Using research for effective health promotion

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Vicki Strange is currently working on the RIPPLE trial: a randomized controlled trial of pupil peer-led sex education in schools. She is also undertaking doctoral research examining the utility of using randomized controlled trials for evaluating social interventions. Before joining the SSRU in 1997 she worked for Waltham Forest Education Authority, managing a team who provided supported employment services for adults with learning difficulties.

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The backdrop for this book is the widely held conviction that health promotion can bring improved health and stem the spiralling costs of health care. Set against that is the growing concern about the evidence base for public policy generally, and the crisis of confidence this provokes for health promotion in particular, where the evidence of effectiveness is scant. The inherent value judgements of recognizing good health, and doubts about the comparative costs and benefits of preventive strategies and treatment, place health promotion under close scrutiny. These problems are being addressed on an international scale by systematic efforts to draw together the research evidence of the effects of health promotion, as well as other health interventions. This book describes the international endeavours of the Cochrane Collaboration for health care (see Chapter 1) and those evolving with the support of the World Wide Web for health promotion specifically (see Chapters 5 and 13).

Within this context, UK policies for managing and funding health promotion often affect the ways in which providers are able to improve their services (see Chapters 3 and 11). Health promotion providers are increasingly called on to justify investment in their services in terms of effectiveness, and to compete for continued funding, often as part of an annual cycle. Such pressures argue in favour of the increased use of interventions known to be effective, but in practice these pressures lead to reduced time available for evaluating new services or drawing on previous research reports for planning services. Thus a rift has appeared between practitioners exhorted to offer effective interventions, and researchers with the skills to supply some of the necessary information. This book bridges this rift by discussing the theoretical underpinning of health promotion and experimental methods in social science in an integrated framework; and by providing time-saving tools to draw on research quickly and critically.
In 1995, the Social Science Research Unit (SSRU) received a three-year grant from the Department of Health (DoH) to establish and coordinate an international effort aiming to advance evidence-based health promotion. This grant allowed for the continuation of a research programme on systematic reviews, and the establishment of an information, resource and training centre to promote the use of research in decision-making in health promotion. This centre was originally named the Centre for the Evaluation of Health Promotion and Social Interventions (EPI-Centre) and has since been renamed the Evidence-informed Policy and Practice Information and Coordinating Centre (EPPI-Centre). Recognition of the role of evidence in policy and practice decisions is spreading. The Department for Education and Employment (DfEE) has recently commissioned a parallel stream of work in which the EPPI-Centre supports groups of people who are systematically reviewing the research literature about interventions in education. A third stream of work reviews the literature about service user or ‘consumer’ involvement in research, which informs the systematic reviews in education and health promotion. In each stream of work the focus is on ‘effectiveness’. This includes: what effective interventions are needed and are they acceptable, feasible and appropriate; how can effective interventions be developed; what interventions have proven to be effective, what have not and what seem promising; how and why are they effective (or not); in what (or whose) terms is effectiveness judged and how is it established?

Much of this book draws on the work that the EPPI-Centre team has undertaken since 1995, based on earlier work of the SSRU. It illustrates how our thinking and working practices have changed over time with the input from other researchers, policy makers and those delivering as well as those receiving health promotion services.

Over the past decades, health promotion has been struggling to establish itself as distinct from disease prevention, which is based on a medicalized notion of health and targets individual behaviour. Health promotion, on the other hand, strives to address the social, political and economic determinants of health seen as ‘a complete state of physical, mental and social well-being’, and to empower people to take charge of their own health. A lot of debate has therefore focused on what can really be called health promotion and how we know whether it works. Within this context the EPPI-Centre has taken the view that there is a wide range of interventions that potentially contribute to improving health, preventing disease and reducing disease impact and social inequalities. These interventions involve different sections of the public and different professionals; from health care workers addressing individual behaviour to politicians making policies on employment or housing conditions. In assessing the relative merits of such interventions, EPPI-Centre work has mainly focused on research on effectiveness, appropriateness and feasibility. As such, our work contributes to
building the knowledge base of health promotion – including different types of research, as well as expert and lay opinion, that need to be considered when making informed decisions.

