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Puerto Rican participation in work place health promotion programs in American organizations : the impact of three values.

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PUERTO RICAN PARTICIPATION IN WORK PLACE HEALTH PROMOTION PROGRAMS IN AMERICAN ORGANIZATIONS: THE IMPACT OF THREE VALUES

A Dissertation Presented

by

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DEDICATION

A Cristóbal Montijo (Chobín) por ser ejemplo de vida, y a mi esposa Nana por todo su amor.

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To my sons, Angel and Manuel, who are my inspiration for building a better future for all the world's children.

My mother taught me that I could be whatever I wanted to be. Now I thank her and tell her she can be proud of me, once again. Her words of wisdom and her love are still guides to the way I live my life. To Wanda and Hiram Soler for all their support and encouragement.

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ABSTRACT

PUERTO RICAN PARTICIPATION IN WORK PLACE HEALTH PROMOTION PROGRAMS IN AMERICAN ORGANIZATIONS: THE IMPACT OF THREE VALUES

SEPTEMBER 1992

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The focus of this dissertation was to determine whether the values of "Familism", "Religion", and "Personalization of Interpersonal Relations" of Puerto Ricans were related to individuals' participation in their work place health promotion programs.

The study was conducted in six private corporations located in the Western New England area which had work place health promotion programs on-site. The sample population of the study consisted of 84 Puerto Ricans working at these organizations. This exploratory study did not deal with hypothesis testing. It set the basis for the formulation of hypothesis to be tested in future research endeavors.

The instrument used in this study consisted of a (Likert-Type Scale) questionnaire, in English and Spanish versions, that combined demographic information and the three value clusters of familism, religion and interpersonal relations that were researched. The questionnaire was administered by the researcher.

The collected data were submitted to analysis using Statistical Packages for Social Sciences (SPSS). Results indicated that this Puerto Rican population was very young, with 98% falling between 18-to-45-years old. There were 40 females and 43 males, one case missing. The levels of education were low, with 66% having high school or less education; and, 66% worked in manufacturing. Overall, there were no gender-based differences in the responses to the questions about values. All participants agreed that their health promotion program did not include activities for the family, and all thought it should do so. In addition, participants agreed that activities were not culturally sensitive, and all thought they should be, including the availability of written materials in Spanish. Responses to questions about religion and interpersonal relations, also showed a disapproval of the health promotion program, since it failed to pay attention to these values in the planning of activities; therefore, negatively influencing the participation of the subjects in the programs. This study was significant because it looked at cultural values as one of the underlying reasons for the lack of participation of Puerto Ricans in health promotion programs. Health promotion programs designers must be culturally sensitive when designing activities for Puerto Ricans, as well as for other special populations. Recommendations for health promotion program planners are offered as first-step solutions to the low participation problem.

TABLE OF CONTENTS

C H A P T E R I

INTRODUCTION AND OVERVIEW

Background of the Problem

The problem with low participation in health promotion programs has existed ever since these programs began to be implemented. O'Donnell and Ainsworth (1984) in their book Health Promotion in the Work place stated that while interest in health was up, dropouts and failures were many, both in personal and in organizational health programs. The authors recounted the experience of one organization that was pleased with the initial response to its program, which consisted of a series of films and lectures on cardiovascular risks and what could be done about them. They described how well the executives had responded initially to the program; after a two-year follow-up study, however, no differences existed between participants and employees who had not participated, and both groups were doing poorly (O'Donnell and Ainsworth, 1984). There are definite root causes to the problem of low participation in health promotion programs. According to O'Donnell and Ainsworth (1984), change is difficult to sustain because investigators have not yet successfully combined individual motivation with cultural support systems. "They [investigators] have made some progress in developing individual motivation techniques but have paid too little attention to the forces of the cultures in which the individual lives, forces that have a tremendous influence on the sustenance

of good health practices" (page 71). The authors further stated that until the culture (be it the culture of the work place, home, or community) supports preventive health behavior, the individual will face great obstacles. Finally, they concluded by saying: "At this stage it is necessary to take extra time to increase understanding and awareness of cultural variables and to realize fully that what we do not do in regard to health is influenced in large part by the cultural norms of our environments. To fully understand motivation, we need to become more conscious of our cultures and their power" (page 73). Several authors have historically advanced definitions for the term "value." "Values will be guides to the way we think and the way we act. Values govern to a large extent our behavior, and they are an essential part of our thoughts and our actions." Values are formed gradually and they constitute the core or an individual's personality (R. Mellado Parsons, 1983). Every culture has its values, which represent the thoughts, actions and feelings of the majority of the members of society. "A greatly influencing factor in the formation of our personal values is our culture" (page 54).

Lawrence W. Green et al, (1980), in their book Health Education Planning: A Diagnostic Approach, explain that personal values are inseparably linked to choices of behavior. They grouped values, knowledge, attitudes, beliefs, and perceptions as predisposing factors, which are factors antecedent to behavior that provide the rationale or motivation for any behavior. They also stated that values, as part of the predisposing factors, are

personal preferences brought by the individual or group to any educational experience. "These preferences [values] may either support or inhibit health behavior; in any case, they are influential" (page 70). Schneider (1990) stated that, "A personal value has been defined as that which a person wants, or seeks to obtain because it is that which one regards as conducive to one's welfare" (page 51). Personal values serve as latent indicators of environments that are significant to individuals. It is the attainment of what is personally valued that determines one's welfare in a work environment (Schneider, 1990). Part of the principal hypothesis presented by Schneider (1990) is that individuals with different values, needs, learning experiences, etc. will be predisposed to differ in what they regard as personally beneficial versus personally harmful, and what they perceive as ambiguous, challenging, loyal, fair, supportive, and warm.

Hispanics seem to share core cultural values that differentiate them from other cultural groups, regardless of the existing socio-demographic differences among the various Hispanic subgroups according to country of origin, educational attainment, and acculturation level (Marín, 1989). Dieppa and Montiel (1978) in their article, "Hispanic Families: An Exploration" refer to Ramírez and Castañeda (1974) as having identified four major value clusters in the traditional Mexican American culture, which may be attributed to other Hispanic families: identification with family, community, and ethnic group; personalization of interpersonal

relationships; status and role definition in family and community; and, Hispanic Catholic ideology.

The National Coalition of Hispanic Health and Human Services Organization (COSSMHO) (1988), in their manual for providers, discusses the importance of family within the Hispanic culture. COSSMHO emphasizes on the broad definition of family: Hispanics include many relatives as "family," not only parents and siblings but grandparents, aunts, uncles, cousins, close family friends, and padrinos (godparents). All these family members may be involved in an individual's health, thus in the case of hospital policies which limit patients to two visitors, hospitals may need to adapt these policies in order to allow for more direct involvement of the extended family network. Gerardo Marín (1989), in his article "AIDS Prevention Among Hispanics: Needs, Risk Behaviors and Cultural Values," also discusses familism, or the significance of the family to the individual, as a key cultural value. Marín explains it as a value which includes a sense of obligation to provide emotional and material support to the members of the extended family, as well as a perception that relatives are both reliable providers of help and attitudinal and behavioral referents. Personalismo, discussed by Marín (1989), refers to the preference for relationships with members of the in group (those with whom one identifies or considers part of the same ethnic group). On the other hand, Vicente Abad et al, (1975), in their article "A Model For Delivery of Mental Health

Services to Spanish-Speaking Minorities", define personalismo as the inclination of Latin people, in general, to relate to and trust persons, rather than institutions, and their dislike for formal, impersonal structures and organizations. Abad further states that this characteristic makes individuals more likely to use those services in which they can easily reach and relate to individuals who will emphasize flexibility and availability and will minimize red tape (Abad and others, 1989). Another explanation of personalismo, offered by COSSMHO (1988), emphasizes that Hispanics tend to stress the importance of this characteristic. In other words, since Hispanics prefer personal rather than impersonal or institutional relationships, they will expect health providers to be warm, friendly, and personal and to take an active role in the patient's life.

Several common values or characteristics of Hispanics exist which relate to the status and role definition in family and community. Abad et al, (1975) discuss machismo, respeto, and the role of women among Puerto Ricans. These characteristics, which can be generalized to the other Hispanic subgroups, have special clinical relevance and are often seen in conflict with American values (Abad and others, 1975). For instance, machismo in the eyes of an Anglo reflect negative connotations of the stereotyped Puerto Rican male. To the Puerto Rican, however, machismo is a desirable combination of virtues, of courage, and fearlessness. A macho is the head and protector of his family, responsible for their well-being and defender of their honor. Referring to mental

health services, Abad adds that it is not surprising that Puerto Rican men will be very under-represented in clinical settings, since it is harder for them to accept help. Marden and Myer (1973), in their book Minorities in American Society, further refer to Hispanics' culture and social system as being male-dominated, with strong emphasis on proving masculinity. Women, on the other hand, must be guarded and accompanied by the responsible males of the family. The National Clearinghouse for Alcohol and Drug Information (1990), in "Reaching Hispanic/Latino Audiences Requires Cultural Sensitivity", also discuss the cultural expectation for Hispanic/Latino females. According to this article, Hispanic/Latino females are expected to act like virtuous ladies (to submit to the men in their lives and to serve their families selfishless). Although their role is somewhat subservient, Hispanic/Latino females are very much respected and cherished in the family structure. Another characteristic discussed by Abad is respeto (respect), which refers to the special consideration and respect that should be shown to elder members in the family and community. Marín (1989) also discusses respeto as a key cultural value of Hispanics. Marín states that respeto addresses the need to maintain and defend one's personal integrity and that of others, and to allow for face-saving strategies whenever conflict or disagreements evolve. COSSMHO (1988) further discusses respeto when referring to strategies for effective patient-provider interaction. COSSMHO states that among Hispanics, respeto (respect) dictates appropriate deferential

behavior toward others on the basis of age, sex, social position, economic status, and position of authority. Health providers, by virtue of their healing functions, education, and training, are seen as authority figures, and as such, are awarded respeto. As in any reciprocal interaction, the Hispanic adult patient expects the provider to treat him/her with respeto. If a Hispanic patient feels that the provider has violated the rules of respeto (offended his/her dignity or honor), the patient may terminate treatment (COSSMHO, 1988).

Religious beliefs are an important dimension in Hispanic life, with profound implications in Hispanics' conceptions about life, health, and illness (Abad et al, 1975). Recognition of the role of religion is crucial. By tying programs to the church in some fashion, planners of health promotion programs, health educators, and health care providers may be more easily accepted and trusted within the community (National Clearinghouse for Alcohol and Drug Information, 1990). In conclusion, the reflection of Hispanic cultural values in developing prevention strategies is one way of helping to ensure that interventions will be culturally appropriate, acceptable, and effective with Hispanics.

The previously discussed values within the Hispanic population are of utmost importance for the success of almost any program or effort targeting this minority population. Language preference and communication style of Hispanics are two other very important traits which have been identified by researchers as

worthy of attention. In regards to language, Saenz (1978) states that a significant minority of Hispanics recognize Spanish as their first language; therefore, in order to increase or improve services the option of communication in Spanish must be offered to these individuals. In regards to communication style--both verbal and physical--, COSSMHO (1988) states that it is very much structured and guided by the cultural values of respeto and personalismo. For example, when interacting with a health provider, many Hispanic patients tend to avoid confrontation and conflict by not disagreeing, not expressing doubts about the treatment, and often, by not asking questions (COSSMHO,1988).

