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 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 difference?), 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.
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.

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”

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.

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.

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

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.

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.

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
  - EBPHR credibility diminished when clear disjunct between practice realities and research evidence.
  - Practicality of recommendations influenced practitioners’ perceptions of relevance.
  - Limited use of EBPHR 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
- Practitioner consultation during development and dafting of resource
- Evidence provided about implementation
- Evidence on minority and disadvantaged groups.

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