How to use ethics and evidence in Health Promotion

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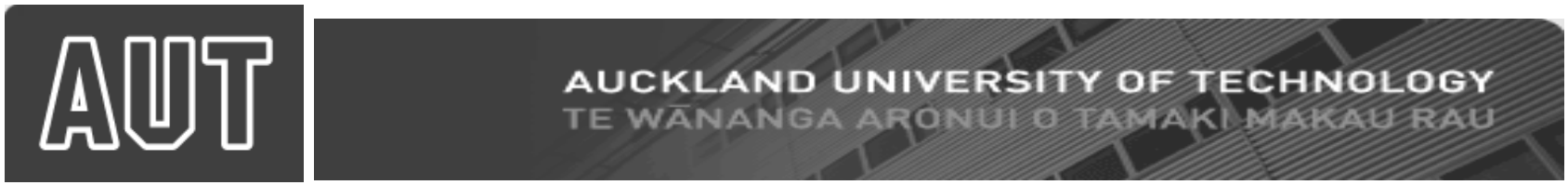

“Motherhood and apple pie”

Arguing for ethics and evidence as drivers of

health promotion practice is like

arguing for motherhood and apple pie.

- Who would argue against them????

- BUT…….

What do we mean by…..

- Ethics…
- socially constructed ways or conventions for making decisions about the the right and proper way to do things
- Not like the principle of gravity; a universal principle that holds across different countries, different political, cultural, religious, philosophical beliefs…
- Ethics depends on where you start from..your underlying values, beliefs, ideologies...derives from contested sites, sites of debate-argument about what is the “your” good life.

Health Promotion/public health values beliefs

- PHA draft set of values
- 1. All people have a right to the resources necessary for health.
- 2. People are inherently social and interdependent.
- 5. People and their physical environments are interdependent.
- 7. Identifying and promoting the fundamental requirements for health in a community are of primary concern to public health.

Societal responsibility
vs
individual (couple) irresponsibility??

- “Economic management”. Treasury briefing document to incoming Labour Govt 1984 on public funding for childcare;

- “the assumption is not just that the benefits of childrearing do not compensate for the disadvantages in terms of loss of external work and educational opportunities, but
- that the public has no obligation to compensate for that net disadvantage from what would be (without compensation) the result of an irrational desire to have children. Or,
- in the case of unplanned children that the public should compensate parents for the unexpected net loss”.

What do we mean by evidence…

- Evidence is……
- Information we believe useful for making judgements about the worth of our practice.

- Whose evidence: who validates this evidence?
- researchers? health workers? community members? Politicians/funders?....

- What evidence:
- what worked (did it make a difference?), how it worked (how did it make a differnce?), who did it work for (who was impressed).

Evidence-based practice
or
practice-based evidence

- Evidence-production model

- Typically has separate roles for research producers and research users.

- Communities of practice: “Knowledge exchange” model

- Proposes model for researchers and practitioners where;

- Research based practices and policies emerge,
- from mutual discussion about health promotion problems,
- through negotiation to create and share technical standards, resources etc.

- Social and intellectual capital are built through the research and practice communities through mutual negotiation, reciprocity, trust and cohesion.

- McDonald, P. (2007). From evidence-based practice making to practice-based evidence making. Health Promotion Practice, 8, 2, 140-144.

Evidence base for population health: Staff views barriers and change strategies

- Survey 104 staff in Division of Population Health, S-W Sydney, serving disadvantaged urban population.
- 80% “strongly agreed/agreed” EBP would improve effectiveness of their work.
- 56% “strongly agreed/agreed” about lack of evidence for population health interventions.
- 82% “strongly agreed/agreed” that EPB training is important .
- 85% of those using EPB needed better skills for discriminating “good” and “bad” research.
- 30% said contradictory policy acts against EPB.

- Adily, A. & Ward, J.E. (2005). Enhancing evidence-based practice in population health : staff views, barriers, and strategies for change. Australian Health Review, 9, 4, 469-477.

Evidence-based practice in community services

- Orthodox approach to evidence-based practice falters at every step: from production of evidence to its use by practitioners.

- Suggests alternative evidence framework: three levels

- Micro: evidence from practice with groups, small communities.
- Meso: evidence from local studies, evaluations, audits, surveys, “action research”.
- Macro: evidence for published research literature.

- Micro and Meso can be accumulated to produce Macro evidence.