Work funded by the DoH grant has focused on a range of health promotion topics mainly relevant to young people; an initial concurrent three-year grant from the North Thames Regional Health Authority focused specifically on sexual health promotion, including HIV/AIDS prevention. Though we necessarily had to focus our work on some areas of health promotion, our methods and tools are designed to apply, with little or no adaptation, throughout the field.

The methods used by the EPPI-Centre have been adapted each time a new research question is tackled, building on new advances in systematic reviewing and taking into account criticism from end-users to previous review efforts. The work of the EPPI-Centre has been strongly influenced by methodological advances in systematically reviewing the effects of health care, which have been led primarily by those working in the field of medicine. Details of methods have been adapted to accommodate practical problems more often encountered in health promotion than in medicine: for instance, a sparsity of randomized controlled trials; interventions aimed at communities rather than individuals; and higher attrition rates with healthy populations in non-clinical settings. The ensuing reviews showed that it was possible to apply systematic methods to reviewing the effects of social interventions, even though these may differ appropriately in their detail from methods developed in medicine.

EPPI-Centre work has also focused on how the findings of an effectiveness review depend upon how it is done: for instance, how studies are sought and what criteria are used to include or exclude studies from the review. As with reviews in other areas of health care, major differences in the conclusions about effectiveness were found between systematic and non-systematic approaches to reviewing. Non-systematic approaches suggest that the vast majority of interventions are effective, and systematic approaches which draw on a wide range of study designs (including non-trials) also offer excessively promising conclusions. However, systematic reviews based on sound methodological criteria generated considerable controversy among health promotion practitioners, and were perceived as disregarding study designs other than trials in the development of health promotion services. More recent EPPI-Centre reviews have therefore tried to accommodate more of the concerns of practitioners, particularly: the lack of attention to the theoretical basis and implementation of interventions; varying ‘quality’ of interventions; and an interest in reviews focused primarily on interventions, settings or populations, rather than health problems. These efforts draw on the willingness to combine qualitative and quantitative, or observational and experimental, approaches, and a commitment to consumer involvement in research.
What to expect from this book

Health promotion can be seen as a subset of all social intervention, or it can be seen as part of the broader health services. In this book we take the view that lessons can be applied from both social science and health services research.

This book is rooted in the fundamental principles of both health promotion and evidence-informed policy and practice. This has implications for how appropriate research is undertaken and how it is used to inform services. The book focuses on the integration of evidence of feasibility, evidence of acceptability and evidence of effectiveness and, as such, aims to contribute to the cross-sectoral debate on how evidence-informed services could make a difference to users’ health and satisfaction. It also provides practical tools to enable practitioners to apply their own judgement to research reports quickly and confidently, and describes new approaches to involving the public in evaluating health promotion services.

This book is of interest to all those wishing to contribute to the current movements towards effectiveness and consumer involvement in health services, including health promotion practitioners, service planners and lecturers and students of MSc and diploma courses in health promotion, public health, nursing, social work and voluntary services. In particular, health promotion practitioners may want to draw on it when: seeking to develop their understanding and critical use of research; preparing research-based service contracts; planning to strengthen their work with appropriate evaluation; preparing reports of their own work; or influencing the research agenda in health promotion. Funders may use it to be better aware of the opportunities and constraints for evidence-based health promotion when preparing contracts with service providers or researchers. Researchers may draw on the tools for identifying and reviewing research reports; for applying principles of integrating qualitative and experimental evaluation methods; and when considering practitioners and the public as co-directors of their work rather than just the subject of it. We hope that this book will also be a valuable tool for those who are targeted by health promotion research and practice; that it will increase their understanding and therefore their participation in setting the agenda, conducting the research and using the research findings.

The book is organized in four parts, each including a number of chapters. Some chapters provide the background and context of evidence-based health promotion; others present analyses of available research or offer tools to facilitate the use of research findings. Overall, the book is unique in describing and explaining advances in this field, and considering the relevance of research to service development and practice.

