Young Adults:
Attitudes Toward Community Health

By Susan MacMillan and Danielle Jantzie

What wellness behaviours do teenagers consider to be important or — "NOT"?

The preliminary results of a larger study of the wellness attitudes of young adults suggest there are dramatic differences in the value teens place on various types of wellness behaviour. The purpose of this article is to compare the response of young adults to the importance of taking action to prevent the spread of sexually transmitted diseases (STDs) and AIDS (autoimmune deficiency syndrome), and the use of bicycle helmets. These are both actions that can greatly reduce the risk of catastrophic injury to individuals and to community health.

The study examined the attitudes and actions of 332 female and 168 male young adults toward well-being. The teenagers were asked to rate the importance of AIDS prevention and the use of bicycle helmets toward well-being. They were then asked to indicate whether or not they included the particular action in their own lives. The Lethbridge young adults included in the study were 12-18 years of age and, generally, still in school. The average age of male respondents was 16.1 versus the 15.6 average age of females.

**Preliminary Findings**

When comparing the responses to the two issues, it is clear that these teens place uncompromising importance on the prevention of the spread of STDs and AIDS (90% of females and 80% of males) yet the response to the importance of helmet use was spread across the continuum, with substantial numbers of female and male teenagers rating helmet use as being unimportant. Only a few females and males (11% and 17% respectively) report helmet use. Safe sex practices were viewed by both as important and most (88% of females and 83% of males) took action.

It should be noted on this point, however, the action of females is even much lower than the attitude results would predict. A number of social factors may be involved here, including the perception of a poor aesthetic value of helmets and their impact on hairstyle.

**Implications**

From the standpoint of community health, the results imply that within the teenage population there is a high level of awareness and action with respect to the issues of STDs and AIDS. This may be interpreted as an admission of sexual activity or of

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It is interesting to note that Alberta is one of the last (if not THE last) provinces in Canada to endorse the "healthy communities" movement. Somehow the idea never got off the ground—perhaps partly because Alberta Health was not able to give the project the support (in leadership and base funding) it really needed.

This is interesting, given that strengthening the collective health of communities seems to be what the World Health Organization and Canadian Public Health Association support.

I don't pretend to have any magical answers for getting this issue to the forefront, but I can tell you that there is a great deal of base interest. The Alberta Urban Municipalities Association Conference offered a special session on "Quality of Life" which was well attended. The Edmonton Metropolitan Regional Planning Commission has identified "Well-Being" as one of its major topics for their Round Table discussions. The Health Unit Association of Alberta is currently producing a booklet which features communities that have implemented a "healthy communities" approach. The new Active Living movement also contains elements of the healthy communities concept.

I think the days are coming when we may be forced to conduct intersectoral discussions and planning (a foundation of the "healthy communities" approach)

"wouldn't it be more empowering... if we choose to use this approach rather than be forced to"

simply because of fiscal restraints. Wouldn't it be more empowering (I almost hate to type this over-used word) if we choose to use this approach rather than be forced to?

If you want more information on the "healthy communities" movement, please give Val Wiebe or Dr. David Swann a call (see their article on page 8). They have a variety of resources that can help clarify the concept, in addition to presenting several ideas on how to get started.

The Alberta Centre For Well-Being also has a number of print and video resources available that will be useful in creating a "healthy communities" project.
It seems that we, in the wellness movement, are playing tug-of-war with a rope as strong as the root of a petrified tree. At one end we are striving to make others aware of the variety of healthy activities one can engage in toward improving quality of life and increasing longevity. At the other end of this solid vine is the present healthcare system, digging its roots into the traditional soil of curative and reactive care. Recreation and leisure professionals are reimbursed from a system of prevention and proactivity. Most health professionals, on the other hand, are not. Although, as “well-being” professionals, we accept the importance of prevention and wellness in improving community health, the structures of the two systems are not always compatible.

Many recreation and health professionals, agencies and associations are attempting to collaborate on health promotion and prevention efforts while desperately trying to bridge the gap between reaction and proaction—to move into the 21st Century with a new set of norms that would allow us to work together—to pull on the same team.

In this issue of *WellSpring*, we explore the concept of strengthening community health, the need to focus on global health, the contrast between current models of human health (curative and preventive), and basic attitudes toward what constitutes healthy behaviour.