Statement of the Problem

The focus of this dissertation was to determine whether the values of "familism", "religion", and "personalization of interpersonal relations" of Puerto Ricans are related to individuals' participation in their work place health promotion programs. This exploratory study did not deal with hypothesis testing. It sought answers to several research questions and probably provoked more questions that it answered. The research questions guiding the study were:

1 - To what extent do Puerto Ricans in private corporations participate in their employee health promotion program?

2 - What are the factors influencing participation (or lack of) in their employee health promotion program?

3 - To what extent does the value of "familism" relate to individuals' participation in their employee health promotion program?

4 - To what extent does the value of "religion" relate to individuals' participation in their employee health promotion program?

5 - To what extent does the value of "personalization of interpersonal relations" relate to individuals' participation in their employee health promotion program?

Purposes of the Study

1. Determine how do Puerto Ricans in Western New England perceive health promotion programs.
2. Conduct a study that provides some answers to several research questions regarding the participation of Puerto Ricans in health promotion programs in corporations. This study set the basis for the formulation of hypothesis to be tested in future research endeavors.
3. Determine to what extent do Puerto Ricans in Western New England are participating in health promotion programs and, if their participation is low, what are the factors that contribute to this lack of participation.

Delimitations of the Study

From the numbers of health promotion programs in the United States, this investigation was limited to Western New England.

The study was be limited to Puerto Ricans employed in private corporations in Western New England which have health promotion programs on site.

Significance of the Study

This study is significant for the following reasons: first, there seems to be a significant lack of participation of Puerto Ricans in health promotion programs in private corporations in the United States. Second, there is a scarcity of studies regarding Puerto Ricans and their participation in health promotion programs in the United States. This study, in fact, constitutes the first of its kind. This also represents an opportunity to elaborate more regarding the health status of Puerto Ricans, and an opportunity for corporate health promotion programs to make a contribution to this population. This study will also benefit the corporate health promotion programs themselves, since the obtained information was substantial for when culturally sensitive programs are designed for Puerto Ricans.

Definition of Terms

In order to set a common frame of reference, key terms used throughout this research study are defined as follows:

Hispanic : A generic term, officially created by the U.S. Bureau of the Census, to designate persons of Spanish origin or descent. Hispanics are subdivided into: Puerto Rican, Mexican,

Cuban, Central and South American, and from other Spanish culture or origin, regardless of race.

Health Promotion : The science and art of helping people change their lifestyle, in order to move in the direction of a state of optimal health.

Health : State of complete physical, mental, and social well- being, and not merely the absence of disease or infirmity.

Participation : Those who first enter the health-related program.

Corporation : Aa group of persons authorized to act as entity having privileges and liabilities distinct from those of its members.

Values : Principles or criteria for selecting what is good or best among objects, actions, life style, and social and political institutions and structures.

Value Cluster : A shared group of values and cultural attributes.

Culture : A set of cognitions shared by members of a social unit.

Site of the Study

The study was conducted in six private corporations located in the Western New England area which have work site health promotion programs on site. Four of these organizations belong to the health-services industry, and the other two belong to the

manufacturing industry. Four of the health services organizations were area hospitals, in addition to one community health center. The manufacturing organizations of this study are well-recognized nationwide trademarks, one for toys and one for computer equipment. Due to confidentiality, however, the identity of these organizations will remain anonymous.

Target Population of the Study

The population of the study consisted of all the Puerto Ricans working for these organizations according to the records of the companies for the duration of the study.

Instrumentation

The instrument used in this study consisted of a questionnaire that combined demographic information with Likert-Type Scale questions that assessed the health status of Hispanics and referred to how the value cluster of this population influences their participation in work site health promotion programs. The values of familism, religion and interpersonal relations were chosen to be researched in this study. The response modes for the questionnaire consisted of "Always," "Most of the Time," "Sometimes," "Almost Never" and "Never" for some questions; "Very Great Extent," "Great Extent," "Some Extent," "Little Extent" and "Very Little Extent" for other questions;

"Very Important," "Important," "Somewhat Important," "Unimportant" and "Very Unimportant" for others; and, "Very Effective," "Effective," "Somewhat Effective," "Ineffective" and "Very Ineffective" were also used.

The structural design of the questionnaire consisted of two specific areas: Section I and Section II. Section I included the demographic information and a brief health appraisal. Section II comprised the questions related to the values of familism, religion and interpersonal relations. The questionnaire was offered in English and Spanish in order to give the subjects an opportunity to choose their preferred language. The English version of the questionnaire was field-tested on ten subjects in a different health organization. The questionnaire was revised according to the field test results. The Spanish version was designed to match the English version. Copies of both versions of the questionnaire are included in the Appendix.

Procedures for Data Collection and Analysis

The questionnaire was administered personally by the researcher. Arrangements were made with the employers for data collection at the work place during lunch break and scheduled fitness center time. The researcher was on-site providing clarification to questions, particularly the terminology used in the instrument. Subjects were afforded the opportunity to respond in either English or Spanish. Information was recorded directly

into the instrument and then transferred to the University of Massachusetts Computer System for processing. Data, once logged into the computer, were submitted to analysis using Statistical Packages for Social Sciences (SPSS). Sub programs "Frequency Counts" and "Cross Tabs" were used.

CHAPTER II

REVIEW OF RELATED LITERATURE

The review of literature will focus on participation in health promotion programs, future directions in health promotion, and Hispanics' participation in various health-related programs.

Hispanics

Currently the second largest minority group in the United States, the 20 million Hispanics represent an estimated 8.2% of the total population reported to the U.S. Census Bureau in 1989. If current trends continue, Hispanics will represent the largest minority population the United States by the early 21st century (Novello, 1991). Hispanic are largely concentrated in the east coast and the southwest. Hispanics' demographic characteristics are now attracting more attention than ever. The following are some facts on Hispanics: Hispanics, with a median age of 23 years, are younger than the U.S. population as a whole; Hispanics are poor; about 30 percent of all families are living below the poverty level, compared with 15 percent for the total population; eighty percent of Hispanics claim Spanish as their mother tongue; the proportion of Hispanic males in the labor force is about 78 percent and for women about 49 percent; the largest area of employment is in manufacturing, and women work in clerical, service and agricultural occupations (U.S. Department of Health

and Human Services, 1986). Hispanics, especially Mexican Americans and Puerto Ricans, are concentrated in the lower echelons of the employment sector, with over 60 percent in blue collar jobs. Less than 20 percent of Mexican Americans and Puerto Ricans have white collar jobs (Dieppa and Montiel, 1978). "Although health, mental health, and human services, as a question of national policy are to be provided to all without discrimination, Hispanic families are often excluded because their language and culture are left out and not accounted for in the planning, development, and delivery of these services" (Dieppa and Montiel, 1978). The lack of bilingual/bicultural professional staff, the location of services away from Hispanic barrios or neighborhoods, and the reluctance to develop services within a Hispanic cultural framework are among the factors that interfere with Hispanics' access to services. Most research available on Hispanic participation in health programs indicates that Hispanics, especially Mexican-Americans, under utilize preventive health services such as routine physical checkups, dental and eye examinations, and pre-natal care (Marks and others, 1991). A study presented in the American Journal of Public Health (1990), "Acculturation, Access to Care, and Use of Preventive Services by Hispanics: Findings from HHANES 1982-84", examined the use of preventive health services (physical, dental, and eye examinations, Pap smear and breast examinations) among Mexican American, Cuban American, and Puerto Rican adults. This investigation, by Solís and others (1990), analyzed data that was

collected in the Hispanic Health and Nutrition Examination Survey (HHANES) conducted by the National Center for Health Statistics (NCHS) from 1982 through 1984. There were two hypotheses offered by the researchers to explain the use of preventive health services by Mexican Americans, Cuban Americans, and Puerto Ricans; one emphasized the importance of acculturation and the other emphasized access to services. The results from the analyses showed differences in preventive service-related behaviors among the three Hispanic groups. The findings demonstrated that access was strongly related to utilization. Most important, however, was the fact that language and not ethnic identification was the greatest predictor of utilization for the Mexican Americans. Language was related to utilization for the Cuban American men but not for the Cuban American women or Puerto Ricans. In the case of the Puerto Ricans, the public health facilities they tend to use (due to Medicaid coverage) may have more Spanish-speaking providers. Finally, the researchers concluded by explaining that after controlling for socio demographic factors and health insurance coverage, the rates of service utilization were higher among non-Hispanic Whites than Hispanics in general. A study by Marks and others (1990) examined health risk behaviors of Hispanics in the United States. Data from the Hispanic Health and Nutrition Examination Survey (HHANES) was again analyzed. The health risk behaviors included: cigarette smoking, alcohol use, dietary practices, and recency of health screening. The findings among Mexican American, Cuban American, and Puerto Rican adults,

showed that a greater percentage of men than women smoked cigarettes and used alcohol. Heavy smoking was most prevalent for Cuban American males, and heavy drinking was most prevalent for Mexican American and Puerto Rican men. The Puerto Ricans' diet was less balanced than that of the other two groups. More men than women had not had a routine physical or dental examination within the past five years. Screening (including Pap smear for women) was lower for those who smoked cigarettes and for those with poor dietary practices, indicating that many Hispanics at special risk of disease under utilize preventive health services. "Health Behaviors, Risk Factors, and Health Indicators Associated with Cigarette Use in Mexican Americans: Results from the Hispanic HANES", a study by Lee and others (1991) , employed data from the HHANES to investigate differences in health behaviors, risk factors and health indicators between cigarette smokers and nonsmokers among Mexican Americans. The results indicated positive associations exist between smoking status and heavy coffee and alcohol consumption across gender and age groups. Lower systolic and diastolic blood pressures in middle-aged smokers, and higher levels of depressive symptomatology among smoking women were found. Those smoking 10 or more cigarettes per day were more likely to report heavy coffee consumption, with younger men reporting greater activity limitation due to poor health. The researchers concluded by stating that associations between cigarette smoking, health behaviors and risk factors found in other studies were confirmed by this investigation. In a study

by Harlan and others (1991), "Cervical Cancer Screening: Who Is Not Screened and Why?", the researchers examined Pap smear screening rates, beliefs about appropriate screening intervals and factors affecting screening. The results indicated that through age 69, Blacks are screened at similar or higher rates than Whites. Hispanics, particularly those speaking only or mostly Spanish, are least likely to have received a Pap smear within the last three years. The researchers concluded that in developing screening programs, Hispanics, particularly Spanish speakers, must be targeted. Language and cultural differences are among the numerous barriers which may interfere with Hispanics' utilization of health care. Antonio Estrada and others (1990) in their study, "Health Care Utilization Barriers among Mexican Americans: Evidence from HHANES 1982-84", ranked specific barrier items. The researchers concluded that the low income groups, younger age groups, the less acculturated, those who lack health insurance coverage, those with functional limitations, and those in poorer perceived health status encounter more barriers than others, and are prevented by these barriers from obtaining health care for themselves (Estrada and others, 1990). The National Coalition of Hispanic Health and Human Services Organizations (COSSMHO, 1988) interviewed experts from all over the United States to describe the barriers to Hispanics' obtaining adequate health services. Some of these barriers were: language gaps between Hispanics and professionals that, when not bridged effectively, severely compromise the quality of care; Hispanics' distrust of the health

care system, borne of repeated negative experiences; high medical costs that severely limit the ability of a large percentage of Hispanics to afford care; cultural and social class stereotyping; institutional policies that display insensitivity to important Hispanic values; and misunderstandings due to differences in cultural expectations, communication styles, and values.