Part 1 has three chapters which are about theory and the need to ground health promotion in sound, methodologically diverse evidence. Chapter 1
addresses the theoretical underpinning of health promotion, its varying scope over time and its links with the social welfare field. It also discusses the position of health promotion within the move towards evidence-based health care. Chapter 2 looks at the origin of evaluation and describes the approaches that have been used to evaluate health promotion. It makes the argument for the integration of experimental and qualitative methods in developing evidence-based health promotion. In Chapter 3, the position of research in the decision-making process is discussed, and general ways of finding and classifying the widely dispersed research literature as a means to facilitating its use in service delivery are presented.

Part 2 provides in-depth discussion and practical tools to allow quick and critical use of research findings. Chapters 4 and 5 concentrate on how to find the evidence both quickly and comprehensively, including through accessing the World Wide Web. Once research reports are identified, there is a need for critically appraising the validity and usefulness of research findings, methods and tools for which are discussed in Chapter 6. Chapter 7 sets out how systematic reviews are undertaken and discusses the EPPI-Centre tools for analysing and integrating the findings from evaluation research in health promotion. It also signposts other sources of systematic reviews.

Part 3 takes young people’s health as a case study, and illustrates how the issues discussed in Part 2 can be practically applied within both primary and secondary research. How studies can be integrated in a systematic review to answer questions of effectiveness, as well as questions of appropriateness, is presented in Chapter 8. Chapter 9 investigates the extent to which young people have been involved in health promotion studies and suggests ways for improving their participation. Ideally, primary research includes participation of the study population and integrates different research methods. Chapter 10 discusses the opportunities and challenges in trying to achieve that in a currently ongoing randomized controlled trial of school-based peer-led sex education.

Part 4 explains how health promotion and its evaluation is changing with political pressures, and presents the opportunities for health promotion to play an important role in the interrelated movements of evidence-based health and consumer involvement. It argues that the desire to meet the information needs of different end-users must influence the research process. Chapter 11 sets out how skills development is necessary but insufficient as a means for facilitating evidence-based health promotion and indicates that there is also a need to change the context in which health promotion is being provided. In Chapter 12 examples are presented of how ‘consumers’ can be involved in research and how they have influenced the nature of research and the degree to which it may be used. Finally, Chapter 13 describes the political influences of health promotion research and discusses the growing enthusiasm for experimental social research and a needs-led
research agenda. It points to some important opportunities for better health in the future.

Evidence-based medicine has been led by medics, but evidence-based therapy, evidence-based nursing and evidence-based policy-making are increasingly attracting attention through journals and books. This book will lead the field in evidence-based health promotion and lay the foundation for evidence-informed education and public participation in research and policy development. These fields of interest deal with what are essentially social interventions, and overlap in their aim to educate and enable people to reach their full potential within the context of a conducive and supportive environment.

We have only just begun a long journey. Further advances will be recorded on the EPPI-Centre’s Web site (http://eppi.ioe.ac.uk/). We invite readers to engage in a dialogue with us and with their colleagues and friends to further, and to improve upon, the knowledge-base of health promotion.

_Sandy Oliver and Greet Peersman_
Part 1

Theory of health promotion and evaluation
What does promoting health entail?

Public health has been defined as ‘an organized response to the protection and promotion of human health which encompasses a concern with the environment, disease control, the provision of health care, health education and health promotion’ (Research Unit in Health and Behavioural Change 1995: xvii). An ageing population, rising health care costs, a widening social class gradient in health and pressure from health lobby groups have put public health firmly on the political agenda (Hawe et al. 1995). But because much of our economy is health-based and the discourse of health is so powerful, different groups and institutions have interests in how health and public health are conceptualized.

