Runanga Whakapiki ake i te Hauora o Aotearoa
HEALTH PROMOTION FORUM
of New Zealand

keeping up to date

Keeping up to date - the 22nd edition

"About Keeping Up to Date
Each issue of *Keeping Up to Date* tells you about current research, evidence and thought on an important issue for your work in health promotion.

Keeping Up to Date reviews academic literature. It references some key articles, especially those that you can get download from the world wide web. If you have difficulty accessing any of the references, please contact us and we can point you in the right direction.

Each issue is peer reviewed. The Health Promotion Forum's Academic Reference Group is the editorial advisory committee for *Keeping Up to Date."*

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Title Health promotion effectiveness: intuition with evidence

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Context This 'Keeping Up to Date' aims to increase awareness of the reasons to use evidence in practice, to stimulate debate about evidence, and to encourage the health promotion workforce to contribute to the evidence base by designing, delivering, and evaluating rigorous programmes.

Health promotion and evidence
Significant evidence exists to justify spending money on health promotion initiatives to improve the health of populations. Within New Zealand, positive outcomes have been achieved in health literacy, supportive environments, policies, and structures, and more recently, the reorientation of health services (Wise & Signal, 2000). The latest report on progress of the New Zealand Health Strategy demonstrates improvements in a range of areas including housing, suicide, and smoking (Ministry of Health, 2005).

There is no doubt that health promotion, like any other field, should continue to provide the best value for the limited healthcare dollar. Resources need to be directed at activities which are likely to be the most effective. This requires the health promotion workforce to locate and evaluate the evidence on a range of interventions to determine the most effective method to tackle a particular health problem. This raises the question about the nature of evidence in health promotion.

In recent years the clinical area has been the main focus of evidence-based practice. This has arisen as a result of unnecessary delays in instituting effective interventions for patients and the high number of harmful interventions which may initially have

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appeared plausible and feasible. This is true too for many health promotion interventions which, at the beginning, appeared to make sense intuitively, but upon evaluation are shown to cause harm and increase inequalities. It can no longer be assumed that all health promotion programmes are beneficial for all involved (Macintyre & Petticrew, 2000). A harmful outcome, similar to an adverse effect in medicine, cannot be accepted in the field of health promotion. Therefore, basing decisions in health promotion on intuition does not always work. Mark Twain noted that the problem wasn't the things people didn't know that was the problem – it's the things they did know that were not true. Therefore, we need to integrate intuition and experience with what is likely to work, and within the New Zealand context there is a wide scope for increasing the use of evidence in practice and also for generating good quality evidence in the health promotion sector.

Evidence as one part of the decision-making process
Many decisions which are made on a daily basis in health promotion practice will rely on some form of evidence. Up to now, evidence on the effectiveness of interventions has dominated the literature. However, in order to identify the needs and health priorities of a community, health promoters will need to examine previous assessments of their community or carry out their own assessment. To examine the causal pathways for the diseases most prevalent in their community, practitioners will rely on epidemiological studies. Practitioners will then need to examine the range of interventions available for the specific health problem or target group (through evaluation research, reviews of interventions, etc) and determine if these interventions are likely to match the community preferences and values. Knowledge of the community values and preferences is also a form of evidence, collected through experience and intimate knowledge of the community, and/or qualitative research. Before embarking on any activity, health promoters should have assessed the evidence to determine which interventions are likely to be effective). In practice, health promotion professionals need to keep asking 'How do we know?'

Evidence of what works
Currently, many organisations throughout the world are working together to determine the criteria for evidence in the field of health promotion, to develop the capacity of the health promotion workforce to evaluate and apply evidence to their practice, and to encourage practitioners to generate their own quality evidence. The present debate about what constitutes evidence in health promotion and public health, is based partly on the values and ideologies of health promotion. These values impact on how evidence is defined and used in practice. There are also questions regarding the complexity and participatory nature of health promotion programmes which do not lend themselves to rigorous evaluation methods. If health promotion is about 'the process of enabling people to increase control over and improve their health' (World Health Organisation, 1986), evidence must examine the process of enabling and improving control (self-determination) and determine the impact of the initiative on healthy public policy, supportive environments, strengthening of communities, development of personal skills, and reorientation of health services. In addition, other health-related outcomes and behaviour changes should be assessed.

