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CRITERIA FOR GOOD PRACTICE IN HEALTH PROMOTION ADDRESSING SOCIAL DETERMINANTS

DEVELOPED BY THE GERMAN COOPERATION NETWORK 'EQUITY IN HEALTH'

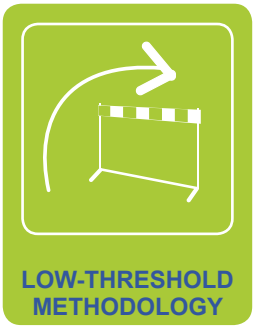
CONCEPT AND PROJECT PLANNING

TARGET GROUP ORIENTATION

SETTINGS APPROACH

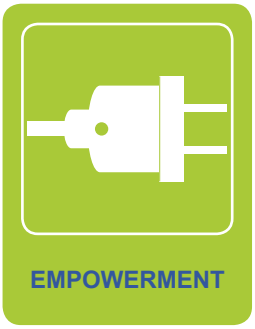
INTEGRATING INTERMEDIARIES

SUSTAINABILITY



LOW-THRESHOLD METHODOLOGY

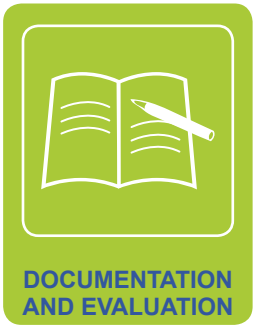
PARTICIPATION



EMPOWERMENT

INTEGRATED ACTION/ NETWORKING

QUALITY MANAGEMENT



DOCUMENTATION AND EVALUATION

CAPTURING COST-EFFECTIVENESS

OPERATIONALISING THE CRITERIA FOR GOOD PRACTICE IN HEALTH PROMOTION

WHY AND HOW?

STARTING POINT

The Criteria for Good Practice in Health Promotion developed by the German Cooperation Network 'Equity in Health' offer a specialised framework for planning and implementing health promotion interventions addressing the social determinants of health. The term 'interventions' also includes ongoing services, projects, measures and special initiatives.
This set of criteria for good practice consists of technical concepts. The good practice examples and criteria provided are intended to inspire stakeholders to initiate and intensify health promotion activities in their respective fields. Once the Criteria for Good Practice in Health Promotion have successfully provided an entry point to this topic, implementing them may be linked to further, process-oriented approaches to quality improvement (e.g. quint-essenz). At the same time, the good practice approach can also support the application of more general quality development concepts to health promotion.

WHAT DOES IT MEAN TO OPERATIONALISE THE CRITERIA FOR GOOD PRACTICE IN HEALTH PROMOTION?

Operationalising the Criteria for Good Practice is intended primarily as a contribution to improving our understanding of their meaning. In addition, it provides practitioners with a 'toolkit' for their day-to-day work practice and supports their efforts in reflecting on their work in light of the criteria, as well as in developing new approaches and adapting or reorienting their activities.
At the core of operationalising the criteria lies the attempt to choose a level of implementation: a range of implementation levels is set out for each criterion, which in turn are presented in ascending order of quality. A model for this approach can be found in the 'Levels of Participation'. Articulating implementation levels for each criterion supports one of the goals of quality development: to find pathways and possibilities for developing health promotion practice.
Conceptual questions regarding operationalisation are discussed in the concluding section, entitled 'Challenges of Operationalisation'.

WHAT ARE THE OBJECTIVES OF OPERATIONALISATION?

Operationalising the criteria is intended to help practitioners

- Become sensitised to the special demands of health promotion addressing social determinants that impact on the target group(s)
- Facilitate access to and working with the Criteria for Good Practice
- Reflect on their own work, and encourage an evaluation or the reorientation of any stated objectives
- Become informed about options for implementing the criteria
- Describe the process of implementing the criteria.

HOW ARE THE CRITERIA OPERATIONALISED?

