Integrating research- and relationship-based approaches in Australian health promotion practice[1]

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Abstract

We examine the perspectives of health promotion practitioners on their approaches to determining health promotion practice, in particular on the role of research and relationships in this process. Using Grounded Theory methods, we analysed 58 semi-structured interviews with 54 health promotion practitioners in New South Wales, Australia. Practitioners differentiated between relationship-based and research-based approaches as two sources of knowledge to guide health promotion practice. We identify several tensions in seeking to combine these approaches in practice and describe the strategies that participants adopted to manage these tensions. The strategies included working in an evidence-informed rather than evidence-based way, creating new evidence about relationship-based processes and outcomes, adopting 'relationship-based' research and evaluation methods, making research and evaluation useful for communities, building research and evaluation skills and improving collaboration between research & evaluation and program implementation staff. We conclude by highlighting three systemic factors which could further support the integration of research-based and relationship-based health promotion practices: (1) expanding conceptions of health promotion evidence, (2) developing 'relationship-based' research methods that enable practitioners to measure complex social processes and outcomes and to facilitate community participation and benefit, and (3) developing organisational capacity.

Introduction

Relationships between people are central to conceptualisations of health promotion. Models of health promotion and guidance for practitioners emphasise building relationships with people in their everyday living environments and seeking to understand people's needs, values, skills and capabilities so that health promotion practice can be useful and appropriate (Hawe et al., 2000; Raeburn et al., 2003). Evidence-based practice has also become important in health promotion. It is now widely accepted that health promotion practice should be supported by sound evidence (NSW Health, 2012). However, it can be challenging to integrate evidence-based practice with a people-centred approach to health promotion (Springett, 2001; Speller et al., 2005; Aro et al., 2008). Tensions arise partly because the evidence base is often "too small to provide firm guidance on consistently-effective interventions" (Gill et al., 2005) (see also South and Tilford, 2000; Raeburn et al., 2003; Hill et al., 2010), and partly because of disagreement about what constitutes *appropriate* evidence and how it should be generated and used in practice (McQueen, 2001; Springett, 2001; Speller et al., 2005; Aro et al., 2008; Hanlon et al., 2012).

Some have been critical of the notion of a scientific evidence base for health promotion. David Buchanan, for example, sees evidence-based practice as a misguided striving for efficiency in maximising bodily health for its own sake. He argues that health promotion should be grounded in a more humanistic view of people in their environments, in which respect for wellbeing, quality of life, autonomy, responsibility, and social justice are more important to health promotion than "goals [that] are prioritized based on concerns for efficiency" (Buchanan, 2006, p. 298). Van Beurden et al (2013) have suggested that linear cause-effect approaches to scientific evidence may produce evidence that is insufficiently useful, appropriate, complex and/or context-sensitive for health promotion. Scholars have

recently begun proposing new approaches for knowledge generation in health promotion that take the dynamic contexts into account in which health promotion interventions are made (Hawe et al., 2009). Seedhouse (2004), meanwhile, suggests that health promotion is driven not by evidence but by values, and that divisions within health promotion are generally divisions between conflicting sets of values.

There is no reliable measure - or even definition - of the health promotion workforce in Australia (James et al., 2001). However 'health promotion officer' is an occupational category in this country, and state-funded health services are the most prominent employer of health promotion officers. Officers in these services are responsible for conducting health promotion activities in a defined geographic area. They are not the only workers conducting health promoting activities in Australia, but they are the most clearly identifiable as a health promotion workforce. We empirically examined day-to-day health promotion practices in three state funded health promotion services in New South Wales (NSW), Australia. We focused on health promotion officers working in the area of obesity prevention because this was a local and national priority at the time of writing (NSW Health, 2008).

We use the term 'health promotion practice' broadly to refer to the overall work of these practitioners. The health promotion practices of the practitioners interviewed in this study included a wide range of activities. Practitioners themselves, or local health promotion units, sometimes had complete control over these activities and sometimes little control. For example, some practitioners were implementing state or nation-wide health education and training initiatives with little change (for example, teacher training to support implementation of a standardised school-based activity program). Other practitioners had been working closely with one community for many years, and were running projects developed specifically for and with that community. Many activities fell between these two extremes. Participants' duties included overseeing programs and engaging with policymakers, engaging with communities, individuals, schools, and other organisations, and advocacy and media. Some practitioners were responsible for multiple initiatives, some for a single strategy, and others had a role that cut across strategies (e.g. media and communications).