After reviewing Hispanic participation in various areas, there are obvious factors that play a crucial role in this population's access and choice of services. What are the forces underlying these choices? Are cultural values the influencing variables behind every individual's choice?

Participation in Health Promotion Programs

Work site health promotion programs, which have emerged in the past decade, are offered by American organizations with the goals of modifying employee health-risk behaviors, potentially reducing health care costs, and increasing productivity (Conrad, 1987; Wilson, 1990; Horton, 1988). Most research attention has focused primarily on such questions as effectiveness at reducing health-risk factors and controlling health care costs (Conrad, 1987). Most studies have concentrated on male-dominated white collar employee groups (Opatz et al, 1990). Recent participation studies have pursued the following directions: individual characteristics, self-selection, organizational factors, demographic characteristics of participants, and a combination of

individual and organizational factors. The problem with low participation, however, is an unexplored area in need of special attention.

Individual Characteristics

Individual characteristics can be defined as psychological and physical factors, health behaviors, attitudes, beliefs, and other factors (Sloan and Gruman, 1988). Davis et al, (1984), in their study of participation, attempted to assess the extent to which a set of psychosocial variables, such as personal efficacy, job stress, and anxiety could enhance the prediction of both dissatisfaction with one's health and intent to change. After using a hierarchical regression and a cross-validation strategy, the researchers concluded that the psychosocial variables contributed significantly to the prediction of dissatisfaction and intent to change. Personal efficacy was the most consistently important; efficacy self-judgments were predictors of both dissatisfaction and intent to change. Job stress and anxiety made a consistent contribution to the prediction of dissatisfaction.

The second study by Davis et al, (1987) consisted in a model of risk factors and psychosocial variables that should enhance the predication of participation in work site health promotion programs. Degree of satisfaction with one's current status, intent to change it, and participation in a relevant program were assessed in four health areas: weight loss, exercise, alcohol consumption, and handling of stress and tension. Their

findings indicated that the tendency of individuals to volunteer for health promotion activities is likely to be associated with felt job stress, and persons volunteering for such reasons may appear in activities indirectly related to stress, such as weight-loss and exercise programs. The researchers concluded that psychosocial factors are important variables in the prediction of participation in work site health promotion efforts.

Self-Selection

Self-selection is as much a direction as it is a limitation of health promotion program participation studies. Researchers have been aware of this limitation (Eddy and others, 1990; Laville and others, 1989; Knadler and others, 1987), which has often been referred to as a possible source of bias. Subjects in participation studies are often self-selected because the majority of health promotion programs tender services to volunteer participants.

In 1984, Davis et al, conducted a study that examined to what extent work site health promotion programs were likely to appeal to persons who needed them. "This is an important question because of the concern raised that such programs only reach the already converted--not those in genuine need of the program" (Davis and others, 1984). The results of their project suggested that even though weight loss, exercise, and stress management programs draw people already committed to improving in those

areas, many of the participants had moderately high risk scores and were participating for the first time in such a program. With respect to cigarette smoking cessation and the nutritional quality of one's diet, it was not clear that those at greater risk were more likely to participate.

Conrad (1988) in his study "Who comes to work site wellness programs?" examined the correlates of participation. He concluded that there appeared to be some self-selection of participants in the programs. He said that it seemed participants were likely to be nonsmokers, more concerned with health matters, perceived themselves in better health, and more interested in physical activities especially aerobic exercise, than non participants. There was also evidence that participants may had used fewer health services and had been somewhat younger than non participants (Conrad, 1987). A Health Risk Appraisal (HRA) has been defined as a procedure for using epidemiologic and vital statistics data to provide individuals with projections of their personalized mortality risk and with recommendations for reducing that risk for the purpose of promoting desirable changes in health behavior (Nice and Woodruff, 1990). The HRA procedure has been most widely adopted in health education and health promotion programs, especially in work sites. In a study by Nice and Woodruff (1990), "Self-Selection in Responding to a Health Risk Appraisal: Are We Preaching to the Choir?", the researchers examined behavioral and socio demographic factors associated with voluntary response to an HRA, and assessed the effects of HRA

feedback on subsequent preventive health behaviors and risk-taking behaviors. The results of this study demonstrated that HRA respondents were older, better educated, had higher health status, smoked less, consumed less alcohol, and used seat belts more often than non respondents. In addition, analyses of the results indicated that HRA participation had no significant effect on subsequent preventive health behaviors and risk-taking factors. Finally, the researchers recommended that one way to eliminate the bias of self-selection in HRAs was the identification of groups which express homogeneous health needs and values. This, according to Nice and Woodruff (1990), would be a way to obtain the participation of a more representative distribution of the target population.

Organizational Factors

Examples of organizational factors are managerial style, performance goals, company-wide norms, interpersonal relationships at work, and work overload and underload (Sloan and Gruman, 1988). Other organizational factors, such as the size of the physical structure and size of the work force, have also been examined. Tsai, Baun, Bernacki (1987) in their study "Exercise and Employee Turnover" attempted to assess the relationship of exercise participation to turnover. The assessment model directly took into account: age, sex, general job category, and duration of employment. The study looked at differences in the effect on turnover of newly hired employees and employees who had been with

the company up to 4 years prior to the initiation of the fitness center. Their findings indicated that individuals in both categories who chose to exercise had a greater duration of employment; thus, implying that participation in an exercise program may have a long-term effect on turnover. They concluded, however, that the difference in retention probabilities between exercisers and non exercisers seemed to diminish over the years. In summary, participation in a fitness program seemed to be associated with reduced employee turnover. Their conclusion stated that due to the association between exercise and job retention, such programs are probably of financial benefit to corporations.

Horton (1988) in his study of participation discussed that participation depended: 1) on the size of the eligible employee group; 2) level of supervision; and 3) amount of square footage in the facility. He sustained that participation declined as the size of the eligible employee group grew. In addition, he also said that participation tended to increase with the level of supervision by fitness professionals, and the number of square feet per eligible employee (Horton, 1988). Emont and Cummings (1990) conducted the first study to assess the effects of work site-level factors on clinic participation and smoking cessation at multiple work settings. They stated that their study was also the first to find a relationship between the presence of smoking policies and both increased participation in smoking cessation programs and actual cessation rates. After examining the effects

of organizational factors on participation rates in a smoking cessation clinic and on one-year quit rates among 68 private sector businesses, the researchers concluded that organizational factors predicted clinic participation. The organizational factors that predicted participation included having had previous health promotion programs, increased motivation to stop smoking, and greater length of employment. Greater cessation rates were observed among work sites with greater smoking clinic participants. Work site size was also positively correlated with cessation rates; larger work sites exhibited greater rates of cessation than smaller work sites. Other factors that predicted cessation at one year included a greater awareness of smoking restrictions, and agreement that passive smoking was dangerous to one's health. The only factor to significantly increase both participation and cessation rates was the presence of smoking policies. The researchers concluded by saying that by manipulating specific work site factors, such as incorporating smoking policies, implementing social support components, removing cigarette vending machines, and rewarding non smoking behavior, it would be possible to determine those factors which could have the greatest influence on participation and behavior change. Seth Serxner (1990), in his study "Organizational Contraction and Participation in Work site Weight Control Programs: A Pilot Study", proposed the hypothesis that overweight workers were more likely to participate in health promotion programs during times of organizational contraction than during other times. Organizational

contraction was defined as the average percentage loss of workers in the firm for three months prior to the program offering. This study showed that the highest rate of participation occurred during the two highest levels of organizational contraction within the company. Gender was the only control variable found to be a significant predictor of participation in weight control programs, in that overweight women were more likely than overweight men to participate. Serxner further suggested that workers were more likely to participate in their companies' health promotion programs when their firm was undergoing staff reductions. "Offering programs when the firm is threatened increases the likelihood of employee participation and improved productivity" (Serxner, 1990).

Demographic Characteristics

Glasgow, Klesges and Klesges, and Somes (1988) examined variables associated with participation and outcome in a work site smoking control program. Demographic variables included: gender, age, marital status, years with current employer, years smoked, average number of cigarettes per day, current cigarette brand, and job satisfaction. Older subjects and heavier smokers were more likely to participate in the work site program than younger, lighter smokers, but were less likely to stop or reduce their smoking once they had joined. Their study was the first to find

that variables positively associated with participation in a smoking cessation program were inversely associated with outcome.

In a study by Laville, Vernon, Jackson and Hughes (1989) participants and non participants in a work site cancer awareness and screening program were compared. Demographic variables, such as sex, age, ethnicity, employment status, health habits, risk factors, family history and personal history, were recorded. The results indicated that young women were more likely to participate. Women with a history of breast cancer in their families were also more likely to participate. Hispanic women were less likely to participate than Hispanic men. Men had slightly higher participation rates than women. Kaman et al, (1990) studied two different methods for measuring health risks of an employee population in order to determine if they both produced the same results. According to the comparison of the two appraisal instruments utilized (The Risk Plan Report and the Healthier People Health Risk Appraisal), the demographic variables of age, sex, and salary level were found to be significantly different between the participants and the non participants. The mere existence of these differences raised some uncertainty about the predicting power of health risks based on normative data and the demographic profile of a specific population.

In a study that examined the relationship between socio demographic characteristics and recruitment, retention, and health improvements in a work site health promotion program, Brill et al, (1991) gave program participants a health screening consisting of

health habit assessment, measurement of clinical variables, physical fitness testing, and a medical examination. After completion of the health screening, participants were offered a 10-week intensive intervention health promotion program of activity classes and health education classes. According to the findings, blacks showed lowest recruitment rates, whites were highest, with Hispanics as intermediates. Employees less than 35 years of age were also less likely to enroll in the program than their older counterparts. No difference was seen between women and men. Blacks and Hispanics were more likely to refuse to participate in follow-up surveys than whites. Older individuals were more likely to participate. Program success was comparable across ethnic groups. The only difference was that the whites in the youngest age group reported less success in smoking cessation compared to Blacks and Hispanics in the same age group.

Individual Characteristics & Organizational Factors

Sloan and Gruman (1988) in their study examined how individual characteristics and organizational factors influenced participation in work place health promotion programs. After randomly selecting 192 AT&T employees, 129 females and 63 males, the researchers administered a questionnaire which included the following information: age, sex, years with the company, position within their organization, satisfaction with specific health areas, intention to make changes in these health areas, perception

of work climate and perceived health risk information. The results indicated that neither years of age nor years with the company distinguished participants from non participants, but more women than men participated. The climate variable of perceived supportiveness of the supervisor showed a significant direct relationship to participation. In other words, the greater the perception of support, the greater was participation. Sex of participant, intention to change, and perceived supportiveness of the supervisor were found to have direct and significant effects on participation. Age had no direct effect upon participation. In conclusion, the findings of this study by Sloan and Gruman (1988) indicated that both individual characteristics and organizational factors are strongly and positively associated with participation.

Lovato and Green (1990) examined the issue of maintaining participation in work place health promotion programs. In this article, they referred to evidence which suggested that combinations of environmental and individual approaches are necessary to address the problem of maintenance. An approach toward maintaining participation is suggested which uses a pre program diagnostic interview model to identify and address environmental and individual factors that may cause an employee to dropout of a program or relapse into prior behavioral patterns. Maintenance of program participation is of primary importance in work place health promotion programs. The real benefits of health promotion programs, however, are realized only through long-term

maintenance of healthful behaviors and environments. According to the researchers, the available evidence, both empirical and anecdotal, suggests that combinations of environmental and individual approaches are necessary to maintain participation, and that research focused on successful approaches for promoting adherence is still needed. The researchers concluded that even though effective techniques are available to increase participation, it is important to recognize that there will always be dropouts and non adherents. "Participation is a complex issue influenced by many factors including personality, history, and environment. Only through both individual and environmental strategies will programs increase the potential for maintenance of health-related behaviors" (Lovato and Green, 1990).