Operationalising the criteria is based on existing specialist concepts for health promotion addressing social determinants, especially those already developed as part of the 'Guiding Concepts of Health Promotion and Disease Prevention' (*http://concepts-health-promotion.bzga.de/*). Each criterion is presented in a profile comprising the following four components:

- **DEFINITION:** A brief summary of the core content of the criterion. Wherever possible or necessary, definitions cross-reference other criteria.
- **IMPLEMENTATION LEVELS:** Where possible, the criteria are presented and illustrated using a series of implementation levels and stages (example: 'Levels of Participation'). Each level has its own recognisable title, which aims to clearly associate the respective work practice with one of the implementation levels, or at least to offer some guidance to do this. At the same time, it indicates possibilities for further development and potential goals. This staged approach emphasises that implementing the criteria is to be seen, above all else, as a process; a process that normally neither begins at 'point zero' nor does it necessarily require reaching the top level of implementation. It is an alternative model to the widely used assessment approach, which only allows for one of two results: 'achieved' or 'not achieved'.
- **EXPLANATIONS:** Each individual implementation level is explained briefly and illustrated by a concrete example. As far as possible, the descriptions (for higher levels of implementation) are taken from existing good practice examples.
- **REFERENCES:** These are references to selected further reading that is practice-oriented, and available online and free of charge (in German). Additional further reading may be found on the internet platform of the German Cooperation Network 'Equity in Health' at *www.gesundheitliche-chancengleichheit.de*.

CHALLENGES OF OPERATIONALISATION

Operationalising the Criteria for Good Practice aims to promote reflection on the quality of the work. Service providers then develop their own concrete measures for improvement. For operationalisation to occur, the challenge for practitioners is to find realistic responses to the following questions:

- **Are the operationalised criteria telling me what to do?**
  Because of the complexity in this field and the diversity of health promotion interventions, it is neither realistic nor useful to provide concrete implementation advice as part of the individual profiles for the Criteria for Good Practice. Rather, in order to be applicable in as many different fields as possible, the profiles offer descriptions of ideal scenarios for the implementation levels that may not be equally relevant to all health promotion fields and service types. It remains the task of practitioners to adapt the ideas and content of the criteria to their respective field of work.

- **Will I always be able to associate my work with one of the implementation levels unequivocally?**
  This will not always be possible since the individual implementation levels may also occur in combination, and often overlap. Complex setting-based interventions may cover several levels simultaneously.

- **Do I always have to try to reach the top level?**
  The order of the levels for implementing the Criteria for Good Practice primarily indicates the general direction in which the quality of health-promotion practice can be improved. For various reasons – e.g. because of time constraints or because of a lack of flexibility in implementation at the local level – even a 'low' implementation level may be considered (at least temporarily) to be the best result possible. If the reasons can be documented, an important objective of quality improvement has been achieved. However, it is important to ensure that suboptimal implementation results do not exacerbate existing social inequalities.

- **Does improvement always lead from one level to the next?**
  Does improvement always lead from one level to the next? This may be the case, but not necessarily. The order of levels does not prescribe a developmental process. Rather, it gives a structure to the possible manifestations of each criterion. In practice, however, some areas within an intervention may skip whole levels or enter at a higher level.

We look forward to your feedback and questions regarding the use of the Criteria for Good Practice profiles. Please email us at *good-practice@gesundheitliche-chancengleichheit.de*.

ACKNOWLEDGMENTS

Our thanks go to all members of the Advisory Committee of the German Cooperation Network 'Equity in Health', and to all partners who contributed feedback, suggestions and helpful examples to the development of the profiles.

The members of the Good Practice Working Group of the Equity in Health Advisory Committee are:

- Christa Böhme (Deutsches Institut für Urbanistik)
- Prof. Raimund Geene (Hochschule Magdeburg-Stendal)
- Iris Grimm (Bayerisches Zentrum für Prävention und Gesundheitsförderung, Koordinierungsstelle Gesundheitliche Chancengleichheit Bayern)
- Susanne Jordan (Robert Koch-Institut)
- Prof. Lotte Kaba-Schönstein (Hochschule Esslingen)
- Holger Kilian (Gesundheit Berlin-Brandenburg e.V.)
- Dr. Frank Lehmann (BZgA)
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- Dr. Andreas Mielck (Helmholtz-Zentrum München)
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THE 12 CRITERIA – OVERVIEW