You will read how communities have achieved goals through people power, and how various individuals can work together to improve the health of their neighbourhoo.

Once again we will visit Active Living—but this time within the broad realm of its impact on community health.

“The concept of healthy in staying in school and developing their potential effectively,”

“Maybe it was Dr. Battle’s heart ruling his head, then, when he developed his theories of self-esteem, suggesting lack of self-esteem is the cause of poor academic achievement, failure, experiences, adjustment problems and suicide. Poor self-esteem certainly results from poor academic achievement or failure experiences, but it does not cause these effects. Therefore it is inappropriate to treat self-esteem as a cause when it is, in fact, a result.

“Now I am walking on conquered ground. Self-esteem is a hallowed subject—one that is not talked of disparagingly. Yet it must be addressed; for low self-esteem, itself, has a cause, beyond the four symptoms listed above, that truly yields to treatment and, once treated, will truly meet the societal needs of this decade and the next century.”

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Healthy Communities Through People Power

By Tammy Horne, PhD

"Healthy communities" initiatives have been organized mainly by professionals with little substantial public input. Two former consultants with the Toronto Healthy Cities Office suggest that this is because the health promotion movement started within government, rather than in the larger society.

An Australian "community development continuum" (see sidebar) might be adapted as a framework to promote a citizen-driven healthy communities movement at both the individual and policy levels. The professional's role is support and facilitation. Because people have different comfort zones with community involvement, and may shift positions based on life changes, upward progression should not be assumed. At all phases, the emphasis is on people to gain the confidence and self-esteem to take control of their lives.

Mutual support recognizes that people can better control their lives if they can share experiences with family, friends, neighbours or self-help groups. Furthermore, a united larger "community" is not assumed when socioeconomic and other power differences exist between social groups.

Issue identification and campaigns mark a transition from a self-care/mutual aid to a social action or policy change emphasis (although the two are not mutually exclusive). The roles of the professional are listening to various individual and groups, ascertaining priorities and potential coalitions, and helping citizens to understand the "system" they are trying to change (e.g., health, school). This third position diverges from the usual healthy community initiatives, where policy recommendations come mainly from service agencies and municipal governments, and the public is only superficially involved (e.g., occasional public forums).

A danger at this third phase is advocacy for changes that go against basic principles of community development (e.g., inclusiveness, equity). For example, there is a difference between working to make public services (e.g., recreational facilities) accessible to all, versus denying some groups (e.g., teens) access. Similarly, lobbying to keep hazardous waste out of one's community is consistent with community development principles, while lobbying to deny rights and freedoms to minority groups is not. Mediation and/or education may be necessary if these situations arise.

In participation and control of services, citizens get involved in running community services that are important to them. It is essential that these citizen participants are truly listened to and not tokenized. Citizens learn skills and make contacts for use in future as well as present involvements.

In the social movement phase, issue involvement becomes more intensive than in positions three and four. This could mean collaboration among individuals and groups to develop a citizen-defined version of a healthy community, and to implement this vision in a way that truly empowers the whole community!
On one hand we are culturally obsessed with looking good. The tall, thin models adorning the pages of popular magazines, and the hard bodies of television and film simply add to this warped perception of human perfection.

On the other hand, many sources state we are not, as a nation, very committed to health and fitness--activities that would enhance our image and appearance. Ironically, our desire to look and feel better have sent fitness revenues soaring to billion dollar heights. Yet, according to several studies and surveys, less than 30% of the entire population are contributing to this revenue rise by participating in regular physical activity.

According to Kevin Arnott of the Kinsmen Sport Centre in Edmonton, preventive healthcare ultimately involves physical activity. "The biggest challenge," says Arnott, "is motivation and adherence." Arnott believes that motivation and adherence are in turn affected by people's attitudes toward exercise and health.

"Health [as an issue] is on the backburner," says Katherine McKeigan of the Fitness Resource Centre at the University of Alberta. "The public is more concerned with other issues such as the economy. Awareness [of the benefits of participating in healthy activities] is there, but people have not yet bought into it," says McKeigan.

Perhaps the current move toward preventive healthcare and the growing popularity of the Active Living Concept will encourage people to pursue healthier lifestyles and participate in regular physical activity.

