Health Promotion Journal of Australia, 2017, **28**, 89–90
http://dx.doi.org/10.1071/HEv28n2_ED1

Editorial

Health Promotion leads the way in 'knowledge translation': but just a new coat?

Jonine Jancey [A,D], ***Colin Binns*** [C], ***James Smith*** [B], ***Lisa Barnett*** [C] ***and Peter Howat*** [A]

[A]Collaboration for Evidence, Research and Impact in Public Health, School of Public Health, Curtin University, GPO Box U1987, Perth, WA 6845, Australia.
[B]Office of the Pro Vice Chancellor Indigenous Leadership, Charles Darwin University, Darwin, NT 0909, Australia.
[C]School of Health and Social Development, Faculty of Health, Deakin University, Burwood, Vic. 3125, Australia.
[D]Corresponding author. Email: J.Jancey@curtin.edu.au

Since 2012, the current Editorial team, have been privileged to review and manage the invaluable work undertaken by our submitting authors. The publishing of the findings by those undertaking health promotion plays a crucial role in the sharing of processes, advancing knowledge and helping the health promotion community and others to do things better, ultimately leading to healthier communities. The significant level of work undertaken and investment in research by government and funding bodies has led to heightened expectations about the need for research findings to result in 'real world' health outcomes.[1] You, our readership may say 'ho-hum we have been doing this for years' and we believe this to be correct. However, these 'real world' activities are now wearing a new coat.

One of the most frequently cited criticisms of research is the time it can take for findings to be available to benefit people. Balas[2] calculated that it takes ~17 years to make 14% of research findings available. These research findings are further compromised by what is called the 'pipeline fallacy',[3] a one-way pipeline that involves the vetting of what research will be funded and therefore what is ultimately delivered to practitioners and policy makers. The controlled flow of this 'pipeline' can inhibit practical processes and fail to take the perspective of the community and practitioners who live with the researched issue every day. The funnelling process starts with the identified priority research issue to be funded, which is then squeezed into shape by protocols, timelines, guidelines and biases of reviewers, whereby a highly refined and perhaps at times unusable product emerges that is not receptive to the applied nature of 'real world' implementation.[3] For example, the peak Australian health research funder, the National Health and Medical Research Council (NHMRC), continues to favour randomised controlled trials with double blinding, which is often not possible within the health promotion context, as we rely much more on observation of people. This results in health promotion projects being rarely ranked highly by reviewers.

However, contrary to these recognised research approaches, over the last 40 years the health promotion community has demonstrated 'real world' positive health outcomes by taking research findings and implementing prevention activities in many areas including: tobacco control, traffic safety (e.g. drink driving, seatbelts, bicycle helmets),[4] HIV-AIDS, skin cancer, physical activity[5] and water fluoridation.[6] However, it seems that the rest of the health community is just waking up to this concept, now referred to as *knowledge translation*.

Knowledge translation (KT), knowledge exchange or implementation research are just a few of the terms used to denote the activities undertaken to advance knowledge to inform policy and practice.[7] KT is now recognised as imperative to good community health outcomes. It has been defined as '*A process that generates or transfer knowledge to enable those utilizing the information to apply it*'.[8] However, understanding and applying this concept of KT can be confusing due to a failure to standardise terminology (over 90 terms are used to describe 'use of research knowledge');[9] lack of awareness of what KT is; lack of training on KT; lack of skills to undertake KT; researcher competing priorities (e.g. citations, H-index, category 1 funding); little reward for working with partners; and lack of support by funding bodies.

The National Health and Medical Research Council (NHMRC) has made some inroads into supporting KT with the development of: Translating Research into Practice (TRIP) Fellowships (introduced 2010); Translation Conferences (inaugural 2011); and the Research Translation Faculty (introduced 2012). The Australian Research Council[10] is currently working closely with the higher education sector, industry and other end-users of research to develop a framework for a national assessment of university research engagement and impact, while smaller funders such as Health promotion foundations and State departments of health do require applications to contain knowledge translation plans.

Yet, there remain challenges to disseminating knowledge and implementing change, with a systematic review by Oliver and colleagues[11] finding that the most frequently reported barriers by policy makers to using evidence was lack of timely access to relevant quality research and limited time or opportunity to use research evidence. Whereas the nominated facilitators to using research

evidence included the availability of relevant quality research and collaborations.