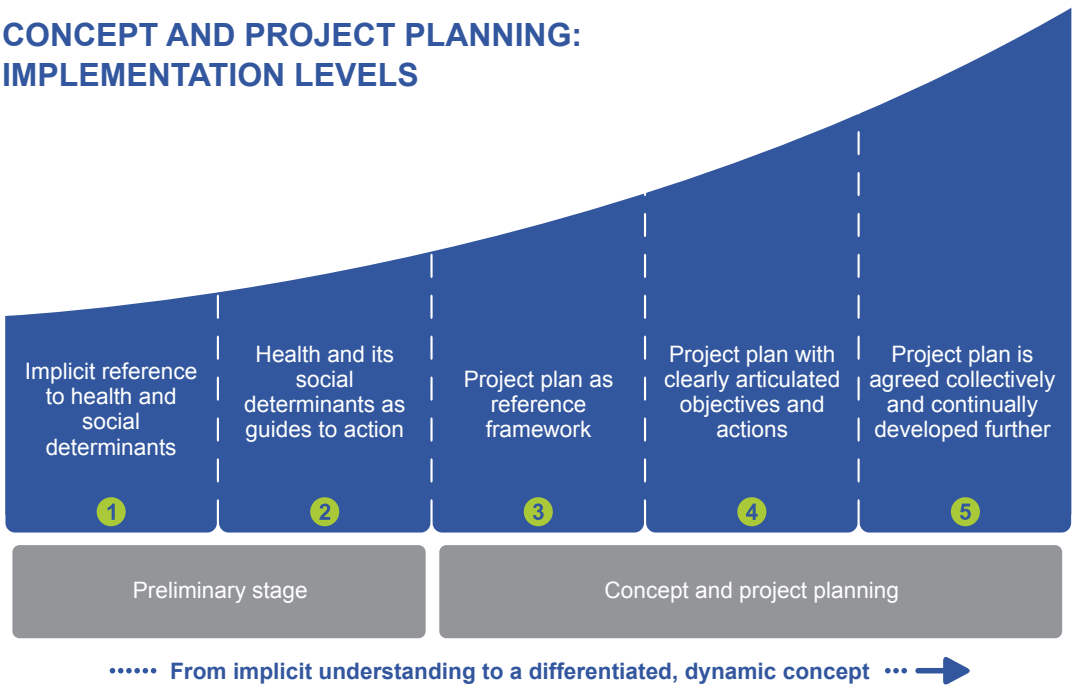
01 CONCEPT AND PROJECT PLANNING

DEFINITION

The project plan for an intervention should establish a clear conceptual connection to health promotion and/or prevention. The project plan explains which (disadvantaged) groups the intervention targets, and articulates, based on an assessed and defined need, measurable objectives. It also describes the measures and methods necessary to achieve the objectives, and to promote equity in health. The project plan also includes information on budgeting and timelines.

The project plan responds to the needs and circumstances of the target group. These should be established, if possible together with the target group (↗ Participation), in advance. The project plan makes clear reference to promoting equity in health, and serves as a guideline for shaping and assessing day-to-day work (↗ Documentation and Evaluation).
All staff should be acquainted with the project plan, which articulates a shared understanding of the work. As the work proceeds, it is – together with the target group and other stakeholders – developed further as the need arises.

CONCEPT AND PROJECT PLANNING: IMPLEMENTATION LEVELS



EXPLANATIONS

LEVEL 1 IMPLICIT REFERENCE TO HEALTH AND SOCIAL DETERMINANTS

Health and its social determinants are used as reference points for the methodology of the intervention and are also part of the professional identities of those involved. Such reference points may be based on a particular part of a city, the health or social situation in the area, within a residential district or in a facility, or on the occupational or professional specialisations of the staff. However, at this level they are not articulated in the project plan for the respective intervention, or in other materials or publications, and therefore only exist implicitly (i.e. they are not spelled out).

EXAMPLE

In a disadvantaged city district, the municipality establishes a new neighbourhood park with a range of exercise areas, but without explicitly mentioning their role in promoting physical exercise in the project plan for the park.

LEVEL 2 HEALTH AND ITS SOCIAL DETERMINANTS AS GUIDES TO ACTION

Health and social determinants are not expressly mentioned in the written project plan for the intervention. They are, however, articulated and evident in e.g. annual reports, specialist articles and other publications.

