Current practice in health promotion

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SUMMARY  Progress in health promotion and preventive programme planning is limited by a lack of data on the development of current activities. A cross sectional survey of hospitals, community health centres, and other health agencies in New South Wales was therefore undertaken to determine the nature and extent of health promotion programmes being conducted in the period July to December 1983. A subsample of 1198 preventive programmes in child and family health was identified, making up 26% of all programmes operating in this period.

Results indicate that three major types of programme are being conducted in child health. These are in the areas of (1) parent education and support, (2) school health education, including drug and alcohol education and personal development, and (3) child safety and first aid. Although the nature of these programmes generally corresponds with current thinking on what priorities in health promotion should be, results also indicate that evaluation of these programmes is limited. Most programmes assess only what participants think of the programme rather than assessing changes in knowledge, attitude, behaviour, or health status. Improvements in evaluation practice are required if preventive intervention programmes are to undertake seriously the task of altering the pattern of diseases and problems in childhood and adolescence.

The health professions are beginning to respond to the call to orientate their practice towards prevention rather than simply treatment or rehabilitation. In doing so, a range of different disciplines, viewpoints, and initiatives is gradually building up the science of health promotion and preventive medicine. Although there have been a number of important achievements through health promotion and education programmes in the past decade,1–8 a vast amount of activity in health promotion is not reported. This makes it difficult to assess the quality of routine health promotion practice. It also hampers the development of appropriate evaluation procedures to be directed at those programmes where effectiveness has not yet been satisfactorily determined.

This paper reports a study that was carried out to determine the range and nature of health promotion activities in child and family health in New South Wales. It was impossible for the survey to identify all programmes being undertaken by public or private practitioners across a range of disciplines, and the decision was therefore made to limit the survey to those being conducted by health professionals in major agencies where programmes are substantially dependent on public funds. In this way, this first major review of health promotion programmes in New South Wales is limited to those areas where demands for public accountability should be highest.

Methods

The study was undertaken as part of a survey of a wide group of health promotion activities in New South Wales. Six sample groups were selected to be surveyed. These were: (1) persons receiving grants from the New South Wales or Federal Department of Health to conduct health promotion programmes, including a 20% random sample of programmes from the Hospital Health Promotion Grant Scheme within the New South Wales Department of Health; (2) health education officers employed by the New South Wales Department of Health; (3) other health education officers employed by other agencies, for example, the Family Planning Association; (4) all teaching hospitals, one major private hospital, and a random sample of 20% of other hospitals stratified by metropolitan and country regions; (5) a random sample of 20% of all community health centres, stratified by metropolitan and country regions; and (6) all other agencies with a primary concern in public health, not included by the other selection methods. Agencies or government departments with
a primary interest in recreation or education were excluded. Those programmes, however, being con-
ducted in schools by staff from health agencies
described above were included. This selection
method identified 196 survey subjects.

Two questionnaires were devised and mailed to
subjects. The general health promotion question-
naire was developed for sample groups 2 to 6 above.
A procedure for subjects to select five of their
programmes randomly was provided. A series of
further questions on each of these programmes was
the substance of the second questionnaire, the
programme details questionnaire. This question-
naire was sent to sample groups 1, 2, and 3. It was
considered that these groups would reflect the best
of current practice in health promotion. In addition,
as filling out questionnaires can be a tedious
business, it was expected that these subjects would
be more likely to comply satisfactorily with detailed
questions. Categories given to describe programmes
were based on terms in current use within the New
South Wales Department of Health. All question-
naires were tested and revised after a pilot survey.

It should be emphasised that the subjects identi-
ified were asked to describe programmes that they or
their agency were involved in during the survey
period. This means that the programmes described
cover the work of a range of health professionals—
such as nurses, doctors, and social workers. Double
counting of programmes between subject groups
was eliminated before data analysis.

Questionnaires were mailed to subjects in Febru-
ary 1984. Subjects were required to report on
programmes conducted in the period July to Decem-
ber 1983. This period was chosen so as to be long
enough to reflect a diversity of seasonal programmes
associated with school activities, water safety etc,
but not so long a period as to make it difficult for
subjects to retrieve details of their programmes
accurately. Reminder letters and additional ques-
 tionnaires with stamped return addressed envelopes
were sent in March 1984.