As health promotion professionals, we recognise the importance of working with collaborators and end-users at the planning and development stage, to establish what information is needed to ensure that the end product is relevant and usable. We understand that it is not just about making information available for consumption, it requires collaborations and the provision of suitable information to act on. Barwick and Lockett[7] suggest that effective knowledge translation should be viewed as a collaborative and problem solving partnership between researchers and decision makers resulting in mutual learning through planning, producing and disseminating. Despite that, as a discipline we have been relatively successful at this process, although we have received little recognition by the health bureaucracy or politicians. There is much opportunity for us to better promote that this is part of our health promotion process and we largely do it very well.[12] As stated earlier health promotion is embedded in the 'real world' context. However, there remains a large gap between the amount of public health research knowledge and its application to the community setting. Should you feel the need to advocate for increased application of research findings to a real world setting Brownson *et al.*[13] offer a few tips, as follows.

- Commitment by university Schools of Public Health by embracing the application of what we learn to improve the populations health.
- Designing of dissemination and translation plans by identifying partners early; identifying who will use the program in the real world; and creating a program that suits adopters' needs.
- Building of trans-disciplinary partnerships (different professions cooperating across disciplines) to improve population health.
- Providing incentives that encourage translation of research findings.
- Developing new ways of communication and presenting information. Sharing information through channels which will reach potential adopters/end-users by developing better skills for working with the media to share discoveries and applications.
- Embedding the concept of knowledge translation into programs and offer training to staff.

Historically, health promotion has undertaken sound knowledge translation as evidenced by Australia's improvements in life expectancy, which is regarded as the best overall index of health status. Indigenous Australian's life expectancy has risen but the gap between Indigenous and non-indigenous has only narrowed slightly,[14] despite the input of resources. Factors such as decreasing smoking rates; reductions in motor vehicle crashes, reduced HIV–AIDS infection rates, improvements in nutrition, immunisations to protect against various diseases, and improvements in breast feeding rates have contributed to this increased life expectancy. Public health in general, and health promotion in particular can take a significant amount of the credit for this outcome.[15]

Fellow health promoters, we must continue to invest time and energy into undertaking high quality research, publishing findings in the *Health Promotion Journal of Australia*, and applying the findings to the 'real world', thereby supporting our discipline and maintaining our leadership in KT. It is not a new concept; it is just wearing a new coat.

References

1. Milat AJ, Bauman A, Redman S. A narrative review of research impact assessment models and methods. *Health Res Policy Syst* 2015; **13**: 18.
2. Balas EA, Boren SA. Managing clinical knowledge for health care improvement. *Yearb Med Inform* 2000; **1**: 65–70.
3. Green LW. Closing the chasm between research and practice: evidence of and for change. *Health Promot J Austr* 2014; **25**(1): 25–9. doi:10.1071/HE13101
4. Stevenson M, Thompson J. On the road to prevention: road injury and health promotion. *Health Promot J Austr* 2014; **25**(1): 4–7. doi:10.1071/HE13075
5. Hills AP, Harris N. Getting Australia more active: challenges and opportunities for health promotion. *Health Promot J Austr* 2014; **25**(1): 30–4. doi:10.1071/HE13085
6. Howat P, Binns C, Jancey J. New international review supports community water fluoridation as an effective and safe dental health promotion measure. *Health Promot J Austr* 2015; **26**(1): 1–3. doi:10.1071/HEv26n1_ED
7. Barwick M, Lockett D. Scientist knowledge translation training. Toronto, Canada: SickKids Learning Institute 2012.
8. Searles A, Doran C, Attia J, Knight D, Wiggers J, Deeming S, Mattes J, Webb B, Hannan S, Ling R, Edmunds K, Reeves P, Nilsson M. An approach to measuring and encouraging research translation and research impact. *Health Res Policy Syst* 2016; **14**(1): 60–13. doi:10.1186/s12961-016-0131-2
9. Buykx P, Humphreys J, Wakerman J, Perkins D, Lyle D, McGrail M, Kinsman L. 'Making evidence count': A framework to monitor the impact of health services research. *Aust J Rural Health* 2012; **20**(2): 51–8. doi:10.1111/j.1440-1584.2012.01256.x
10. Australian Research Council. National Innovation and Science Agenda; Engagement impact assessment consultation paper: Australian Government: Department of Education and Training 2015.
11. Oliver K, Innvar S, Lorenc T, Woodman J, Thomas J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. *BMC Health Serv Res* 2014; **14**: 2.
12. Smith J, Jancey J, Binns C. System reform in the human services: what role can health promotion play? *Health Promot J Austr* 2017; **28**(1): 1–4. doi:10.1071/HEv28n1_ED1
13. Brownson RC, Kreuter MW, Arrington BA, True WR. Translating scientific discoveries into public health action: how can schools of public health move us forward? *Public Health Rep* 2006; **121**: 97–103. doi:10.1177/003335490612100118
14. Statistics ABC. Deaths, Australia 2013. Canberra, ACT: ABS2014 Contract No.: 3302.0.
15. Binns C, Howat P, Jancey J. Health promotion success in Australia and a note of warning. *Health Promot J Austr* 2014; **25**(3): 157–59.