The question of evidence in health promotion*

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SUMMARY

Health promoters require credible evidence to identify relevant determinants of health, choose activities to promote health, and then evaluate the effectiveness of these chosen activities. The issue of evidence in health promotion is a complex one that requires critical examination of what is meant by health promotion, the focus of health promotion activities, and the ideological issues and principles that inform health promotion practice. It is argued that health promoters should be explicit about the principles and values behind their health promotion activities, and consider how ideology, values, principles and data interact to produce evidence. Resources that will provide assistance in these tasks are provided.

OVERVIEW AND PURPOSE

Evidence in health promotion is important because health promoters need justification for the decisions they make. Health promoters need to identify relevant determinants of health, choose activities to promote health, and then evaluate the effectiveness of these chosen activities. The issue of evidence has also become prominent in these times of economic rationalism as health promoters are increasingly being asked to justify their activities by providing evidence of effectiveness. This paper on the question of evidence in health promotion is based on three propositions. The first is that what counts as evidence in health promotion is a contested issue. I outline some of these debates and examine their implications for health promotion practice. The second proposition is that ideology, values and principles strongly influence what is accepted as valid evidence. I will argue that ethical health promotion practice requires explicit recognition of the interactions among ideologies, values, principles and rules of evidence. The third proposition is that decision-making in health promotion should draw upon local evidence even when conclusions from the health promotion literature are available. The issue of evidence in health promotion is especially timely given the increasing profile in the literature of terms such as evidence-based medicine, evidence-based practice and evidence-based health promotion. These concepts themselves need to be critically evaluated.

POSITIONING THE QUESTION OF EVIDENCE IN HEALTH PROMOTION PRACTICE

My first proposition is that the concept of evidence in health promotion is a contested issue. Much of what passes for fact in health care and health promotion has a ‘taken for granted’ quality (Berger and Luckmann, 1966). For example, many health care professionals and epidemiologists routinely define health as the absence of mortality and morbidity, and direct their attention to identifying causes of, and effective treatments for, disease. These are certainly important activities and epidemiological research

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programs—based on natural science research paradigms—frequently focus on individuals’ exposures to physical environmental agents such as micro-organisms and toxins and the outcomes of specific treatments. Ultimately, analysis is at the individual level and mechanisms are seen as involving cell pathology. The tool kit of research methods for those subscribing to these concepts of health are experimental, rely upon quantitative data, and are directed towards identifying linear cause and effect relationships between independent and dependent variables, whether the focus is on the causes of disease or the effects of treatment. Extrapolations of this way of thinking about health to lifestyle issues usually involve identifying individual risk factors and behaviours, and demonstrating cause and effect relationships between these risk factors and incidence of illness and death.

Contrast this with the research methodologies required to identify causes and effects when health is defined as ‘a resource for daily living ... a positive concept emphasizing social and personal resources, as well as physical capacities’ and health promotion is defined as ‘the process of enabling people to increase control over, and to improve, their health’ (WHO, 1986). The concepts introduced by these definitions include social determinants of health, individuals attaining control over these determinants, and a focus upon the communal in addition to the individual. This expansion of concern has led many to argue that traditional research methodologies, and their associated theories of health, are not appropriate for examining issues relevant to health promotion.

Within the literature there are varying rationales for health promotion. For example, the Saskatchewan Population Health Promotion Framework (Government of Saskatchewan, 1998) identifies the purpose of health promotion as being the reduction of mortality and morbidity, providing a resource for daily living, and improving quality of life. While on the surface, there would appear to be no logical grounds why these three concepts of health promotion are not made explicit (Seedhouse, 1997).

Evidence for what purpose
Paralleling these distinctions between health as the absence of disease and as a resource for daily living is Labonte’s outlining of three approaches toward health: the biomedical, lifestyle and socio-environmental (Labonte, 1993). In the biomedical approach, emphasis is on high-risk groups, screening of one sort or another, and health care delivery. The behavioural approach focuses on high-risk attitudes and behaviours, and developing programs that educate and support individuals to change behaviours. The socio-environmental approach focuses on high-risk conditions and considers how individuals adjust to these conditions or move to change them. Another way of thinking about focus is whether the key interest is upon the individual (including biomedical and lifestyle aspects), community (including social supports and connections), or structural (including community resources, policy decisions and distribution of economic resources) (Raphael, 1999; Raphael, 2000a).