Through our empirical analysis we identified two approaches to determining health promotion practice which we will refer to as the 'relationship-based' and 'research-based' approaches. In this paper, we describe the 'relationship-based' and 'research-based' approaches, how practitioners used them and how they negotiated back and forth between them in an endeavour to integrate them both in their daily practice. We then describe the tensions between the two approaches, and how these tensions were managed. We conclude by highlighting some important systemic factors which could further support the practical integration of research- and relationship-based health promotion.

Methods

This study is part of a larger project which critically examined the nature, role and interactions of values, ethics and evidence in current health promotion interventions in overweight and obesity in New South Wales, Australia. The study methodology was qualitative, drawing on Kathy Charmaz's iteration of Grounded Theory (Charmaz, 2006).

We selected three study sites, which varied substantially in levels of urbanisation, socioeconomic status and degree of research activity. Within the sites, all health promotion practitioners working on obesity prevention programs (including healthy eating, physical activity promotion, food security and active travel) and those with cross-sectional roles (such as media & communications, research & evaluation and management) were invited to participate; most of them agreed. Per site respectively 20, 21 and 13 practitioners participated.

We conducted 58 semi-structured interviews with 54 participants (4 participants were interviewed twice); interviews lasted between 35 and 150 minutes. The participants featured a broad variety of professional backgrounds, levels of experience (from 6 months to over 30 years) and/or seniority. The positions held by participants ranged from junior project officers, to senior managers, and site directors.

The interviews began with broad questions about the participants' careers and everyday activities, and then became more focused on their values and professional reasonings. As a result of an iterative feedback process between data gathering and analysis, the interview questions were revised twice. The final interview schedule is summarised in Box 1. Interviews were transcribed verbatim by a professional transcription service.

Box 1: INTERVIEW SCHEDULE

Introductory questions:

Can you please tell me the story of your career so far?

What have been the best things in your career in health promotion?

What have been the *worst* things in your career in health promotion?

What has been the most rewarding project? What has made it rewarding?

What has been the most *frustrating* project? What has made it frustrating?

What values drive you personally in health promotion? [Probe if difficult: What really matters to you as a health promotion professional?]

Values in overweight and obesity prevention:

If you made the decisions, what kinds of programs would you develop and fund in overweight and obesity prevention? [Probe: What is it about those programs?]

Are there programs that you wouldn't fund? [Probe: What is it about those programs?]

What effect has the increased focus on overweight and obesity had on your work? [Probe: What effect has it had on health promotion resources?] [Note: adjust question depending on participants' seniority to ask instead about their team's work or the work of health promotion in the Area Health Service]

Evidence:

When you develop or implement a program, what information do you need before going ahead?

Thinking about times when you are trying to some support for a program, what kinds of information do you need to get this support? [Probe: what's needed to gain management support, to gain funding support, support of participating agencies, evaluation support etc.]

What do you think about evidence-based practice in health promotion? [Probe: how does it apply to programs that you work on? How do you deal with situations where you think an idea or program is good, but there's not much formal evaluation or published evidence?]

How are programs evaluated in your health promotion service? What do you think about the evaluation methods used? [Probe: how appropriate are the methodologies used? Are evaluation findings applied? Any ideas about how evaluation could be done better?]

Ethics:

Do you think there are right and wrong ways to do health promotion? [Probe: how did you come to that point of view?]

Have there been times when colleagues have disagreed about what was the right or wrong thing to do? [Probes: what was it about that issue? why did people feel so strongly about it?]

Finishing questions:

If you had the freedom to determine the role of a health promotion service, what should it do? [Probe: what is it about those ideas / directions that is important?]

You've been in health promotion for x years. [For experienced people:] What's kept you there? [For less experienced people:] Do you think you will stay? What guides your intentions?

