How a Print Resource on Policy Change Was Used by Community and Public Health Practitioners

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Numerous publications are produced to both inform and guide the practice of people working in the field of health promotion. While there is a large body of literature on diffusion of innovation and knowledge utilization, there have been few efforts to establish normative rates on how print resources are being used by community and public health practitioners.

According to Rogers,¹ diffusion of innovation proceeds through four stages: knowledge, persuasion, decision and implementation. With respect to a print resource, then, there would be a proportion of people who are unaware of the resource (no awareness), know about the resource but have not used it (knowledge), are persuaded about the usefulness of the resource in their direct work and have recommended it to colleagues (persuasion), have decided to use the resource in the near future (decision), and have used the resource as needed or as intended (implementation). Rogers suggests that implementers will then seek to expand their knowledge base with additional, confirming information and research.

This report describes the results of a telephone survey designed to determine the extent and ways in which one print resource was being used by community and public health practitioners.

METHOD

A telephone survey was conducted with a sample of recipients of "Making a

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Difference in Your Community: A Guide for Policy Change",² a resource prepared, produced and disseminated by the Ontario Public Health Association (OPHA) with funding from the Ontario Ministry of Health. In the guide, a step-by-step approach to the process of local-level health-promoting policy change is provided and 19 community stories are used to illustrate the practical considerations when advancing a policy agenda.

Copies of the guide were distributed in one of three ways: through direct, unsolicited mail; upon request; and at workshops and training events designed to support the resource. From June 1, 1995 to January 31, 1996, 2,835 guides were distributed. While the guide was translated into French, comparatively fewer (N=284) copies of the French version were disseminated.

Telephone contacts with a sample of English guide recipients were made between December 15, 1995 and February 20, 1996. The survey instrument contained both forced-choice and open-ended items. The length of time between guide receipt and telephone survey ranged from one to eight months, with a mode of seven months and a mean of six months. The

final sample consisted of 88 respondents out of an originally selected sample of 100. The sample was culled from the pool of guide recipients who had returned a tracking card and indicated a willingness to participate in the follow-up. It was proportionately stratified on the basis of geographic region and organization type.

RESULTS

The findings revealed that respondents were represented across Rogers' stages of innovation diffusion (Figure 1).¹ Very few respondents (28%) had used or intended to use the guide directly within the context of their work. This low rate of usage did not, however, seem to be related to negative perceptions about the guide—most respondents (58%) felt it was a "good-to-excellent" resource (no opinion/no response = 41%). When asked what parts of the guide were most helpful, most respondents identified specific chapters, the conceptual model of the process and the community stories—aspects that distinguished it from other print resources on the topic.

Usage of the guide varied with respondents' level of "involvement". For the pur-

poses of the analysis, workshop attenders were classified as HI (high involvement), guide requesters were classified as MI (medium involvement) and people who received the guide in the direct mailing were classified as LI (low involvement). When asked how they had used the guide, 46% of the HI, 35% of the MI and 17% of the LI used information from the guide directly within the context of their work. The guide had been used in such ways as a teaching/training tool; a planning tool for working with community groups; a guideline for a specific policy change initiative (e.g., smoking policies in the workplace); and a source of background information.

Despite low implementation rates, over half of the respondents had encouraged others to use the resource: 57% of the HI, 58% of the MI and 54% of the LI reported that they had encouraged others to use the guide. When asked to specify whether they had encouraged use of the guide to people within or outside their organizations, 54%, 43% and 32% of the HI, MI, and LI "encouragers", respectively, shared the guide with people outside their organizations. Most of those who encouraged use of the guide did so because they thought the guide would be useful to others and because the passing on of resources was part of their job. Reasons for not encouraging use of the guide were unrelated to the guide (e.g., "It didn't occur to me to pass it on.").

DISCUSSION

While the direct mailing was methodically designed to include the "key players", there appeared to be little support for this approach given the low implementation rate and the costs involved (i.e., nearly \$12,000 in material, postage and labour was spent in direct mailing to people who had *not* implemented use of the guide). Guide requesters and workshop attenders, given their higher implementation rates, may have had more immediate need for the guide and may have been working on issues for which the information could be applied. Investing in promotional strategies to reach this target group would likely be a more fruitful approach to facilitate resource use.

One possible reason for the low implementation rate is that the activity level in terms of local policy change may be rather low—there simply may not have been many opportunities for people to use the guide. Some respondents did indicate that this was the case and we know, for example, that public health units in Ontario had been intensely engaged in a province-wide measles inoculation campaign during that time. Certainly, timing is a key consideration with respect to resource implementation.

Other respondents indicated that while the guide was interesting, policy change was not within their current mandate and there was even some trepidation about engaging in the policy change process.

However, the shift to a population health framework suggests that the skills required to facilitate health-promoting policy change will become increasingly important. "Health promotion specialists increasingly recognize that to be effective in improving the health and quality of life of citizens, they must incorporate policy advocacy interventions as integral, if not priority, strategies."³ In this vein, OPHA has been funded to provide additional curricular and bibliographic resource support to practitioners with the aim of enhancing capacity to influence and advance health-promoting policy.

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