the path, we make the path viable." (Nims, 1994, p. 9).

References are available from the ACFWB.

Acknowledgement

Appreciation is extended to Dr. Barry McIntosh for helpfully handing me this topic for an invited symposium presentation at the World Congress on Physical Activity, Aging and Sport in Heidelberg, Germany. I must thank my doctoral student at the time, M. koto Chogahara, Ph.D. for assisting in collecting articles. Ongoing work with M.ister's student at the time, M. ry McNirick, and her cultural learnings with First Nation's peoples and Active Living International have provided me with insight and some confidence to discuss their situations on this topic.

Reprinted with author permission from World Leisure and Recreation, 9(3).

Discussion

Researchers are cautioned that within any large cultural group there are smaller social collectives representing often highly diverse traditions. For example, Blacks are made up of Africans, Jamaicans, Haitians and Cubans. Native Americans and Canadian Aboriginals represent dozens of tribal cultures such as Cree, Blackfoot, Mohawk, Cheyenne, Hupa, Cherskee, Shoshone and N waho. Hispanic origins may be Mexican, Puerto Rican or Cuban. Asian cultures include Japanese, Chinese, Filipinos, Korea, Singapore, Hong Kong, Cambodian and Viet Nam (H'ardia & Kim, 1995). Finally mainstream "while culture" also has a variety of ethnic representatives - British, French, German, Mediterranean, Scandinavian, and Eastern European. Each of these peoples has different ways in which they resolve health issues affecting their group (Gibbs, 1993), and their "old" ways of wellness seem to hold the future for culturally sensitive health promotion.

Ripe for exploration in understanding how beliefs about staying well change the way people are Latin American accounts of humoral pathology and the thermal principle of opposite (Poter, 1984). A theme of "catching ones death of cold" in Northern climates needs to be contrasted with more southern cultures who live in extreme of desert heat and cold. We need to know how elders who physically labour in hot climates reconcile this activity in terms of their health, and who older adults in Northern climates avoid wasting activity even when the climate is cool.

The health of mainstream society would do better to celebrate the unique traditions of various cultural groups, and facilitate or adopt those physical pursuits that promote the health of interested participants. International food fairs could be accompanied by physical opportunities for the general population to experience a range of ethnic activities. For example, the Inuit Games, pow-wows and hundreds of similar events provide opportunities for cultural sharing and restoration of proud traditions. One success story is Tai Chi, a slow-motion Chinese martial art that is spreading from older adults in North America. As one wise aboriginal elder has said, "By walking the path, we make the path viable." (Nims, 1994, p. 9).

References are available from the ACFWB.

Acknowledgement

Appreciation is extended to Dr. Barry McIntosh for helpfully handing me this topic for an invited symposium presentation at the World Congress on Physical Activity, Aging and Sport in Heidelberg, Germany. I must thank my doctoral student at the time, M. koto Chogahara, Ph.D. for assisting in collecting articles. Ongoing work with M.ister's student at the time, M. ry McNirick, and her cultural learnings with First Nation's peoples and Active Living International have provided me with insight and some confidence to discuss their situations on this topic.

Reprinted with author permission from World Leisure and Recreation, 9(3).

Discussion

Researchers are cautioned that within any large cultural group there are smaller social collectives representing often highly diverse traditions. For example, Blacks are made up of Africans, Jamaicans, Haitians and Cubans. Native Americans and Canadian Aboriginals represent dozens of tribal cultures such as Cree, Blackfoot, Mohawk, Cheyenne, Hupa, Cherskee, Shoshone and N waho. Hispanic origins may be Mexican, Puerto Rican or Cuban. Asian cultures include Japanese, Chinese, Filipinos, Korea, Singapore, Hong Kong, Cambodian and Viet Nam (H'ardia & Kim, 1995). Finally mainstream "while culture" also has a variety of ethnic representatives - British, French, German, Mediterranean, Scandinavian, and Eastern European. Each of these peoples has different ways in which they resolve health issues affecting their group (Gibbs, 1993), and their "old" ways of wellness seem to hold the future for culturally sensitive health promotion.

Ripe for exploration in understanding how beliefs about staying well change the way people are Latin American accounts of humoral pathology and the thermal principle of opposite (Poter, 1984). A theme of "catching ones death of cold" in Northern climates needs to be contrasted with more southern cultures who live in extreme of desert heat and cold. We need to know how elders who physically labour in hot climates reconcile this activity in terms of their health, and who older adults in Northern climates avoid wasting activity even when the climate is cool.