EXAMPLE

In a letterbox-drop leaflet distributed on the occasion of the opening of the new neighbourhood park, the municipality uses the headline “Sports and Exercise in the Great Outdoors” to direct the attention of the local population in an disadvantaged part of the city to the exercise areas now available in the new park. The overall contribution of these areas to promoting physical exercise, however, is not mentioned expressly in the project plan for the park.

LEVEL 3 PROJECT PLAN AS REFERENCE FRAMEWORK

A project plan is prepared in which reference is made to social determinants and health promotion as core reference points for the work. They thus function as an important framework for orienting the project’s activities.

EXAMPLE

In the project plan for the new neighbourhood park, the municipality explains that promoting physical exercise among the local population is one of the central reference points for the establishment of this new public green space.

LEVEL 4 PROJECT PLAN WITH CLEARLY ARTICULATED OBJECTIVES AND ACTIONS

The project plan describes how the work relates to health and social determinants, and articulates measurable overall objectives within this context. These could, for example, be based on the 'SMART' criteria:

- **S**pecific
- **M**easurable
- **A**cceptable
- **R**ealistic
- **T**ime-bound

The plan also articulates concrete actions for achieving these objectives.

EXAMPLE

The municipality embeds promoting exercise among the local population in the project plan as one of the main objectives for the new neighbourhood park. It also explains in the project plan how this goal can be reached: through the exercise-promoting design of the park on the one hand, and, on the other hand, through cooperating with a neighbourhood sports club that offers an exercise programme in the park for a range of age groups.

LEVEL 5 PROJECT PLAN IS AGREED COLLECTIVELY AND CONTINUALLY DEVELOPED FURTHER

The relationship of the intervention to health and social determinants, as well as the values, attitudes, methodologies and quality standards to guide the work of individual contributors, are based in a collectively agreed project plan with relevant, clearly articulated objectives and actions. The project plan is – according to the 'public health action cycle' (cf. Ruckstuhl et al. and Rosenbrock & Hartung in the references section) – revised regularly regarding its original objectives, and regarding the degree to which they have been reached (↗ Documentation and Evaluation) and further developed (↗ Sustainability) in collaboration with the target group (↗ Participation).

EXAMPLE

One year after the opening of the new neighbourhood park, the municipality organises a public consultation in that part of the city. The central topic is the level of acceptance and utilisation of the new park by the local population. The discussions with the attending residents, among them many adolescents, also include whether the exercise equipment and activities available in the park are being accepted and used by the local population, as well as any other wishes or suggestions for their further development. Based on the results of these discussions, the project plan for the park is revised and – with sponsorship through a local company – a skate park for adolescents is built in the park as an additional exercise facility.

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Please quote this profile as follows:
German Cooperation Network 'Equity in Health' (2015): 'Concept and Project Planning' – Criteria for Good Practice in Health Promotion Addressing Social Determinants, Cologne and Berlin.

The profiles for all twelve criteria may be found at *www.gesundheitliche-chancengleichheit.de/good-practice*.

