ABSTRACT

Lifestyle exposures account for the greatest proportion of risk factors for cancer, yet these exposures have proven most difficult to alter. Despite intensive intervention efforts, many behaviour change programs are ill suited to the community. This research was undertaken to increase our understanding of prevention activities of interest to a sample of residents in two Ontario communities. 248 (62.3%) adult residents responded to a semi-structured self-administered questionnaire including open-ended questions on health issues, exposures and prevention activities of interest. While some of the beliefs expressed by respondents might have been anticipated (e.g., cigarette smoking and family history increase risk of cancer), others were not (e.g., only between 40 and 75% of respondents thought a high fat diet increased risk). Furthermore, many of those with personal health concerns expressed an interest in prevention. This process is proposed as a first step in launching more appropriate and sustainable community-based health promotion programs for cancer prevention.

ABRÉGÉ

Les niveaux d'exposition découlant des habitudes de vie sont à l'origine des facteurs de risque les plus importants, mais il s'agit des éléments les plus difficiles à modifier. Malgré des efforts d'intervention soutenus, les programmes de modification du comportement sont souvent mal adaptés au milieu. Nous avons voulu mieux comprendre les activités de prévention qui conviennent à un échantillon de résidents provenant de deux collectivités de l'Ontario. En tout, 248 adultes (62,3 %) ont répondu à un questionnaire auto-administré semi-structuré. Certaines des opinions émises étaient prévisibles (le tabagisme et les antécédents familiaux accroissent les risques de cancer), contrairement à d'autres (de 40 à 75 % des répondants seulement estimaient qu'une alimentation riche en matières grasses augmentait les risques). Par ailleurs, un grand nombre de personnes ayant des problèmes de santé s'intéressaient à la prévention. La démarche que nous avons employée pourrait constituer une étape préalable à la mise en place de programmes communautaires de promotion de la santé adaptés et durables en vue de prévenir le cancer.

Cancer Prevention in the Community: A Survey of Community Residents

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Preventable lifestyle behaviours account for about 75% of all cancers,¹ posing a significant opportunity for reducing cancer incidence. However, many behaviour change programs are often poorly suited to the community, resulting in low compliance and modest support for the initiatives.^{2,3} These disappointing results have raised questions about the utility of the traditional "top-down" health planning approach to disease prevention and health promotion.⁴ Recent health demonstrations point to the importance of targeting the community's perception of needs and priorities before substantive community problems can be addressed.⁵⁻⁸

Bottom-up approaches, such as "community organization and development"⁴ or "participatory research",⁹ are advocated as more effective processes for improving health and effecting social change.^{4,5,9} The philosophy of these approaches suggests that health promotion is more likely to be successful when the community identifies its own health concerns and develops valued prevention programs. A recent Royal Society of Canada report on participatory research maintains that health promotion calls for greater involvement of the public in controlling their own health, having more active roles in defining health needs,

setting health goal priorities and controlling the application of interventions.⁹ The eventual success of this approach is attributed to the principal goals and outcomes of the ongoing process, including empowerment, organization, education and ownership in the community.^{5,9-12}

At the outset, community involvement is being increasingly valued, particularly for gaining an appreciation of community perceptions of health risks and health issues of greatest concern.^{4,9,10,13} Yet, it is not clear whether or at what level community residents should be directly involved in the process of identifying concerns and planning interventions.^{3,6,14,15} Very few studies (e.g., see refs. 14, 16, 17) report the involvement of community members directly rather than through community leaders and community institutions (e.g., local health clinics, community centres and local organizations).¹⁸⁻²⁰ Fewer still directly involved community residents in cancer prevention specifically¹⁹ and many studies focus specifically on disadvantaged or minority communities.^{2,4,9,14,17}

Kinne et al.⁶ maintain that the direct involvement of community residents is important for defining problems and solutions for the development of appropriate and sustainable prevention activities. The main objective of the present study was to explore the use of an introductory survey as a method to begin to identify community needs, interests and valued prevention activities from the perspective of community residents. Findings from this survey are intended as a first step in community-based participatory research, thereby facilitating the development of more appropriate, valued and sustainable prevention programs.