In an ideal world, what would the next 10 years of your career in health promotion look like? How would you like them to look?

Early data analysis, which took place in parallel with interviewing, involved detailed coding, extensive memo writing and team discussion. Later analysis became more structured; it focused on advancing and combining preliminary codes, exploring relationships and developing analytic categories (Charmaz, 2006). Final analysis consisted of refining the core categories and developing theoretical concepts as presented in this paper.

Ethics approval was obtained from the relevant Area Health Service and University of Sydney Human Research Ethics Committees. All participants gave individual consent to be interviewed and were free to withdraw from the study at any time. The data were de-identified, including replacing participant names with alphanumeric codes.

Results

From the participants' descriptions of how they determined health promotion practice, we identified two leading sources of knowledge underpinning practice, which we have named the relationship-based and the research-based approach. We do not claim that these were the only approaches employed by participants. However, we focused on these approaches not only because they featured prominently in the participants' accounts of practice, but also because they were in tension, and this tension was an important part of daily practice. In the relationship-based approach, practitioners determined what they should do by engaging and collaborating with partners and communities. In the research-based approach, practice was determined both by interpreting and applying research evidence, and by conducting research, including program evaluation, to generate new evidence. Most practitioners did not pursue one approach *or* the other. They rather drew on both approaches, sometimes emphasising one over the other but mostly endeavouring to integrate them in order to practice 'good' health promotion. Practitioners' accounts of the 'good' in health promotion have been described by Carter et al. (2012).

How the two approaches manifested in practice

The relationship-based approach

The relationship-based approach gave particular emphasis to relationships between the practitioners and the communities they worked with as a source of knowledge. Information derived from these relationships was an important source of guidance for health promotion intervention.

The relationship-based approach involved collaborating and spending time in and with communities, building rapport, establishing credibility and good will and winning people's trust. Practitioners listened, observed and learned from communities in order to understand their needs and their demographic, social, cultural and historical contexts. This was done with an attitude of reciprocity, openness, honesty and respect for people's current beliefs and practices.

The relationship-based approach required involving communities in the process of developing, implementing and evaluating health promotion interventions and enabling them to become involved - processes that were often referred to as 'community development'. Community enablement and participation was achieved through sharing knowledge and resources, teaching transferable skills, negotiating mutual understanding, motivating and inspiring people to participate, and, more generally, being innovative, opportunistic, flexible and responsive.

The relationship-based approach also involved forging strategic and opportunistic partnerships and networks with stakeholders, inside and outside of communities, who could support community-based health promotion work.

In the relationship-based approach practitioners generally saw themselves as active, involved members of communities. They regarded people in communities as partners in knowledge and program development and they allowed community members' experiences and their own experiences in the community to inform their thinking about health promotion practice: that is, in the relationship-based approach, the practitioners tended to take an 'insider' perspective. Knowledge was generated from within the community.

The research-based approach

In the research-based approach, the primary emphasis was different. Practitioners prioritised research-informed planning, i.e. researching and evaluating local programs, and using published evidence as the main basis for health promotion practice. In contrast to the relationship-based 'insider' approach, the research-based approach required a distanced, more objective 'outsider' perspective where practitioners emphasised more rational, transparent, systematic and analytic decision-making processes. When adopting this way of thinking, practitioners perceived themselves rather as impartial professionals than involved community members; they used their research and evaluation skills and resources to arrive at and justify decisions, they drew upon existing formal evidence and assessed the potential impact, reach, sustainability and evaluability of interventions.

For the majority of participants the research-based approach involved both *applying* existing research and, increasingly, *generating* new research and *disseminating* the results. Although

practitioners reported being increasingly expected to generate as well as apply research, not all practitioners had the necessary research and evaluation training to fulfil this growing expectation.

This was often a role taken up by Research & Evaluation staff or - for larger, centralised programs - the state or national Head Office.