NOTES

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02 TARGET GROUP ORIENTATION

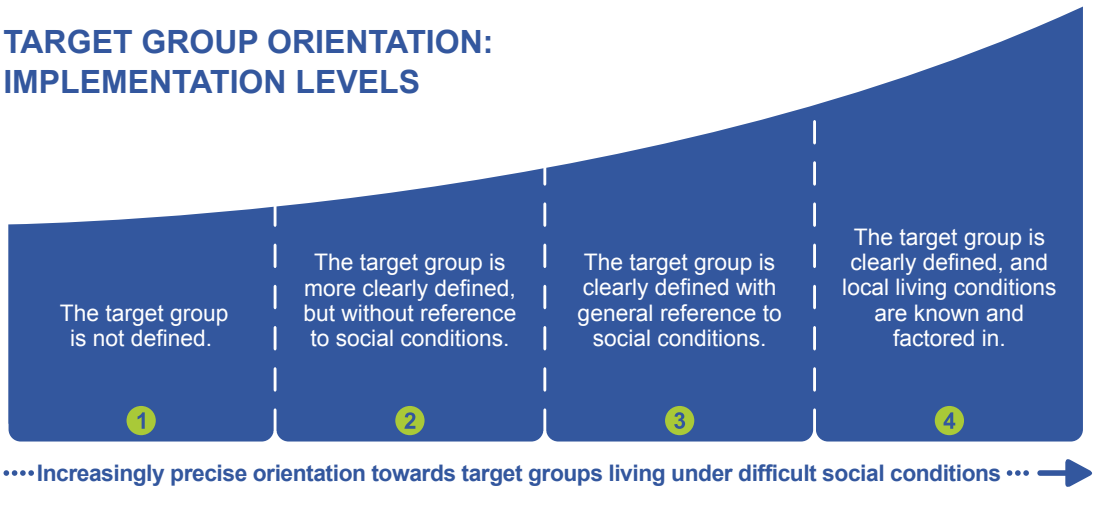
DEFINITION

The target groups should be clearly defined in the ➝ Concept and Project Plan. Any problems resulting from difficult social circumstances and social disadvantage should also be described in detail. Examples of markers of social disadvantage are material poverty, lack of education and both parents having a migration background – especially when they occur in combination. Further characteristics of the target group should also be included, e.g. age and sex (discussed in the professional literature under the terms 'cultural competence'/'diversity'). A range of target groups for health promotion addressing social determinants is listed in the German 'Equity in Health' practice database.

Health-promoting activities are geared toward improving individual coping mechanisms (➝ Empowerment) and health-related living conditions of socially disadvantaged target groups (➝ Settings Approach) in the long term. The intervention reflects the particular needs and skills of the target groups (➝ Participation) and is easily accessible (➝ Low-Threshold Methodology).

A brief note on the ongoing **debate regarding the term 'target group'**: the term 'target group' is easy enough to understand, though the metaphor projects an image that is likely unintentional – that someone turns others into targets and a separate group of individuals is the 'target'. This metaphor cannot be reconciled with the concept of participation. One could also say 'recipients', but this has a rather abstract and academic sound to it. Since no better term seems to have been found yet, 'target group' is used in this and all other profiles.

TARGET GROUP ORIENTATION: IMPLEMENTATION LEVELS



EXPLANATIONS

LEVEL 1 THE TARGET GROUP IS NOT DEFINED

The → Concept and Project Plan for the intervention does not indicate, or only indirectly indicates the population group to be addressed.

EXAMPLE

As part of an intervention to prevent tobacco use, health promotion materials are developed that inform the reader about the health risks of smoking. They are made available in public buildings, distributed to schools and used during information sessions. In addition to health information, the materials also include contact details of local counselling services and links to online information sources.

LEVEL 2 THE TARGET GROUP IS MORE CLEARLY DEFINED, BUT WITHOUT REFERENCE TO SOCIAL CONDITIONS

The intervention is limited to a specific population group, though there is no explicit focus on groups living under difficult social conditions.

EXAMPLE

An intervention to prevent tobacco use aims to sensitise children and adolescents in particular, and to motivate them not to start to smoke in the first place. Information materials designed for children and adolescents are developed, and distributed during information sessions at schools and during other activities. Also included are youth centres and sports clubs across the municipality.

LEVEL 3 THE TARGET GROUP IS CLEARLY DEFINED, WITH GENERAL REFERENCE TO SOCIAL CONDITIONS

The role of social conditions is illustrated based on general information contained in the project plan for the intervention. Health effects on the target group associated with social disadvantage are mentioned explicitly, albeit based only on findings from general studies or other reliable sources.

EXAMPLE

An intervention to prevent tobacco use among children and adolescents (see also the example for Level 2) uses the results of the German national survey on the health of children and adolescents (KiGGS). The intervention is primarily directed at children and adolescents from 10 to 11 years of age who – statistically speaking – do not smoke yet. Because, according to the KiGGS study, the proportion of adolescents who smoke is closely related to socioeconomic status, activities are focused on particularly underdeveloped city districts.

LEVEL 4 THE TARGET GROUP IS CLEARLY DEFINED, AND LOCAL LIVING CONDITIONS ARE KNOWN AND FACTORED IN

The stated factors leading to social disadvantage and burden of disease among the target group for the intervention are based not only on generalised types of evidence; specific local living conditions and problems are also described. This is achieved through including representatives of the target group in the planning phase of the intervention (→ Participation) or by including relevant intermediaries (→ Integrating Intermediaries). Detailed knowledge about and participation of the target group maximise the potential effectiveness of the intervention.

