Using evidence in health promotion in local government: contextual realities and opportunities

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Abstract

Issue addressed: New national and state preventive health investments have provided significant funding for local governments (LGs) to be involved in planning and implementing health promotion interventions. There is an expectation that this work is evidence based; however, inadequate support and systems exist for evidence-informed planning and decision making in LGs. Previous initiatives have aimed to build capacity and leadership in LG health promotion, but the training, support and infrastructure have been sporadic.

Methods: Across 2009–11 we implemented a National Health and Medical Research Council of Australia (NHMRC)-funded university–LG research project to explore the feasibility, usefulness and outcomes of a knowledge translation (KT) intervention to increase the use of evidence in LGs. Within this exploratory cluster randomised controlled trial, one strategy being evaluated was workforce capacity building, during which group discussions revealed contextual challenges in delivering evidence-informed health promotion within the current funding context. Discussion was recorded. The group acknowledged the need to identify barriers and realistic practical solutions, and to communicate these more broadly.

Results: Barriers to sourcing and applying evidence to inform health promotion emerged from discussions with LG representatives. System-level contextual factors affecting decisions were also discussed, namely concerns about organisational capacity and ‘culture’ to plan, implement and evaluate effective initiatives in LGs. Possible solutions suggested included: systems for access to academic literature; processes that make it easier to use evidence; training in evidence-informed health promotion to build organisational culture and capacity; and research–practice partnerships and mentoring.

Conclusions: Targeted strategies with individuals (LG staff) and organisations (leadership, systems) are needed to realise the potential of current health promotion investments. Research–practice partnerships are likely to be important. It seems obvious that it is impossible to be evidence informed without mechanisms to access and apply evidence. We invite other LGs to reflect upon their experiences in such initiatives, and to consider whether the strategies we propose may be useful.

So what? The increased emphasis on health promotion and non-communicable disease prevention programs may be limited by the capacity, confidence and organisational culture to inform policies and programs with best-available evidence. We describe some of the current challenges and contextual factors as they are being experienced. There are opportunities for national and state governments, organisations representing local government (e.g. municipal associations) and research partners to provide targeted support to councils. This may assist in achieving effective health promotion at the community level.

Key words: evidence-based practice, local government, community-based intervention, workforce development, partnerships.

Introduction

In recent decades, Australian local governments (LGs) have adopted a broader role in planning for health outcomes and health promotion in communities, further to traditional roles of health protection. Historically, lessons learned from previous initiatives that have aimed to support Australian LGs to plan and act upon the environmental...
determinants of health have emphasised a need for ongoing relationships between the health sector and LG, ongoing capacity building and leadership in LGs. Some examples of these initiatives include Healthy Cities and, more recently, the Victorian Department of Health “Environments for Health” framework and “Good Practice Program” to support municipal public health planning, as well as VicHealth’s ‘Leading the Way’. Following these initiatives, awareness of the multiple determinants of health has increased within LGs and been incorporated into local health planning, and momentum for further action upon the environments for health has occurred. Recently, the National health promotion agenda has called for LGs to expand their role in implementation of health promotion interventions, facilitated through new Federal funding opportunities, such as the ‘Healthy Communities Initiative’. This has created a shift from the conventional roles of LGs in health protection and healthy environments to a broader role in healthy lifestyle program implementation. Although this presents an exciting opportunity for cross-sectoral health promotion, some of the new foci are less congruent with the traditional capacity of LGs, presenting potential challenges to council staff in planning, implementing and evaluating such initiatives to achieve health outcomes. In addition, evidence-informed decision making (EIDM) is encouraged, which, in health policy and practice, involves the incorporation of best-available evidence in the context of all other political and organisational factors. However, the extent to which LGs are being supported externally with appropriate infrastructure required to implement evidence-informed initiatives, and guidance as to how to integrate these initiatives with existing health plans, has also been inconsistent.

Methods

Across 2009–11 we developed and implemented a research project with Victorian LGs to explore the feasibility, usefulness and outcomes of a knowledge translation (KT) intervention for public health decision making. The methods of the study and the preliminary research conducted, including a state-wide survey, interviews of the sector, systematic review and literature review, have been reported elsewhere. The findings of this study are in the process of analysis. The KT intervention activities included biannual group training sessions during which facilitated discussions occurred, revealing new and ongoing contextual challenges in relation to planning and implementing evidence-informed health promotion. Although not part of the empirical study plan, a small group was eager to communicate these outputs from group discussions, to describe and advocate for solutions to address the contemporary health promotion planning and implementation challenges in LGs. Thus, a group discussion held in 2011 was recorded as meeting minutes, and further clarification and discussion was captured by follow-up group email communications. Key issues were summarised by a researcher and distributed to all LG participants for review. Together as researchers and practitioners we considered feasible solutions to these challenges. Ethical approval for this project was granted by The University of Melbourne Human Ethics Committee (0722362).