Tensions arising from using the two approaches

The majority of participants were striving for a health promotion practice that drew on elements of both, the relationship-based and the research-based approaches. In fact, good health promotion practice was considered by many to be firmly grounded in both approaches. However, participants consistently experienced practical difficulties with integrating the two approaches into one coherent way of working. This is the central point of our analysis: practitioners reported that both approaches existed and had real value for health promotion, but that the two approaches were also frequently in conflict with each other, and this conflict needed to be managed in practice. The remainder of this section outlines the nature of this conflict and how practitioners managed it.

From the participants' descriptions, we identified five tensions between the two approaches, as described below. Practitioners attached varying degrees of weight to these tensions, influenced by the extent to which they managed to integrate the two approaches.

Existing research often does not answer questions that are important for the relationship-based approach

The first tension was between the desire and/or perceived responsibility to practice in a research-based way and the frustration felt when existing research was either insufficient or not transferable to the work that participants wanted to do with communities. Applying research that was not tailored to the specific values, needs and capabilities of local communities was regarded as problematic and unsatisfactory. Generating new – potentially more suitable – knowledge was demanding on time, skills and resources, often beyond the workforce's capacity.

Relating can be more immediately rewarding than researching

Another tension arose from the rewards available from the research- and relationship-based approaches respectively. Investigating systematically and rigorously was often perceived to require more technical and analytic thinking skills than engaging with communities and partners. For some participants, particularly those without formal research & evaluation training or skills, the research-based way of working was difficult. It was also perceived as less meaningful and rewarding, whereas relating with communities was regarded as something that could provide immediate job satisfaction and be more easily learned on the job than research & evaluation.

We have already noted that some practitioners perceived relationship-building to be 'invisible' to decision-makers or managers because its value and outcomes were difficult to measure. Conversely however, for practitioners themselves, the benefits of relating with people and communities were more tangible and, especially when helping and supporting people was involved, intrinsically rewarding.

> *You need some of that hands-on to feel like you're doing something meaningful sometimes. Writing plans ... doesn't feel as meaningful day-to-day as actually getting involved ...* [A1:392]

Measuring the processes and outcomes of the relationship-based approach is difficult

Although a range of practitioners described the relationship-based approach as an easier and/or more rewarding way of determining health promotion, they were clear about its weaknesses. Factors that were important to participants in the relationship-based approach – such as identifying community values and needs, capacity building, empowering, strengthening partnerships and engendering behaviour change – were often difficult to measure because they were complex, contextual and dynamic.

Relationship-based processes such as building trust, forming and strengthening partnerships, learning about community values and needs, building capacity and empowering people were reported to be particularly time-consuming, often stretching beyond research and program funding periods. This contributed to the difficulties in measuring their impact within available resources and timeframes.

Due to the difficulties with measuring the processes and outcomes of the relationship-based approach, some participants described this approach as working 'invisibly' or 'silently' – that is, relationship-based work was perceived to be largely undocumented and thus unrecognised beyond immediate colleagues. There was tension between wanting to engender change and producing evidence of an association between health promotion practice and change in the community. It was suggested that relationship-based processes and goals tended not to be sufficiently planned and/or documented.

Without evidence of the effectiveness of the relationship-based approach, a range of participants were concerned that this approach may at times produce a "fluffy" or unfocused "feel-good" activity:

> *... it would be very easy to keep doing things that just felt good because you had connections with the community and it gave you a really nice warm fuzzy feeling... But the warm fuzzy feeling may not necessarily be the best practice. It's essential to have evidence-based practice and to keep drawing back to that ...* [C11:990]

It was sometimes implied that the aims, processes and outcomes of health promotion activities associated with the relationship-based approach were lacking rigorous planning and documentation.

> *We inherited quite a lot of community development type work that largely was very unfocussed and so over time we've had to disinvest in some of that.* [Q: Why do you think the community development work wasn't really worthwhile?] *There were no identified outcomes there was no plan for what it was that they were actually trying to achieve. It was really for the sake of doing it.* (A12:481)

Researching communities may jeopardise the relationships established through the relationship-based approach

Relationship-based and research-based practices were seen to be in direct conflict if a community was repeatedly studied, or studied without any direct or apparent benefit to its

members. This was a particular problem for communities that were already identified as over-researched, for example, Aboriginal and Torres Strait Islander people. There were concerns that studying already over-researched communities with a research-focused agenda could risk jeopardising their good will and thus the existing good relationships with them.