As many of us are finally grasping, the old "high intensity, three times a week" fitness message doesn't work for most Canadians. It was a good message, but even its founders, like Dr. Kenneth Cooper, who coined the phrase 'aerobic fitness', along with his well-known colleague, Dr. Steven Blair, are changing their tunes.

Cooper and his fellow researchers at the Cooper Clinic in Dallas, Texas, now draw a distinction between physical fitness training and exercise for good health. They claim very modest exercise (considered useless in the past because it fell below thresholds deemed necessary to achieve aerobic benefit) can actually have a profound effect on well-being and general health. (Dr. Steven Blair will be lecturing in Edmonton and Calgary in May--see page nine for details.)

According to Arnott and McKeigan, these original aerobic messages also failed because they only reached 30% of the population, whom were already exercising--the "converted" as McKeigan calls them.

Today, Cooper's new formula and that of many other leaders in health, wellness, recreation, physical education and exercise physiology, leans toward active living, which targets a whopping 70% of the population.

Active Living incorporates a broader vision of what exercise means, to include mental, social, emotional, and spiritual health--in essence, wellness.

Our governments are investing big bucks in this concept, and for good reason. People who were "less likely to be smokers, more likely to follow Canada's Food Guide, and more likely to reduce dietary fat" are added to the regular aerobic fitness enthusiasts as the target audience.

The fitness and recreation professionals have readily adopted the concept--tangible benefits have been spelled out and more people of all walks of life are attracted to this "a little goes a long way" approach. Aerobic guilt is hopefully a thing of the past--a comic rung on the evolutionary ladder toward community health.

Both health and recreation professionals are finding ways to incorporate the active living concept into existing programs without taking away from the aerobic/endurance formula which continues to attract many participants.

Vitality--yet another holistic health concept created by the federal agencies--also continued on page 13
For too long, health has not been recognized as one of the cornerstones of human and national development. Only recently have the global prospects for human health begun to attract the attention of the world community. The impact of environmental degradation on human health, the AIDS pandemic, and the realization that modern transport and mobility promote the speedy transmission of disease have contributed to this awareness. Media brings into our living rooms vivid reminders of human suffering in all countries of the world.

The main strategies of Primary Health Care (PHC), as articulated in the World Health Organization (WHO) and UNICEF’s joint Conference Declaration of Alma-Ata in 1978, place emphasis on the importance of water and sanitation, information, agriculture extension, and other services designed to protect and improve health status. It is also necessary to stress intersectoral activity and the importance of focusing on vulnerable groups. PHC is identified in the Declaration as the key to achieve Health For All by the Year 2000.

This declaration has been endorsed by most countries. It is important to stress that according to the Alma-Ata, even in 1978, health was seen not merely as the absence of disease but the ability for all to lead a socially and economically productive life—the basis for the concept of well-being.

The World Health Assembly’s Report On World Health, 1992, states that more than 1,000 million people or about 20% of the global population, are suffering from disease at any one time. Of the 50 million deaths worldwide, 46.5 million can be directly associated compared to 2.4% of deaths in industrialized countries.

However, the number of childhood deaths has been dropping slowly in the past five years. This drop is largely due to the increased access to Primary Health Care services—vaccinations against the six common childhood illness, safe water supply and adequate excreta disposal, availability of essential drugs, attendance by trained personnel during pregnancy and child birth, and care for the child during the first year of life.

In the least developed countries, 70% of the population have access to at least local health services, a 21% increase in the past five years, while in all developing countries, the availability of health care has increased by 19%. Immunization levels for childhood illnesses has reached a global average of 80% and the access to oral rehydration therapy has increased to about 70%. Disparity between and within countries continues to exist, and efforts to maintain high immunization rates must be continued.

"The tragedy is that there are at least 20 million deaths each year that could be prevented"
It is clear that preventive measures, rather than purely curative, remain an important part of health programs around the world.

However, these measures are not likely to be implemented without the contribution of resources from more developed countries, Canada included. In this light, the cuts to the development budget of CIDA could not come at a worse time.

In the “mini-budget” presented by the Honorable Donald Mazankowski this past December, the level of Canada’s contributions for development was cut by 10% in 1993 with further cuts projected for 1994. This translates into a reduction of $50 million in 1993-1994. These cuts threaten health and the ability of people to provide them. With health comes the realization of human potential. The reduction of budgets also reduces the number of projects NGOs can undertake to assist less developed communities to establish and maintain services to improve their quality of life.