Concretely, these distinctions translate into the following questions. Is health promotion about improving medical treatment? Is health promotion about changing lifestyles? Is health promotion about helping people cope with social conditions? Or is health promotion about changing social conditions? On the surface these definitions would not appear to be incompatible, yet they may be in practice. Additionally, it has been argued that each definition of health and health promotion involves a values position (Tesh, 1990; Seedhouse, 1997). And a values position directs attention to differing forms of evidence and the credibility of these forms of evidence. How issues of focus and values determine what counts as evidence constitutes the content of this paper.

Why is evidence needed?
Evidence is needed to reduce uncertainty in decision-making. Health promoters need to answer questions such as the following. What are the health problems? What are the causes of these problems? What are the health promotion activities that can lead to solution of these problems? How do we know whether we have been effective in solving these health problems?
Answers to these questions clearly depend on the definitions of health and health promotion held by the health worker. The health worker concerned with improving medical treatments may focus primarily on issues of patient compliance with treatment regimens. The health worker concerned with lifestyle issues will direct efforts to reducing tobacco use, increasing activity or changing diet. Another worker may enhance coping with social conditions by developing support groups for at-risk groups. A concern with changing social conditions will direct another workers’ efforts towards community development work or policy advocacy. Are all these activities consistent with health promotion thinking as outlined in the Ottawa Charter for Health Promotion? (WHO, 1986).

It is becoming increasingly apparent that progress in health promotion requires agreement on basic definitions and values. Seedhouse argues that failure to be explicit about definitions and values leads to conceptual confusion and sloppy practice (Seedhouse, 1997). While pluralism is certainly a worthy goal, the development of health promotion as a discipline requires closure on some key issues. Macdonald and Davies provide a compelling argument for accepting the Ottawa Charter definition of health promotion (Macdonald and Davies, 1998)—‘Health promotion is the process of enabling people to increase control over, and improve their health’ (WHO, 1986). For them, there are clear advantages in classification of activities for doing so:

The key concepts in this definition are ‘process’ and ‘control’; and therefore effectiveness and quality assurance in health promotion must focus on enabling and empowerment. If the activity under consideration is not enabling and empowering it is not health promotion [(Macdonald and Davies, 1998), p. 6].

This definition suggests that some useful and health protective activities may not necessarily be enabling or empowering. Examples that come to mind are standard medical treatments for illness, public health efforts of mandating polio vaccinations or restricting tobacco use, and government establishment of breakfast programs for children or shelters for the homeless. MacDonald and Davies (MacDonald and Davies, 1998) further argue that:

These concepts [of enabling and empowerment] are reflected in the action areas of the Ottawa Charter for Health Promotion [building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services] which fundamentally advocates a basic change in the way society is organized and resources distributed [(Macdonald and Davies, 1998), p. 6].

The implications of this view are noteworthy. First, health promotion is about enabling people to improve their health; and secondly, evidence relevant to health promotion should bear directly on factors that support or prevent enablement and empowerment (determinants of health), activities that support enablement and empowerment (health promotion), and assessing whether these activities have been successful (evaluation of health promotion). It also makes explicit the strong values statement that underlies health promotion work.

Defining evidence
Evidence reduces uncertainty in decision-making. Evidence is about reality, about what is true and not true. The nature of reality itself, however, is the basis for continuing debate in the social sciences, less so in the health sciences. Consensus is being reached within the traditional health sciences and within the health promotion fields of what constitutes evidence, but with little congruence between these fields. Are there the makings of a paradigm war?

Evidence-based approaches
Initial examination of definitions of evidence-based medicine would suggest pluralism in how the question of evidence is approached:

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice [(Sackett et al., 1996), p. 71].

A similar definition of ‘evidence-based health promotion’ suggests the same pluralism: ‘Evidence-based health promotion involves explicit application of quality research evidence when making decisions’ [(Wiggers and Sanson-Fisher, 1998), p. 126]. However, closer analysis
indicates that when issues of quality of evidence are considered, this pluralism is illusory. Wiggers and Sanson-Fisher, in writing about evidence-based health promotion, subscribe to the NHS Centre for Reviews and Dissemination (NHS Centre for Reviews and Dissemination, 1996) hierarchy of research evidence when information about effectiveness is needed.

Level I refers to at least one properly designed randomized control trial; II-1 corresponds to well-designed controlled trials without randomization; II-2 are well designed cohort prospective studies from more than one centre or research group; II-3 are well-designed case control retrospective studies, preferably from more than one centre or research group; III are large differences in comparisons between times and/or locations, with or without intervention; and IV are opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees. Dever provides a similar hierarchy for evidence in public health practice (Dever, 1997).