The research-based approach impedes acting opportunistically and innovatively

Finally, participants noted that there were instances where research-based practices inhibited working innovatively, creatively and opportunistically, which were seen as important characteristics of the relationship-based approach. If practitioners only did what had been shown to work in the past – that is, if they waited for the evidence to be strong enough to act – they could miss out on unexpected or unplanned opportunities to network with and engage key stakeholders, to act in a timely manner on issues that emerged as important in communities and to work with people when they were most susceptible to change.

> [Health promotion] *can be very opportunistic; sometimes things need to happen quickly. And sometimes something can be investigated to the point that the opportunity is lost before you actually do anything … I see practitioners in the field get bogged down with* [evidence]. *They refuse to move because they're concerned the evidence isn't strong enough, or they'll spend a year reading the articles, by which time the opportunity to do something about it has already passed, or the situation's changed anyway.* [B15:942/1109]

How practitioners bridged these tensions

Despite the above described challenges, many participants found creative ways of bridging the tensions between the research-based and the relationship-based approach. They did this in the following ways.

Working in an evidence*-informed *way

It is commonly observed that health promotion generally needs to be evidence-*informed* rather than evidence-*based* (we will consider this further in the discussion). Unsurprisingly, most practitioners endorsed this view. Most interesting for this analysis was that evidence-informed practice *was seen as a method for combining research-based and relationship-based principles*. Formal evidence was supplemented by drawing on relationships and community participation as important sources of knowledge. Many kinds of relationship-derived knowledge were used in addition to published literature and formal evaluations: community observations and feedback, local needs assessments, practitioners' past experiences as a health professional and as a community member, intuition and common-sense, the results of pilot studies, grey and unpublished literature and insights from professional collaborations and networks.

Formal knowledge, using research-based principles, ensured that health promotion work was "*based on reasonably sound logic*" (B20:1392), thoroughly planned and well-documented. Knowledge generated from within the community, using relationship-based principles, allowed for procedural flexibility, innovation, creativity and opportunism, and allowed pursuit of 'likelihood' or 'promise'. This engendered some uncertainty about probable outcomes, but research-based strategies helped to address these uncertainties. In general, "*the*

greater [i.e. bigger] *the project, the more it would need to have some research backing it up*" (B12:1192) and the better it needed to be evaluated: that is, larger projects would tend to emphasise the research-based approach more strongly.

Creating new evidence

Some practitioners described their efforts to build new evidence for their innovative work. In this process, they integrated core values of the relationship-based approach, such as engaging flexibly, innovatively and opportunistically with communities and partners, with core values from the research-based approach, such as systematically determining outcomes.

> *We don't know if this is going to work. So our duty is to evaluate it well and disseminate that finding. That's what we've got to do in the absence of evidence.* A1:799

Some participants worked on large-scale research projects to generate new formal evidence, but it was rare for practitioners to have the support and resources needed for systematic academic research. For many, the gap between wanting to create new formal evidence and having the resources and/or skills to do so felt unbridgeable.

Using 'relationship-based' research & evaluation methods

Many participants emphasised the need to apply research methods that could generate a more *useful* and *appropriate* foundation for health promotion practice. This often included qualitative methods such as narrative or participatory action research. Such qualitative research methods were described as giving people and communities – the researched – an active voice. They provided practitioners with tools to combine relationship-based principles (listening to and learning from communities) with research-based principles (working in a methodical, systematic and justifiable way).

Increasing familiarity and confidence using research-based methods and improving collaboration between research & evaluation and program implementation staff

One participating health promotion service had instituted a team process to enhance staff familiarity and confidence using research-based practices to improve planning and evaluation. The merit of each planned intervention was systematically worked out in a group applying a broad set of criteria such as evidence, rigor, innovation, equity, reach, impact, sustainability, costs and risks. The team process improved collaboration between research & evaluation and program staff and developed planning and evaluation skills in program staff. With increased skills and confidence, practitioners perceived the research-related elements of their work as more meaningful and rewarding, which in turn facilitated the integration of research and relationship-based values. Improved planning and evaluation rigor also provided an audit trail for relationship-based work and made relationship-based decisions more robust.