The face of public health has changed over time depending on the dominant disease patterns and the status of scientific advances and technological know-how to combat these. From the seventeenth to the nineteenth centuries, public health was preoccupied with eliminating diseases such as the plague, cholera and smallpox, which posed a threat to a large number of people. With industrialization and rapid urbanization in the nineteenth century, public health gained a broader vision, dealing with all aspects of environmental sanitation, including living conditions, mainly with the aim of securing a functioning working population (Lewis 1986). The bacteriological revolution and further scientific advances in the late nineteenth and early twentieth centuries shifted attention away from the social and structural causes of ill health towards personal hygiene and an increased interest in the ‘healthy body’ (Lewis 1986). Subsequently, three post-war eras led to the development of a health promotion policy in the USA: ‘the era of resource development’, which produced a disease-focused medical infrastructure; ‘the era of redistribution’, which introduced laws to give consumers
medical purchasing power and used health education to increase health service utilization; and ‘the cost containment era’, which aimed to control costs by decreasing the need for medical care and used health education to target appropriate use of health services and to advocate self-care (Green and Kreuter 1991). The term ‘health promotion’ emerged in US health policy in 1975, it is said, as a last minute substitute for the term health education, merely to avoid having the bills referred to the education committees where they would have died for lack of interest or priority (Green and Kreuter 1991). The publication of the ‘Lalonde Report’ (Lalonde 1974) in Canada and the ‘Healthy People Report’ (US Surgeon General 1979) in the USA institutionalized a vision that disease was strongly, although not exclusively, associated with controllable risk factors rooted in individual behaviour. The locus for change that might improve the public health clearly shifted away from social factors, such as housing, employment and income, to individual psychological factors, such as coping, social support and healthy lifestyle (Research Unit in Health and Behavioural Change 1995). Though public health strategies at the levels of institutional change, legislation and policy were included, they proved difficult to implement, especially in an era of fiscal conservatism (Minkler 1989). As citizen participation and self-care had taken the shape of a significant social movement, and represented a welcome relief for programme budgets, it was a short step for public health to shift its emphasis from institution building and centrally planned programmes to self-reliance, person-centred initiatives and individual participation in health (Green and Kreuter 1991). An additional advantage of stressing the individual approach was the voluntary nature of interventions that ensued and the protection of the right to choose one’s lifestyle, as opposed to the coercive tendency of state interventions trying to assert the interests, rights and obligations of the community against the individual (Yeo 1993).

The notion of health promotion in Europe had its origins in 1980 when the World Health Organization (WHO) Regional Office recognized that health education in isolation from other measures would not necessarily result in radical changes in health, and introduced a range of non-educational approaches which were designated ‘health promotion’ (Parish 1996). These centred on health as ‘a complete state of physical, mental and social well-being and not merely the absence of disease’, and focused on the social, political and economic determinants of health not amenable to improvement by medical care (Robertson and Minkler 1994). As such, health promotion provides an alternative to the medicalized notion of health, and aims to go beyond individual lifestyle strategies. Though it is often thought of as a ‘new’ concept, a development of the ‘new public health’ of the 1970s and 1980s, some authors argue that it is merely a ‘renaissance’ of a broad and encompassing concept of public health (Green and Kreuter 1991).

Similar trends in public health, from environmental engineering to health education, occurred in the UK (Bunton and MacDonald 1992). The first
Public Health Act emerged in 1848 as a direct result of the recognition that there is a relationship between poverty and ill health, linked to bad sanitation at home and at work. The second Public Health Act in 1872 created local medical officers of health, who initially had a broad remit to include sanitation and housing, but gradually drifted towards the biomedical aspects and lifestyle determinants of illness and disease. Health education in the UK started with the establishment of the Central Council for Health Education in 1927, for which the Society of Medical Officers of Health had lobbied. The principle functions of the Council were ‘to promote and encourage education . . . in the science and art of healthy living’, and ‘to coordinate the work of all statutory bodies in carrying out their powers and duties under the Public Health Acts . . . relating to the promotion . . . of Public Health’ (Bunton and MacDonald 1992: 10). While the Council took the first function to heart, mainly concentrating on lifestyle, it neglected the second, mainly ignoring structural approaches. Upon its foundation in 1948, the National Health Service (NHS) contributed about 50 per cent of its budget to local authority health education work (Sutherland 1987). After the 1974 NHS reorganization, however, health education became the responsibility of health authorities and was ‘officially’ separated from environmental health, which remained the responsibility of the local authorities. This separation further enhanced the medical dominance of health education. Though the Health Education Council in 1981 preferred to use the term ‘health promotion’ rather than ‘health education’, recognition of the fact that determinants of health were broader than just lifestyle (Health Education Council 1983) had little impact on policy. The emphasis on individuals rather than structures was continued with the publication of the Health of the Nation document by the Department of Health in the early nineties (Thomas 1993). Despite the medicalization of ‘health promotion’, particularly as it was practised by health professionals as an adjunct to their clinical care, health promotion attracted new specialists and voluntary sector workers who shared anti-authoritarian attitudes, were sympathetic to social science critiques of health promotion and favoured community empowerment approaches (Kelly and Charlton 1992). It is only recently that the UK government has refocused its attention to better health on a concerted action between national and local players, as well as the general public.