Most of the less developed countries have fared worse than Canada during this global recessionary period. Structural adjustment programs have weakened many countries’ social sector infrastructure. In many of the countries in which the Canadian Public Health Association is supporting projects, drought has seriously affected family and national incomes.

In view of the constraints that are currently inhibiting developing countries’ efforts to maintain the health of their populations, it is more important than ever for Canadians to continue to contribute resources, both financial and technical. It is only through united efforts that we will attain Health For All by the Year 2000.


Young Adults' Attitudes (continued from page one)

abstinence. The question did not ask for individual interpretation, and thus did not assess the accuracy of the knowledge held by this age group. For example, they may simply avoid social contact with homosexuals or those people they suspect to be HIV positive as a means of preventing transmission when it is highly unlikely that such action would help.

The awareness and actions toward the prevention of STDs and AIDS, more than helmet safety, is at least partially due to the nature of the health promotion campaigns themselves. While the AIDS campaigns are conducted on a global level, with celebrity spokespeople, and an extremely high profile, the campaigns for helmet safety are generally run at local levels, using predominantly expert information on risk and injuries.

Community health will benefit from the level of awareness and action indicated by this age group toward the issues of STDs and AIDS.
The Evolution of a Vision: The "Healthy Communities Movement"

By David Swann and Val Wiebe

"No amount of material welfare will serve to arrest the developing sense of alienation in our society."  
Robert Nesbitt—Megatrends

Locally and globally there is a call for a new way of approaching the human condition, the way we live, work and relate to one another and the planet, to one which is more life-giving, slower-paced, and sustainable in economic, social and environmental terms.

Coincident with this is a widespread recognition of the need to shift from the "expert" and "top-down" service delivery model for human services to a more wholistic, integrated and population-based model grounded in the perceptions, aspirations and capacities of local people in their communities. A central feature of the thinking in both human health and ecological sustainability is the need to recover a sense of community as a crucial aspect of healthy human development.

It is now seven years since the World Health Organization formulated its Health Promotion Principles and, along with Canadian leadership (A Framework For Health Promotion—Epp, and the Ottawa Charter), launched an important new movement for health and prevention in the Western World. The Healthy Communities Project evolved to "engage individuals and communities, with local government, in collaborative action to improve quality of life and health".

In Canada a national office for Healthy Communities existed for several years to facilitate provincial activities across the country. This spawned networks for Healthy Communities in nearly all provinces except Alberta, most actively in Quebec and British Columbia.

In Alberta, an enthusiastic start with Edmonton and Calgary was followed by projects in several towns, including Medicine Hat, St. Paul, Cold Lake, Wetaskiwin, Ft. McMurray, Edson and Banff. Each has its own story of identifying community issues and planning actions to address them. Each has struggled to sustain volunteer or inter-agency efforts needed to work in different ways (inclusively and intersectorally), find support (organizational and interpersonal) and engage people (physically and spiritually) in the demanding task of defining community issues and acting for health. Two questions serve to stimulate organizing and planning:

1) What would a healthy community be like?
2) How can we work together towards one?

Some innovative projects have arisen, ranging from recycling and toxic waste programs to collective kitchens, multicultural conferences, video productions, surveys, community food co-ops and advocacy for greater community input in development projects.

However, these communities have lost momentum as Healthy Communities projects. Why?

A Few Barriers To Community-Based Planning and Action Include:

1. The breadth of our recent understanding of "health"—physical, social, emotional, spiritual, environmental and political dimensions—has made it difficult to focus on concrete, manageable issues and actions. Furthermore, the issue involves many groups and sectors not well prepared to work collaboratively.
2. Citizen reluctance to address the complex and intimidating systems which dictate who has resources and...
3. Lack of resources to manage and implement projects, particularly in Alberta, leaves volunteers overloaded, particularly in these demanding economic times.

4. Lack of philosophical and political support, provincially and locally, since the process involves power sharing and greater local accountability on the one hand, and a greater citizen commitment on the other.

The Basic Process of the Healthy Communities Project Includes:

1. Challenging citizens, local government and agencies to think about the conditions that create health and how they are achieved.