Mark G. Wilson (1990) reviewed organizational and individual factors necessary for increasing participation. He stated that non participation mostly has been attributed to lack of interest, lack of time, social support, inconvenient facilities, perception of good physical conditioning and conflicts with work. Two variables which have demonstrated a relationship to participation, according to Wilson, are education and income. Both variables have been found to be related to personal health practices. Age also has a relationship to participation; studies have shown that participants tend to be younger than non participants. Wilson also stated that occupational status, defined as blue collar and white collar, has a relationship to participation, with white collar more likely to participate voluntary. Also, women are more

likely to participate than men. Wilson also mentioned that when the entire employee population does not participate in health promotion programs, it may be due in part to the design or promotion of the program and not exclusively due to factors intrinsic to the participants.

Future Directions in Health Promotion

Exactly as O'Donnell and Ainsworth (1984) had a visionary solution to the problem with low participation, which research studies continue to prove practical and veritable, other researchers and scholars have examined demographic predictions for this nation, in order to prescribe knowledge that will guide the fate of health promotion programs in American organizations. For instance, Don R. Powell (1987) in his article, "A Crystal-Clear Vision: Predictions for the Future of Health Promotion," predicts that a trend that will make an impact in the wellness arena is a focusing on specific population groups. He proceeds to focus on minorities in the work force and states that by the year 2000, white male workers will constitute only 15 percent of the new entries to the work force (Powell, 1987; Brill and others, 1991). Powell refers to a very important fact about minorities' health. He says that minorities show different patterns of illness. Therefore, health promotion programs need to address the special needs of minorities (Powell, 1987).

Brill and others (1991) in their study, which focused on demographics, recommended that it may be important to market

health promotion program to minority employees based upon their special needs. They stated that since lower levels of education have been correlated with higher levels of risk factors associated with major diseases, then various demographic subgroups must have different health habits and morbidity and mortality experiences; moreover, the results of their study supported these claims. "Attitudes, knowledge, and behaviors of minorities are important factors to consider when attempting to market this population" (Brill and others, 1991).

A specific minority group that has been steadily growing during the past 30 years is that of Hispanics. Dr. Jane L. Delgado, President and CEO of COSSMHO (1991), emphasizes that efforts in disease prevention and health care are not reaching Hispanic communities. This is an alarming fact for Hispanics suffer from ill health, lack of access to health care,and dramatic population growth. These are several of the reasons why it is important for health promotion efforts to focus on the special needs of Hispanics.

C H A P T E R III

FINDINGS OF THE STUDY

This chapter presents the findings of the study and an analysis of the data gathered. It discusses some information about the participants demography, responses to a brief health appraisal, and relevant statistical information about factors influencing the participation of Puerto Ricans in employee health promotion programs in organizations in Western New England.

Demography of Participants

To obtain a better understanding of the data it is necessary to look at a profile of the participants. This part of the chapter presents a series of figures that give a picture of the type of population involved in the study.

Out of 84 Puerto Ricans working at five organizations in the Western New England area who participated in this study, 40 are female and 43 are male, one case is missing. Of these participants, 35% work in the health services industry while 66% work in the manufacturing industry. Since the identity of the organizations will remain anonymous. Each organization is referred to using letters (A, B, C, D, E.) Organizations A, B, and C belong to the health services industry; D and E belong to the manufacturing industry. The responses to this question follow:

Organizations	F	M	Number	Percent
A (Health)	4	11	15	18 %
B (Health)	1	5	7	8 %
C (Health)	2	5	7	8 %
D (Manufacturing)	8	2	10	12 %
E (Manufacturing)	28	16	44	52 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

After obtaining the data, it is evident that the majority of the participants have low levels of education. Thirteen percent of them had no high school diploma, while 53% had only achieved a high school diploma as their highest level of education. The breakdown for education is as follows:

Highest Degree Earned	F	M	Number	Percent
No High School	2	9	11	13 %
High School Diploma	20	24	44	53 %
Vocational	1	1	2	2 %
Two-Year College or Junior College Certificate	7	3	10	12 %
Bachelor's	3	4	7	8 %
Master's	2	1	3	4 %
Doctorate	0	0	0	0 %
No Answer or Other	5	1	6	7 %
TOTAL	40	43	84	100 %

Fifty-two percent of the participants have salaries between $13,800 and $26,799. Ninety-eight percent of the participants fall between 18 and 45 years of age, with 29% belonging to the 18 to 20 age group. The breakdown for these two questions is as follows:

Salary ($)	F	M	Number	Percent
less than 12,000	1	4	5	6 %
12,000-13,800	2	5	7	8 %
13,800-17,799	8	10	18	23 %
17,800-21,799	16	12	28	33 %
21,800-26,799	11	6	17	20 %
26,800-32,799	2	1	3	4 %
32,800-39,999	1	0	1	1 %
40,000-48,699	0	1	1	1 %
48,700-59,399	1	0	1	1 %
59,400-over	0	0	0	0 %
No Answer or Other	1	1	2	2 %
TOTAL	40	43	84	100 %

Age	F	M	Number	Percent
18-20	0	0	0	0 %
20-25	8	15	24	29 %
26-30	8	6	7	17 %
31-35	8	8	10	19 %
36-40	9	6	44	18 %
41-45	6	7	15	16 %
46-50	1	1	2	2 %
51-55	0	0	0	0 %
Over 55	0	0	0	0 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Forty-five percent of the participants are married, live with their spouses and have children, while 26% are single. The breakdown for this question is:

Marital Status	F	M	Number	Percent
Single	9	13	22	26 %
Married, lives w/family	20	18	38	45 %
Married, lives alone	0	5	5	6 %
Separated/Divorced, lives alone	2	3	5	6 %
Separated/Divorced, lives with children	7	0	7	8 %
No Answer or Other	0	0	7	8 %
TOTAL	40	43	84	100 %

Number of Years Living in the United States

The average number of years the participants have been living in the United States is 17. The average number of years that they have been working for the organization is 5 years.

Health Appraisal

The participants answered a few questions concerning their health status and kind of formal health education received. Answers to some of these questions follow. The majority (65%) said they were exposed to some form of health education in school, either physical education or health education, for three years of less; 24% said they had no exposure to health or physical education. The breakdown of the responses is:

Years of Health Education in School	F	M	Number	Percent
0 years	8	12	20	24 %
1-3 years	19	15	34	41 %
4-6 years	6	5	11	13 %
More than 7 years	6	9	15	18 %
No Answer or Other	1	2	4	5 %
TOTAL	40	43	84	100 %

Three-quarters of the participants (75%) do not smoke. The majority (60%) does not drink alcohol. Two-thirds of the participants (68%) drink coffee, at least sometimes. The breakdown for these three questions follows:

Smoke	F	M	Number	Percent
Never	31	26	58	69 %
Almost Never	1	4	5	6 %
Sometimes	2	7	9	11 %
Most of the Time	5	2	7	8 %
Always	1	4	5	6 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Drink Alcohol	F	M	Number	Percent
Never	19	8	28	33 %
Almost Never	13	9	22	26 %
Sometimes	8	19	27	32 %
Most of the Time	0	7	7	8 %
Always	0	0	0	0 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Drink Coffee	F	M	Number	Percent
Never	10	6	16	19 %
Almost Never	2	7	10	12 %
Sometimes	14	13	27	32 %
Most of the Time	5	9	14	17 %
Always	9	7	16	19 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

Participation of Puerto Ricans in Health Promotion Programs (HPP)

This section will present and discuss the participants' responses to some of the 41 questions included in the questionnaire. An attempt to present the participants' responses

to questions concerning their perceptions, feelings and opinions about their participation in their employee health promotion program (referred to as HPP throughout this discussion) will be made. Other responses are included in the Appendix.

The presentation of data will follow an item by item format in most instances. When deemed appropriate and for clarification purposes, items will be consolidated when presented.

Factors Influencing the Participation of Puerto Ricans in HPP

In an effort to objectively determine what factors influence the participation of Puerto Ricans in their work place health promotion programs, and to what extent they participate, the subjects of the study provided several questions. The answers to these questions reflect that all these Puerto Ricans participate to some degree in their company's health promotion program; however, the existence of factors relevant to the Puerto Rican value system plays a decisive role in their participation.

Low Participation

This exploratory study focused on how Puerto Rican cultural values are an influence or are linked to the participation of individuals in their work place health promotion program. From the answers to the questionnaire, it can be inferred that the overall participation of Puerto Ricans in these programs is low. Thirty-two percent of the respondents said they participate in healthy lifestyle practices (such as jogging, aerobic exercise,

walking, etc.), and 34% of the participants said they participate in recreational activities with their family. Twenty-five percent said they participate in recreational activities offered by their churches. A breakdown of these responses follows:

Individual Participates in Healthy Lifestyle Practices	F	M	Number	Percent
Never	8	2	10	12 %
Almost Never	5	6	11	13 %
Sometimes	14	21	35	42 %
Most of the Time	10	11	21	25 %
Always	3	3	6	7 %
No Answer or Other	0	0	1	1 %
TOTAL	40	43	84	100 %

Participate in Recreational Activities with their Family	F	M	Number	Percent
Never	7	3	10	12%
Almost Never	1	6	7	8%
Sometimes	15	22	37	44%
Most of the Time	15	7	22	26%
Always	2	5	7	8%
No Answer or Other	0	0	1	1%
TOTAL	40	43	84	100%

Participates in Recreational Activities Offered by Church	F	M	Number	Percent
Never	9	11	20	24 %
Almost Never	9	8	17	20 %
Sometimes	14	11	26	31 %
Most of the Time	3	8	11	13 %
Always	5	5	10	12 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Even though their participation in the HPP activities is low, most of the respondents consider such activities as important. Seventy-three percent said they think it is important to participate in recreational activities with their family. The breakdown of this response is as follows:

Participation of Family in Recreational Activities	F	M	Number	Percent
Very Unimportant	0	0	0	0 %
Unimportant	2	4	6	7 %
Somewhat Important	6	10	16	19 %
Important	15	17	32	38 %
Very Important	17	11	29	35 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

Culture as a Factor Influencing Participation

Cultural elements are factors that belong to the Puerto Rican culture, such as music, holidays (ex. Three Kings Day,) food and others. Cultural values for this study are familism, religion and interpersonal relations. This combination of the cultural elements and values forms the core of the Puerto Rican culture. Culture seems to influence the participants' decisions to participate in HPP activities; thus, culture is considered important by the respondents. Seventy-three percent of the participants said the HPP never offers activities that reflect the Puerto Rican culture, and another 64% said the HPP activities fail to be culturally sensitive. Eighty-two percent said the HPP should include Puerto Rican cultural elements into its activities, and another 80% said the HPP staff

should understand Puerto Rican cultural values. The participation of other Puerto Ricans was considered essential by 76% of the respondents. The breakdowns of these five questions follow:

HPP Promotes Activities that Reflect Puerto Rican Culture	F	M	Number	Percent
Never	16	29	45	54 %
Almost Never	11	5	16	19 %
Sometimes	9	3	12	14 %
Most of the Time	2	5	7	8 %
Always	1	1	2	2 %
No Answer or Other	1	0	2	2 %
TOTAL	40	43	84	100 %

