Health promotion indicators. Coming out of the maze with a purpose

Donald Schon in ‘Beyond the Stable State’ spoke of ideas in ‘good currency’ (Schon, 1971). The notion of indicators in health promotion is certainly in good currency. Those involved in health promotion theory and practice in many countries have been energetic in developing a large number and range of indicators in the last decade. A key stimulus for this has been the requirement of funding bodies for increased accountability both in terms of how the resources are used and the outcomes of health promotion initiatives. The health promotion and associated literature is contributing to the growth in our understanding of indicators, and is attempting to map and delineate the types of indicators which may be useful in understanding and learning about health promotion activities (Whelan et al., 1993; Raphael et al., 1996; Kolbe et al., 1997; MacDonald, 1997; Nutbeam, 1997).

There has been an apparent shift from emphasizing (largely) personal indicators to attempting to look at the person in context. The settings approach to health has driven much of this, and the very fine work of many in the Healthy Cities and Health Promoting Schools international movements has encouraged us to explore a more sophisticated set of indicators (Ashton, 1992; WHO, 1996). An examination of the literature reveals health promotion indicators in the following areas: biological measures; personal behaviours; individual knowledge; specific skills; altitudinal measures; policy development and implementation; physical environment; social environment; partnerships.

Health promotion indicators in some areas, e.g. biological measures, individual knowledge, have a long history of development in the health sector. There are numerous and accepted ways of gathering data which give an indication about a person’s health status and/or health knowledge. But health promotion is more holistic than this, and is focussed more on the settings and environments in which people live. In this domain, the indicators do not have a long history, nor do they have the acceptability from a number of other disciplines in the health field, e.g. biomedical science.

The discourse in health promotion is often about the big picture, and is intersectoral and eclectic in combining disciplines and fields of studies, e.g. combinations in the biological, social and political sciences with an increasing influence from economics. The practice in health promotion in most cases is little picture—an intervention to change a behaviour, build a skill, develop and implement local policy. We need to be reminded that ‘think globally, act locally’ implies an explicit connection to the big picture in terms of how we practise health promotion. In particular, there is the need to indicate what we have done, how we have done it, and what has happened, during the intervention, just after its completion and following a reasonable time lag. Our challenge is to develop and refine specific indicators in these areas so they lead us back to understanding how we have influenced the big picture.

Implicit in this plea is a belief, perhaps even a faith, that local and specific actions will influence the big picture. Will the local measures support a strong evidence-based argument for widespread adoption of the health promotion intervention? Or, are most quality local health promotion interventions only successful because they astutely contextualize the program design and develop a sense of local ownership and commitment? More questions need to be asked about the contribution of small and local efforts to large-scale health promotion programs, and whether the indicators we use give us an understanding of how local
initiatives contribute to regional and county health promotion priorities. Perhaps we may need to develop and choose indicators which realistically link local actions with national priorities, rather than assume that local indicators for the health promotion intervention will be generalizable to the bigger picture.

A number of authors, e.g. Hawe et al. (1990), Whelan et al. (1993), and Raphael et al. (1996), have cogently developed schemas of health promotion indicators, and have argued persuasively for care in choosing indicators which have meaning and reference to both the health promotion program and the stakeholders in the program. These maps and typologies are useful for practitioners as they plan their programs and seek the most appropriate indicators for their stakeholders and target audiences. Yet the size of the total number of individual indicators in health promotion is such that it makes problematic the choice of indicators which are most relevant and useful. Most useful and relevant to whom and for what purposes? Clearly one cannot report on everything. The various requirements of the stakeholders means that often more indicators are chosen than the level and complexity of the program warrants. We now have health promotion programs developing indicators for country priorities, funding bodies, local agencies, population groups, professional and health sector interests, administrators and program and project staff. It is unlikely that a small set of indicators which tells us something useful about the intervention will meet the needs of many of the stakeholders. We tend to pursue the breadth of indicators for political expediency, rather than the depth for program understanding. It is not surprising that we dilute our examination of the health promotion intervention to such an extent that it is difficult to connect the findings to the big picture at a regional or country level.

It is asserted that our energy and commitment to indicators in recent times, plus the need to be increasingly accountable to stakeholders who are becoming more demanding, has taken our attention away from the prime focus of health promotion programs—people, with whom we are working to enhance their health. As Catford (1997: 3) pointed out, we exhort health promotion practitioners ‘to analyse, to envision, to communicate, to empathise, to enthuse, to advocate, to mediate, to enable and to empower a wide range of disparate individuals and organizations’. We encourage them to work with people, not on them. However, an examination of the indicators which are reported in the literature suggests many of us in health promotion have unwittingly succumbed to a somewhat mechanistic and reductionist set of indicators which are often predetermined and shaped by those in political, administrative and economic fields.

It is time we were more assertive in refocussing the emphasis on indicators which tell us something about health promotion and its contributions to communities rather than merely accommodating the requirements of those who finance and administer programs. The situation is not either/or—rather it is a responsibility of health promotion planners, practitioners, evaluators and theorists to articulate more clearly and forcibly the relevance and usefulness of those indicators which will contribute to improved community health which can be sustained over time.

There are many studies which have appeared in this journal and in others which have shown how the careful choice of indicators, and the rigorous collection and analysis of data can demonstrate local contributions to larger health priorities. The health promotion profession has many examples of ‘program champions’ in countries across the world—individuals, groups and institutions who push excellence in the design and implementation of health promotion initiatives. We now need ‘indicator champions’ to emerge, to reclaim the territory, and enrich the literature with evidence, frameworks and well argued rationales about the types of indicators which are germane to health promotion.

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REFERENCES