Clearly, the idea of ‘evidence-based’ knowledge does not extend to non-traditional methods associated with naturalistic, ethnographic or critical approaches. These evidence-based approaches emphasize experimental methods, quantitative data collection and analysis, and identification of linear cause and effect relationships. These forms of research tend toward an individualistic focus, to the detriment of contextual factors, and in their more extreme forms, only consider data concerned with physical and concrete phenomena. Additionally, it is argued that these methods are ‘objective’ such that hypotheses are tested by ‘putting the question to nature’ thereby allowing truth to emerge (Lincoln and Guba, 1985). Traditional public health medicine and epidemiological practice clearly reflects these assumptions.

Health promotion theory, principles and practice provide a direct challenge to this concept of reality. These challenges have been provided by writers in the general social sciences as well as in the health promotion field. Much of the criticism concerns the inappropriateness of traditional quantitative data analysis approaches for understanding human experience; an essential component of what constitutes health promotion activities (Raphael and Bryant, 2000). Additionally, the complex nature of the determinants of health and the process of health promotion may make traditional science methodology inappropriate for health promotion evaluation. The WHO European Working Group on Health Promotion Evaluation (WHO, 1998) concluded:

A multidimensional focus on the determinants of health and the impossibility of imposing tight environmental controls, or their unacceptability, are inherent features of most health promotion initiatives. The random clinical trial is often an inappropriate and potentially misleading means of evaluating these efforts. For a better understanding of the impact of health promotion initiatives, evaluators need to use a wide range of qualitative and quantitative methods that extend beyond the narrow parameters of randomized controlled trials [(WHO, 1998), p. 11].

Similarly, in the recent volume Quality, Evidence, and Effectiveness in Health Promotion, Macdonald and Davies write:

This traditional biomedical approach to evaluation has received a great deal of criticism in recent years and a consensus is undoubtedly emerging that an over emphasis on outcome measures and indeed on quantitative data is an outmoded and inappropriate way to measure the effectiveness of health promotion programs and interventions [(Macdonald and Davies, 1998), p. 8].

They go on to describe the traditional approach to deriving evidence as follows. ‘Its underlying ideology is expert-driven, authoritarian and disempowering; seeking evidence through narrow clinically based methods and short-term quantitative outcome measures’ [(Macdonald and Davies, 1998), p. 209]. One need not subscribe completely to these views to suggest the need for greater pluralism in considering the nature of evidence.

THE CASE FOR PLURALISM IN HEALTH PROMOTION METHODOLOGY

A key criticism of traditional methodological approaches is their inability to focus upon the lived experience of people (Bryman, 1988). Concerning the assessment of need and the identification of the causes of behaviour, many community members’ experiences involve complex patterns of interactions and situations that are rarely dealt with through traditional approaches. Lincoln has argued that the most effective way of understanding the kinds of health-related issues that health promoters are concerned with is by discerning individuals’ perceptions and constructions of events (Lincoln, 1994). Blaxter’s, Williams et al.’s
and Williams and Popay’s work on the meaning of health and staying healthy among community members is a striking example of the richness of insights that cannot be easily assessed by traditional approaches (Blaxter, 1990; Williams et al., 1995; Williams and Popay, 1997). The increasing popularity of qualitative methods is a result of a perceived failure of traditional methods to provide insights into the determinants—both structural and personal—of whether people pursue or do not pursue health-promoting actions.

There is also increasing concern that traditional approaches may not be appropriate for detecting and evaluating changes in the community and societal conditions that support health. Changes that occur as a result of health promotion activities are complex, emergent, and frequently unique to individuals and situations. Baum argues that for many community health promotion activities it is impossible to specify simple cause and effect relationships between independent and dependent variables either before, during or after the health promotion activity (Baum, 1998). This is not to say that such projects are not important or evaluable, but that traditional methods are not the best means of detecting and evaluating program effects, both simple and complex.

Additionally, evaluations of health promotion activities need to be able to detect changes in the conditions that support health. Changes that occur as a result of health promotion activities are complex, emergent, and frequently unique to individuals and situations. Nutbeam distinguishes between health promotion outcomes and health outcomes (Nutbeam, 1998). Many health promotion outcomes are emergent and require use of a paradigm that is sensitive to unanticipated effects. Consistent with this is a need to focus upon process measures that can detect changes in aspects of social capital and cohesion. Indeed, it is suggested that these aspects of communities should be seen as valuable outcomes in their own right. An emphasis upon community members’ and health promoters’ perceptions and interpretations makes detection of such effects more likely.

These kinds of concerns led the WHO-EURO working group (WHO, 1998) to recommend that policy makers should ensure that a mixture of process and outcome information is used to evaluate all health promotion initiatives, and policy makers should support the use of multiple methods to evaluate health promotion initiatives [(WHO, 1998), p. 6]. Davies and Macdonald suggest focusing on process and intermediate indicators sensitive to changes in the environments that support health (Davies and Macdonald, 1998). What sorts of evidence could be gathered from such pluralist efforts?