Results

The overall response rate of subjects was 72%
(range 30 to 100%). In order to extrapolate to all
of New South Wales, an estimation procedure was
devised to take into account the differential
sampling and response rates among samples. This
produced the weighted data that will be reported
here.

The survey showed that 4654 health promotion
programmes were conducted in New South Wales in
the survey period. Of these, 1198 or 26% could be
classified as being primarily concerned with the
health of children, adolescents, and their families.
The analysis of this sample of programmes is
reported in this paper. Note that the data is derived
from two questionnaires, the general health promo-
tion questionnaire for which the number of pro-
grames of interest identified was 1198 and the
programme details questionnaire, which reports on
a smaller subsample of programmes (n=289). This
accounts for the different sample sizes reported in
the Tables. Also note that because a programme can
have more than one goal or more than one target
age group percentages do not total 100% unless
otherwise indicated.

Target group and programme type. Most pro-
grammes (47%) are directed towards people aged 21
to 45 years. The next major target group is older
adolescents aged 16 to 20 years. Thirty nine per cent
of programmes are directed at this group. Thirty
seven per cent of programmes are directed at
younger adolescents aged 11 to 15 years.

Table 1 gives an indication of the range of pro-
grammes being conducted and the six major
programme types. The largest proportion of pro-
grammes are directed at parents. School based
programmes include teacher education programmes
as well as programmes specifically designed for the
children themselves.

Programme goals and strategies. The question-
naire asked respondents to distinguish between short and
long term programme goals. In the immediate term,
78% of programmes are reported as attempting to
have an impact on health knowledge. A further 61%
are intended to change attitudes in the short term.
Fifty three per cent of programmes are directly
concerned with changing behaviour in the short
term. Twenty per cent of programmes are simply
directed at extending the social support network of
programme participants.

Table 1 Programme type* (n=1198)

<table>
<thead>
<tr>
<th>Major categories of programmes*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Parent education, parent support</td>
<td>31</td>
</tr>
<tr>
<td>2 School health education</td>
<td></td>
</tr>
<tr>
<td>a) Primary physical health emphasis eg. drug and alcohol, smoking, dental, hygiene</td>
<td>15</td>
</tr>
<tr>
<td>b) Primary mental and social health emphasis eg. personal development, social skills, sexuality</td>
<td>13</td>
</tr>
<tr>
<td>3 Child safety and first aid</td>
<td>10</td>
</tr>
<tr>
<td>4 Health displays, film and pamphlet development</td>
<td>9</td>
</tr>
<tr>
<td>5 Antenatal</td>
<td>4</td>
</tr>
<tr>
<td>6 Nutrition</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
</tr>
</tbody>
</table>

*These six categories make up 86% of the total number of programmes in child and family health promotion in New South Wales. The remaining 14% are a heterogeneous group.
The long term goals of most programmes reflect an emphasis on primary prevention and mental and social health. Sixty four per cent of programmes intend to improve psychological and social well being. Forty eight per cent are directed at promoting ‘wellness’. A smaller group, 36%, are directed at reducing disease incidence, and 17% attempt to reduce mortality.

The strategies being employed to achieve these goals are outlined in Table 2. Corresponding to the main short term goal of programmes, there is a clear emphasis on providing health information. The next major thrust of programme strategies provides participants with social contact or support. This improves people’s access to informal networks that can provide continuing practical and emotional help.

**Evaluation methods.** Tables 3 and 4 present the evaluation methods presently being used to assess programme performance. Evaluation methods are fairly crude. Less than a quarter of programmes compare the performance of programme participants with those of a control group who received no intervention. Most evaluation is process orientated, that is, it assesses what clients think of the programme rather than its possible subsequent impact or outcome.

**Discussion**

This survey is the first of its kind in Australia. The response rate, 72%, is fairly high considering that the only two other similar surveys elsewhere in the world yielded response rates of 23% and 27%. Analysis showed no major differences between respondents and non-respondents in terms of whether the health agency was metropolitan or country based. The field of activities described by the survey can probably be considered to be a fairly good indication of the nature and range of health promotion programmes in child and family health, conducted by health agencies across the state.