Results and discussion

Our discussions revealed some of the contemporary challenges experienced by LG staff “on the ground”, in particular relating to using evidence to inform health promotion. In this paper, jointly developed by researchers and LG practitioners, we highlight some of the experiences and context that could inform future strategies to support and build individual capacity and organisational culture for effective LG health promotion.

Barriers to sourcing and applying evidence to plan effective health promotion in LG

The barriers to accessing and using research evidence to inform practice and policy in government have been described previously. Broadly, this includes individuals’ confidence and competence in accessing and using research, as well as organisational culture and systems for research use. Access to research evidence is a particular issue for LGs given that access to academic literature is much more limited in this setting than in state government (where, generally, there is access to databases; e.g. in Victoria, through the Clinicians Health Channel). Although we acknowledge that any individual or agency in Australia can freely access public health research syntheses (e.g. Cochrane reviews; see http://www.thecochranelibrary.com, accessed 16 October 2012), information in original research articles can be crucial for identifying what programs may be applicable and effective to implement at a local level, and how these might be operationalised.

Possible ways forward

We would advocate for access to key academic databases, potentially via state government or organisations representing LGs collectively (e.g. municipal associations).

Limited organisational culture for research evidence use in program planning

Another contemporary issue for LGs is the lack of organisational ‘culture’ for EIDM at the senior decision-making level, which predates its limited influence. This has been described previously and likely exists for many agencies, but it appears that this problem is more pronounced for LGs; this may be due to a corporate, customer service-oriented culture. For example, LGs tend to rely on methods of accountability rather than what evaluation research illuminates. Australian LGs have capable staff interested in promoting evidence-informed, robust ideas for health promotion but, without the imprimatur from senior decision makers, ideas may not translate into actions for the community. During one of the group training sessions of our intervention, LG project officers and coordinators described the need for internal ‘champions’ to support EIDM and innovative implementation.
**Possible ways forward**

To build an EIDM culture, there is perhaps a role for additional and sustained targeted workforce capacity building around health promotion principles, evidence and evaluation, at all levels of LG, including senior decision makers and councillors. This may result in similar outcomes as those achieved during initiatives such as ‘The Good Practice Program’ and ‘Leading the Way’. There may also be a role for knowledge brokering or mentoring via research–practice partnerships, which is supported by current perspectives on enhancing the effectiveness of community-level initiatives, and our empirical KT study aims to determine the effectiveness of such strategies. Research–practice partnerships could be considered a potentially feasible option given current local examples, such as the evaluation capacity building provided by ‘Research Practice Leaders’ for councils within the violence prevention work led by VicHealth.

Further, within our KT intervention, the knowledge broker and LGs attempted to co-create processes or systems that promote evidence utilisation and evaluation competencies: analysis of the effectiveness of these strategies is underway. Examples include evidence ‘prompts’ within meeting agendas and action-planning templates, “toolkits” for guiding evidence use and criteria on evidence and evaluation skills within position descriptions.

**Broader contextual factors affecting health promotion decisions in LG**

The political environment in which public health decisions are made has implications for research use. For LGs, the shift towards a broader national (Council of Australian Governments) agenda of non-communicable disease prevention programs presents some unique challenges to EIDM. Although LGs have been invited to coordinate the delivery of healthy eating and physical activity initiatives, not all LGs feel equipped to take on this role. Common problems being experienced include insufficient capacity and confidence in health promotion development, implementation and evaluation and a lack of external guidance and resources for evidence-informed health promotion planning. LGs are generally competent in delivering such initiatives when supported by external funding and dedicated project staff with health promotion or public health training, but this may be an unsustainable model due to workforce shortages and turnover. Participating LGs also noted that there is often a lack of communication between LG departments, especially in larger LGs, which tends to result in missed opportunities for collaboration on health promotion projects. External support for evaluation is also needed to better understand what is working for whom (or not) and why, and what unintended outcomes may occur as a result of healthy behaviour or lifestyle modification programs.

**Possible ways forward**

Again, external support (including support obtained through partnerships) in creating an evidence-informed health-promoting culture within LGs among senior decision makers may facilitate further communication between council departments and teams. In turn, this may strengthen existing health plans and projects and build capacity to embed both health outcomes and EIDM into the organisational culture.

**Conclusions**

As researchers and LG practitioners we have been involved in a program of work designed to facilitate EIDM within a context driven by national, state and local priorities. We have described some of our common challenges in sourcing and applying evidence to health promotion, and in developing skills and capacity for planning, implementing and evaluation. In summary, to propose ‘ways forward’ we would advocate to national and state governments and municipal associations for: (1) subsidised access to academic literature databases; (2) targeted workforce development for senior decision makers and councillors to continue to build a “culture” of EIDM; and (3) organisational-level processes and infrastructure to make it easier to incorporate a range of sources of evidence. The latter may include research–practice partnerships and mentoring to facilitate KT. Without this kind of support, we ask program funders to consider what is implementable, and sustainable, for contemporary health promotion in LG settings.

**References**