Another way of interlocking research-based and relationship-based approaches was via "*linking up strategic thinkers with the doers and vice versa*" (B5b:1402), for example through in-house research & evaluation training, mentoring and consultation, and through supporting implementation staff with research & evaluation tools such as reference libraries.

Making research and evaluation activities useful for communities

Finally, it was suggested that "over-researching" and its problems could be mitigated by integrating research & evaluation into the program implementation process, for example by using participatory action research methods, thus making research activities useful for participating communities through providing some direct benefits for them. Such benefits could include sharing and discussing research findings, or providing additional program implementation support.

Discussion

The health promotion practitioners in this study perceived their work to incorporate two distinct approaches, which we named the relationship-based and the research-based approach. Practitioners did *not* favour one approach over the other but rather endeavoured to integrate the two approaches to the best of their abilities with the aim of practicing effective and ethical health promotion. In a combined approach, engaging with local communities and partners was as important as being rigorous, analytic, systematic and transparent in planning, implementing and evaluating health promotion. An integrated approach encouraged combining knowledge generated from within local communities and knowledge generated from formal evidence to determine health promotion practice. Integrating the values and principles inherent in each of the two approaches *in practice*, however, was not problem-free. Participating practitioners suggested the existence of a range of tensions between the two approaches. They also suggested strategies to bridge these tensions (Figure 1).

The pattern described by these practitioners is consistent with broad trends in the health promotion literature suggesting a shifting trend from evidence-based to evidence-informed practice (Bowen and Zwi, 2005; Armstrong and Murphy, 2012; Meagher-Stewart et al., 2012), an identified need for more appropriate and locally relevant health promotion evidence (Macdonald et al., 1996; McQueen, 2001; James et al., 2007; Biggs and Stickney, 2011), a need for greater recognition of complexity in population health (e.g. Campbell et al., 2000; McQueen, 2001; Gibbon et al., 2002; Aro et al., 2008; Craig et al., 2008; Hawe et al., 2009) and a greater focus on community participation and benefit in health promotion research (e.g. Springett, 2001; Institute of Medicine, 2003; Tellnes, 2005; Cargo and Mercer, 2008; Khodyakov et al., 2012; Layde et al., 2012; Miller et al., 2012). These perspectives share an understanding that health promotion is an eclectic profession in which a number of disciplines and theoretical frameworks are integrated (Nutbeam and Harris, 1998), which is also reflected in research and evaluation methods commonly used in health promotion (Nutbeam and Bauman, 2006).

In the literature on evidence-based health promotion, the reasons for limited or non-use of evidence are often described to arise from either a practitioner deficiency (e.g. insufficient knowledge or skills), or an evidence deficiency (e.g. absence of evidence about interventions or lack of locally relevant evidence). Beyond these impediments, our study has suggested an additional challenge: a tension between two approaches, both of which practitioners value.

Our analysis provides new terms for these tensions, naming and defining 'research-based' and 'relationship-based' approaches, and discussing the relationship between them. After conference presentations based on these findings, practitioners have suggested to us that these

terms have face validity and are useful. Practitioners readily located their own activities as primarily research-based or relationship-based or both and could personally relate to the tensions and ways to manage them described above. This suggests that these concepts might be usefully incorporated into health promotion planning and problem-solving, as well as into undergraduate and continuing education. Identifying strategies or interventions as primarily relationship- or research-based, or ideally as containing elements of both, might assist practitioners, managers and funders to pre-empt potential tensions and to suggest solutions.