**Various types of evidence**

Park (Park, 1993) outlines three forms of knowledge/evidence: instrumental; interactive; and critical (Table 1). Each form of evidence can be used to identify determinants of health as part of needs assessments and assess effectiveness of health promotion activities through evaluations (Williams and Popay, 1997).

Instrumental knowledge is also known as traditional, scientific, positivist, quantitative or experimental knowledge. Instrumental knowledge is developed through traditional scientific approaches and is concerned with controlling physical and social environments. Its philosophical traditions include positivism and operationalism. Instrumental knowledge is drawn from traditional research and data collection methods using truth criteria such as internal and external validity of design, and reliability and validity of measurement.

Examples within health promotion needs assessments involve the systematic collection of mortality and morbidity data about communities. Surveys can elicit information about income, availability and use of services, as well as elements of lifestyle. Data can also be collected about societal structures, community aspects, in addition to individual-level data. This is the dominant approach used within public health to identify need. Similarly, traditional methods can be used to evaluate effectiveness through use of experimental, quasi-experimental and non-experimental methods (Wiggers and Sanson-Fisher, 1998).

### Table 1: Three forms of knowledge (Park, 1993)

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<thead>
<tr>
<th>Form of Knowledge</th>
<th>Description</th>
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<tbody>
<tr>
<td>Instrumental knowledge</td>
<td>Developed through traditional scientific approaches. It is concerned with controlling physical and social environments.</td>
</tr>
<tr>
<td>Interactive knowledge</td>
<td>Derived from sharing lived experiences. It is concerned with understanding and the connections among human beings.</td>
</tr>
<tr>
<td>Critical knowledge</td>
<td>Derived from reflection and action on what is right and just. It is concerned with raising consciousness about the causes of problems and means of alleviating them.</td>
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Interactive knowledge is derived from lived experience. It is also known as constructivist, naturalistic, ethnographic or qualitative knowledge, and its focus is on meanings and interpretations provided to events by individuals. Its theoretical bases are phenomenology, symbolic interactionism and grounded theory. Interactive knowledge is concerned with understanding the connections among human beings using truth criteria of credibility, dependability, confirmability and transferability (Lincoln and Guba, 1985).

Two needs assessment approaches working within this paradigm are the Pathways to Building Healthy Communities in Eastern Nova Scotia Project (PATH Project, 1997) developed by the Antigonish Women's Association, Eastern Regional Public Health Nursing Services, and the Extension Department of St. Francis Xavier University and the Community Quality of Life Project developed by the Centre for Health Promotion, and the Lawrence Heights and South Riverdale Community Health Centres in Toronto (Raphael et al., 1998a; Raphael et al., 1998b; Raphael et al., 1998c; Raphael et al., 1999).

The Pathways project adapts the story-telling technique developed by Labonte and Feather for use by community members to identify components of and determinants of health (Labonte and Feather, 1996). Community members are asked to tell stories that demonstrate some aspect of health based on personal experience. The group then goes on to summarize what happened in the story, why it happened and what has been learned from this experience. This kind of information is used to identify relevant determinants of health, and then identify means of addressing the issue. An evaluation tool is designed to allow for assessment of success of such efforts. Analysis of stories is also carried out within the framework of determinants of health developed by Health Canada.

In the Community Quality of Life Project, community members, service providers and elected representatives discuss aspects of the community that support or do not support quality of life. They are also asked to discuss community efforts to support health, and barriers and supports to such efforts. These responses are used to create community profiles that identify needs to be addressed and strengths that should be preserved. Findings are interpreted in terms of the determinants of health and the health promotion action areas of the Ottawa Charter. There are a number of texts that provide guidelines for carrying out qualitative evaluations (Patton, 1987; Patton, 1990; Creswell, 1994; Denzin and Lincoln, 1994). Baum (Baum, 1998) and Scott (Scott, 1998) specifically discuss qualitative evaluation in health promotion activities. The journal Qualitative Health Research is a rich source of examples of qualitative evaluations of health-related activities.

Critical knowledge is also known as reflective knowledge. Examples of critical knowledge approaches are critical, materialist or structural, and feminist theory. Critical knowledge is derived from reflection and action on what is right and just. It is concerned with the role that societal structures and power relations play in promoting inequalities and disenabling people. The goal of such research is to illuminate these health-harming societal structures and raise consciousness about the causes of problems and deriving means of alleviating them (Fay, 1987).

