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Original Research

Exploring conceptualizations of knowledge translation, transfer and exchange across public health in one UK region: a qualitative mapping study

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ABSTRACT

Objectives: Knowledge translation (KT) is becoming common vocabulary, but as a concept it is not clearly defined. Many related terms exist; these are often used interchangeably and given multiple interpretations. While there is a growing body of literature exploring these concepts, using it to inform public health practice, strategy, research and education is challenging given the range of sources and need for local 'contextual fit'. This study explores how various public health stakeholders make sense of, and experience, KT and related concepts.

Study design: A qualitative mapping study using a phenomenographic approach.

Methods: Thirty-four academics, students and practitioners working in public health across the north east of England participated in six focus groups and five one-to-one interviews. Discussions were audio-recorded, transcribed and analysed using a thematic framework approach. The framework drew on findings from reviews of the existing literature, whilst allowing unanticipated issues to emerge.

Results: Three main themes were identified from the stakeholder discussions:

- (i) *Definitions:* there was some agreement in terms of meanings and interpretations of core concepts relating to KT, although stakeholders spoke of the differing 'languages' across disciplines and sectors;
- (ii) *Process issues:* access to funding, targeted messages, the nature of the evidence base, and wider contextual factors were identified as barriers or facilitators to KT; and
- (iii) *People:* various KT roles and responsibilities were highlighted for the different stakeholder groups.

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Conclusions: This study has enabled further development of theoretical understandings of the KT discourses at play in public health, and identified the ways in which these may be bound by discipline and context. Ironically, the findings suggest that terms such as knowledge translation, transfer and exchange are seen as themselves requiring translation, or at least debate and discussion.

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Introduction

Evidence-based medicine is defined as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’,¹ where ‘best evidence’ tends to equate with published research findings. The rise of evidence-based medicine was prompted by wide variations in clinical practice, poor uptake of effective therapies, and persistent use of ineffective technologies.² Similar patterns have been observed in other fields, including social care, education and public health. The assumption is that closing the research-practice gap leads to more effective policy and practice, both in terms of cost and clinical outcomes.³ However, it is estimated that securing evidence uptake may take up to 10 years, if it occurs at all.^{4,5} Furthermore, it is now recognized that getting evidence into, or indeed out of, policy and practice is not a straightforward or linear process and to view it as such may be misleading.^{6–9}

The Cooksey review⁴ of publicly-funded health research in the UK highlighted two key gaps: in translating ideas from research into new products and approaches; and putting those products and approaches into practice. The term ‘knowledge translation’ (KT) is increasingly used to describe the work required to close or bridge these gaps.^{10–15} KT is becoming common vocabulary, but it is not clearly defined nor are there agreed meanings in many areas of health and social care. The core issue involves the multiple interpretations, paradigm perspectives and discourses that exist across a range of contexts.¹⁶ These perspectives range from a linear bench-to-bedside view to a focus on co-creation and the organic complexity of systems.^{8,14,17} A multitude of related terms exist and are often used interchangeably; for example, knowledge transfer, knowledge exchange, knowledge mobilization and knowledge management.¹⁸ While there is a growing body of literature exploring these concepts, using it to inform public health practice, strategy, research and education is often difficult given the range of sources, worldviews upon which they are based and need for local ‘contextual fit’.

The north east of England provides the context for the study reported here. Levels of health and deprivation in the region are among the worst in the UK, with some of the lowest life expectancies in England and the highest rates of binge drinking, adult smoking and early deaths from cancer.¹⁹ Enhanced approaches to knowledge development and implementation are crucial in understanding and tackling local issues. Funded by Fuse (a UKCRC Centre for Translational Research in Public Health), this study was undertaken

to map and explore the ways in which different public health stakeholder groups make sense of, and experience, KT in practice.

Methods

Drawing on a phenomenographic approach, a qualitative concept mapping exercise was carried out to address the study aim. Concept mapping is a useful strategy in qualitative inquiry, allowing researchers to surface participants’ meaning, whilst also exploring the connections that participants identify and discuss across concepts or bodies of knowledge.²⁰ Furthermore, concept maps help to ensure that qualitative data is embedded in a particular context.²¹ Phenomenography is an empirical research tradition focusing on describing, exploring and comparing the conceptions people hold.^{22,23} It investigates ‘the qualitatively different ways in which people understand a particular phenomenon or an aspect of the world around them’ (p. 335).²⁴ It is concerned with the relationships people have with the world, in recognition that different people will not experience a given phenomenon or aspect of reality in the same way. In the context of this study, phenomenography has been used to explore and define the different ways in which people experience, perceive, understand, interpret and conceptualize the phenomenon of KT.

Sampling and recruitment

The Fuse centre administrator distributed study information to Fuse mailing lists incorporating over 400 individuals working, studying or volunteering in the field of public health within various agencies and sectors across the north east. The email emphasized that participation was voluntary and invited people to ‘opt in’ by reply. Respondents were asked to circulate the study information to relevant others. The concept of organizational, academic and practice knowledge contexts was used to organize respondents into stakeholder groups.^{25,26} Fifty-two individuals expressed interest and 34 consented to take part in the study, including 15 academic staff, 14 PhD students/early career researchers (ECRs), and five people working in public health practice in the public, private or voluntary sectors.

Data collection

Focus groups were chosen as the main mode of data collection, allowing several perspectives to be collected and enabling participants to question each other, as well as

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