2. Facilitating a process in which citizens and communities create a vision of their community into the future.

3. Assisting them in planning specific actions to achieve their visions.

4. Determining measures of existing health (physical, social, environmental, economic, etc.).

5. Linking with other groups and with local government to facilitate healthy public policies.

6. Evaluating local process and outcome indicators to assess achievements and the need for change.

The Alberta Centre for Well-Being, The Alberta Cancer Board and The Alberta Heritage Foundation for Medical Research are hosting a series of guest lecturers in behavioural science. In April, Dr. James Prochaska, Professor of Psychology from the University of Rhode Island, visited Alberta for a two-day tour, presenting seminars and public lectures at the Universities of Alberta and Calgary. Dr. Prochaska addressed research questions and methodologies arising from the trans-theoretical model of behaviour change in addition to an exploration of the theoretical underpinnings and research applications of the "Stages of Change Model".

On May 17th and 18th, Dr. Steven Blair, Director of Epidemiology, Institute for Aerobics Research, Dallas, Texas, will also visit Edmonton and Calgary. Dr. Blair's research focuses on the association between lifestyle and health, with a special emphasis on exercise, physical fitness and chronic disease (particularly cardiovascular disease and cancer).

In early June, Dr. Neville Owen will visit from Adelaide, Australia, where he serves as senior lecturer in Community Medicine. Dr. Owen will discuss his research in the use of psychological theory in the development of public health interventions and policy. Special areas of application include behaviour related to cardiovascular disease and cancer risk in adults, children and adolescents; and the determinants of physical inactivity, smoking and other related risks in adults.

For further information on times and locations of the seminars and public lectures to be given by Dr. Steven Blair and Dr. Neville Owen in Edmonton and Calgary, please call the Alberta Centre For Well-Being at 1-800-661-4551 or in Edmonton at 453-8692.
We envision a vital, safe community where everyone works together toward the social and economic well-being of the Boyle Street and McCauley communities. The basis of this well-being is the opportunity for all ethnic, income and household groups to participate fully in community life. Residents take pride in their neighbourhood and have hope for the future.

—Vision statement of the Boyle St./McCauley ARP.

The Boyle Street and McCauley communities make up the heart of Edmonton's inner city. The two neighbourhoods suffer from the highest unemployment rate in the city, the highest incidence of inadequate housing and the greatest level of violent crime. These communities have also been the traditional first home to various immigrant populations.

In the summer of 1992, the City of Edmonton began a review of the out-dated Area Plan. Through the lobbying efforts of a coalition of community leagues and agencies, the City agreed to consider a new model for the revised Area Redevelopment Plan (ARP).

The planning process has several unique features. First, the plan addresses social and economic concerns, not just land use issues. Second, an independent Community Planning and Development worker facilitates resident involvement in the planning process. Third, a community-based Planning Coordinator Committee (PCC) oversees the management of the ARP. The PCC is not an advisory body—it is an equal partner with the City administration. Fourth, culturally sensitive approaches, diverse consultation techniques, expanded decision-making opportunities, and ongoing implementation activities allow for easy access to the planning process.

New Partnerships

Early on it was recognized that a healthy community could only develop if all of the "players" became "stakeholders" in the process. This understanding has led to a strong commitment to partnership.

The Housing Sub-committee, for example, is comprised of a home owner, a resident of a co-operative, a resident of a social housing project, a rooming house owner and operator, a local developer, a representative of an agency which builds social housing in the community, and a representative of the City Housing Commissioner's Office. Such inclusiveness has produced new insights into complex issues and has lent credibility to the process.

Tangible benefits of such partnership have already been demonstrated. One neighbourhood, which has been under tremendous commercial development pressure, faced a major rezoning application on residentially zoned property. Rather than force a political confrontation, a joint committee of the PCC and the local business association worked to reach a compromise. After a year of meetings, a planning document was accepted by both groups, and the rezoning application was unanimously defeated by City Council. The partnership experiment appears to be succeeding.

Next Steps

As the community struggles toward its vision of the future, the process continues to evolve. The task is far greater than the writing of a new Area Redevelopment Plan. The challenge is to maintain the momentum the plan has generated; to develop a community organization which will ensure the implementation of the plan and continue the process of community development. It is hoped that the plan will remain a living document that sets the course for a vibrant, empowered and healthy community.
The Medicine Hat College Fitness Resource Centre is part of the provincial Be Fit For Life Network, facilitating regular physical activity, health and lifestyle services to people in the Southeastern region of the province.