Based on our findings and the literature, we suggest three systemic factors that may assist practitioners to better integrate research-based with relationship-based approaches (Figure 1):

1) The first is to continue to expand understandings of what constitutes appropriate evidence to inform health promotion practice. This includes legitimising that health promotion evidence can come from an expanded range of information sources such as "field knowledge" generated from within local communities (e.g. Raphael, 2000; Springett, 2001; Smith, 2010; Potvin et al., 2011; Meagher-Stewart et al., 2012). This is consistent with evidence-informed rather than evidence-based practice and reflects the complexity of the translation and implementation of evidence and knowledge (see also Palinkas and Soydan (2012) who argue for an integration of practice-based experience and contextual characteristics in the process of translating and implementing evidence in the field of social work).
2) The second is to continue to build 'relationship-based' research and evaluation methods. We reiterate that health promotion practitioners valued both, the relationship-based and the research-based approach. While the relationship-based approach may by some have been seen as more readily rewarding, the value of research was widely recognised as a way of ensuring the quality of health promotion practice. The second systemic factor, suggested here, could help practitioners to integrate the two approaches more smoothly. It comprises tools that are suitable for measuring complex and dynamic social processes including communication, psychological and social support issues (Victora Cesar G. et al., 2004; Riley et al., 2005; Aro et al., 2008; van Beurden and Kia, 2011; Macintyre, 2012; McQueen, 2012; Watkins, 2012), and that enable community participation and benefit. This may include methods for measuring community capacity (Goodman et al., 1998; Laverack and Labonte, 2000; Labonte and Laverack, 2001; Ebbesen et al., 2004; Liberato et al., 2011; McQueen, 2012) and applications of complexity science and systems thinking tools to health promotion (Ureda and Yates, 2005; Hammond, 2009; Naaldenberg et al., 2009; Norman, 2009; Best, 2011; Kremser, 2011; BeLue et al., 2012; Van Beurden et al., 2013). Many of these tools are still in their infancy and not very well understood, developed and established by the health promotion research community.
3) Thirdly, although access to resources is always contentious, many practitioners wished that they had access to more staff, time, funds and skill development opportunities to increase their research and evaluation potential and output, particularly regarding the generation of evidence of the effectiveness of relationship-based practices (see also Laverack and Labonte, 2000; McQueen, 2001; Hill et al., 2010; Biggs and Stickney, 2011). Combining outsider and insider perspectives to generate new health promotion knowledge requires practitioners to competently use