The journal Critical Public Health is devoted to critical examination of public health and health promotion issues. Some recent examples of health promotion work within the critical tradition include examinations of health promotion models by Collins (Collins, 1995) and Eakin et al. (Eakin et al., 1996). Travers carried out a study of structural issues underlying nutritional inequalities (Travers, 1996), and McIntyre et al. critically examined whether children’s feeding programs in Atlantic Canada were reducing or reproducing inequities (McIntyre et al., 1999). Raphael et al. examined community perceptions of the effects of Ontario government policies upon health in relation to public health’s continuing neglect of policy issues (Raphael et al., 2000). Everitt and Hardiker discuss the characteristics of a critical approach to evaluation (Everitt and Hardiker, 1996).

There is, therefore, increasing attention being paid to interactive and critical approaches in health promotion. Systematic overviews of evaluation issues in health promotion are now available (Peberdy, 1997a; Peberdy, 1997b). Indeed, a consensus seems to be emerging that these latter forms of evidence are essential to answer the kinds of questions increasingly being asked by health promoters:

There is a growing realization that traditional logical positivist approaches to health promotion research and evaluation no longer provide the right questions (or indeed answers) for many health promotion interventions. These approaches tend to be firmly rooted in the biomedical model and the origins of disease,
which although the mainstay of many early health promotion research programs, are now giving way to more pluralist, post-modernist approaches, based on the origins of health [(Macdonald and Davies, 1998), p. 1].

The increasing attention being paid to alternative types of evidence in health promotion greatly expands what can be termed as acceptable evidence for health promotion decision-making (Guba, 1990). The question frequently raised about these methods is whether these forms of knowledge are objective. One of the main arguments against non-traditional approaches is their supposed lack of objectivity. It has been argued that in traditional approaches, the test of hypotheses is put to nature with truth emerging in the form of facts. Kuhn among others criticized this idea by showing how facts are interpreted within the light of existing paradigms or world views (Kuhn, 1970). More recently, it has been argued that virtually all knowledge concerned with understanding human behaviour is socially constructed, a concept familiar to behavioural psychologists who have always accepted the idea that constructs exist within the minds of those creating the operational definitions used to describe behaviour (Kerlinger, 1986). It should not be surprising then, that what constitutes evidence in health promotion is influenced by one’s world views; which themselves reflect commitment to principles and values as well as one’s theory of society. For some, the idea that ideology and values influence what qualifies for evidence is disconcerting.

THE ROLE OF IDEOLOGY AND POLITICS IN HEALTH PROMOTION

The second proposition of this paper is that ideology, values and principles strongly influence what is accepted as valid evidence. Ideology is the world view or frame of reference that one uses to interpret a phenomenon. Sylvia Tesh’s (Tesh, 1990) book *Hidden Arguments: Political Ideology and Disease Prevention Policy* examines the role of ideology and values in ongoing debates on the causes of illness. During the 19th century the competing views on the causes of illness were the contagion, supernatural, personal behaviour and miasma theories. Each had associated political ideologies associated with it, and competing beliefs about economics and society frequently determined who advocated each disease approach. In the end, the revolution in public health sanitation that began in England in 1848 was due to the demonstrated health benefits that accrued from belief in and action consistent with the miasma theory. The miasma theory of disease—that disease was caused by bad smells—was eventually shown to be inaccurate.

If this all seems somewhat quaint, compare these theories with 20th century debates in health and health promotion. Tesh saw 20th century competing theories as being germ, lifestyle and environmental. Gene theory can be added to these three. Tesh argues that adherence to a particular theory may be based more on ideology and values than the objective evidence associated with each theory. In current health promotion debates about the determinants of health, ideology plays itself out in debates about the relative importance of personal and structural factors in determining health.

Consider the implications of phrasing some current health promotion issues in differing ways (Table 2). If the issue is seen as smoking, the focus is on individuals and the choices they make. If the issue is phrased as involving tobacco, questions arise as to the role of corporations, government support of tobacco growing, and continued marketing of tobacco through sponsorships and advertising. Similar analyses are easily made of the other contrasting statements about health issues presented in Table 2. Another striking example of the role that ideology can play is the contrast between the 10 tips for better health provided by the British Medical Officer Liam Donaldson and Professor David Gordon of Bristol University (Table 3). The former sees the determinants of health as primarily involving lifestyle choices and within individual control, the latter conceptualizes health determinants as primarily structural and beyond individual control.