The varieties of questions practitioners ask on a daily basis suggest that health promotion evidence can take many forms. There is current agreement that there will never be one type of evidence that is superior for all purposes; it depends on the question being asked (Kemm, 2006; Jackson et al, 2004). To be able to determine the barriers and facilitators to healthy behaviour it is necessary to have an insight into the factors (eg. personal, structural) that relate to why some people choose to engage with health promoting behaviour or not. Questions also need to be asked to determine which types of interventions (and outcomes) are appropriate for communities. The process of enabling communities (or implementation of the intervention) also needs to be assessed. All of the above questions will require an in-depth exploration of the community or participants, usually achieved through qualitative research. Questions about the effectiveness of a programme to achieve positive health-related outcomes and behaviours, may utilise a more quantitative or mixed-methods approach. Caution would be placed on proxy measures of success (eg. knowledge, intentions to change) given the limited correlation these have to actual behavioural changes (Whitelaw, Baldwin, Bunton, & Flynn, 2000).

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The use of quantitative methods has been the traditional approach to gathering evidence of effectiveness. However, all too often in health promotion evidence is in the form of simple before and after studies. These study designs only provide weak evidence of effectiveness and the results of which may be misleading (Rosen, Manor, Engelhard & Zucker, 2006). It is, therefore, essential that health promotion evidence is rigorous. Hawe and others (2004) recommend that randomised controlled trials can be a useful form of evidence in health promotion, but they encourage us to rethink approaches to standardisation. They recommend it should be the function and processes rather than the traditional intervention components (such as content) which require standardisation. This would mean that evidence in health promotion would be judged according to adherence to intervention logic or the underpinning theoretical framework, as these are more strongly associated with a successful intervention.

Evidence of effectiveness needs to incorporate both quantitative and qualitative approaches to answer the questions 'what works?' and 'why does or doesn't it work?' Therefore, a pluralistic view of evidence in health promotion has now become widely recommended by practitioners and researchers, to better integrate process data with impact or health outcomes. The World Health Organisation (1998) and the International Union for Health Promotion and Education (1999) recommend that evidence in health promotion incorporate multiple methods for evaluation. In New Zealand, it is important that practitioners and researchers come together to openly discuss how we can move forward in determining the criteria for evidence and developing our own sound evidence base, relevant to our practice. The health promotion workforce also needs to determine realistic expectations for using and developing our own evidence in practice.

Community values and evidence

Community values and evidence of effectiveness can be married to form a healthy, constructive relationship. They intertwine like strands of DNA, and cannot be separated (Perkins, Simnett, & Wright, 1999; Raphael, 2000). Even when the evidence may support a particular intervention or programme, if it doesn't feel right for a practitioner it should not be carried out. The insights health promotion practitioners have into their communities will continue to be worth their weight in gold. What is important, however, is that evidence is an explicit part of the decision-making processes in health promotion practice. Consequently, skills in finding, evaluating and applying research to practice are fundamental for both an effective and ethical health promotion practice. These skills are acknowledged in the Health Promotion Competencies for Aotearoa-New Zealand (available at www.hpforum.org.nz) and the draft Public Health Practitioner competencies (www.pha.org.nz). Incorporating evidence into practice is not a threat to the professional experience and autonomy of the health promotion workforce. Knowledge of the community's needs and preferences will always be vital and should be considered a form of evidence. In addition, it is imperative that funders and decision-makers are aware of the benefits of using and applying research to practice and are explicit about the evidence which justifies their funding decisions. This could result in fewer 'quick fix' strategies demanded or recommended by funders, such as health education and resource development, as the evidence would signpost the likely ineffectiveness. In essence, if evidence was utilised more in funding decisions, it could reduce or eliminate ineffective strategies.

When there is no evidence: generating your own

Using evidence to aid decision making is not always possible. In order to make good decisions we need quality evidence. However, much of the health promotion literature does not contain conclusive evidence of effectiveness (Perkins et al, 1999). Also, much of the health promotion evidence available for making decisions is often at a reduced level of rigour and poorly evaluated (Nutbeam, 1998; Tilford, 2000; Rosen, 2006). This can be dangerous as a poorly designed evaluation may mask the harm of an intervention. A further difficulty is that much of the health promotion evidence may not be relevant to the particular context or to the needs of the population. In this case, practitioners will need to look for evidence of the effectiveness of the theoretical basis of interventions, rather than the intervention *per se*.

Given the lack of high quality evidence relevant to the New Zealand context, it is imperative that the health promotion workforce is involved in generating new evidence. Skills can be developed or shared within teams to collect and document evidence to disseminate to others who also work towards achieving public health goals. This process will

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produce evidence that is practice-based, which is in high demand by other practitioners. Health promoters can use the evidence generated to make funders more aware of realistic outcomes when only a limited resource pool is available for health promotion activities.

Health promoters must share their stories. Health promotion is an applied discipline; it needs to acquire knowledge from relevant and high quality evidence and apply it with reference to the values, interests and resources of the target communities.

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