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METHODS

Using data from the province-wide Ontario Health Survey,²¹ 43 Public Health Units (PHU) in Ontario were categorized into quartiles based on the percentage of their populations with: low income, current daily smokers and visits to a health professional within the past 12 months. Each PHU was assigned a score, based on the sum of the three quartile scores. Two communities, one from each of the high and low extremes of the scoring, were selected for their similarity in population size according to 1986 Census data.²²

The survey questionnaire collected baseline information on current attitudes and behaviours toward health promotion. Many of its questions were drawn from existing surveys.²³⁻²⁵ Also, it covered several important areas not included in the source surveys, such as residents' views of the problems facing their community, and the nature and extent of public involvement in community problem-solving. Open-ended questions pertaining to key areas of interest such as health issues of concern, exposures and desired prevention activities were included. In addition, the final question asked respondents to comment on any other issues of interest to them that were not covered in the survey (questionnaire available on request). The purpose of the questionnaire was to elicit information on the following:

- health care issues and behavioural exposures which were perceived to be important;
- exposures for which respondents would most like to have intervention programs available;
- sources currently used by respondents to obtain information about health and risk factors;
- current health practices;
- perceptions of control or influence at the community level;
- attitudes on self-efficacy.

Subject selection in the two communities was based on a random sample of listed residential telephone numbers purchased from Info-Direct, a service of Bell Canada.

TABLE I
Percentage of Respondents Who Believe That the Following Risk Factors Increase the Chance of Getting Cancer, by Sex and Age

Risk Factor	Female Age (years)			Male Age (years)		
	24-39	40-49	50-65	24-39	40-49	50-65
Cigarettes	96.7	100.0	92.1	95.2	88.2	95.0
Worry/Anxiety	42.4	50.0	48.6	35.7	42.4	45.0
High Blood Pressure	28.3	25.0	22.2	21.4	34.3	20.5
Diabetes	20.0	19.4	17.6	14.3	33.3	17.9
Being Overweight	37.3	50.0	54.1	21.4	32.4	50.0
Overwork	27.1	40.6	21.6	28.6	20.6	25.0
Coffee	22.0	18.8	16.2	19.0	11.4	28.2
High Fat Diet	54.2	75.0	64.9	41.5	60.0	61.5
Family History	98.3	97.0	92.1	78.6	82.9	72.5
Cholesterol	48.3	37.5	21.6	35.7	26.5	25.0

TABLE II
Percentage of Respondents Who Believe That the Following Exposures are Harmful to Human Health, by Sex and Age

Exposure	Female Age (years)			Male Age (years)		
	24-39	40-49	50-65	24-39	40-49	50-65
Second Hand Smoke	96.7	93.8	92.1	97.6	88.6	95.0
Noise	56.7	71.0	75.7	65.9	80.0	66.7
PCBs	82.5	93.6	94.6	90.2	85.3	89.2
Smoking	98.3	96.9	94.7	100.0	97.1	97.5
Water Pollution	93.3	96.9	100.0	95.1	97.1	92.5
Sunlight	80.0	81.3	73.7	80.5	85.3	82.5
Stress	88.3	96.9	83.8	85.4	82.9	84.6
Automobile Exhaust	91.7	90.6	97.3	87.8	94.1	100.0
Radon	72.2	96.6	90.0	73.0	66.7	77.1
Cholesterol	88.3	84.4	78.4	87.8	85.7	87.5
Air Pollution	91.7	96.9	100.0	92.7	97.1	97.4