**Table 2**: Impact of how health issues are framed

| ‘Cigarette smoking causes cancer’ versus ‘Tobacco causes cancer’. |
| ‘Eating junk food causes obesity’ versus ‘The marketing of junk food causes obesity’. |
| ‘Poor people have poor lifestyles’ versus ‘Poverty causes poor health’. |
In addition to the impact of ideology on problem definition, ideology influences the extent to which ‘evidence’ is accepted. Tesh discusses the ambiguity that exists in findings of the relationship between lifestyle factors and illness, yet lifestyle efforts in health promotion continue unabated (Tesh, 1990). While there is no ambiguity related to the findings of the effects of homelessness, poverty and low income upon health, there is little emphasis on alleviating poverty within the mainstream media press, among traditional public health workers and governments (Canadian Institute on Children’s Health, 1994; Raphael, 1998; Raphael, 2000b).

Similarly, Seedhouse argues that every health promotion activity has an underlying political ideology: ‘All health promotion—even the most routine and mundane—is based on one political philosophy or another’ [(Seedhouse, 1997), p. 69]. Seedhouse argues that biomedical approaches—despite their protestations of objectivity and detachment from politics—reflect values of prudence, preserving the status quo and conservatism. Similarly, he sees community development approaches as representing values of egalitarianism and social democracy. Seedhouse argues that all health promotion decisions involve aspects of ideology. This is not in itself problematic. What is problematic is not making explicit the values base underlying health promotion decisions. Ideology leads to concentration upon certain factors, variables or issues to the exclusion of others. Biomedical researchers ignore community and societal factors in their studies and discount evidence related to these issues. Lifestyle advocates minimize structural issues in their work and downplay structurally related evidence. Structural advocates minimize lifestyle choice issues and the importance of this kind of evidence.

How do health promoters determine what is credible evidence? Do health promoters make decisions on the basis of evidence or on the basis of values? It does not appear that one has to depend on one or the other; indeed they cannot be separated. Facts and values constantly interact in a dialectic such that each continually affects the other. Tesh argues:

> "The reality that truth is only discoverable by human beings, in all their humanness, does not mean that we must abandon the hope of finding it. We just have to hold facts lightly, continually testing them against experience and logic, recognizing their connections to the rules and contexts within which they appear, and more important, never ceasing to scrutinize the values that necessarily permeate them [(Tesh, 1990), p. 177]."

\*Bring values and principles to the fore in health promotion*

Such an analysis suggests a need to bring the values and principles that permeate health promotion to the fore in an attempt to identify the kinds of

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**Table 3: The role of ideology in health promotion**

<table>
<thead>
<tr>
<th>Ten tips for better health (Donaldson, 1999)</th>
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<tbody>
<tr>
<td>(1) Don’t smoke. If you can, stop. If you can’t, cut down.</td>
</tr>
<tr>
<td>(2) Follow a balanced diet with plenty of fruit and vegetables.</td>
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<tr>
<td>(3) Keep physically active.</td>
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<td>(4) Manage stress by, for example, talking things through and making time to relax.</td>
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<tr>
<td>(5) If you drink alcohol, do so in moderation.</td>
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<tr>
<td>(6) Cover up in the sun, and protect children from sunburn.</td>
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<td>(7) Practise safer sex.</td>
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<tr>
<td>(8) Take up cancer screening opportunities.</td>
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<tr>
<td>(9) Be safe on the roads: follow the Highway Code.</td>
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<tr>
<td>(10) Learn the First Aid ABC—airways, breathing, circulation.</td>
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<tr>
<th>An alternative 10 tips for better health (Gordon, 1999)</th>
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<tbody>
<tr>
<td>(1) Don’t be poor. If you can, stop. If you can’t, try not to be poor for long.</td>
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<tr>
<td>(2) Don’t have poor parents.</td>
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<tr>
<td>(3) Own a car.</td>
</tr>
<tr>
<td>(4) Don’t work in a stressful, low-paid manual job.</td>
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<tr>
<td>(5) Don’t live in damp, low-quality housing.</td>
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<tr>
<td>(6) Be able to afford to go on a foreign holiday and sunbathe.</td>
</tr>
<tr>
<td>(7) Practise not losing your job and don’t become unemployed.</td>
</tr>
<tr>
<td>(8) Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.</td>
</tr>
<tr>
<td>(9) Don’t live next to a busy major road or near a polluting factory.</td>
</tr>
<tr>
<td>(10) Learn how to fill in the complex housing benefit/asylum application forms before you become homeless and destitute.</td>
</tr>
</tbody>
</table>
evidence that are particularly relevant. What are some of the values that are intrinsic to health promotion? Tonks considers principles [values] as either ideological or functional (Tonks, 1996). Ideological principles are about how things should be, and functional principles are about how to best bring about a moral end. His health promotion principles are health, equity, healthy public policy, reorientation of health services and empowerment. As noted earlier, the Ottawa Charter contains principles of enablement and empowerment, equity and justice. The Saskatchewan Framework for Population Health Promotion (Government of Saskatchewan, 1998) outlines principles of respect, participation, sharing resources, social justice, and concern for the environment. The WHO-EURO Working Group on Health Promotion Evaluation (WHO, 1998) outlines the following principles for the evaluation of health promotion initiatives: participation; multiple methods; capacity building; and appropriateness.