Activities are Sensitive to the Puerto Rican Culture	F	M	Number	Percent
Never	10	22	32	38 %
Almost Never	11	11	22	26 %
Sometimes	12	7	19	23 %
Most of the Time	4	2	7	8 %
Always	0	0	0	0 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Important to Include Puerto Rican Cultural Elements into HPP Activities	F	M	Number	Percent
Very Unimportant	0	2	2	2 %
Unimportant	2	4	6	7 %
Somewhat Important	2	4	7	8 %
Important	8	10	18	21 %
Very Important	28	23	51	61 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

HPP Staff Should Understand Puerto Rican Cultural Values	F	M	Number	Percent
Very Unimportant	0	2	2	2 %
Unimportant	2	1	3	4 %
Somewhat Important	3	8	12	14 %
Important	7	8	15	18 %
Very Important	28	24	52	62 %
No answer or other	0	0	0	0 %
TOTAL	40	43	84	100 %

Think Essential Participation of Other Puerto Ricans in HPP	F	M	Number	Percent
Very Little Extent	3	3	6	7 %
Little Extent	1	0	1	1 %
Some Extent	3	10	13	16 %
Great Extent	15	10	25	30 %
Very Great Extent	18	20	39	46 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Language as a Barrier to Participation

One can only assume that participation would increase if the communication barrier of language would be addressed by planners of HPP. For instance, 86% of the participants responded that the HPP should provide some materials in Spanish, and 78% said the HPP staff should know some Spanish. The breakdowns of these questions follow:

HPP Materials Should be Available in Spanish	F	M	Number	Percent
Very Unimportant	0	1	1	1 %
Unimportant	3	2	5	6 %
Somewhat Important	1	5	6	7 %
Important	6	9	15	18 %
Very Important	30	26	57	68 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Important that HPP Staff Know Some Spanish	F	M	Number	Percent
Very Little Extent	1	1	2	2 %
Little Extent	1	3	4	5 %
Some Extent	7	5	13	16 %
Great Extent	6	9	15	18 %
Very Great Extent	25	25	50	60 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Values of Family, Religion and Interpersonal Relations

This part of the discussion focuses on assessing the values of family, religion and interpersonal relations individually, as they impact the decision of employees to participate in the HPP.

Participation, Family and Health

To what extent does the value of "familism" relate to individuals' participation in their employee health promotion program? Seventy-three percent answered that their family should support his or her participation in the HPP and 63% said it is important to exercise with their family. These were the detailed responses:

Think Family Should Support His or Her Participation in HPP	F	M	Number	Percent
Very Unimportant	2	0	2	2 %
Unimportant	0	3	3	4 %
Somewhat Important	8	10	18	21 %
Important	13	18	32	38 %
Very Important	17	12	29	35 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Importance Given to Exercising with Family	F	M	Number	Percent
Very Unimportant	0	1	1	1 %
Unimportant	1	2	3	1 %
Somewhat Important	10	18	28	4 %
Important	14	11	25	33 %
Very Important	15	10	26	30 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

Ninety-three percent of the participants said that it is important that the family see them as healthy individuals, and another 94% consider having a healthy family important. Seventy-five percent of the participants think that talking to their family about health is important. The following are the answers in detail:

Important that Family see Individual as Healthy	F	M	Number	Percent
Very Unimportant	0	0	0	0 %
Unimportant	2	0	2	2 %
Somewhat Important	2	2	4	5 %
Important	8	15	24	29 %
Very Important	28	26	54	64 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Importance to Having a Healthy Family	F	M	Number	Percent
Very Unimportant	1	0	1	1 %
Unimportant	0	0	0	0 %
Somewhat Important	0	3	3	4 %
Important	3	9	12	14 %
Very Important	36	31	67	80 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

Talk to Family about Health	F	M	Number	Percent
Very Unimportant	0	0	0	0 %
Unimportant	2	2	4	5 %
Somewhat Important	5	11	16	19 %
Important	14	11	25	30 %
Very Important	19	18	38	45 %
No Answer or Other	0	1	1	1 %
TOTAL	40	43	84	100 %

Only 15% of the participants answered that planned activities from work attract their family's interest; furthermore, this could be because 62% said that the HPP never offers family-oriented activities. The breakdowns for these two questions follow:

Planned Activities from Work Attract Family	F	M	Number	Percent
Never	8	17	25	30 %
Almost Never	7	9	16	19 %
Sometimes	18	12	30	36 %
Most of the Time	5	2	7	8 %
Always	2	3	6	7 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Health Promotion Program offers Family-oriented Activities	F	M	Number	Percent
Never	15	16	31	37 %
Almost Never	12	9	21	25 %
Sometimes	7	12	20	24 %
Most of the Time	4	6	10	12 %
Always	0	2	2	2 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Inclusion of Family in Health Promotion Program

An overwhelming majority of the participants (87%) said that the HPP should send health information home for their family. These are the answers:

Think Family Should Receive Health Information from HPP	F	M	Number	Percent
Very Unimportant	2	0	2	2 %
Unimportant	0	0	0	0 %
Somewhat Important	1	8	9	11 %
Important	13	17	31	37 %
Very important	24	18	42	50 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

While seventy-five percent of the participants think their family feels it is important to include them in HPP, 50% said they personally fail to promote the inclusion of family members in the HPP. Perhaps this is because the HPP does not offer activities that give the employees the opportunity to include the family. The breakdowns of the answers to the questions follow:

Thinks Family Feels It's Important to Include Them in HPP	F	M	Number	Percent
Very Unimportant	3	0	3	4 %
Unimportant	0	1	1	1 %
Somewhat Important	5	12	17	20 %
Important	15	16	32	38 %
Very Important	17	14	31	37 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Individual Promotes the Inclusion of Family in HPP	F	M	Number	Percent
Very Little Extent	12	14	26	31 %
Little Extent	6	10	16	19 %
Some Extent	12	11	23	27 %
Great Extent	6	5	11	13 %
Very Great Extent	3	3	7	8 %
No Answer or Other	1	0	1	1 %
TOTAL	40	43	84	100 %

Religion and the Health Promotion Program

When trying to determine whether the value of "religion" relates to an individual's participation in the employee health promotion program, the data gathered in the study seem to suggest that religion determines, to some degree, an individual's decision to participate in HPP activities. The questions included in the questionnaire that focused on religion were mainly formulated to help determine if Puerto Ricans observed religious holidays which would interfere with their participation in HPP activities. For instance, if a HPP activity was to be offered during Christmas time (from 12/24-Christmas to 1/6-Three Kings Day,) 62% answered that they would not participate in the HPP during this season. Another time of the year which is religiously compromised is Holy Week, which is observed by most Roman Catholic Puerto Ricans. Fifty-eight percent of the participants said they would not participate in HPP activities during Holy Week. The breakdowns for the answers to these questions is presented next.

Participates in HPP during Christmas Time (12/24 to 1/6)	F	M	Number	Percent
Never	13	19	33	39 %
Almost Never	7	6	13	16 %
Sometimes	5	9	14	17 %
Most of the Time	11	6	17	20 %
Always	4	3	7	8 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

Participates in HPP during Holy Week	F	M	Number	Percent
Never	13	24	38	45 %
Almost Never	7	4	11	13 %
Sometimes	11	8	19	23 %
Most of the Time	5	1	6	7 %
Always	4	6	10	12 %
No Answer or Other	0	0	0	0 %
TOTAL	40	43	84	100 %

The majority of the participants (59%) said the HPP should consider their religion when planning activities. Fifty-six percent of the respondents said they think the HPP does not consider their religion when planning activities. This is the breakdown:

Think HPP Activities Should Consider Religion	F	M	Number	Percent
Very Unimportant	4	1	6	7 %
Unimportant	3	7	10	12 %
Somewhat Important	6	12	18	21 %
Important	15	10	25	30 %
Very Important	11	13	24	29 %
No Answer or Other	1	0	1	1 %
TOTAL	40	43	84	100 %

HPP Considers Individual's Religion for Program Activities	F	M	Number	Percent
Very Little Extent	11	18	29	35 %
Little Extent	9	9	18	21 %
Some Extent	8	10	19	23 %
Great Extent	6	2	8	10 %
Very Great Extent	4	3	7	8 %
No Answer or Other	2	1	3	4 %
TOTAL	40	43	84	100 %

It is well-known that preachers of all religions speak about health of mind, body and spirit. Most religions ask their followers to abide to a certain way of life, which may include abstinence from smoking and drinking, or forbidding certain foods or actions. Fifty-two percent of the participants consider that their religion promotes health. Following are the responses in detail:

Religion Promotes Health	F	M	Number	Percent
Very Little Extent	3	5	9	11 %
Little Extent	3	6	9	11 %
Some Extent	10	12	22	26 %
Great Extent	9	10	19	23 %
Very Great Extent	14	10	24	29 %
No Answer or Other	1	0	1	1 %
TOTAL	40	43	84	100 %

Interpersonal Relations and Participation

The value of "personalization of interpersonal relations", or the ways in which Puerto Ricans "take everything personally" relates to an individual's participation in their employee health

promotion program. The importance that the participants award to the ways in which the HPP staff interacts with them will influence their decision to participate in the HPP. When asked if they trust the HPP staff, only 20% said yes, and merely 32% said they think the HPP staff is friendly. The answers in detail are:

Trust in HPP Staff	F	M	Number	Percent
Very Little Extent	8	13	21	25 %
Little Extent	8	7	15	18 %
Some Extent	15	12	27	32 %
Great Extent	4	8	12	14 %
Very Great Extent	4	1	5	6 %
No Answer or Other	1	2	4	5 %
TOTAL	40	43	84	100 %

Think HPP Staff is "Simpatico"	F	M	Number	Percent
Very Little Extent	8	15	23	27 %
Little Extent	9	4	13	16 %
Some Extent	8	11	19	23 %
Great Extent	12	8	20	24 %
Very Great Extent	2	5	7	8 %
No Answer or Other	1	0	2	2 %
TOTAL	40	43	84	100 %

The majority (61%) thinks that the HPP fails to interact informally with them. Consequently, only 40% said their relationship with the HPP staff is effective. These are the detailed answers:

HPP Staff Interacts with Informally with Individual	F	M	Number	Percent
Never	17	17	35	42 %
Almost Never	6	10	16	19 %
Sometimes	12	10	22	26 %
Most of the Time	2	6	8	10 %
Always	1	0	1	1 %
No Answer or Other	2	0	2	2 %
TOTAL	40	43	84	100 %

How Effective is Relationship with HPP Staff	F	M	Number	Percent
Very Ineffective	6	12	19	23 %
Ineffective	8	5	13	16 %
Somewhat Effective	9	7	16	19 %
Effective	12	10	22	26 %
Very Effective	4	8	12	14 %
No Answer or Other	1	1	2	2 %
TOTAL	40	43	84	100 %

In order to engage in an organization's HPP, an employee needs to understand certain procedures, for example, how exercise equipment is used or what are the hours during which the employee may use the equipment. Only 34% of the participants said they understand the procedures to participate in the HPP. The answers to this question are:

Understand Procedures Required to Participate in HPP Activities	F	M	Number	Percent
Very Little Extent	9	12	22	26 %
Little Extent	8	6	14	17 %
Some Extent	12	10	22	26 %
Great Extent	7	12	19	23 %
Very Great Extent	3	3	6	7 %
No Answer or Other	1	0	1	1 %
TOTAL	40	43	84	100 %

C H A P T E R IV

CONCLUSIONS AND RECOMMENDATIONS

Having described in detail the major findings in the study, the present chapter attempts to:

1. Derive the most important conclusions about how the values of family, religion and interpersonal relations influence the participation of Puerto Ricans in work place health promotion programs in American organizations.