TABLE III
Percentage Distribution of Health Status Indicators, by Sex and Age

	Female Age (years)			Male Age (years)		
	24-39	40-49	50-65	24-39	40-49	50-65
Health Status						
Excellent	15.0	6.3	7.9	16.7	8.6	12.9
Very Good	53.3	53.1	55.3	47.6	45.7	41.0
Good	21.7	21.9	23.7	33.3	34.3	41.0
Fair	10.0	18.7	10.5	2.4	8.6	55.1
Poor	0.0	0.0	2.6	0.0	2.8	0.0
Worry About Health						
None	15.0	9.4	7.9	26.2	14.3	7.5
Hardly Any	45.0	34.4	52.6	38.1	51.4	47.5
Some	36.7	46.9	31.6	33.3	28.6	37.5
Great Deal	3.3	9.3	7.9	2.4	5.7	7.5
Energy Level Compared to Others						
Much More	6.7	12.5	15.8	16.7	8.6	15.0
More	26.7	21.9	28.9	38.1	22.8	32.5
Average	55.0	56.2	47.4	45.2	62.9	45.0
Less	11.6	9.4	7.9	0	5.7	7.5
Satisfaction with Health						
Very Satisfied	11.6	6.1	29.0	16.7	14.3	7.7
Satisfied	41.7	51.5	36.8	59.5	42.9	53.8
Neutral	10.0	12.1	15.8	7.1	22.9	10.3
Dissatisfied	26.7	27.3	15.8	16.7	17.1	23.1
Very Dissatisfied	10.0	3.0	2.6	0	2.8	5.1

A cover letter and a self-completed questionnaire were mailed to 600 households over a five-week period. Follow-up to non-respondents was done with postcard reminders and telephone calls.

RESULTS

A total of 248 participants (62.3% of those eligible) returned the completed questionnaire. The study was intended to

TABLE IV
Percentage of Respondents Who Believe That Each of the Following Health Issues is Important to Family or Community, by Sex and Age

Level of Concern	Health Issue	Female Age (years)			Male Age (years)		
		24-39	40-49	50-65	24-39	40-49	50-65
Family	Heart	89.8	100.0	89.5	88.1	91.4	95.0
	Diabetes	50.0	74.2	78.4	59.5	58.8	82.5
	Osteoporosis	58.3	90.6	84.2	55.0	45.5	84.2
	Motor Vehicle Accidents	65.0	54.8	61.1	78.6	82.4	66.7
	AIDS	56.7	51.6	61.1	47.6	61.8	61.5
	Lung Cancer	75.0	84.4	78.4	76.2	80.0	80.0
	Arthritis	63.3	96.8	94.7	59.5	70.6	80.0
	Suicide	32.2	36.7	35.1	26.2	41.2	33.3
	Breast Cancer	78.3	90.3	89.5	81.0	93.9	72.5
	Back Pain	76.7	80.6	71.1	83.3	82.9	72.5
	Prostate Cancer	56.7	70.0	68.4	76.2	82.9	80.0
	Respiratory Illnesses	61.7	73.3	64.9	54.8	64.7	75.0
	Skin Cancer	81.7	93.3	78.9	66.7	76.5	72.5
	Prenatal Care	51.7	43.3	44.1	53.7	41.2	37.5
	Alzheimer's	53.3	66.7	84.2	59.5	44.1	75.0
Community	Heart	91.2	92.9	91.9	90.2	91.2	90.0
	Diabetes	77.2	77.8	89.2	61.0	60.6	82.5
	Osteoporosis	61.4	66.7	86.5	57.5	60.6	84.2
	Motor Vehicle Accidents	70.7	82.8	83.3	70.7	81.8	64.1
	AIDS	77.6	75.0	81.1	73.2	90.9	66.7
	Lung Cancer	78.9	82.1	89.2	85.4	91.2	87.5
	Arthritis	65.5	78.6	94.6	85.4	78.8	82.5
	Suicide	58.6	57.1	78.4	41.5	60.6	53.8
	Breast Cancer	84.5	89.3	91.9	87.8	90.9	82.5
	Back Pain	58.6	64.3	48.6	58.5	52.9	75.0
	Prostate Cancer	61.4	75.0	89.2	65.9	45.5	75.0
	Respiratory Illnesses	75.9	82.1	89.2	73.2	84.8	80.0
	Skin Cancer	84.5	85.7	86.5	65.9	78.8	70.0
	Prenatal Care	75.9	75.0	81.1	60.0	72.7	64.1
	Alzheimer's	67.2	71.4	91.9	68.3	72.7	80.0

further refine the issues and the questions of concern to communities; therefore no statistical tests were considered appropriate. Thus the analysis shown here is limited to descriptive statistics that serve to highlight the potential of an initial survey to gain insights into community residents' perceptions of health issues and interests in prevention activities.