The health of mainstream society would do better to celebrate the unique traditions of various cultural groups, and facilitate or adopt those physical pursuits that promote the health of interested participants. International food fairs could be accompanied by physical opportunities for the general population to experience a range of ethnic activities. For example, the Inuit Games, pow-wows and hundreds of similar events provide opportunities for cultural sharing and restoration of proud traditions. One success story is Tai Chi, a slow-motion Chinese martial art that is spreading from older adults in North America. As one wise aboriginal elder has said, "By walking the path, we make the path viable." (Nims, 1994, p. 9).

References are available from the ACFWB.

Acknowledgement

Appreciation is extended to Dr. Barry McIntosh for helpfully handing me this topic for an invited symposium presentation at the World Congress on Physical Activity, Aging and Sport in Heidelberg, Germany. I must thank my doctoral student at the time, M. koto Chogahara, Ph.D. for assisting in collecting articles. Ongoing work with M.ister's student at the time, M. ry McNirick, and her cultural learnings with First Nation's peoples and Active Living International have provided me with insight and some confidence to discuss their situations on this topic.

Reprinted with author permission from World Leisure and Recreation, 9(3).
Intramural, Recreation and Determinants of Health

Rick Turnbull
Executive Vice President
Canadian Intramural Recreation Association

The Canadian Intramural Recreation Association (CIRA) supports Health Canada. It focuses on the need to promote physical activity for all ages in order to reduce the risk of chronic disease. CIRA works to enhance the health of all Canadians by promoting physical activity through intramural and recreational programs. In addition, CIRA supports Health Canada's goal of reducing the risk of chronic disease and the promotion of active living through intramural and recreational programs.

Executive Vice President
Rick Turnbull

Determinants of Health
Intramurals, Recreation and healthy lifestyle choices and decisions. Failure, affirming a child's confidence in games eliminate the fear and feeling of caring and respect by peers, which in social support network involves sharing, experimentation. For practical application and recreation complement academic where play is involved. Intramurals and student leadership - they have fun, develop social skills, and learn leadership skills, plays a role in reducing the impact of poverty and may help to break the cycle of poverty.

Income and Social Status
Intramural and student leadership programs play an important role for children and youth living in poverty because of their inclusive nature. Participation in intramurals and recreation, as well as in leadership skills, plays a role in reducing the impact of poverty and may help to break the cycle of poverty.

Social Support Networks
The philosophy behind intramural and recreation programs is something for everyone - supporting and caring for all. It broadened my horizons. It increased importance of Active Living in one's life. The work of the association, through the above focuses population areas, in turn supports population health. The work of the association, through the above focuses population areas, in turn supports population health.

Physical Environment
A safe school environment where children and youth can play and learn is an important aspect of an intramural and recreation program. Safety and risk management are important considerations for any physical activity program. CIRA encourages teachers, student leaders, and administrators to address safety considerations, including supervision, safe play and respect for others, when developing intramural and recreation activities. These values are promoted through CIRA's Playground Leadership Program. Incorporating time throughout the day for outdoor activities is also important for the health and well-being of children and youth.

Biological and Genetic Endowment
While we cannot affect the genetic makeup of children and youth, we can influence their appreciation for involvement in physical activity, regardless of ability. By providing skill instruction, positive experiences, encouragement, and an opportunity to practice and play with peers, children and youth can develop habits that will reinforce an active lifestyle throughout their lives. It is our hope that active lifestyle habits that are adopted by this generation of young people will be passed on to succeeding generations.

Personal Health Practices and Coping Skills
Intramural programs are physically active, diverse, fun and can be done daily. CIRA's message is that regular physical activity is a significant contributor to overall physical and mental health. But more importantly, we know that activities that are personally valued and enjoyable are related to sustained physically active health behaviors.

The first six years of a child's life are critical to the development of fundamental skills for a happy, healthy life. Children require continuous involvement in physical activity and recreation programs throughout their early and teenage years for healthy development. Proactive, positive and consistent intervention is important. To enhance children's self-esteem and self-confidence through physical activity, intramurals also require positive experiences that encourage individual progress. Intramural and recreational activities with peers and friends can be a source of social experience, resulting in an active lifestyle that can last a lifetime. Children feel good about themselves and their accomplishments gain self-confidence and learn to deal with stress.

Kendy Bentley, 1995 - 1998
Kendy has been active in the field of health promotion and active living in the workplace for over 20 years. Her consulting and management firm has, with the support of a great team of physical educators, kinesiologists and associates, had a great impact on the wellness scene in Calgary working with clients like Shell Canada Limited, PanCanadian Petroleum Ltd. and ENMAX Corporation.

Not only did they bring a wealth of knowledge and experience in workplace health, but Kendy's famous words of "so what?" kept us grounded to the practical side of theories, research and ideas.