2. Offer recommendations which are necessary for increasing Puerto Rican participation in health promotion programs in American organizations and make the participation a more productive and meaningful one.

3. Propose recommendations for future research.

Conclusions

The data collected in this study suggest that Puerto Ricans participate to some extent in their work place health promotion programs; however, this participation appears to be low. Factors related to the Puerto Rican value system seem to play an important role in an individual's decision to participate in the program. A health promotion program will be unsuccessful, if the employees fail to engage in it.

In this study, the participants as a group have low levels of education and work primarily in manufacturing. Among the women, about an equal number of them work in the health services area as in manufacturing; whereas, a disproportionate number of males work in manufacturing as opposed to a small number that works in health services. This difference may be due to males having lower levels of education, compared to a more educated group of females. Another gender-based difference from this study appeared in the question related to the sharing of health information with the family; a larger number of women answered positively to this question. This is in agreement with the finding by Sloan and Gruman (1988) that stated that more women than men participated in the health promotion program. It is apparent that women are more active in the process of health as is also predicted by the Hispanic value cluster, since women are expected to care for the rest of the family (COSSMHO, 1988).

The population of this study is was relatively young, with the majority falling between 18-and-45-years old. Since their levels of participation are low, this is in agreement with the research conducted by Brill et. al. (1991), where it was found that employees less than 35-years-old were less likely to enroll in the health promotion program. The finding of young age and low participation is in contradiction with the study by Sloan and Gruman (1988) where it was found that age had no direct effect upon participation. The low participation of Puerto Ricans in work place health promotion programs in organizations in the

Western New England area seems to be linked to a lack of cultural sensitivity on behalf of the organization running such programs. Both males and females agree that the health promotion program activities do not promote activities that reflect the Puerto Rican culture, and these participants consider very important the inclusion of cultural elements into the activities. The participants clearly are committed to the Hispanic value cluster of family, religion and interpersonal relations. In the questions about cultural sensitivity, the males were more critical of the health promotion program by saying that the activities never took their culture into consideration. This is in agreement with Abad et. al. (1975) and the discussion of the Puerto Rican value system, where it is said that males are protectors of the family and the culture.

In accordance with Estrada et. al. (1990), who found that young, less educated, and lower income Hispanics were also most likely to encounter more barriers to obtaining health care, this study's findings suggest that the lack of cultural sensitivity toward Puerto Rican employees is the greatest barrier to their participation in their organization's health promotion program. The findings of this study also show that the participants have a strong preference for the Spanish language; about half of the participants chose the Spanish version of the questionnaire. This directly relates to the findings by Solís et al (1990) which showed that language was the greatest predictor of utilization of health services by Hispanics. Perhaps, the participation of

Puerto Ricans in health promotion programs can increase if more services and materials were provided in Spanish.

In agreement with O'Donnell and Ainsworth (1984), if the planners of the health promotion programs paid attention to the cultures from which the individuals come from, the programs would be more successful. For instance, if more activities included the employees' families then the employees would probably participate more in the programs. In this study, the participants thought that the health promotion program should do more to include their family and their religion into the planning of activities. In the case of religion, for example, the majority of Puerto Ricans are Catholics; therefore, if the health promotion program planned activities for Holy Week, the Puerto Rican employees would certainly fail to attend.

Work environments in the United States have been predicted to become more diverse as the white population ages and a younger minority population enters the work force. All demographic indicators suggest that Hispanics will constitute the largest minority group by the year 2000 and a significant percentage of the United States' work force. Health promotion programs will depend to a large extent on planners' and participants' capacity and ability to expand their horizons and go beyond their limitations. Greater understanding of the importance of values awareness will increase the potential and necessary impact that health promotion programs can have among Hispanic participants.

Recommendations

1. Planners and facilitators of HPP need to increase their understanding of the diverse nature of their employee population; it would be effective to work and educate for values awareness.
2. Programs should be reevaluated and reformed taking into consideration cultural aspects of the work force that would gear to a better health services.
3. Methods of recruitment of Spanish-speaking providers in the HPP to increase role-modeling and sensitivity to the special needs/language, religion, etc. of the Spanish-speaking population.
4. Create in-service trainings, values-conflict team-work, diversity workshop, and an Internship programs in community-based institutions. All this would enhance the understanding of the realities of the 2000 work force.
5. Efforts of networking with organizations that have accessibility to information and experience working with Hispanics all over the country, especially in health promotion.
6. A strong campaign to reach out to Puerto Ricans and other minorities by involving their families in the health promotion programs.

APPENDICES

APPENDIX A

PARTICIPANT CONSENT FORMS

(SPANISH AND ENGLISH VERSIONS)

Dear _____:

I am a doctoral student at the School of Education, University of Massachusetts, Amherst Campus. I am conducting a study about Puerto Rican participation in health promotion programs in American organizations in Western New England. The data obtained from this study will be useful to those who make decisions in the development and implementation of health promotion programs in the future. Because there is very limited academic literature about the participation of Puerto Ricans in health promotion programs, the results of this study will make a much needed contribution to the literature on Puerto Rican participation in health promotion programs.

I will be in touch with your office during the next week to learn about your decision regarding this matter. Thank you very much for your attention, and I truly hope you are willing to be part of this study.

Cordially,

Edmundo M. Jiménez
Researcher

CONSENT FORM

I, _____, agree to participate in a study entitled: Puerto Rican Participation in Worksite Health Promotion Programs in American Organizations: The Impact of Three Values.

The study will be conducted by Edmundo M. Jiménez, a doctoral candidate at the University of Massachusetts, School of Education.

I understand that:

1. The purpose of the study is to develop a better understanding of the participation of Puerto Ricans in health promotion programs in American organizations.

2. The information generated from my participation in this study will be initially used to prepare a written doctoral dissertation, and at a later date journal articles for academic publications.

The researcher and the undersigned agree to the following conditions regarding the collection and safeguarding of information collected for the study:

1. That I will answer a questionnaire that will be administered by the researcher.

2. My participation in this study is voluntary and anonymous and I reserve the right to withdraw from participation anytime.
3. I will receive no monetary compensation for my participation.

_____ _____

Participant Researcher

_____ _____

Date Date

FORMA DE ACUERDO COMUN

Yo, _____, estoy de acuerdo en participar en el estudio titulado: Participación de los Puertorriqueños en Programas de Promoción de Salud en el Trabajo en Compañías Americanas: El Impacto de Tres Valores.

El estudio será llevado a cabo por Edmundo Jiménez, candidato al grado doctoral de la Escuela de Educación de la Universidad de Massachusetts. Entiendo que:

1. El propósito del estudio es el de desarrollar un mejor entendimiento de la participación de los puertorriqueños en programas de promoción de salud en compañías americanas.
2. La información generada por mi participación en el estudio será usada inicialmente para preparar una disertación doctoral escrita, y en fecha posterior para publicar artículos en revistas académicas.

El investigador y el aquí firmante están de acuerdo con las siguientes condiciones relacionadas a la colecta y protección de la información recopilada en el estudio:

1. Que yo contestaré un cuestionario que será administrado por el investigador.
2. Mi participación en este estudio es voluntaria y anónima y me reservo el derecho de retirar mi participación en cualquier momento.
3. Yo no recibiré ninguna compensación monetaria por mi participación en este estudio.

_____	_____
Investigador	Participante
_____	_____
Fecha	Fecha

APPENDIX B

QUESTIONNAIRE
(SPANISH AND ENGLISH VERSIONS)

Participación de los Puertorriqueños en
Programas de Promoción de Salud en el Trabajo
en Compañías Americanas: El Impacto de Tres Valores

Los propósitos de este estudio son: 1) Llevar a cabo un estudio que brindará algunas respuestas a varias preguntas de investigación concernientes a la participación de los puertorriqueños en programas de promoción de salud en compañias americanas; 2) Determinar hasta qué punto los puertorriqueños en el oeste de Nueva Inglaterra están participando de los programas de promoción de salud de sus trabajos y, si su participación es baja, cuáles son los factores que contribuyen a esta falta de participación, y; 3) Determinar cómo los puertorriqueños del oeste de Nueva Inglaterra perciben los programas de promoción de salud.

Este cuestionario consiste de dos secciones. La Sección I trata de información demográfica y una breve apreciación de salud. La Sección II trata con asuntos dirigidos a sus percepciones, opiniones y sentimientos acerca de diversos aspectos relacionados con su participación en el programa de promoción de salud de su trabajo. Por favor note que para las diferentes secciones existen diferentes escalas.

Por favor lea cada pregunta y responda utilizando la escala correspondiente. Conteste todas las preguntas. Escriba sus respuestas directamente en el cuestionario. Todas sus contestaciones son estrictamente confidenciales.

Ahora, por favor proceda a contestar el cuestionario. Le debe tomar de 20 a 30 minutos. Siéntase en completa libertad de hacer comentarios dondequiera que usted encuentre apropiado hacerlos. Una vez haya terminado el cuestionario, por favor entréguelo usando el sobre incluído.

Gracias por su tiempo y su valiosa ayuda.

Atentamente,

Edmundo M. Jiménez-Montijo
Investigador

Sección I - Información Demográfica

Por favor marque con un círculo la mejor alternativa que describa el grado escolar más alto que usted haya obtenido:

A- Menos de escuela superior
B- Escuela superior
C- Dos años de universidad o grado asociado
D- Escuela vocacional
E- Bachillerato
F- Maestría
G- Doctorado
H- Otro (Especifique)_____

Por favor especifique el tiempo (días, meses, años) que lleva trabajando en su posición actual:

Por favor especifique el tiempo (días, meses, años) que lleva trabajando para esta compañia:

Por favor marque con un círculo la alternativa que mejor refleje su nivel de salario en esta compañia: (sueldo en $ anuales)

1. menos de 12,000
2. 12,000 - 13,800
3. 13,800 - 17,799
4. 17,800 - 21,799
5. 21,800 - 26,799
6. 26,800 - 32,799
7. 32,800 - 39,999
8. 40,000 - 48,699
9. 48,700 - 59,399
10. 59,400 - ó más

Estado Civil:

1. Soltero(a)
2. Casado(a), viviendo con esposa(o) e hijos
3. Casado(a), viviendo separado de esposa(o) e hijos
4. Separado(a) o divorciado(a) sin hijos viviendo con usted
5. Separado(a) o divorciado(a) con hijos viviendo con usted
6. Otro (Especifique) _____

Por favor marque con un círculo la categoría que mejor refleje su edad:

1. 18-20
2. 20-25
3. 26-30
4. 31-35
5. 36-40
6. 41-45
7. 46-50
8. 51-55
9. Mayor de 55

Por favor marque con un círculo su sexo:

1. Femenino
2. Masculino

Por favor indique de que pueblo de Puerto Rico proviene usted y/o su familia:

¿Hace cuántos años vive usted en los Estados Unidos?

Apreciación de Salud

¿Cuándo fue la última vez que visito a su doctor para un examen de rutina anual?

Si usted es mujer: ¿cuándo fué la última vez que le hicieron un Papa Nicolao y una mamografía ? (Especifique fecha de cada examen)

Si usted es hombre: ¿cuándo fué la última vez que le hicieron un examen de la próstata?

