

Capacity building for evaluation of social connectedness

Greer Lamaro and Bernie Marshall

There is an increasing body of work addressing the health priority of social connectedness, but published evaluations remain limited. Evaluation evidence is important for informing health promotion practice,¹ and a need to improve health promotion practitioners' evaluation capacity has been identified.²

A pilot study was conducted to investigate the capacity of health promotion practitioners to evaluate community level interventions addressing social connectedness. Practitioners working in agencies affiliated with Primary Care Partnerships in Victoria (formalised networks of agencies that work collaboratively on agreed health priorities) were invited to participate by direct invitation and snowballing. Nine people from five organisations participated in semi-structured interviews, and evaluation documents from all organisations were analysed regarding evaluation practice. Data were coded inductively and key themes identified.

A considerable challenge to evaluation was participants' difficulty understanding and defining social connectedness. Some participants advocated for the development of a standard definition, contending that the lack of such contributes to uncertainty and anxiety about evaluating this concept. Others felt that a broad interpretation facilitates flexibility in evaluation to enable agencies to meet their own needs.

Selecting and using appropriate measurement indicators was another challenge highlighted, due to uncertainty about what to measure and the lack of a specific evaluation tool. Participants generally agreed that a wide range of indicators are used, often drawn from tools designed to measure other similar yet distinct concepts such as social capital. Identifying and selecting appropriate indicators was reported to be overwhelming for some practitioners. However, other participants supported the use of multiple tools to enable contextual evaluation.

The question of whether a common definition and measurement tool for social connectedness should be developed is contentious. Social connectedness is, by nature, highly contextual. Interventions addressing social connectedness often involve collaborations between stakeholders who may have varying understandings of the concept. Developing an accepted common definition and measurement tool would be challenging, and the appropriateness of doing so is questionable given the diversity of opinions discussed previously. Prior undertakings to enhance workforce evaluation capacity have been useful for developing practitioners' generic evaluation skills.³ However, more work is needed to build practitioners' skills and confidence in applied evaluation particularly for complex or contested topics like social connectedness. Evaluation capacity building efforts should now focus on developing health promotion practitioners' skills, confidence and flexibility to use a range of tools to identify and apply appropriate indicators for evaluation.

References

1. Department of Human Services. *Integrated Health Promotion Resource Kit*. Melbourne (AUST): Victorian Government Public and Community Health Branch; 2003.
2. Department of Human Services. *Request for Quotation: Health Promotion Workforce Development Project; Evaluation Skill Development in The Primary Health Care Sector*. Melbourne (AUST): Victorian Department of Human Services Primary and Community health Branch; 2004.
3. Round R, Marshall B, Horton K. *Planning for Effective Health Promotion Evaluation*. Melbourne (AUST): Victorian Department of Human Services; 2005.

Authors

Greer Lamaro, Centre for Health through Action on Social Exclusion (CHASE), Deakin University, Victoria

Assoc. Prof. Bernie Marshall, Faculty of Health, Deakin University, Victoria

Correspondence

Ms Greer Lamaro, School of Health and Social Development, Deakin University, Geelong Waterfront Campus, Locked Bag 20000, Geelong, Victoria 3220; e-mail: greer.lamaro@deakin.edu.au

Workplace health promotion and pedometers: response to Hess, Borg and Rissel

Margo Saunders

Despite the importance of their concluding call for workplace health promotion interventions focusing on male employees in the healthcare sector, the report by Hess, Borg and Rissel¹ raises concerns about the design of current workplace health promotion programs. Specifically, the program that they describe – the TEAM Challenge at Liverpool Hospital – risks being regarded an example of how in health promotion, as in history, those who do not learn from the past are doomed to repeat it.

The 12-week TEAM Challenge involved a multi-faceted intervention to increase physical activity and healthy eating. The authors cite several studies about workplace interventions which use pedometers and note that part of the Challenge was based on the Rockhampton approach of aiming to reach 10,000 steps per day using a pedometer. Of the hospital employees who chose to participate in the TEAM Challenge, 93% were female.

Previous studies have found that health-promoting activities involving pedometers and a 10,000 steps approach have had limited effectiveness with men. In a review of 26 studies which was cited by the authors as supportive of pedometer programs combined with a daily step goal,² Bravata et al found that participants in pedometer-based physical activity programs were overwhelmingly women, with men comprising only 15% of participants.

In another study cited by the authors,³ a pedometer-based program with a 10,000 steps goal was implemented among non-hospital staff of the former South Australian Department of Human Services. The initiative was presented to all relevant staff, of whom 63% were

female. Of the slightly more than one-third of the total eligible staff who registered to participate in the program, three-quarters were women.

