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Health promotion research: thinking critically about knowledge production

In the last issue of *Health Promotion International*, Stephan Van den Brouke posed an important question in his editorial ‘How international is health promotion?’ (Van den Brouke, 2016). Acknowledging the importance of global voice and recognizing the contextual nature of the experience of health, he described the need for research and research methodologies that honor and elevate non-western approaches to the knowledge and knowledge creation in health promotion (citing for instance de Leeuw and Hussein, 1999; Silva, 2012). Broadening the scope of this issue, I ask ‘how *critical* is health promotion?’

As a field that centers itself in an ecological understanding of the creation of health, we clearly recognize the impact of social determinants on the human experience. Health promotion developed as a multidisciplinary field, and has always employed diverse research methods to inform its understanding of life, health and well-being on the planet. In this issue alone, we present examples of diverse quantitative, qualitative, mixed and community-based participatory research methods. Each of these methods contributes to understandings of the effectiveness of interventions and other important areas of inquiry for practice. Here, I argue that some methods—particularly indigenous and critical methodologies (Evans *et al.*, 2009) which center race, indigeneity, power and other key liberation-oriented concepts—may be more suited to producing the knowledge that enables us to understand the socially determined *experience* of health disparities.

Research examining the impact of context, power and identity on health are becoming more mainstream (e.g. Ford and Airhihenbuwa, 2010; Gelb *et al.*, 2012; McPhail-Bell *et al.*, 2013). These approaches recognize the intersectional nature of identities and their connections to health disparities—gender expression, gender identity, race, religion, socio-economic status, age,

abilities, geographic location, citizenship and other factors all work together to create the individual experience of life, health and well-being (Corbin and Tomm Bonde, 2012). By employing research methods intended to examine this subjective experiences, we are able to peer into a diversity of experience, created in a diversity of contexts. In *Health Promotion International*, just as in the ‘real world’ where research, policy and practice interact and influence each other, a—validated and scrutinized—diversity of approaches, theories, methodologies and tools reinforce the field and are responsive to the needs of the vast plane of stakeholders.

DESCRIBING REALITY

To maintain such relevance, once in a while it is important to zoom out from the details of data collection and the general grind of academia to reflect on the *purpose* of research—knowledge production. Zooming out further, we reflect on the even grander philosophical underpinnings of knowledge production: how do we come to understand the nature of reality itself?

Each research tradition frames its own answer to this existential question. Quantitative research, born from the (post)positivist tradition, presupposes there is a single reality that exists ‘out there, beyond ourselves’ which can be observed and where causes determine effects. We set out to prove hypotheses—constructing reality by applying measure, tallying numbers and through statistical analyses (Creswell, 2008).

Qualitative research, emerging from the social constructivist notion that reality is constructed through lived experiences and social interactions, produces knowledge as a co-construction between the researcher and the researched, and is shaped by their individual experiences (Creswell, 2008).

Since health promotion is primarily concerned with equity, and since inequity is rampant in the global experience of health, it would seem there is a particular place in health promotion research for understanding a pluralistic vision of reality as put forward in the social constructivist tradition. Furthermore, recognizing inequity in the socially determined experience of health creates disparities particularly along the lines of race and poverty. Further understanding that racism and poverty are part of a legacy of colonialism and slavery (Leary and Robinson, 2005), a country or a peoples' historic experience of colonialism plays a crucial role in the current state of health among its populations.

Thinking critically in these terms and understanding research as a historic tool of colonialism (Denzin *et al.*, 2008), we must ask ourselves if our ways of researching health promotion is reproducing patterns of domination that prevent some people(s) from being able 'to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (WHO, 1986).' What methods are we employing to begin to uncover and interrogate history and power in our work? If we are not actively engaging in research that is ethical, performative, healing, transformative, decolonizing and participatory (Denzin *et al.*, 2008), are we part of the problem? Are we reproducing the exact inequity we seek to mitigate?

PART OF THE PROBLEM?

For argument's sake, I offer the case of employing mixed methods research to examine partnerships as an example of how our good intentions can be subsumed by the dominant research traditions.

Many authors writing about research on health promotion partnerships argue for the inclusion of more mixed method studies (e.g. Granner and Sharpe, 2004; El Ansari and Weiss, 2006). Some of the arguments for adopting more mixed method studies include the ability to mix approaches which can unbind the researcher to a particular tradition and allow a wider range of research questions (Brent and Kraska, 2010). Proponents also argue that words, images and stories can add meaning and depth to quantitative data (Brent and Kraska, 2010), while quantitative research can add specificity and breadth to qualitative findings (Jick, 1979, De Lisle, 2011). Furthermore, it is argued that reliability and validity can be enhanced through a convergence of qualitative and quantitative evidence (De Lisle, 2011) and that triangulation of research methods can create more complete knowledge that a single method may overlook (Jick, 1979).

While these arguments sound compelling, there are some problems. Symonds and Gorard (Symonds and

Gorard, 2010) take issue with the adoption of mixed methods research suggesting it is based on limiting stereotypes of the two approaches. Rather than stimulating new ways of thinking, they assert, mixed methods research actually perpetuates division and in this way acts against its own aims. Giddings and Grant (Giddings and Grant, 2007) argue mixed methods are a covert way of perpetuating the dominance of quantitative methods as the only 'acceptable' kind of research, describing mixed methods as the Trojan Horse of positivism. They write 'scrutinizing the available mixed methods research literature, the reader may gain the impression that qualitative research is only exploratory to, or supportive of, quantitative research data. This intimates that qualitative research cannot stand on its own and is only validated by being attached to a scientific, quantitative, evidence-based methodology (p. 58).'

Sim and Sharp (Sim and Sharp, 1998) take issue with the concept of 'triangulation.' They assert that some questions are only appropriately answered with one method. If for instance some researchers wanted to know about patients' experience with chronic illness they would want to do in-depth interviews with them on their experience. If they also administered a questionnaire they might gather some interesting information but it would not provide information relevant for the initial research question about their personal experience. Perhaps the most telling critique is that there is a fundamental conflict between the epistemological traditions of quantitative and qualitative research and the notion of triangulation (Sim and Sharp, Giddings and Grant). If quantitative and qualitative methods are being used to triangulate the phenomenon understudy and they disagree, which method is superior? How do you determine the true version of reality? This issue points to the larger question and the most pertinent of these points—does the whole concept of triangulation for the purposes of validity presuppose that there is *one observable reality*? And if that is the case, that is not in line with notion of a pluralistic and socially constructed reality, and cannot claim adherence to the philosophical underpinnings of qualitative methods. Thus, the pluralistic intention is subsumed by the dominant (post)positivist notion of reality (see Cook, 2012 for a discussion of this in relation to 'reliability' in qualitative research).

CRITICAL METHODS FOR GREATER EQUITY

As we engage in research, we question and come to understand our reality. By engaging in research that

employs feminist, indigenous, anticolonial, critical race and other critical methodologies, we might ask better questions, locate better data and define a more multi-voiced and representative interpretation of reality. As we uncover and unravel the complex ways in which inequity is reproduced, we might move toward understanding how to create a truly emancipatory experience of health promotion—one in which, all people(s) are able to realize their aspirations as an equitable, self-determined, place-based experience. Such perspectives are no doubt challenging to many in the field, and at *Health Promotion International*, we see it as our role to provide a safe and supportive forum that encourages reflection on knowledge production in its many forms.

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