**What principles underpin health promotion?**

A large body of evidence has demonstrated the relationship between socioeconomic status and disease (Black *et al.* 1980; Whitehead 1992; Feinstein 1993; Kreiger *et al.* 1993; Davey Smith *et al.* 1994; Acheson 1998), but the gap between the health status of rich and poor is becoming wider still.
Logically, this means that giving special consideration to disadvantaged 
population groups and changing their social and material context is not 
only an ethical imperative, but also a promising route to better public 
health. According to Yeo (1993), health promotion ethics essentially needs 
to address two main issues: ‘distributive justice’ and ‘intervention ethics’. 
Distributive justice is aimed at clarifying principles and values for allocating 
resources to health, one of which is reducing inequity in health status 
within and across populations. Intervention ethics deals with assessing various 
health promotion interventions for their impact on cherished values such as privacy, freedom, responsibility and the common good (Yeo 1993). Intervention ethics could also, and perhaps foremost, address the fundamental admonition of ‘first do no harm’.

The Ottawa Charter for Health Promotion (1986), which emerged out of the first International Conference on Health Promotion, acknowledged that the basic prerequisites for any improvement in health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity, but how these are to be obtained is less obvious. Two decades later, the two million children that still die each year from diseases for which there are effective vaccines are testament to the lack of political will and commitment from individual governments as well as the international community to reducing these tolls (Nakajima 1998). Most of these deaths occur in developing countries, few of which have reaped the public health or other benefits of technological advances. Some argue that epidemiology has dominated and is still pivotal to public health teaching and practice, while the social sciences, which stress a broader view including social conscience, are largely ignored (Research Unit in Health and Behavioural Change 1995). Greater attention to the social sciences is, however, shown in health promotion today.

The centrepiece of the health promotion paradigm is the concept of empowerment – enabling people to increase control over and to improve their own health. Empowerment claims to attribute responsibility to people not for the existence of the problem, but for finding a solution to it. The goal is then ‘full and organised community participation and ultimate self-reliance’ (Yeo 1993: 233). Health promotion perceives the community as a setting or social system that has the potential to act as a resource to promote health from the bottom up (Macdonald and Davies 1998). The role of the health promotion professional is only to facilitate the strengthening or building of such communities. Some go as far as claiming that ‘if the activity under consideration is not enabling and empowering then it is not health promotion’ (Macdonald and Davies 1998). The vehicles for operationalizing this approach are based on settings where people live and work, such as Healthy Cities and Health Promoting Schools (Macdonald and Davies 1998). However, the extent to which its key strategies of empowerment and community participation have improved people’s lives or their health remains
virtually undocumented. In addition, little or no guidance is provided on how to deal with potential conflicts over perceived needs and resources between different communities and stakeholders, or between the agenda of the community and the larger agenda of equity and social justice (Robertson and Minkler 1994).