While there were some differences between respondents in the two communities in terms of education and income (data not shown), these differences did not translate into differences in response to questions on health, disease risk, and prevention programs. Therefore, the data from the two communities were combined for the remaining analyses.

The percentage of respondents who reported believing that cigarette smoking increased the chance of getting cancer was uniformly high across age and sex strata. Other factors believed to be important for cancer risk were: family history (ranging from 72.5% of men aged 50-65 years to 98.3% of women aged 24-39 years); high fat diet (approximately 60-65% of women

and 60% of men in the two oldest age strata); worry and anxiety (nearly 50% of women and 40% of men); and being overweight (reaching 50% in the oldest age group). A majority of respondents did not judge other risk factors, including cholesterol, to increase the risk of cancer.

Table II shows the percentage of respondents who believe that various exposures are harmful to health in general. Classic epidemiological exposures such as PCB exposure and smoking (including environmental tobacco smoke) were considered harmful across all age and sex strata. However, concern was also expressed for exposures that have not received as much attention from epidemiologists, including water pollution, automobile exhaust, air pollution, and stress. In contrast, only a small number of participants considered noise and sunlight (and radon for young respondents and males) to be harmful.

Family and community health issues are shown in Table III. While many of the listed conditions were rated as important to both the respondent's family and to his/her community at large, the differences

are generally in the direction of the health issue being more important for the latter. This is especially true for conditions such as AIDS, suicide, and prenatal care.

Table IV shows the health status indicators as reported by the respondents. While a large percentage of both men and women rated their health as good or better, 40-50% had some or a great deal of worry about their health, and 20% of men and 30% of women were dissatisfied with their health. Furthermore, while worry about health increases with age, dissatisfaction does not: the younger respondents are at least as dissatisfied as the older.

Interest in prevention activities is shown in Table V, by sex and by worry about one's health. It should be noted that respondents were not asked to rank their level of interest and could indicate strong interest in all programs listed. The percentage of respondents interested in prevention activities did not vary substantially among those with and those without health worries. There was a trend, however, for a greater proportion of those reporting worry about health than those not worried to

express interest in prevention activities of all types. This difference was particularly striking for smoking cessation, reduction in alcohol use, and stress reduction, among both men and women. When respondents were asked to identify the one prevention program of most importance to them, 55-65% of all sex and age strata selected a combination of healthy eating and exercise, while only 10-15% were concerned about weight loss and stress reduction, or smoking and alcohol use (data not shown).

The perceived barriers to participation in behaviour change programs are shown in Table VI. Almost regardless of sex, age, and level of health worry, upwards of 50% of respondents indicated internal factors such as 'problem not serious', 'lack of self-discipline', 'too depressed', 'don't want to change current habits' as the main reason for not making the desired changes. Approximately 33% said there was no reason for not changing, and another 25-30% regarded lack of time as the primary barrier.

DISCUSSION

This study explored the utility of an initial survey for the development of community prevention programming. Given that very few if any studies directly involved a random sample of community members at the outset, the survey was intended as a means of gaining representative and quantitative data in the pre-planning phase. We chose a semi-structured mailed survey that included questions from validated surveys together with original open-ended questions on key areas of interest: health issues of concern, exposures and desired prevention activities.

TABLE V
Percentage of Respondents Who Are Interested in the Following Prevention Activities, by Sex and Level of Worry About Health

Activity	Female Level of Worry About Health		Male Level of Worry About Health	
	None/Low	Moderate/High	None/Low	Moderate/High
Sun Protection	72.5	74.1	61.1	62.8
Weight Loss	70.4	71.4	56.3	60.5
Physical Fitness	87.3	91.1	83.3	83.7
Healthy Eating	84.3	87.5	83.3	88.1
Smoking Cessation	55.7	61.8	50.0	68.3
Reduction in Alcohol Use	45.1	58.2	39.9	58.1
Stress Reduction	70.0	87.5	70.8	86.4
Control of Blood Pressure	65.7	61.8	58.3	79.1
Safety in the Home	68.6	78.2	77.8	79.1