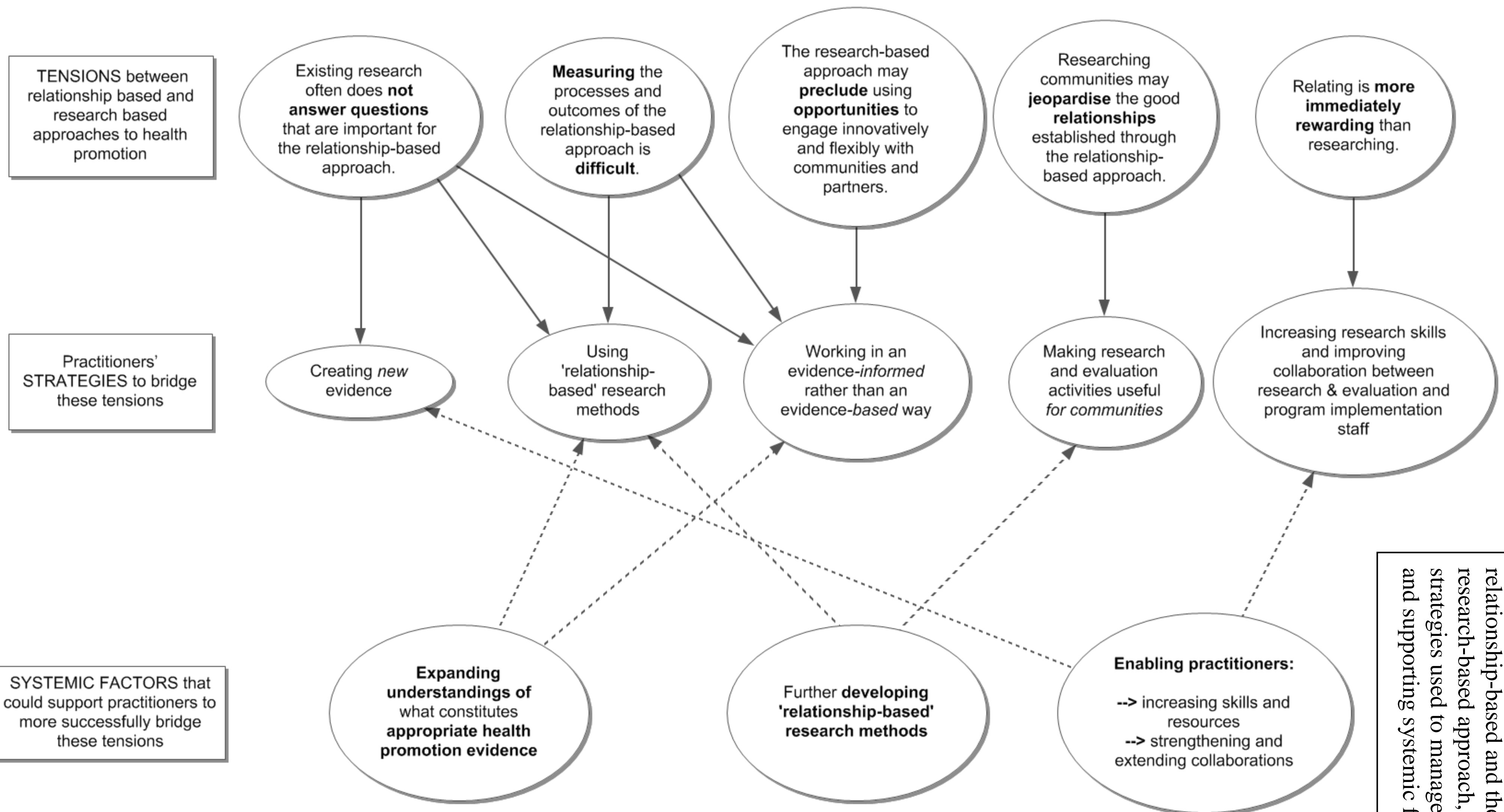

Figure 1: Tensions between the relationship-based and the research-based approach, strategies used to manage them and supporting systemic factor

mixed (qualitative and quantitative) research methods as appropriate. Strengthening and extending formal collaborations with established research institutions could provide additional support for health promotion professionals in this endeavour (Speller et al., 2005; Buchanan, 2006; Craig, 2007; NSW Health, 2010; Biggs and Stickney, 2011).

As the options available for practitioners to access, use and generate health promotion evidence increase over time in these ways, so will the appropriateness of evidence available to inform each step in the health promotion cycle.

Empowering practitioners in the above-described ways may be difficult in jurisdictions emphasising centralised development and roll-out of health promotion interventions. In such contexts, practitioners may be expected to focus on program implementation rather than program development and evaluation.

There are two possible limitations to this study. First, our findings are situated in the conditions governing health promotion in NSW, which may differ from the way it is organised in other locations. Second, the findings and resulting conclusions presented in this paper are largely based on data from health promotion practitioners working in the area of obesity prevention, as this was a priority action area at the time of writing. However, the interviews contained considerable conversation about health promotion in general; a large proportion of the interviewed practitioners had extensive professional experience in a variety of health promotion fields and worked across a range of health promotion projects/areas. We therefore believe that our analysis is applicable beyond obesity prevention. Further research would be needed to confirm the generalisability and transferability of our findings.

Conclusion

Practitioners described two approaches to health promotion practice, the relationship-based and the research-based approach, each reflecting important professional values. Most practitioners wanted to integrate both approaches and felt that this was an ideal form of practice. Although participants described considerable efforts to integrate the two approaches, tensions remained. These tensions might be relieved by a range of supportive systemic factors including a broad definition of what constitutes health promotion evidence and increased support to grow health promotion research capacity. Apart from the beneficial effect this may have on health promotion effectiveness and population health outcomes, this may also strengthen the legitimacy of the health promotion profession when competing for limited funding and help “demonstrate to others that it is a field with tangible benefits to offer the public” (McQueen, 2001 p.261). Making the research- and the relationship-based approaches, the tensions between them, and strategies for integrating them explicit might improve both the standing of health promotion and the job satisfaction of practitioners, and will be increasingly important as evidence-informed practice continues to evolve in the field.

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