In promotion of physical activity and healthy lifestyle choices, programs range from personal or group fitness appraisals and exercise counselling to presentations, delivery of fitness leadership program, rural outreach, employee lifestyle services, maintenance of a resource library and special events.

Three special events were implemented this past winter and early spring. The first is the Lifestyle Action Challenge which has become an annual event in Medicine Hat, co-sponsored by the City of Medicine Hat and the Family YMCA. In 1992, 357 people were involved in the Challenge with a greater response in 1993.

The Lifestyle Action Challenge is designed to initiate or encourage employees of businesses in Medicine Hat to take responsibility for their own level of wellness. The Challenge spans a 15 week period in which points are awarded for weekly physical activity (20 minutes; 3 times per week), participation in lifestyle education and awareness (seminars, blood pressure or cholesterol checks, etc.), participation in a fitness appraisal and involvement of family or friends. Prizes are awarded to the male and female recording the highest scores overall, individuals scoring highest in each employee group, and to the business with the highest average score. The Lifestyle Action Challenge concludes with the annual Corporate Challenge, which may be described as an "executive track and field day"—although somewhat less athletically oriented.

A second special event, being launched for the first time in Medicine Hat, is a post-holiday healthy weight loss initiative, "Weight to Go", a six-week motivational program, also follows a "challenge" format, but unlike the Lifestyle Action Challenge, it is not limited to employee groups. The focus of "Weight to Go" is threefold—eating properly, Exercise, and Education (triple E). Points will be awarded for exercising, attendance at one educational seminar and healthy weight loss (1 to 2 pounds per week). Through educational seminars, participants can explore the relationship of exercise to weight loss, eating for an active lifestyle and using Canada's Food Guide for meal planning and label reading.

Since the preliminary focus is healthy weight management behaviours rather than weight loss itself, motivation may be sustained even for people with particular difficulty losing weight. In addition, participants compete in teams to minimize individual advantages and disadvantages, and to promote inter-team support. Participants are given the option of having body composition measures taken by a certified appraiser at the beginning and end of the project.

The final special event occurring this Spring is the annual "Ratler Run", a 10 kilometer or 5 kilometer road race attracting casual and serious runners from around the province. The Medicine Hat College Fitness Resource Centre is funded by the Recreation, Parks and Wildlife Foundation with Alberta Lotteries monies. Administrative support is provided by the Medicine Hat College.

For more information on any of these programs or resources available from the Centre, please call 529-3839.
The "Push" and "Pull" of Marketing Health

In marketing, there are two basic strategies; The "push" and "pull." The push strategy is aimed at resellers—the intermediaries who promote or distribute the information (e.g., policy-makers, professionals and facilitators). The pull strategy is aimed directly at the public—those who will benefit from the information. When combined, these two strategies have a synergistic effect.

The push strategy delivers the information to key influencers responsible for policy development, program decisions and for incorporating health information into their programs for dissemination to their respective audiences.

The pull strategy works by targeting information directly to specific segments of the population to stimulate a demand for policy and program change. It is particularly effective in prompting change through key influencers, or "gatekeepers" who may be reluctant to initiate because of some vested interest or for other reasons.

While the push strategy is commonly used in the health field, the pull strategy—the advocacy campaign—is not as popular. However, research shows that agencies who use the pull and push strategies collaboratively achieve more noteworthy results.

An example of a push-pull campaign is the ACFWB Wellness Wagon in which targets include community partners (push) and the general public (pull). Wellness information is targeted to health, recreation and municipal professionals through a program which incorporates direct targeting of the general public. The tools are provided to these "community partners" to in turn offer to their respective audiences.

In a world with more and more women in the workforce, moms heavily involved in school, community activities, teens with part-time jobs, and children with after-school and weekend activities that almost require a daycare to track, it can be difficult to find time for family activities.

While the old saying "The family that plays together stays together" may seem outdated, it holds much promise for the problems that can arise when family members are rushing off in different directions.