More detailed information may have been collected using focus group methodology and additional content areas may have been uncovered. However, the semi-structured survey method was favoured in that it allowed for the collection of original open-ended response data as well as quantifiable data in key areas of prevention planning. As such the results from this type of survey can serve as an initial step in the development of a community-based participatory research approach to more appropriate and sustainable prevention programs. Potential conclusions are:

- socio-demographic differences in these two towns had a negligible influence on health perceptions and priorities;
- well-publicized (e.g., smoking) as well as less-publicized (e.g., air pollution) exposures were of concern to community residents of all age-sex groups;
- community-perceived need was a criterion for interest in a prevention activity;
- residents were interested in prevention activities regardless of the level of worry over their own health;
- the prevention program of foremost interest, for all age and sex strata, was a

combination of healthy eating and exercise;

- mental health, youth health and environmental protection were important areas of health concerns not queried in the survey. (This information came from comments contributed by the study participants);
- barriers to participation in prevention programs included internal reasons (problem not serious, no urgency, lack of self-discipline or energy, depression, resistance to change), time constraints, lack of social support, and various external factors.

These findings illustrate the importance of this type of survey as a first step in identifying a community's perceptions of health issues and priorities for prevention activities. Moreover, a survey of this nature may help to identify factors that influence residents' interest in prevention programs (e.g., gender and level of health worry) and likewise factors that may act as barriers to participation (e.g., resistance to change and costs in time and money).

Given the poor sustainability of behaviour change programs, early identification

TABLE VI
Percentage of Respondents Reporting Barriers to Making Improvements, by Sex, Age and Health Worry

Barrier	Female Age (years)						Male Age (years)					
	24-39		40-49		50-65		24-39		40-49		50-65	
	Level of Worry None/ Low	Mod/ High	Level of Worry None/ Low	Mod/ High	Level of Worry None/ Low	Mod/ High	Level of Worry None/ Low	Mod/ High	Level of Worry None/ Low	Mod/ High	Level of Worry None/ Low	Mod/ High
Time Constraint	36.1	29.2	28.6	27.8	21.7	20.0	37.0	26.7	17.4	25.0	9.1	16.7
Social Support*	13.9	12.5	0.0	11.1	0.0	6.7	7.4	13.3	4.4	8.3	4.6	0.0
Internal Factors†	61.1	66.7	35.7	66.7	73.9	66.7	59.3	66.7	52.2	50.0	54.6	66.7
External Factors‡	11.1	29.2	14.3	44.4	0.0	6.7	0.0	20.0	21.7	8.3	4.6	22.2
No Barrier	33.3	8.3	35.7	16.7	26.1	26.7	37.0	26.7	34.8	33.3	36.4	38.9

* Includes: Peer pressure; Lack of support from family or friends; Don't know how to get started, lack knowledge.

† Includes: Problem not serious, no urgency; Lack of self-discipline, energy; Too depressed; Don't want to change current habits.

‡ Includes: Too difficult; Too costly; Other (e.g., no childcare available).

of community-valued programs and anticipated barriers will allow for more informed and appropriate planning at the outset. As such, the community survey is proposed as a first step in launching a community-based health promotion program for cancer prevention. Successive stages of a community-based participatory research approach would see community members and/or representatives directly involved in the prioritizing, planning, development and implementation of prevention programs as well as in the ongoing monitoring and evaluation of these programs.

We propose that utilizing what is learned from the initial survey to develop valued programs through a participatory approach will lead to successful and sustainable prevention activities. Hence, programs focussed on the continued involvement of residents, leaders and organizations in the community, which foster organization, empowerment and ownership of valued prevention activities at the community level, will result in long-term sustainable programs.

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Building a Healthy Future

Canada Health Day 2001

To commemorate the 2001 celebrations, a new campaign theme has been created and promotional materials developed. The theme for Canada Health Day 2001, "Building a Healthy Future", highlights the importance of every Canadian playing a role in promoting health, preventing disease and working together to improve the determinants of health, such as literacy and education, the way children develop and the conditions we live with every day. Canadians have the knowledge, the will, the skills and the energy. Now is the time to take action to build a healthy future!

For more information, contact the
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