Health promotion impact factor: join up, no translation

An increasing number of national research funding bodies are becoming aware that research without impact may be of limited value. In terms of the current dominant science paradigm unless cost-effectiveness can be demonstrated then the results of studies are almost useless. This is evidenced for example by the Organization for Economic Co-operation and Development OECD, which has issued a number of reports looking at the social impact of the Research and Development enterprise. Most recently it has argued that its member states should invest more in intellectual and knowledge development rather than in further developing the hardware production sector, or industrial development (OECD, 2006).

This development should not cause alarm to the health promotion endeavor. It is, ultimately, our commitment to contribute—through research and practice—to improving human and ecosystem health, and achieving positive changes in the social determinants of health. However, our ambitions and the pathways that we choose to follow in the pursuit of these objectives may not be concordant with the standards that are being applied for judging our success.

For a decade or so the issue of ‘evidence’ has been the subject of much debate in the health sciences. The original idea was that only specific scientific research methods would establish credible evidence of effectiveness, preferably through randomized controlled trials or less-favored quasi-experimental designs. Fortunately, there seems to be recognition now that there are many more sources of evidence and ways of generating the knowledge that inform sound decision-making. This includes community testimonials, qualitative research and even anecdotal sources of information which together with more traditional academic procedures can assist policy developers and practitioners in making the best possible decisions. This is consistent with a call for the development of procedures to demonstrate social impact of health research by other means, for instance in The Netherlands (Smith, 2001).

The debate has thus reached a new level: how can the availability of evidence successfully influence policy and practice? One approach advocated by some national health research organizations (notably in Australia and Canada) is ‘knowledge translation’. This is defined as ‘the exchange, synthesis and ethically sound application of knowledge—within a complex system of interactions among researchers and users—to accelerate the capture of the benefits of research through improved health, more effective services and products and a strengthened health care system’ (CIHR, 2006). Whilst recognizing the complexities associated with putting knowledge into action, this terminology, to say the least, is suspect.

The notion of translation suggests that different languages are spoken in different realms, thus separating the realities of knowledge generation between different spheres: politics, practice, academe and community action. Knowledge generated in academe, it would appear, thus seems to be qualitatively different from knowledge generated in communities. Gibson (2004) demonstrates that this notion of different communities with different cultures is seriously flawed, and that other conceptualizations and practices around the joint generation and application of knowledge are required.

In itself the ‘translation’ discourse would be harmless if the interpretation is done reciprocally; we academics also need to listen to translation efforts that are directed towards academe from those ‘other’ groups. This is a common methodological practice to validate
research efforts in different ‘natural’ languages, but may not happen in the assumed interaction between health academe, decision-makers and communities.

As an aside, it is worth noting that this discourse can hardly be observed in any other sphere of social development. In areas of education, social justice, economics and elsewhere there is no need for ‘translation’, but rather for ‘knowledge transfer’, ‘diffusion’ or ‘utilization’. In contrast to Australia and Canada, other national health research councils, for instance in Finland and The Netherlands, do look at the inclusion of effective strategies to apply and diffuse newly generated knowledge in their assessment of research proposals.

The semiotic nature of ‘knowledge translation’ also signifies a much darker element. In those situations where academe can effectively separate its enterprise from those sectors where true impact is to be made, there is no apparent need to amend its procedures to what is truly needed. Research on and in communities can continue business-as-usual, whereas research with and for communities could comfortably be defined as esoteric, inappropriate, ineffective or too difficult to theorize, finance, develop, implement, analyze and report.

Perhaps surprisingly, the original proponents of a limited approach to evidence generation, participants in the Cochrane Collaboration, are only now struggling to take up Archie Cochrane’s challenge, phrased by Silagy (1999): “The Collaboration is an outstanding example of efforts to ensure that consumers not only are co-producers in the design and conduct of research, but also have the results fed back to them. This was one of Cochrane’s strongest beliefs.” In fact, the production of health, salutogenesis, is located initially within the realm of people, and not professionals. The invention and promotion of health—as well as the prevention of disease—comes about as the result of intricate interactions between society’s institutions, community values and contexts, and joined-up inquiry.

The articles in this issue of Health Promotion International suggest that the health promotion guild has already transcended the second stage in the evidence debate and has generated knowledge in joined-up environments with ‘other’ sectors, be they communities, the corporate world, policy-makers or voluntary associations. The authors from around the world (Australia, Finland, Israel, USA and Malaysia) tell us that work with communities and community institutions can effectively be developed, and that such endeavors create significant added value to our mutual understanding of what creates health. This work does impact demonstrably and favorably on salutogenesis. Health promotion researchers need to continue to focus on impact through a holistic joined-up approach and be accountable for their efforts rather than ‘handballing’ the hard stuff to a new tribe of health promotion interpreters.

Evelyne de Leeuw
Assistant Editor
E-mail: evelyne.deleeuw@deakin.edu.au

REFERENCES