"To make physical activity a family affair, you must find the time then choose things that will make for a happy outing," says Kendy Bentley, a health promotion consultant based in Calgary. Drawing on her professorial background in helping people become more active and her practical experience as a mother of two active young girls, Bentley offers the following suggestions:

* Plan a family activity on a regular basis and put it on the calendar
* Have family members take turns choosing the time so that everyone has a chance to plan around their schedules
* Start with "bite-sized" chunks of activity if you're not very active now. Pick things that don't require too much time or energy.
* Include physical activity along with other planned events. Walk to the movie theatre, for example. Or walk the kids to and from school.

"The point of all this togetherness is not to make a team of superathletes," says Bentley, "but to experience the joys and benefits of being active while at the same time having a chance to explore the thoughts and dreams of other family members."

Bentley's final piece of advice has to do with role models: "Just remember that if parents don't make regular physical activity a priority," she says, "chances are your children won't either."
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helps round out the many possibilities that exist along the trek to achieving well-being for all.

It's interesting to note that the future of community health is no longer the solitary domain of traditional community health professionals. Others are striving to change the basics elements of a system with long, solid roots in the curative model.

The leisure industry, for example, has blossomed in the past few decades from preventive soils—a fertile and inviting ground in which to cultivate well-being.

How will people respond to the active living and well-being messages? So far, so good, according to industry leaders. The next challenge is to continue to build bridges between recreation and health agencies—to fortify bonds already formed and work together to spread awareness, spur to action and gradually make changes to the health care system to truly achieve health for all by 2000.

A Bicycle Helmet Safety Resource Kit from the Grey Nuns Hospital, Edmonton.

Every spring and fall thousands of children ride their bikes to school, and why not? Cycling is a fun and relatively safe activity. Yet, there is the potential for serious head injuries.

Why should we be concerned about bicycle helmet safety?

* Over 50,000 Canadians will be injured in bicycle accidents this year.
* Over 100 Canadians will die from head injuries as a result of bicycle accidents this year.
* Children aged 5 to 14 years will account for half of these deaths.
* 85% of serious head injuries caused by bicycle accidents can be prevented through helmet usage, yet only 2 to 5% of all children in Canada in 1990 used helmets!

By using the Grey Nuns Hospital Bicycle Safety Campaign Resource Kit in designing a health promotion and injury prevention program in your community you can help reduce these startling statistics. The first of its kind in Western Canada, the kit will help educators and healthcare professionals throughout Alberta teach children about helmets by:

* Providing proven detailed approaches and lesson plans for specific age groups.
* Outlining proven fun filled participative programs for students.
* Showing step by step instructions on how to conduct a helmet safety campaign.

Over 100 schools throughout the province have successfully utilized the programs described in the Resource Kit. Helmet usage among 1100 students from 12 test schools involved in the pilot project has increased from 18% to a remarkable 67% after only one year.

To order a copy of the Resource Kit, please write the Grey Nuns Hospital Bicycle Helmet Campaign, 1100 Youville Drive West, Edmonton, AB, T6L 5X8. (7)

Canada's Fitweek is May 28th to June 6th, 1993.
But first, let us define self-esteem. It is simply to hold a favorable opinion of oneself as a result of goal achievement, from meeting success in one's endeavors.

"Two popular authors, Ward (Letters of a A Businessman to His Son) and Mackay (Swim With Sharks) both quote on happiness and success from Dr. Frankl, an Austrian psychiatrist who survived the Nazi concentration camps. Dr. Frankl believes, 'happiness is achievement' and no one can deny self-esteem is commensurate with happiness. True happiness, to Dr. Frankl,

occurs upon achievement of some goal--self-esteem enhancement. This self-esteem cannot be taught or learned, it must be earned. All too often, the social and emotional problems of school children are treated superficially; the symptoms are addressed, not the causes.

Low self-esteem is not a cause of these problems, but a symptom.

What, then, is the cause?
In a lifetime of work, Dr. Carl Kline, an eminent Canadian psychiatrist, has treated over four thousand children and adolescents for behavioral, social and emotional problems.

The majority of these cases resolved themselves to a single issue: functional literacy. Dr. Kline taught these kids to read and gave them self-confidence, a chance to succeed and an immeasurable dose of self-esteem. Like Dr. Battle, Alvin Toffler had words of advice for the 21st Century. He said the skill needed would be the ability to learn, unlearn, then learn again. Functional illiteracy precludes that skill."