The characteristics of programmes being conducted in New South Wales generally correspond with the nature of interventions being called for today in paediatric health promotion. There is a major focus on programmes directed at educating and supporting individuals in two main life transition stages—adolescence and parenting. Appropriate adaptations in these periods are critical to the prevention of a range of important problems. These include adolescent pregnancy, teenage substance abuse, childhood emotional and learning problems, and child abuse. In a recent review, Chamberlin highlighted these as priority areas for prevention in maternal and child health, pointing out that programmes should focus on new parents and socially isolated families. Cust also puts forward a model of health promotion in paediatrics which emphasises the importance of parent education and support.

While the focus and style of programmes generally corresponds with current thinking, however, evaluation practice in health promotion seems to be poorly developed. Most evaluation is oriented towards assessing the process of programme delivery rather than assessing the programme’s impact or outcome. Less than a quarter of programmes have evaluation design that permits a reasonable casual inference to be drawn about programme performance. It should be noted, however, that the questionnaire did not ascertain whether a programme had been adequately evaluated previously. A pro-

**Table 2 Strategies of intervention* (n=289)**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education/information</td>
<td>95</td>
</tr>
<tr>
<td>Social contact/support</td>
<td>52</td>
</tr>
<tr>
<td>Skill development</td>
<td>41</td>
</tr>
<tr>
<td>Community organisation and development</td>
<td>16</td>
</tr>
<tr>
<td>Screening</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
<tr>
<td>None</td>
<td>11</td>
</tr>
</tbody>
</table>

*Programmes may have more than one strategy of intervention, hence the total does not equal 100%.

**Table 3 Method of evaluation (n=289)**

<table>
<thead>
<tr>
<th>Method of evaluation</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral feedback from participants</td>
<td>26</td>
</tr>
<tr>
<td>Questionnaire before and after programme</td>
<td>14</td>
</tr>
<tr>
<td>Questionnaire at end of programme only</td>
<td>29</td>
</tr>
<tr>
<td>Control group comparison</td>
<td>21</td>
</tr>
<tr>
<td>No evaluation</td>
<td>8</td>
</tr>
<tr>
<td>No response</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table 4 What evaluation assessed (n=267)***

<table>
<thead>
<tr>
<th>Evaluation aspect</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>What clients thought of the programme</td>
<td>44</td>
</tr>
<tr>
<td>Knowledge change</td>
<td>31</td>
</tr>
<tr>
<td>Attitude change</td>
<td>28</td>
</tr>
<tr>
<td>Behaviour/health status change</td>
<td>23</td>
</tr>
<tr>
<td>Other aspects</td>
<td>8</td>
</tr>
</tbody>
</table>

*This is a further analysis of the subset of programmes that were reported as being evaluated in Table 3.
programme with known effectiveness would only need some simple form of monitoring to ensure that it was being implemented appropriately. The possibility, however, that the poorly evaluated or unevaluated programmes in this survey had already proved their worth is unlikely. It is more likely that the present lack of sophistication in evaluation practice also represents a past lack of sophistication. If anything, we may be conducting some programmes that are in fact already known to be ineffective. Bartlett, for example, has extensively reviewed the literature in school health education, and noted that, with few exceptions, programmes are generally ineffective in changing health practices and there is a ‘dearth of confirmatory empirical studies’. Indeed, some programmes have been shown to increase drug use and teenage motor vehicle accidents and death rates.

The possibility that we may in fact be doing a disservice to programme participants underlines the need for appropriate review and evaluation of programmes. Reasons why health promotion programme evaluation is limited are likely to include lack of skills and lack of resources. The design of health promotion evaluation is particularly difficult. Practitioners do not have a strong tradition in evaluation to guide them. No health promotion programme evaluation training course exists in Australia even at a Masters degree level. Evaluation in health promotion can also be expensive. Evaluation by a randomised controlled trial may take up well over half the project budget. Furthermore, while health care resources are severely restricted, evaluation of preventive programmes may be considered by some administrators to be a low priority. Some investigation, however, of the context and reasons for a relatively low level of sophistication in programme evaluation may be required if standards are to be raised. It is no use knowing that our health promotion programmes presently seem to coincide with desired priority areas if we cannot rely on the evaluation methods of these programmes to indicate whether or not the desired achievements are being made.

This research was funded by a grant from the New South Wales Department of Health. The support of Dr A Cripps is gratefully acknowledged.

References


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Received 24 July 1985