EXAMPLE

An intervention to prevent tobacco use among children and adolescents refers to national government health reports (see level 3) and also includes – where available – the findings of local sociological and health reports. In addition, those responsible talk to teachers, parents, staff at youth centres and sports clubs, as well as to students themselves in order to obtain further information about the smoking behaviour of children and adolescents. Discussion topics include, for example, the role of smoking in social situations, possible 'initiation scenarios', as well as the role of peers and places where people smoke. Based on this information, the intervention is designed to enable children to work on the topic of 'smoking' against the backdrop of their actual living conditions, and in a way that takes their own settings into account (→ Settings Approach).

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Please quote this profile as follows:
German Cooperation Network 'Equity in Health' (2015): 'Target Group Orientation' – Criteria for Good Practice in Health Promotion Addressing Social Determinants, Cologne and Berlin.

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03 SETTINGS APPROACH

DEFINITION

A settings approach takes people's lived experience and social environment into consideration, including the conditions for playing, learning, working and accommodation (in accordance with the Ottawa Charter for Health Promotion). The conditions in the respective settings – be it at school, at work, in the city district or in the local neighbourhood – exert a significant influence on the opportunities for living a healthy life.

Health promotion according to the settings approach aims to establish healthy living conditions. It also strengthens individual and collective skills, as well as the resources people have within their respective setting (→ Empowerment) to actively participate in shaping these conditions (→ Participation).

Health promotion according to the settings approach is thus more than just health promotion occurring *within* a social setting (e.g. information sessions at school). The settings approach aims to create healthy living conditions in a participatory way – with the active involvement of those immediately affected, for example by establishing health-oriented programmes for schools development. Here, the approach makes reference to organisational development concepts.

As good practice in a settings approach depends on working on several components and on several levels simultaneously (see diagram), operationalising this criterion is

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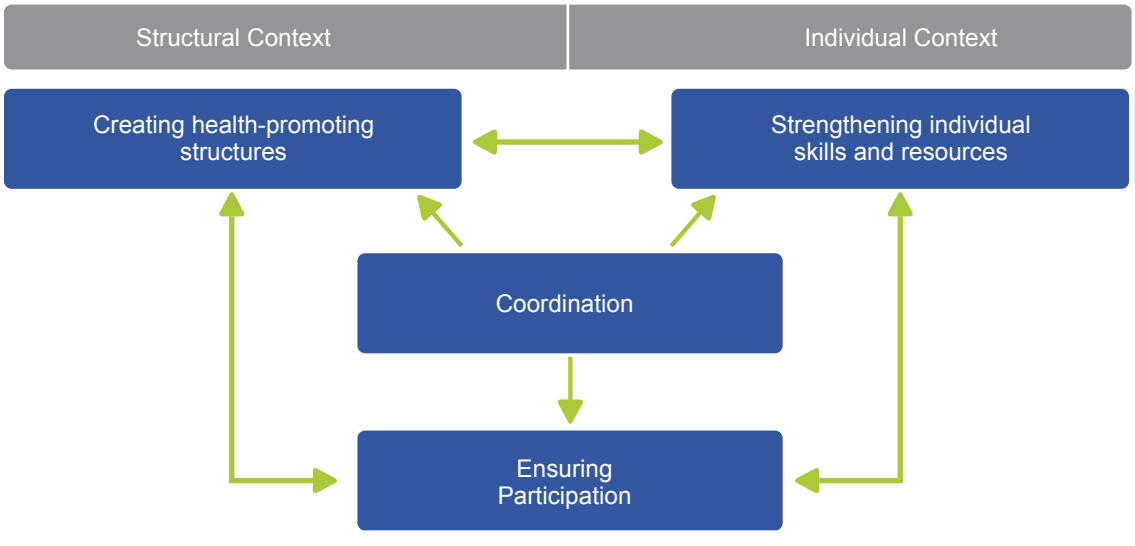
SETTINGS APPROACH – COMPONENTS



Based on: **Gesundheit Berlin-Brandenburg e. V.** *(ed.) (2014): Aktiv werden für Gesundheit – Arbeitshilfen für kommunale Prävention und Gesundheitsförderung, Heft 1: Gesunde Lebenswelten schaffen. 4th revised edition, Berlin. p. 15.*

Continued from page 15

not divided into levels of implementation, but into components.