V.E. Charlton
Reading and Literacy Institute of Alberta

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**Oh...by the way,**

**Godlessness--like cigarette smoking--may be harmful to your health according to a recent study from Purdue University published in the Journal for the Scientific Study of Religion. Researchers have found that people who worship regularly experience less illness than those who don't.**

1473 individuals similar in age, education and income, were asked about their overall health, frequency of hospitalization and religious affiliation and involvement. It was discovered that "non-practitioners"--those who do not regularly participate in religious activities--were more than twice as likely as "practitioners" to report health problems.

Comparing the effects of religion on health to that of age and social class, the Purdue researchers found a more significant influence from religion on an individual's general health.

The scientists conclude that there are several reasons for this influence. Some churches require healthful behavior (abstinence from smoking, drugs and alcohol, or advocate practices like monogamy and sexual abstinence until marriage). Even a mandated day of rest does wonders to relieve six days of stress.

Religious practice tends to foster networks of social support which are increasingly linked to good health. Fellow worshipers may bring you food if you are ill, take you to the physician, help take care of your home responsibilities while you recover and provide moral and emotional support. These individuals represent a group of individuals one can turn to in times of crisis.

The Purdue researchers will continue by studying an interesting trend that emerged from their data: People who belong to more liberal denominations were in general healthier than those from more conservative sects. For now, the message appears clear: keep your health, keep your faith.

Call For Presentations:
The Steering Committee of the Well-Being For the Future III Conference: "Creating Healthy Environments Through Collaboration" is calling for presentations. The three streams of focus for the 3rd provincial well-being conference will be: community, workplace and schools. If you have, or know of an individual who has, a presentation, workshop, seminar or program that supports the creation of healthy environments and well-being in workplaces, schools or the community, please send an outline and curriculum vitae to "Steering Committee, Well-Being For The Future III, Calgary Branch Office, Alberta Centre For Well-Being, 4235-53 St NW, Calgary, AB, T3A 1V5". The deadline for submissions is June 30th, 1993. The conference will be held March 3-4, 1994 in Calgary.

First International Conference on Community Health Nursing Research, Sept. 27-29, 1993, Edmonton Alberta. Speakers from around the world will be presenting. Call the Edmonton Board of Health at (403) 482-4194 for more information.

Sustaining Our Communities: Health For The Future, CPHA 84th Annual Conference, July 4th to 7th, 1993, St. John's, Newfoundland.

Do You Have Hearing Loss? Are You A Former Teacher? Do You Have Some Lip Reading Skills? Are You Aware of Special Needs? If you have any of these attributes, you could be a good candidate for teacher training in the "Coping With Hearing Loss Independence Program". For more information, please contact Lynn Wheaton at 282-6311.


ACFWB PRESENTS:

Building the Self-Esteem of Youth. A workshop with Dr. James Battle. May 20th, 1993. 9:00 am to 12:00 noon. Percy Page Centre, Edmonton. Free Parking, fee is $40 + GST; $25 + GST for students. Please call 453-8692 to register. Limited enrollment.

May

May is Cystic Fibrosis Month, Medic Alert Month, Multiple Sclerosis Awareness Month, Motorcycle and Bicycle Safety Awareness Month, Speech and Hearing Awareness Month. May 1 - 7: National Summer Safety Week.

May 2 - 8: Mental Health Week, National Forest Week, Immigration Week, National Pitch-In Week.

May 8: World Red Cross Day

May 9: Mother's Day

May 10 - 16: Nurses Week

May 12: Canada Health Day

May 12 - 18: National Cellular Safety Week

May 21 - 27: National Road Safety Week.

May 24: Victoria Day

May 24 - 29: Calgary International Children's Festival

May 26 - 30: Edmonton International Children's Festival

May 30 - June 5: National Tourism Awareness Week, May 31: World No-To-Bacco Day

May 31 - June 6: National Access Awareness Week

June

June is Taste Alberta Made Month.

June 1 - 7: Water Safety Awareness Week

June 5: World Environment Day

June 5 - 12: Environment Week

June 6 - 12: Senior Citizen's Week

June 20: Father's Day

June 21 - 27: Canadian Occupational Health and Safety Week

June 27: World Diabetes Day

July

July 1: Canada Day

July 11: World Population Day

July 17: Parks Day

July 25 - 31: National Farm Safety Week

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