Por favor marque con un círculo, ¿cuántos años de clases de educación de salud y/o de educación física tomó usted en la escuela?

1. 0
2. 1-3
3. 4-6
4. Más de 7

Para las próximas preguntas, por favor escriba una cruz (X) sobre la mejor respuesta.

a. ¿Cuán frecuentemente usted fuma?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

b. ¿Cuán frecuentemente usted toma bebidas alcohólicas?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

c. ¿Cuán frecuentemente usted toma café?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

Sección II

Para esta sección, por favor escriba una cruz(X) sobre la mejor respuesta. Note las diferentes escalas.

A. Familismo

1. ¿Cúan frecuentemente el programa de promoción de salud de su trabajo ofrece actividades orientadas hacia la familia?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

2. ¿Cuán frecuentemente usted participa en actividades recreativas con miembros de su familia?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

3. ¿Cuán frecuentemente usted comparte con su familia la información de salud que recibe en su trabajo?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

4. ¿Cuán frecuentemente las actividades planificadas en su trabajo atraen a su familia?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

5. ¿Cuán frecuentemente estas actividades son sensitivas a su cultura?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

6. ¿Cuán frecuentemente usted practica actividades propias de un estilo de vida saludable (ejemplo: trotar, jugar baloncesto, caminar, etcetera)?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

7. Dada la oportunidad, ¿cuán frecuentemente usted participaría con su familia en actividades de salud ofrecidas por el programa de promoción de salud de su trabajo?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

8. ¿Hasta qué punto usted siente que el programa de promoción de salud se preocupa por las necesidades de salud de su familia?

Muchísimo Mucho Bastante Poco Muy poco

9. ¿Hasta qué punto usted promueve la inclusión de su familia en el programa de promoción de salud?

Muchísimo Mucho Bastante Poco Muy poco

10. ¿Hasta qué punto el programa de promoción de salud responde a sus sugerencias?

Muchísimo Mucho Bastante Poco Muy poco

11. ¿Hasta qué punto usted se percibe como un modelo de salud para su familia?

Muchísimo Mucho Bastante Poco Muy poco

12. ¿Cuán importante es para usted que su familia esté saludable?

Muy importante Importante Algo importante Sin importancia Sin importancia alguna

13. ¿Cuán importante es para usted hacer ejercicios con su familia?

Muy importante Importante Algo importante Sin importancia Sin importancia alguna

14. ¿Cuán importante es para su familia hablar de salud?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

15. ¿Cuán importante es para su familia el participar en actividades recreativas?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

16. ¿Cuán importante es para usted el que el programa de promoción de salud coordine actividades para toda la familia?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

17. ¿Cuán importante es para usted el que su familia lo(a) vea como una persona saludable?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

18. ¿Cuán importante es para usted el que su familia reciba información de salud envíada por el programa de promoción de salud?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

19. ¿Cuán importante es para usted el que su familia apoye su participación en el programa de promoción de salud?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

20. ¿Cuan importante usted cree que es para su familia el que se le incluya en el programa de promoción de salud?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

21. ¿Cuan eficiente es el programa de promoción de salud en atraer el interés suyo y de su familia?

Muy eficiente	Eficiente	Algo eficiente	Ineficiente	Muy ineficiente

22. ¿Cuán eficiente es el programa de promoción de salud en promover la salud dentro de su familia?

Muy eficiente	Eficiente	Algo eficiente	Ineficiente	Muy ineficiente

23. ¿Cuan eficiente es la comunicación (mayormente escrita) entre el programa de promoción de salud y su familia?

Muy eficiente	Eficiente	Algo eficiente	Ineficiente	Muy ineficiente

B. Religión

24. ¿Cuán frecuentemente usted participa en actividades recreativas ofrecidas por su iglesia?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

25. ¿Cuán frecuentemente usted participa en el programa de promoción de salud durante la epoca navideña (diciembre 24 - enero 6)?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

26. ¿Cuán frecuentemente usted participa en el programa de promoción de salud durante la Semana Santa?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

27. ¿Hasta qué punto su religión promueve la buena salud?

Muchísimo	Mucho	Bastante	Poco	Muy poco

28. ¿Hasta qué punto las actividades ofrecidas por el programa de promoción de salud toman en consideración su religión?

Muchísimo	Mucho	Bastante	Poco	Muy poco

29. ¿Cuán importante es para usted el que las actividades ofrecidas por el programa de promoción de salud tomen en consideración su religión?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

C. Personalización de Relaciones Interpersonales

30. ¿Cuán frecuentemente el personal del programa de promoción de salud saca tiempo para relacionarse informalmente con usted (como parte) dentro del mismo programa?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

31. ¿Cuán frecuentemente el programa de promoción de salud promueve actividades que reflejen la cultura puertorriqueña?

Siempre	Mayoría del tiempo	A veces	Casi nunca	Nunca

32. ¿Hasta que punto usted confía en el personal del programa de promoción de salud?

Muchísimo	Mucho	Bastante	Poco	Muy poco

33. ¿Hasta qué punto el personal del programa de promoción de salud es simpático con usted?

Muchísimo	Mucho	Bastante	Poco	Muy poco

34. ¿Hasta qué punto usted entiende el procedimiento requerido para participar en las actividades del programa de promoción de salud?

Muchísimo	Mucho	Bastante	Poco	Muy poco

35. ¿Hasta qué punto usted considera esencial que otros puertorriqueños participen en el programa de promoción de salud?

Muchísimo	Mucho	Bastante	Poco	Muy poco

36. ¿Hasta qué punto usted considera importante que el personal del programa de promoción de salud hable y/o entienda un poco de español?

Muchísimo	Mucho	Bastante	Poco	Muy poco

37. ¿Hasta qué punto usted considera importante que el personal del programa de promoción de salud se interese un poco en su vida personal y familiar?

Muchísimo	Mucho	Bastante	Poco	Muy poco

38. ¿Cuán importante es para usted que los materiales del programa de promoción de salud estén disponibles tanto en inglés como en español?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

39. ¿Cuán importante es para usted que el programa de promoción de salud incluya elementos de la cultura puertorriqueña (ejemplo: música) en sus actividades?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

40. ¿Cuán importante usted cree que es que el personal del programa de promoción de salud conozca sobre los valores culturales puertorriqueños?

Muy importante	Importante	Algo importante	Sin importancia	Sin importancia alguna

41. ¿Cuán eficiente es la relación entre usted y el personal del programa de promoción de salud?

Muy eficiente	Eficiente	Algo eficiente	Ineficiente	Muy ineficiente

QUESTIONNAIRE

The purposes of this study are to: conduct a study that will provide some answers to several research questions regarding the participation of Puerto Ricans in health promotion programs in corporations; determine to what extent do Puerto Ricans in Western New England are participating in health promotion programs and, if their participation is low, what are the factors that contribute to this lack of participation; and determine how do Puerto Ricans in Western New England perceive health promotion programs.

This questionnaire consists of two sections. Section I deals with demographic information and a brief health assessment. Section II deals with items addressing your perceptions, opinions and feelings about diverse aspects of your participation in your worksite health promotion program. Please note that there are different sections which call for different scales. Please read each item and respond to it using the applicable scale. Answer all the questions even if you feel compelled not to. Put your answers directly on the instrument. All responses are strictly confidential.

Now, please proceed to answer the questionnaire. It should take about 20-30 minutes. Feel free to add comments wherever you might find appropriate to do so. Return your completed questionnaire using the enclosed envelope.

Thank you for your time and invaluable help.

Sincerely,

Edmundo M. Jimenez-Montijo

Section I - Demographic Information

Please circle the appropriate item(s) which describe(s) the highest educational degree you earned:

A- Lower than High School
B- High School
C- Two-year College Degree
D- Vocational School
E- Bachelor's
F- Master's
G- Doctorate
H- Other (Specify) _____

Please specify the number of years you have been at your present position:

Please specify the number of years you have been working for this organization:

Please circle below the item which best reflects your salary level at this organization:

1. less than 12,000
2. 12,000 - 13,800
3. 13,800 - 17,799
4. 17,800 - 21,799
5. 21,800 - 26,799
6. 26,800 - 32,799
7. 32,800 - 39,999
8. 40,000 - 48,699
9. 48,700 - 59,399
10. 59,400 - over

Please indicate your marital status:

1. Single
2. Married, living with spouse and children
3. Married, living apart from spouse and children
4. Separated or divorced with no children living with you
5. Separated or divorced with children living with you
6. Other (Specify) _____

Please circle the bracket that best reflects your age:

1. 18-20
2. 20-25
3. 26-30
4. 31-35
5. 36-40
6. 41-45
7. 46-50
8. 51-55
9. Over 55

Please circle your gender:

1. Female
2. Male

Please indicate which town in Puerto Rico you or your family come from.

How many years have you lived in the continental United States?

Health Assessment

When was the last time you visited your doctor for a yearly check-up?

If you are a female: When was the last time you had a pap smear and mammogram ? (Specify for each)

If you are a male: When was the last time you had a prostate exam?

Please circle how many years of health education and/or physical education did you take in school?

1. 0 years
2. 1-3 years
3. 4-6 years
4. More than 7 years

For the following questions, please make a cross (X) over the best answer.

a. How frequently do you smoke?

Always	Most of the time	Sometimes	Almost Never	Never

b. How frequently do you drink alcoholic beverages?

Always	Most of the time	Sometimes	Almost Never	Never

c. How frequently do you drink coffee?

Always	Most of the time	Sometimes	Almost Never	Never

Section II

For the following section, please make a cross (X) over the best answer. Note the different scales.

A. Familism

1. How frequently does your health promotion program offer family-oriented activities?

Always	Most of the time	Sometimes	Almost Never	Never

2. How frequently do you participate in recreational activities with members of your family?

Always	Most of the time	Sometimes	Almost Never	Never

3. How frequently do you share with your family the health-related information that you receive at work ?

Always	Most of the time	Sometimes	Almost Never	Never

4. How frequently do the activities planned at work attract your family?

Always	Most of the time	Sometimes	Almost Never	Never

5. How frequently are these activities sensitive to your culture?

Always	Most of the time	Sometimes	Almost Never	Never

6. How frequently do you engage in healthy lifestyle practices (i.e. jogging, playing basketball, walking, etcetera.)?

Always	Most of the time	Sometimes	Almost Never	Never

7. Given the opportunity, how frequently would you participate with your family in health-related activities offered by your employer's health promotion program?

Always	Most of the time	Sometimes	Almost Never	Never

8. To what extent do you feel that the health promotion program worries about your family's health needs?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

9. To what extent do you promote the inclusion of your family in the health promotion program?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

10. To what extent does your health promotion program respond to your suggestions?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

11. To what extent do you perceive yourself as a role model of health for your family?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

12. How important is it for you that your family be healthy?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

13. How important is it for you to exercise with your family?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

14. How important is for your family to talk about health?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

15. How important is it for your family to participate in recreational activities?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

16. How important is it for you that your health promotion program coordinate activities for your entire family?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

17. How important is it for you that your family see you as a healthy individual?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

18. How important is it for you that your family receive health-related information sent out by the health promotion program?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

19. How important is it for you that your family support your participation in the health promotion program?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

20. How important do you think it is for your family to be included in the health promotion program?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

21. How effective is the health promotion program in attracting your and your family's interest?

Very Effective	Effective	Somewhat Effective	Ineffective	Very Ineffective

22. How effective is the health promotion program in promoting health within your family?

Very Effective	Effective	Somewhat Effective	Ineffective	Very Ineffective

23. How effective is the communication (mostly written) between the health promotion program and your family?

Very Effective	Effective	Somewhat Effective	Ineffective	Very Ineffective

B. Religion

24. How frequently do you participate in recreational activities offered by your church?

Always	Most of the time	Sometimes	Almost Never	Never

25. How frequently do you participate in your health promotion program during Christmas time (Dec. 24 - Jan. 6)?

Always	Most of the time	Sometimes	Almost Never	Never

26. How frequently do you participate in the health promotion program during Holy Week?

Always	Most of the time	Sometimes	Almost Never	Never

27. To what extent does your religion promote health?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

28. To what extent do the activities offered by the health promotion program take your religion into consideration?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

29. How important is it for you that the activities offered by your health promotion program take your religion into consideration?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

C. Personalization of Interpersonal Relations

30. How frequently does your health promotion program staff take time to interact informally with you (as part of) inside the program?