Four components are of central importance for implementing the settings approach:

- Creating health-promoting living conditions (at the structural level)
- Strengthening the skills and resources of the people living or working within the social setting (at the individual level)
- Active participation of the people within the setting in all phases of planning, and implementing behaviourally and structurally focused activities (→ Participation)
- Continuous and professional coordination of all activities.

EXPLANATIONS

Each of the four core components of the settings approach described below must not be seen in isolation. Rather, they are mutually dependent and support each other. Only in synergy do they develop their ability to promote sustainably healthy social settings.

CREATING HEALTH-PROMOTING STRUCTURES

Health-promoting components that are established in a social setting sustainably and for the long term become a fixed structural component of that setting. The nature of these components is determined collectively by the stakeholders in the setting, using participatory processes (see also the 'Ensuring Participation' component of this criterion). This ensures that structural changes are accepted and 'lived' by all involved. Organisational development methods can be helpful in carrying out this task. In this process, points of connection to local government health promotion strategies are identified and developed (→ Integrated Action/Networking).

EXAMPLE

- As part of a 'Healthy Schools' strategy, aspects of everyday life at school that promote, and those that are detrimental to health, are identified, and changes are agreed and implemented sustainably in a joint process involving teachers, students and parents. This includes, for example, classroom architecture and the design of outdoor areas, school lunches, rules for interaction among teachers and students within the school, the pace of lessons as well as the active participation of the school in the implementation of integrated local government (health) strategies. All changes are documented in writing, and included in a consensual mission statement and the school's strategic plan.

STRENGTHENING INDIVIDUAL SKILLS AND RESOURCES

The target group is enabled to actively address problems and sources of stress, to articulate solutions and coping strategies, and to implement them. These skills are important prerequisites for becoming actively involved in participatory processes (see also the 'Securing Active Participation' component of this criterion) and to influence the design of health-promoting structures (see also the 'Creating Health-Promoting Structures' component of this criterion). This also illustrates the close relationship of this component to the → Empowerment criterion.

EXAMPLE

As part of a 'Healthy Schools' strategy, students spend time – in lessons, as part of week-long projects and even at dedicated weekend events – considering what benefits them and what keeps putting them under stress in their everyday school life. They learn to articulate their judgements and experiences, to advocate for them with parents and teachers, and to collectively translate them into concrete suggestions for change. Teachers and parents also expand their skills by engaging, for example, with the topic of health, and with designing participatory processes.

ENSURING PARTICIPATION

All activities and interventions to implement the settings approach are carried out with the active participation of all affected parties. The participatory and shared decision-making processes are transparent, binding and documented. A prerequisite for the success of participatory processes is that they result in concrete and sustainable changes (see also the 'Creating Health-Promoting Structures' component of this criterion), and that the participants develop the necessary skills (see also the 'Strengthening Individual Skills and Resources' component of this criterion). The close relationship of this component to the → Participation criterion becomes apparent here, too.

EXAMPLE

All stakeholder groups involved (teachers, students, parents and other contributors) agree in a transparent process on all developmental steps towards a 'Healthy School'. This provides all groups with opportunities to participate in decision-making, e.g. in the form of a steering committee. Participatory processes are binding and have become a central component of the school's modified structures (see also the 'Creating Health-Promoting Structures' component of this criterion).

COORDINATION

All activities within the settings approach are coordinated continuously and professionally. Conceptually, coordination is an integral part of the settings approach and is based on solid financial and human resources. Those in a coordinating role should be closely acquainted with the respective social setting, be accepted by the individuals persons or groups represented within it, and be familiar with, among others, organisational development and participatory quality development methods.

BEISPIEL

Along the way towards a 'Healthy School', a 'health team' is established that accompanies the entire process and supports further development, for example by preparing matters to be decided by the school's steering committee (see also the example for the 'Ensuring Participation' component of this criterion). This health team consists of teachers, parents, students, as well as additional partners (e.g. a statutory health insurance provider), if appropriate. The school appoints a teacher to act as 'health promotion coordinator', who facilitates the health team and coordinates the developmental process taking place at the school. The teacher's class contact hours are reduced to free up time for these coordination tasks.