These values may conflict, and Seedhouse (Seedhouse, 1997) provides an interesting illustration in relation to tobacco use as a public health problem. He provides contrasting arguments on whether smoking should be encouraged (e.g. smoking saves health care costs, promotes employment and improves coping) or whether it should be discouraged (e.g. leads to premature death, reduces capacity, smells). The point being made is that even with the most taken for granted health promotion activity, there are values underlying the activities that need to be made explicit. In Ethics: the Heart of Health Care, Seedhouse (Seedhouse, 1997) describes how use of his ‘Ethical Grid’ can help in making values and their influence on decision-making explicit. Users can consider the extent to which decisions that are made are consistent with principles of creating and respecting autonomy, doing good, considering the costs and benefits to community members and the society at large, disputed evidence, codes of practice, and the law, among other considerations. The interaction of forms of evidence, ideology, and values and principles is presented in Figure 1.

MAKING DECISIONS—DEALING WITH UNCERTAINTY IN UNCERTAIN TIMES

The third proposition in this paper is that decision-making in health promotion should draw upon local evidence even when conclusions from the health promotion literature are available. But prior to doing so, the health promoter must take the time to consider the purposes of their activities, the values that permeate these activities, and the degree to which these activities must conform with stakeholder concerns and requirements. Concerning needs assessment, Hancock and Minkler discuss the tensions that exist between varying approaches to needs assessment and outline means of assuring the activities are value based (Hancock and Minkler, 1997). Raphael does the same concerning evaluation of health promotion initiatives (Raphael, 2000c).

In addition, health promoters should also consider the information that is available from previous work and the health promotion literature. Concerning the latter, health promoters require justification for their activities and there is ample evidence that health promotion activities can be so justified. I deal with the justification issue first.

Justifying health promotion activities

Enough evidence is now available to justify health promotion as a discipline that can improve the health of the population. Evidence concerning the impact of the determinants of health is available, whether one wishes to choose a biomedical, lifestyle or structural approach (Raphael, 1996). The World Health Organization document ‘Social Determinants of Health: The Solid Facts’ (Wilkinson and Marmot, 1998) provides the evidence for considering each of the following as a significant determinant of health: the social
gradient; stress; early life; social exclusion; work; unemployment; social support; addiction; food; and transport. The document also discusses program implications and implications for health promotion of sets of findings for each issue.

Wilkinson’s Unhealthy Societies: the Afflictions of Inequality summarizes findings to 1996 on how economic inequality within a society produces poor population health (Wilkinson, 1996). Recent volumes document how widening economic inequality is related to population health in Canada (Townsend, 1999), the USA (Kawachi et al., 1999), and the UK (Acheson, 1998; Shaw et al., 1999). Raphael considers the mechanisms by which economic inequality influences health (Raphael, 1999; Raphael, 2000a), and Montague provides careful popular summaries of this literature (Montague, 1996; Montague, 1998). The University of Washington maintains an Internet site with evidence related to this issue (International Health Program, 2000). The implications of social inequities in health within the European context are discussed in the World Health Organization document ‘Social Inequalities in Health: What Are the Issues for Health Promotion’ (Whitehead et al., 1998). Within Canada, the National Forum on Health (National Forum on Health, 1998) produced three large volumes that summarize the factors that determine health.

Similarly, an ever-growing literature discusses issues concerning the effectiveness of health promotion activities (Macdonald et al., 1996; Naidoo and Wills, 1998). One of the most recent and thoughtful reviews of the effectiveness of health promotion was carried out by Hyndman (Hyndman, 1998). In this detailed monograph, Hyndman reviewed the history of health promotion and carefully outlined the various meanings of the concept. After considering differing forms of knowledge related to research and evaluation, Hyndman considered the evidence of effectiveness of health promotion in relation to the five action areas of the Ottawa Charter: strengthening community action; developing personal skills; building healthy public policy; creating supportive environments; and re-orienting health services. Hyndman concluded:

There is substantial evidence that health promotion has contributed to maintaining and improving the health of individuals, communities and populations. It is also clear that more substantial outcomes are likely to be achieved if more than one strategy is employed, as the five strategies of the Ottawa Charter are synergistic and most effectively used in combination [(Hyndman, 1998), p. 69].