The authors do not mention the discussion by Burton and colleagues about middle-aged men's responses to the Rockhampton 10 000 Steps program.⁴ Importantly, the researchers found that most men did not find the 10,000 steps message engaging or appealing. The men generally preferred different goals (e.g. 30 minutes or 3 km) and felt that the 10,000 steps message took no account of the intensity of activity. Also relevant to the Liverpool Hospital's 12-week program was the Rockhampton finding that the majority of men strongly rejected the idea of wearing a pedometer ("it's just another trinket") for more than a few weeks. Burton and colleagues note that their findings have important implications for the uptake and sustainability of pedometer-based interventions among men and also refer to other reports (including one co-authored by Rissel) of men being significantly less likely than women to be represented in pedometer initiatives.

In an environment of limited health promotion resources, repeating strategies which have been found to be relatively ineffective, perhaps because we like them and want to believe that they work, cannot be justified. Designing a workplace health promotion program – especially one that relies on individual behaviour change without corresponding environmental changes – is a complicated business. Designing a program which achieves a respectable gender balance is not impossible, however, if it builds on what we know. The burgeoning literature on men's health, especially qualitative research on men's health-related attitudes and beliefs, should be regarded as essential reading for health promoters.

References

1. Hess I, Borg J, Rissel C. Workplace nutrition and physical activity promotion at Liverpool Hospital. *Health Promot J Austr.* 2011;22(1):44-50.
2. Bravata DM, Smith-Spangler C, Sundaram V, Gienger AL, Lin N, Lewis R, et al. Using pedometers to increase physical activity and improve health: a systematic review. *JAMA.* 2007;298(19):2296-304.
3. Thomas L, Williams M. Promoting physical activity in the workplace: using pedometers to increase daily activity levels. *Health Promot J Austr.* 2006;17:97-102.
4. Burton NW, Walsh A, Brown J. It just doesn't speak to me: Mid-aged men's reactions to '10,000 Steps a Day'. *Health Promot J Austr.* 2008;19(1):52-9.

Author

Margo Saunders, Public Health Policy Consultant

Correspondence

Margo Saunders; e-mail: e-mail: margos@aapt.net.au

Authors' reply:

Chris Rissel, Janelle Borg and Isabel Hess

We thank Margo Saunders for her letter¹ commenting on the TEAM Challenge program at Liverpool Hospital.² She notes that the intervention was promising with our mostly female study population (which is typical of the health sector workforce) and points out that there is some evidence available that pedometers may work

less well with men, who are less likely to want to wear gadgets like pedometers for very long.

This is an important point and the author is correct in warning us that workplace health promotion programs with men may do well to avoid relying on pedometers. In addition to pedometers, our intervention also included a nutrition focus, encouraged active travel to work, used a team component to encourage competition and used basic marketing strategies (for example, footprint prompts to use stairs, posters) to support the walking program.

Not every program will work with every target group. Translational research³ needs to be conducted to understand better how we can take new programs and evaluate them not only for their immediate impact, but their relative effectiveness with different populations and in different settings. Burton et al's process evaluation of the 10,000 Steps a Day program did report mixed views from men about pedometers, but some men liked them.⁴ In the original trial of the Step by Step program⁵ qualitative feedback from the men involved in this study (unpublished) told us that the diary we used to record their daily steps could be improved to make it more appealing to men by making it more 'scientific'. Wearing a pedometer for lengthy periods may be one issue, but how the accompanying materials are presented to men may be another.

Men do tend to participate less frequently than women in health promotion programs, and to some extent this is likely to be a function of how the programs are designed. We maintain that men should be a priority for workplace health promotion programs, and agree that qualitative research with men will be an essential feature of designing better programs.

References

1. Saunders, M. Workplace health promotion and pedometers: response to Hess, Borg and Rissel. *Health Promot J Austr.* 2011;22(2):156.
2. Hess I, Borg J, Rissel C. Workplace nutrition and physical activity promotion at Liverpool Hospital. *Health Promot J Austr.* 2011;22(1):44-50.
3. Nutbeam D, Bauman A. *Evaluation in a Nutshell; A Practical Guide to the Evaluation of Health Promotion Programs.* Sydney (AUST): McGraw-Hill; 2006.
4. Burton NW, Walsh A, Brown J. It just doesn't speak to me: Mid-aged men's reaction to '10,000 Steps a Day'. *Health Promot J Austr.* 2008;19(1):52-9.
5. Merom D, Rissel C, Phongsavan P, Van Kemenade C, Smith B, Bauman A, et al. Promoting walking with pedometers in the community: the Step by Step trial. *Am J Prev Med.* 2007;32(4):290-7.

Authors

Chris Rissel, School of Public Health, University of Sydney,
New South Wales

Janelle Borg and Isabel Hess, Health Promotion Service, Sydney South
West Area Health Service, New South Wales

Correspondence

Chris Rissel, School of Public Health, University of Sydney,
Level 2 Medical Foundation Building K25, 92 Parramatta Rd,
Camperdown, New South Wales 2050;
e-mail: chris.rissel@sydney.edu.au