Health promotion, in essence, seeks to effect changes in the health behaviour of individuals. Health promotion practitioners are often eclectic in practice, using varied conceptual models for understanding and modifying behaviour, research methodologies and differing philosophical frameworks for contextualizing risk and protective behaviours associated with health promotion and disease prevention (DiClemente and Raczynski 1999). A wide range of theories and models have been developed to explain the factors that determine behaviour and the mechanisms by which they do so, such as the health belief model (Rosenstock 1974), the theory of reasoned action (Ajzen and Fishbein 1980), social-cognitive theory (Bandura 1986), the transtheoretical model of change (Prochaska and DiClemente 1986), the persuasion communication model (McGuire 1985), attribution theory (Weiner 1986), social network and social support theories (Gottlieb 1985) and the diffusion of innovations theory (Rogers 1995). This wide-ranging literature has led to some confusion about how theory can be used to guide the development, implementation and evaluation of health promotion interventions. Indeed, some argue that

attempts to change health-related behaviours by health educators and others have largely failed because of undue reliance on the literature of social psychology and the application of models of behavioural change which owe more to the cooperation of American college students than they do to an understanding of the context and complexity of the phenomenon itself.

(Research Unit in Health and Behavioural Change 1995: 67)

Although psychological theories have contributed to our understanding of how to motivate and maintain behaviour change, there is a need for health promotion programmes to incorporate more structural alterations (Macdonald and Davies 1998). A particularly useful contribution to the theoretical underpinning of health education and health promotion practice was presented by Bartholomew and colleagues (2001), who gave an overview of behaviour-oriented theories, mostly from behavioural sciences, environment-oriented theories and the socio-political sciences, mapped on to ‘ecological’ levels. The social ecological paradigm focuses on the inter-relationships between individuals, with their biological, psychological and behavioural characteristics, and the physical, social and cultural aspects that exist across the individual’s life domains and social settings. ‘The picture that emerges is a complex Web of causation as well as a rich context for intervention; looking for the most effective leverage points within this Web,
across levels, reduces the complexity and is necessary for the development of effective multi-level interventions’ (Bartholomew et al., 2001: 5).

An intervention method, then, is a defined process by which theory postulates how change may occur in the behaviour of an individual, a small group, or a social structure; and the translation of selected intervention methods into action is completed through the development of strategies, i.e. ways of organizing and operationalizing the methods (Bartholomew et al. 2001). For example, to increase fruit and vegetable consumption by children in the school canteen, methods of persuasion and modelling may be used to influence the purchasing practices of the food service manager. Strategies may include testimonials by food service personnel from other schools who already have incorporated healthier buying practices (Bartholomew et al. 2001). While health interventions can occur at many different levels (e.g. the individual, the family, the neighbourhood, the worksite, the organization, the community, the city), health interventions essentially have two basic targets: factors within the control of the individual, and factors outside the individual’s control (Cohen et al. 2000). Interventions targeting the latter are underutilized approaches for improving the nation’s health. However, some have claimed that ‘the individualistic approach will persist . . . because however misguided, [it] is less costly politically as well as for programme budgets, and for economies – at least in the short term’ (Yeo 1993: 399).

Challenges from medicine

Three major challenges face health promotion in the UK: competition from medicine for funds; the appeal and convenience of individualistic approaches for their apparent simplicity and low cost; and the medical dominance of NHS policy and practice. The dominant vision among health promoters today is that too much emphasis has been placed on the health care system – relabelled by some a ‘sickness care’ system – and that priorities need to be re-examined. Taking the field of HIV/AIDS as an example, Hunter and Chen (1992: 399) pointed out back in 1988:

It has become almost banal to assert that in the absence of an effective vaccine or treatment, education is the only weapon against the AIDS epidemic. Yet most funding worldwide still goes to clinical or laboratory research . . . Possible causes include lack of communication between the competing scientific cultures of the biomedical and social sciences, the influence in AIDS funding decisions of representatives of developed countries trained to look for technological solutions, and the frequent dominance of medically trained scientists with the same technological orientation in national AIDS committees in all countries.
More than ten years on, nothing much has changed in the balance between medicine and health promotion, and we are still waiting, unfortunately, for a technological solution to HIV/AIDS. As mentioned above, the NHS in the UK contributed about 50 per cent of its budget to local authority health education work in 1948 (Sutherland 1987). In 1996, on the other hand, spending on health promotion represented less than 1 per cent of the NHS annual budget, and less than the expenditure in staff cars and travelling and subsistence in 1995–6 (Speller et al. 1997).