Always	Most of the time	Sometimes	Almost Never	Never

31. How frequently does your health promotion program promote activities that reflect the Puerto Rican culture?

Always	Most of the time	Sometimes	Almost Never	Never

32. To what extent do you trust the health promotion program staff?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

33. To what extent is your health promotion program staff "simpatico" (friendly) toward you?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

34. To what extent do you understand the procedures required to participate in your health promotion program activities?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

35. To what extent do you consider it essential that other Puerto Ricans participate in your health promotion program?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

36. To what extent do you think it is important that the health promotion program staff know some Spanish?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

37. To what extent do you think it is important that your health promotion program staff express interest in your personal life?

Very Great Extent	Great Extent	Some Extent	Little Extent	Very Little Extent

38. How important is it for you that your health promotion program's written materials be in English as well as in Spanish?

Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

39. How important is it to you that your health promotion program include Puerto Rican cultural elements (i.e. music) into its activities?

_____	_____	_____	_____	_____
Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

40. How important do you think it is that the health promotion program staff understand Puerto Ricans' cultural values?

_____	_____	_____	_____	_____
Very Important	Important	Somewhat Important	Unimportant	Very Unimportant

41. How effective is the relationship between you and the health promotion program staff?

_____	_____	_____	_____	_____
Very Effective	Effective	Somewhat Effective	Ineffective	Very Ineffective

BIBLIOGRAPHY

Angel, Ronald and Guarnaccia, Peter J. "Mind, Body, and Culture: Somatization Among Hispanics." Social Science Medicine, Volume 28, Number 12 (1989).

Brill, Patricia A. and others. "The Relationship Between Socio-demographic Characteristics and Recruitment, Retention, and Health Improvements in a Work site Health Promotion Program." American Journal of Health Promotion, Volume 5, Number 3 (January/ February 1991).

Conrad, Peter. "Who Comes to Work-Site Wellness Programs? A Preliminary Review." Journal of Occupational Medicine, Volume 29, Number 4 (April 1987).

Damberg, Cheryl L. "Strategies for Promoting the Health of Minorities: The School-Age Population." Health Values, Volume 10, Number 3 (May/June 1986).

Davis, Keith E. and others. "Intent to Participate in Work site Health Promotion Activities: A Model of Risk Factors and Psychosocial Variables." Health Education Quarterly, Volume 11, Number 4 (Winter 1984).

Davis, Keith E. and others. "Determinants of Participation in Work site Health Promotion Activities." Health Education Quarterly, Volume 14, Number 2 (Summer 1987).

Dieppa, Ismael and Montiel, Miguel. "Hispanic Families: An Exploration."Hispanic Families: Critical Issues for Policy and Programs in Human Services. Edited by Miguel Montiel. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Services Organizations, 1978. Eddy, James M. and others. "Impact of a Physical Fitness Program in a Blue- Collar Work force." Health Values, Volume 14, Number 6 (November/December 1990).

Emont, Seth L. and Cummings, K. Michael. "Organizational Factors Affecting Participation in a Smoking Cessation Program and Abstinence Among 68 Auto Dealerships." American Journal of Health Promotion, Volume 5, Number 2 (November/December 1990).

Estrada, Antonio and others. "Health Care Utilization Barriers among Mexican Americans: Evidence from HHANES 1982-84." Fernando Treviño, Editor. American Journal of Public Health, Supplement Volume 80 (December 1990).

Fitness and Amateur Sport, Government of Canada. Report on the Employee Fitness and Lifestyle Project, Toronto,1977-1978. Canada, 1981.

Gebhardt, Deborah L. and Crump, Carolyn E. "Employee Fitness and Wellness Programs in the Work place." American Psychologist, Volume 45, Number 2 (February 1990).

Glasgow, Russell E. and others. "Variables Associated With Participation and Outcome in a Work site Smoking Control Program." Journal of Consulting and Clinical Psychology, Volume 56, Number 4 (1988).

Green, Lawrence W. and others. Health Education Planning: A Diagnostic Approach. Palo Alto, California: Mayfield Publishing Company, 1980.

Harlan, Linda C. and others. "Cervical Cancer Screening: Who Is Not Screened and Why?" American Journal of Public Health, Volume 81, Number 7 (July 1991).

Horton, William L. "Program Success Determinants." Fitness in Business, (October 1988).

Ilgen, Daniel R. "Health Issues at Work: Opportunities for Industrial/Organizational Psychology." American Psychologist, Volume 45, Number 2 (February 1990).

Kaman, Robert L. and others. "Comparison of Health Risk Prevalence Reported in a Health Risk Appraisal and Predicted Through Demographic Analysis." American Journal of Health Promotion, Volume 5, Number 5 (May/June 1991).

Knadler, Gary F. and others. "Physical Fitness Programs in the Work place. WBGH work site Wellness Series." Washington Business Group on Health and Office of Disease Prevention and Health Promotion, Department of Health and Human Services. Washington, DC: 1987.

Laville, Elizabeth A. and others. "Comparison of Participants and Non participants in a Work Site Cancer Awareness and Screening Program." Journal of Occupational Medicine, Volume 31, Number 3 (March 1989).

Lee, David J. and Markides, Kyriakos S. "Health Behaviors, Risk Factors, and Health Indicators Associated with Cigarette Use in Mexican Americans: Results from the Hispanic HANES." American Journal of Public Health, Volume 81, Number 7 (July 1991).

Lovato, Chris Y. and Green, Lawrence W. "Maintaining Employee Participation in Work place Health Promotion Programs." Health Education Quarterly, Volume 17, Number 1 (Spring 1990).

Marden, Charles F. and Meyer, Gladys. Minorities in American Society. New York, Toronto and London: D. Van Nostrand, 1973.

Marks, Gary and others. "Health Risk Behaviors of Hispanics in the United States: Findings from HHANES, 1982-84." Fernando Treviño, Editor. American Journal of Public Health, Supplement Volume 80 (December 1990).

Matteson, Michael T. and Ivancevich, John M. "Work site Health Promotion: Some Important Questions." Health Values, Volume 12, Number 1 (January/ February 1988).

McBride, Leslie G. and Hellison, Don. "Toward Wellness for Risk Youth: A Values Education Model." Health Values, Volume 10, Number 2 (March/April 1986).

Mellado Parsons, Ramón. La Moral en la Educación. Primera Edición. Río Piedras, P.R.: Editorial de la UPR, 1983.

National Coalition of Hispanic Health and Human Services Organizations. Delivering Preventive Health Care to Hispanics: A Manual For Providers. Washington, D.C. 1988.

National Coalition of Hispanic Health and Human Services Organizations. "Hispanic Healthy People 2000." The COSSMHO Reporter, Volume 16, Number 1 & 2 (January - June, 1991).

Nice, D. Stephen and Woodruff, Susan I. "Self-Selection in Responding to a Health Risk Appraisal: Are We Preaching to the Choir?" American Journal of Health Promotion, Volume 4, Number 5 (May/June 1990).

Novello, A.C. and others. "Hispanic Health: Time for Data, Time for Action." The Journal of the American Medical Association, Volume 265, Number 2 (January 9, 1991).

O'Donnell, Michael P. and Ainsworth, Thomas H. Health Promotion in the Work place. New York and Toronto: John Wiley & Sons, Inc., 1984.

Opatz, Joseph and others. "Economic Impact of Worksite Health Promotion." Anthology of Speakers Papers, Association for Fitness in Business, Draft #4 (August 1, 1990).

Parr, Richard B. "Education: An Important Component of Health Promotion Programs." Fitness in Business. (October 1988).

Powell, Don R. "A Crystal-Clear Vision: Predictions for the Future of Health Promotion." Health Action Managers, Volume 5, Number 1 (January 10, 1991).

Presno, Vincent and Presno, Carol. The Value Realms: Activities For Helping Students Develop Values. New York and London: Teacher's College Press, 1980.

Roman, Paul M. and Blum, Terry C. Ethics in Worksite Health Programming: Who is Served?" Health Education Quarterly, Volume 14, Number 1 (Spring 1987).

Rudman, William J. "On the Road to Fitness: The Navistar Challenge." Health Education, Volume 21, Number 4 (July/August 1990).

Saenz, Javier. "The Value of a Humanistic Model in Serving Hispanic Families." Hispanic Families: Critical Issues for Policy and Programs in Human Services. Edited by Miguel Montiel. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Services Organizations, 1978.

Schneider, Benjamin. Organizational Climate and Culture. San Francisco, California: Jossey-Bass Publishers Inc., 1990.

Schwartz, Barry. "The Creation and Destruction of Value." American Psychologist, Volume 45, Number 1 (January, 1990).

Serxner, Seth. "Organizational Contraction and Participation in Worksite Weight Control Programs: A Pilot Study." American Journal of Health Promotion, Volume 5, Number 1 (September/October 1990).

Sloan, Richard P. and Gruman, Jessie C. "Participation in Work place Health Promotion Programs: The Contribution of Health and Organizational Factors." Health Education Quarterly, Volume 15, Number 3 (Fall 1988).

Spradley and McCurdy, "Culture and the Contemporary World." American Anthropologist, (1988)

Solís, Julia M. and others. "Acculturation, Access to Care, and Use of Preventive Services by Hispanics: Findings from Hispanic Health and Nutrition Examination Survey 1982-84."Fernando Treviño, Editor. American Journal of Public Health, Supplement Volume 80 (December 1990).

Thorolfur, Thorlindsson; and Others. "Sport Participation and Perceived Health Status: A Study of Adolescents." Social Science Medicine, Volume 31, Number 5 (1990).

Torres-Gil, Fernando Manuel. "Age, Health, and Culture: An Examination of Health Among Spanish-Speaking Elderly." Hispanic Families: Critical Issues for Policy and Programs in Human Services. Edited by Miguel Montiel. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Services Organizations, 1978.

Tsai, Shan P. and others. "Relationship of Employee Turnover to Exercise Adherence in a Corporate Fitness Program." Journal of Occupational Medicine, Volume 29, Number 7 (July 1987).

U. S. Department of Health and Human Services. "Volume VIII: Hispanic Health/Inventory/Survey." Report of the Secretary's Task Force on Black & Minority Health, (January 1986).

U. S. General Accounting Office. Health and Nutrition: Collection of Vital Statistical Data on Hispanics - Briefing Report to Congressional Requesters. Division of Human Resources, Washington, D.C. (March 1988).

Wilson, Mark G. "Factors Associated with Issues Related to, and Suggestions for Increasing Participation in Work place Health Promotion Programs." Health Values, Volume 14, Number 4 (July/August 1990).