- All need to be integrated to produce “practical realist theories”

Burton, M. & Chapman, M. J. (2004). Problems of evidence based practice in community based services. Journal of Learning Disabilities, 8, 1, 56-70.

Evidence discourse: truth power and fascism.

- Evidence-based movement in the health sciences is “outrageously exclusionary and dangerously normative”
- Good example of “microfascism” at play in contemporary scientific arena.
- A dominant ideology that excludes other forms of knowledge, therefore acting as a fascist structure.
- A “regime of TRUTH” that enjoys a privileged status.
- Scholars have not only a scientific duty but also an ethical obligation to deconstruct these regimes of power.
- Holmes,D., Murray, S.J., Perron, A. Rail, G. (2006). Deconstructing evidence-based discourse in health sciences: truth power and fascism. International Journal of Evidence Based Health Care, 4, 3, 160-166.

Healthy Settings: Evidence for effectiveness

- Why such poorly developed evidence base after over 2 decades of healthy settings approach.

- Three key challenges;

- The way evidence is constructed
- Diversity of conceptual understandings and real-life practice
- Complexity of evaluating ecological “whole system” approaches

- Leads to evaluation of discrete projects in settings, fails to capture the “added value” of whole system working.

- Key issues:

- Funding evaluation within and across settings
- linking evidence, policy and practice, and
- clarifying and articulating theories that underpin settings approaches.

- Dooris, M. (2006). Healthy settings: Challenges to generating evidence of effectiveness. Health Promotion International 21, 1, 55.

Challenges to systematic reviews of public health interventions

Complexity due to;

- multi-component interventions,
- diverse study populations,
- multiple outcome measures,
- mixed study designs, and
- lack of detail on context effects on design, implementation, and effectiveness.

Context effects critical for policy makers, funders, though frequently missing from intervention s studies.

Issues re quality, worth/value and replicability missing from most studies

Jackson, N. & Waters, E. (2005). Criteria for systematic review of health promotion and public health interventions. Health Promotion International, 20, 4, 367-374.

Context in evidence-based public health

- Context plays important role in effective public health programmes
- But context seldom reported in systematic reviews of public health and health promotion interventions
- Proposes a template for measuring applicability and transferability of intervention effectiveness to other settings. List of settings' attributes, resources etc that can be rated to inform decision-making in local settings.
- Wang, S., Moss, J.R., & Hiller, J. E. (2006). Applicability and transferability of interventions in evidence-based public health. Health Promotion International, 21, 1, 76.

Evidence-based public health: value for developing countries?

- Population health initiatives critical for developing countries.

- Lack of evidence-based reviews relevant for developing countries priorities,

- Due to
- Limited resources for implementation,
- Lack of implementation infrastructure and other barriers to health,
- Complexity of broad intersectoral development goals, and
- Collaborative social policy initiatives.

- McMichael, C., Waters, E., & Volmink, J. (2005). Evidence based public health: What does it offer developing countries? Journal of Public Health, 27, 2, 215-221.

Evidence and Knowledge translation for health promotion practitioners

- Translating evidence into practice is challenging: Evidence on how to do this is limited.

- Practitioner survey on usefulness of specially commissioned evidence-based health promotion resources EBHPR.

- Results:

- Consistent agreement that EBP was important. (motherhood and apple pie!).

Evidence and Knowledge translation for health promotion practitioners

- Barriers to use of EBPHR

- Varied perceptions about what constitutes evidence
- EBHPR credibility diminished when clear disjunct between practice realities and research evidence.
- Practicality of recommendations influenced practitioners' perceptions of relevance.
- Limited use of EBHPR resources in planning interventions or guiding interventions
- Resources consulted on "ad hoc" basis rather than primary source.
- Felt need for capacity building in evaluating and applying evidence.

Evidence and Knowledge translation for health promotion practitioners

Attributes likely to increase use of resources.

- Short clear summaries
- Plain language explanations for translating resource into practice
- Case studies to illustrate planning, implementation and evaluation
- Practtioner consultation during development and dafting of resource
- Evidence provided about implementation
- Evidence on minority and disadvanteged groups.

Need for Knowledge management process from generation, synthesis, to translation. “Knowledge broker” concept.

Armstrong, R., Waters, E., Crockett, B. & Keleher, H. (2007). The nature of evidence resources and knowledge translation for health promotion practitioners. Health Promotion International, 22, 3, 254-260.