Health promotion clearly needs to assert itself, but is further challenged by the medical dominance of policy and practice. Much health promotion practice is carried out by clinicians such as doctors, nurses, dentists and pharmacists, and health promotion policy falls within the management of consultants of public health medicine. These groups have been strongly influenced by the emergence of evidence-based practice as one of the dominant themes within the NHS in the UK.

The provision of health care is about making decisions, which often involves choosing between a number of alternative actions. In health promotion, there is a wide choice of interventions involving a range of professionals, practitioners and policy makers in different settings – from health care workers targeting individual behaviour to politicians making policies on employment, housing conditions, transport and so on, that potentially contribute to improving health, preventing disease and reducing social inequalities. In making a decision on where to allocate resources, we can draw on a wide variety of information, such as professional or personal experience, client preferences, external rules and constraints, and scientific evidence. Appleby and colleagues (1995: 5) state that ‘evidence-based health care in essence involves a shift in the culture of health care provision, away from basing decisions on opinion, past practice and precedent, and towards making more use of science, research and evidence to guide decision-making.’ Definitions of evidence-based practice vary, but they all have in common the drive to make informed decisions based, at least in part, on the best available evidence, i.e. sound evidence from rigorous research where available. No advocates of evidence-based health care would argue that evidence dictates what should be done in any particular circumstance, but instead they stress that research findings should always be considered together with the preferences of clients and professional judgement. Even in cases for which evidence is difficult to find or poor in quality, the decision-maker must search for it, appraise and present it, even if the decision taken may ultimately be dominated by values and resources (Gray 1997).

The problem of access to research evidence and skills for critically appraising it is a recurrent one, and fundamental to evidence-based policy and practice.

Anyone with the responsibility to help individuals and communities change health risk behaviour, initiate health-promoting behaviour,
change environmental factors, or manage illness must design or adapt existing effective interventions and develop plans to implement them. Yet there remains some confusion about how planners can integrate the wealth of information, theories, ideas, and models to develop interventions that are logical and appropriate in their foundations and are practical and acceptable in their administration. Seldom do health educators write in depth about the process of intervention development, and complicated interventions are often reduced to several sentences in evaluation articles.

(Bartholomew et al. 2001: 8)

Conducting, maintaining and disseminating systematic reviews of the effects of health care, including health promotion, is a logical step in the progress towards evidence-based health care. Systematic reviews are a short-cut to accessing and integrating the findings across individual studies. They differ from ‘traditional’ literature reviews in their methods, which consistently aim to limit potential bias and other errors. These methods are explicitly reported so that others can assess the integrity of the review process and, hence, the validity of the review. The very task of conducting systematic reviews, and thus increasing access to the best available evidence, has become the focus of a rapidly growing international group of individuals from a wide variety of backgrounds (including clinicians, sociologists, methodologists and consumers) who have formed the Cochrane Collaboration. The Cochrane Collaboration aims to help people to make well informed decisions about health care by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of health care interventions. So far, more than 900 systematic reviews on the effects of a variety of health care interventions have been completed and over 800 are in progress. These reviews, together with other resources, are widely disseminated as The Cochrane Library on CD-ROM or on-line (http://update.cochrane.co.uk). The Cochrane Field of Health Promotion and Public Health aims to facilitate the full integration of health promotion in evidence-based health care. Several systematic reviews of the effectiveness of health promotion interventions have been compiled (see Chapter 3). However, they have not always been received well, especially by health promotion practitioners (see also Chapter 11). This has been mainly due to criticism of the type of evidence incorporated in those reviews: primarily randomized controlled trials (RCTs).