Quality of evidence: thinking and acting locally

While there is enough accumulated evidence to assume that what health promoters do is generally valid, health promoters will carry out local needs assessment, design local programs and evaluate local activities. There are two main reasons for carrying out such local activities. The first is that frequently information concerning the local situation may not be available. Even when information is available about an issue, community or situation, fresh data collection will usually be necessary because the form of the available information has not involved the collection of interactive or critical knowledge from those whose health we are concerned with.

The second reason for carrying out fresh data collection is to develop a process by which the community is involved from the beginning of needs assessment right through to the evaluation of outcomes. The idea that health promotion can be carried out without immediate community involvement is antithetical to basic principles of health promotion. Such involvement also makes it likely that results of such activities can be used to good effect.

In these cases, evidence needs to be created. What determines the quality of these efforts? The question: Have we collected credible evidence of need? must be addressed. At a later point the question, Was the health promotion activity effective? must be answered. The purposes of the activities, reflecting in part the chosen approach to health promotion, must be reconciled with the values and principles (e.g. empowering and enabling, respect, participation, sharing resources, social justice, etc.) of health promotion. Whatever methods are used, there are rules for establishing the credibility of the conclusions reached.

For traditional studies, design considerations usually predominate. Was the sample representative? Are the data reliable and valid? Are there threats to the validity of the design? For interactive studies, truth criteria have been outlined by Lincoln and Guba (Lincoln and Guba, 1985). These include issues of credibility: time spent in the field, validation of findings by collaborators and participants, triangulation of findings through
differing methods and sources of information. The questions asked about quality are: Have the researchers persuaded us that they have captured and described the interpretations and meanings held by participants? Are the findings plausible considering our own experiences and beliefs? Truth criteria in critical theory are more complicated and involve a combination of both instrumental and interactive knowledge truth criteria. Additionally, findings from critical theory should illuminate how the observed phenomena reflect structural aspects of society, illuminate the role of power relations within society, and lead to means of moving towards a more just world (Lincoln, 1995).

Consistency with mandates and stakeholder concerns

Once health promoters have made explicit their assumptions, examined their values, and determined the kind of data they would prefer to collect, they have to recognize their own situation within the world. Health promoters do much of their own work under particular mandates of what is acceptable work. The health promotion policy environment is different across countries, states or provinces, and even local employment sites. Many health promoters are faced with satisfying stakeholders whose research world views are predominantly traditional and require what is seen as generalizable quantitative knowledge. A paradigm shift is under way and health promoters should be able to forcibly argue that pluralism of methods is called for in health promotion work. Some of the examples of non-traditional activities presented in this paper should help support such calls for pluralism of methods.

Additionally, health promoters must consider what is practical concerning available resources. Non-traditional methods may be more labour and cost intensive than traditional methods. One means of dealing with these costs is to incorporate needs assessment and evaluation into the ongoing activities of health promoters in a manner that minimizes costs.

CONCLUSION: MAKING THE IMPLICIT, EXPLICIT

In conclusion, it is important to recognize that the quality of evidence is influenced by a range of conceptual and technical factors. To date, it has generally been believed that only traditional or instrumental forms of knowledge are valid. Alternative forms of knowledge are as valid as—or even more valid—than traditional approaches for the kinds of issues health promoters deal with. It is important that the various forms of evidence be collected, documented and shared with others in health promotion. Some of the resources provided in this paper should assist in this task.

These conceptual issues may seem daunting to health promoters as most public health and community health agencies and funders do not make explicit the paradigm within which they are working and set tight guidelines and narrow goals for public health funding. Nevertheless, the relationship of evidence to the ideology and values of health promotion should be made explicit and such evidence should be evaluated according to the truth criteria associated with the knowledge type. The guidelines presented in Table 4 should assist in these tasks.

Health promotion is proving to be effective in improving the health of the population. That such is the case is probably not due to set scripts of methods and procedures health promoters employ, but because effective practice is based on principles and values consistent with ethical practice. There can be no better argument for health promoters to justify their activities than to state that not only is health promotion an ethical and principled discipline, but it is because of its values-based approach that it is effective.

### Table 4: Guidelines for making decisions and using evidence in health promotion

1. Be as explicit as possible regarding your principles and values that you bring to your health promotion activities.
2. Recognize the tensions and interactions between structural and individual determinants of health and between values and facts.
3. Whenever possible, use multiple sources of evidence.
4. Use truth criteria associated with each form of knowledge.
5. Show awareness of the decisions you make concerning evidence: be a reflexive practitioner.
REFERENCES