Davis Graham, 1995 - 1998
Davis is currently an Investment Advisor with a full service brokerage firm in Edmonton. While on the WellSpring Editorial Advisory Committee, Davis was an active administrative director with the Capital Health Authority. Davis brought his strong interest in social marketing to our planning meetings. Now he enjoys helping people to achieve wellness and balance in their lives by providing sound financial, estate, and investment advice.

Jim Gurnett, 1995 - 1998
Jim, the Executive Director of The Hope Foundation, at the time, brought a perspective on the spiritual and psychological components of health to our discussions. "I enjoyed the opportunity to be a part of the WellSpring Editorial Advisory Committee because it offered a balance of broad discussion about the issue of health in the fullest sense, and how to develop an effective communications tool to share information with those concerned about health. At the same time, it provided me with the opportunity to be actually involved in the 'nuts and bolts' of creating each issue."

Jim is now the Manager of Community Physical Activity at Bissell Centre where he supports the managers who deliver a range of services from emergency child care, summer camps through temporary employment services; publishing "Our Voice", Edmonton's dirt newspaper, to operating an adult drop-in for those who are homeless.

Brett Hodson, 1999 - 2000
Brett is the Regional Health Promotion Coordinator at Headwaters Health Authority. He joined the Headwaters RH A after graduating with an MSc in Health Promotion from the University of Alberta. Brett's contribution during his time with the WellSpring Editorial Advisory Committee is commendable. His leadership and dedication to support children and youth living in poverty is remarkable. His involvement in the School as a Health Environment Committee is commendable. His leadership and dedication to support children and youth living in poverty is remarkable. His involvement in the School as a Health Environment Committee is commendable.

Mike Keeling, 1995
Mike, who is hearing-impaired, owns Keeping Tech Aids, a company that specializes in assistive technology for deaf, hard of hearing, speech-impaired, and blind individuals. He brought to WellSpring a perspective of those with a disability, specifically auditory impairment. Michael's participation enlighten us to some of the practical realities when including persons with a disability in our programs, services or projects.

Orlin Lyssong, 1995 - 2000
Olin is currently the Executive Director of the Schizophrenia Society of Alberta, Fort Saskatchewan. Olin and WellSpring provided a health perspective from the provincial government, particularly in mental health. "Being on the WellSpring Editorial Advisory Committee," he says, "I developed a wider awareness of the importance of Active Living in one's life. It broadened my horizons. It increased participation in social and community activities."
It’s Never Too Late! Contending with physical challenges

Emma Smith, MSc
University of Calgary

There are a number of factors that influence our health. Health Canada recognizes 12 health determinants that work together to significantly impact health outcomes. Some of the determinants can be manipulated, such as Physical Environment, Personal Health Practices, Coping Skills and Education/Lifelong Learning. Is there anything that can be done to improve health outcomes for the factors that cannot be altered, i.e., Biology and Genetics? Physical activity could be the answer.

If only we could choose our parents, then we could drastically reduce the chance of inheriting certain disabling conditions. If we could choose, who would we choose? For individuals with most disabilities, whether physical activity can prevent or reduce the effects of some disabling conditions. If the condition is present, what are some guidelines for recommending an exercise program?

Can Physical Activity Help?

What first comes to your mind when someone mentions they have a disability? Do you envision someone who uses a wheelchair? Someone with a parasitic? Someone missing a limb? These may or may not be the first images that come to mind. As health practitioners, we must be aware of other disabilities, the visible and invisible. When first meeting a client, would you know if they had an anxiety disorder, osteoporosis, arthritis, hypothyroidism, muscular dystrophy? You probably would not know until you spoke to the person. It is equally important to find out about their general health history in order to recommend programs which best reduce the risk of acquiring these conditions.

Despite overwhelming evidence that physical activity is associated with numerous health benefits, only 33% of adults achieve the recommended levels of moderate intensity physical activity on most or all days of the week, and few are active enough to derive health benefits (Paluska and Schwenk, 2000). An increase in level of physical activity, especially for sedentary individuals will have the benefit of reducing the risk of heart disease, osteoporosis, type-2 diabetes mellitus, hypertension, and other disabling conditions. According to Paluska and Schwenk (2000), physical activity appears to be as effective as psychotherapy for the treatment of mild to moderate depressive symptoms. Exercise may improve the quality of life and bring about significant health benefits for individuals with most disabilities including cerebral palsy, Duchenne muscular dystrophy, learning disabilities, Down syndrome, and multiple sclerosis, to mention a few. Physical activity can only delay the progression and improve the symptoms of some of these disabilities; it cannot reverse the effects (Sayers, 2000).