**Challenges to trials**

Within the UK, as in many other parts of Europe, and in the USA, health promotion had to cope with a greater emphasis on monitoring and evaluation,
The view that evidence-based health service agendas are associated with new approaches to rationing is widespread (House 1993). In addition, there is concern about an over-concentration on outcome measures and quantitative data, which are seen by many as an outmoded and inappropriate way to measure the effectiveness of health promotion programmes (Macdonald and Davies 1998). Objective measures of health are often viewed as precluding one of the principles of health promotion: that communities should be involved in developing their own notions of positive health (Hancock 1993). Overall, there appears to be a tension between the focus of health promotion on subjective health and more standard definitions of preventing disease and illness, including economic considerations. Attempts to compare the cost-effectiveness of different interventions have been seen as having limited practical value because of the inevitable lack of comparability of outcomes between different projects (Burrows et al. 1995). Many evaluation techniques have been accused of being based on an unrealistic idea of what health promotion could or even should achieve (Macdonald and Davies 1998).

Towner and colleagues (1993) have specifically cautioned against RCTs being seen as the ‘gold standard’ in evaluating health promotion, since this may draw attention towards certain types of approaches, especially those targeting individual behaviour, which are not necessarily more effective but can be more easily evaluated with RCT designs. In addition, health promotion specialists have argued that it is often impossible to demonstrate causal links owing to the complex interplay of variables; and that there are inevitable time lags related to health status outcomes, often inter-generational. Essentially what critics are arguing is that health promotion programmes and interventions need to be assessed in relation to the social and structural influences that determine health. They therefore need to adopt an approach to evaluation that implicitly acknowledges the need for outcome data but explicitly concentrates on process or illuminative data that helps us understand the nature of that relationship.

(Macdonald and Davies 1998: 6)

There is an additional concern that, while health promotion aims to empower and should be participative, research is often developed in a non-participative manner. Alternative approaches to research that are action-oriented and community-controlled have been proposed (Hancock 1993). At first sight these are at odds with the application of the RCT design, with its standardized health outcome measures and the lack of appropriate emphasis on the practicalities of mounting health interventions. However, there are now several good examples of community-based RCTs, and other experimental designs, that have incorporated the needs of the targeted community, have invited the community to play an active role in the development and delivery
of appropriate interventions and have included qualitative methods which can offer critical and illuminating evidence of what happens during a programme. Several chapters in this book discuss these issues in more detail.

Evidence-based health care has developed in parallel with the growth of consumer involvement in health and ‘patient power’, with raised expectations for high-quality services and a justification of decisions made by health care providers (CASP 1999). This empowerment of individuals and communities requires professionals to be frank about the effectiveness of a particular intervention, and to provide comprehensive information in an appropriate way to those targeted by the intervention in order to enable them to share in the decision-making. Although clinicians place the patient at the centre of evidence-based health care, there is a tendency for them to project their own understanding of patient priorities rather than allowing patients to set the agenda. As patients’ opportunities for making their own choices increase, evidence-based medicine is challenged in much the same way as it has itself challenged health promotion. In fact, health promotion can draw on its longstanding experience with action research and community participation methods to make an important contribution to evidence-based health care. Here is an excellent opportunity for health promotion to take a leading role, rather than trailing behind medicine, in one of the central issues of evidence-based decision-making, one to which medicine has only recently opened itself up and has few lessons to offer: how to integrate the client perspective and methodological pluralism (combining qualitative and quantitative methods) in issues of effectiveness. Isn’t the aim to take the best of what we know and put it to use in a concerted effort to make a real difference in people’s lives? As Bartholomew and colleagues (2001: 7) put it, ‘The emphasis in health promotion is on participation, with a commitment to bringing both a community and a multi-disciplinary professional perspective to bear on a problem and create the most intelligent, productive consensus possible on the planning and conduct of health promotion activities.’

**Conclusions**

The key messages of this chapter are:

- Health promotion goes beyond a focus on individual lifestyles, to take into account the broader determinants of health. It goes beyond the perspectives of professionals, to include the active participation of communities.
- Evidence-informed policy and practice makes decisions based on the best available research evidence, moderated by client circumstances and drawing on professionals’ expertise, skills and judgement.

This book is rooted in the fundamental principles of both health promotion and evidence-informed policy and practice and offers suggestions for
reconciling apparent conflicts between the two. Health promotion has a unique opportunity to contribute to evidence-based methods, leading the way in how the client perspective and a methodological pluralism can be integrated in issues of effectiveness.

References

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