People with physical disabilities have the same physical, emotional and psychological needs as individuals without disabilities. Physical activity promotes improved physiological and psychological function, which may in turn lead to greater independence, greater self-esteem, fewer problems with activities of daily living, and improved overall health. Older adults are more susceptible to the adverse effects of a sedentary lifestyle than younger persons and the prevalence of sedentary behavior increases with age (Pescatello, 1999).

Exercise can prevent an additional bone mineral density loss for individuals with osteoporosis and can reduce the incidence of hip fractures in the older population by almost half (Rutherford, 1999). Being physically active greatly reduces the risk of falling by improving muscular strength, coordination and balance.

What Can You Do?

What does this mean for the health practitioner? Most people have been told that physical activity is good for their health, yet the statistics show that very few people are physically active. We need to design programs that can be adhered to. Consider the following guidelines when beginning programs for persons that are either predisposed to disabling conditions or who currently have a disability. Also note that exercise prescription will vary between disabilities and between individuals with the same disability.

- Obtain medical clearance for anyone who has not exercised in a long time.
- Ensure proper breathing technique
- Maintain steady state exercise
- Perform gentle warm ups before exercise
- Obtain medical clearance for individuals to use the Borg scale of perceived exertion (is self-administered physical activity exertion scale. Participants must be able to participate in the self-administered perceived exertion scale). The Borg scale is a numerical scale of 6-20 to describe the effort clients perceive as a result of their activity.

Rating of Perceived Exertion (RPE)

<table>
<thead>
<tr>
<th>RPE</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very, very light</td>
</tr>
<tr>
<td>2</td>
<td>Very light</td>
</tr>
<tr>
<td>3</td>
<td>Fairly light</td>
</tr>
<tr>
<td>4</td>
<td>Somewhat hard</td>
</tr>
<tr>
<td>5</td>
<td>Hard</td>
</tr>
<tr>
<td>6</td>
<td>Very hard</td>
</tr>
<tr>
<td>7</td>
<td>Very, very hard</td>
</tr>
</tbody>
</table>

Ilustration 1. Borg Scale

A method of monitoring the intensity of physical activity is by using the Borg scale developed by Swedish psychologist, G.A. Borg. The Borg scale uses the numbers 6 to 20 to describe the effort clients perceive as a result of their activity.

References


WellSpring Editorial Committee Members continued from page 1

my awareness of other concepts, and in turn, I got a better understanding of health promotion."

Wilfreda Thurston, 1995 - 1996
Wilfreda Thurston is an Associate Professor in the Department of Community Health Sciences, and former Director of the Office of Gender and Equity Issues, Faculty of Medicine, University of Calgary. Her research interests in the field of health promotion are based on the link between program and policy theory, practice and evaluation. Participation and partnerships, gender and family violence; substantive areas of interest.

“I feel I widened the understanding of women’s health policy and program issues as well as encouraged a critical perspective on theory and practice.”

Pearl Upshall, 1995 - 1995
During her time on the WellSpring Advisory Committee, Pearl Upshall was the Administrator of the South Peace Health Unit in Grande Prairie, and President of the Alberta Public Health Association. Involving victims in prevention and health education, maintaining adequate resources to preserve health and maintain their lifestyle. Along with informing the public about the environmental factors related to maintaining health, I believe that individuals and populations need appropriate fiscal resources to sustain health and well-being.

Since retiring, Pearl divides her time between her family and business. Pearl has developed a global business training and health consulting service, including fitness. Colin Young, 1995 - 1998

Colin is presently a Programmer Analyst for the Faculty of Science, University of Alberta. He was formerly with Web Networks, a not-for-profit Internet service that works with non-profit organizations in the fields of social justice (e.g. health, environment, women’s issues, labor and international development). My area of interest is environmental issues. “I wanted to develop a stronger link between the community and the environment community and the health community. I was also interested in getting to know what was going on in the community I come from (the environment community) and to do some networking. No one of the benefits of working with WellSpring, however, was to broaden my vision on how to approach things by looking at the projects and methods people were doing. It was also rewarding to feel like you are bringing a different perspective to the table and that there was a willingness to listen to it.”

W. Keith Mclaughlin, 1997 - 1997
Keith is currently the Project Leader on the Alberta Primary Health Care Project (1997-2001), funded by federal Health Transition Fund. This umbrella project involves 27 primary care health (PHC) projects, largely in regional health authorities, with the purpose of taking leading on innovations and embedding PHC services/activities, and sharing the learning and best practices widely. Keith’s area of interest is prevention, health promotion and evaluation. During his committee term, Keith brought information and linkages to current disease injury prevention and health promotion initiatives being undertaken by Alberta Health and Wellness with diverse partners.