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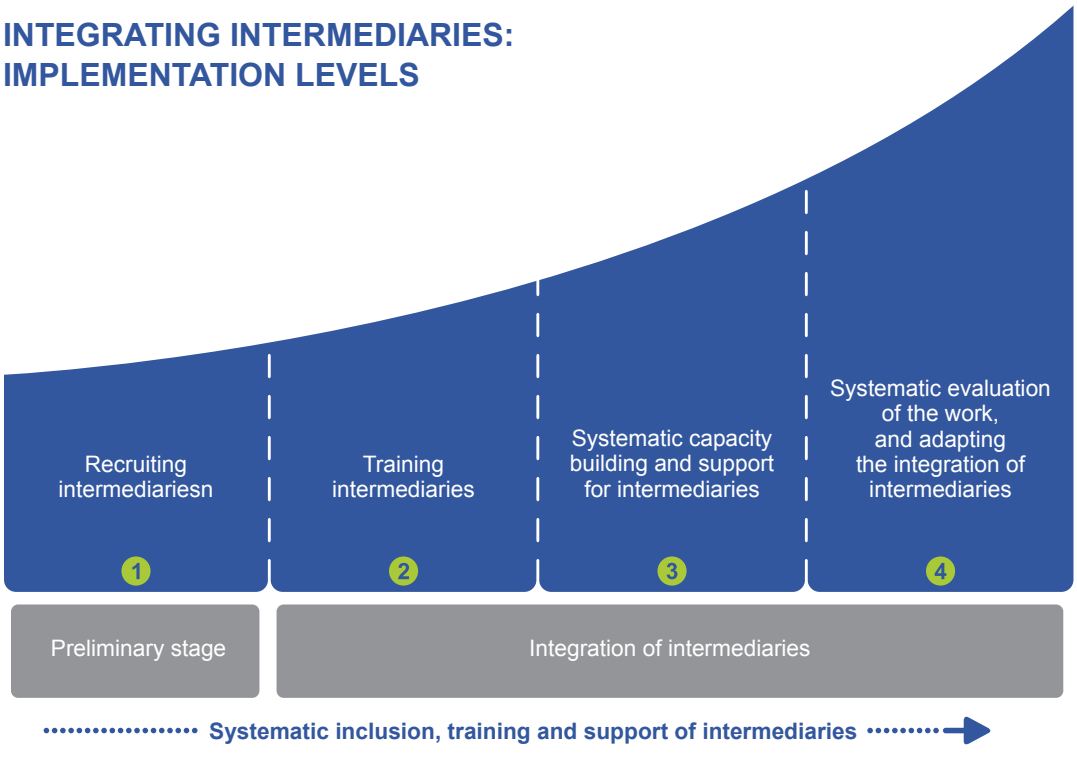
04 INTEGRATING INTERMEDIARIES

DEFINITION

Integrating intermediaries means deciding which individuals, groups of individuals or institutions will be involved and how they will be systematically integrated into and trained to carry out the intervention. Intermediaries communicate health promotion content and messages to members of the ↗ Target Group. They may, for example, provide information about a service and support members of the target group in accessing it.

Following the requisite training, intermediaries may also independently address topics, for example by teaching courses or leading groups. Considered as potential intermediaries may be 'professionals' (e.g. physicians, social workers and teachers), or accepted and trusted members of the target group ('peers'), who then function as 'key individuals' in groups that professionals have difficulty accessing.

INTEGRATING INTERMEDIARIES: IMPLEMENTATION LEVELS



EXPLANATIONS

LEVEL 1 RECRUITING INTERMEDIARIES

Staff members who implement an intervention approach potential intermediaries with a request to contribute to health promotion with and for the target group. Having agreed, they are then requested to support the set objectives and the actions required to achieve them as best they can.

EXAMPLE

A health insurance provider would like to inform the parents of primary school students about the topic of drug and alcohol prevention. The insurer produces informational materials and passes them on to the schools. Teachers are requested to hand out the materials during parent-teacher nights and to draw attention to the importance of the topic. The teachers are thus integrated as intermediaries.

LEVEL 2 TRAINING INTERMEDIARIES

The → Project Plan of the intervention prescribes that selected intermediaries are to be trained according to a training plan. The training ensures that they are familiar with the objectives, the required actions and any potential problems in order to be able to support the work as much as possibl

EXAMPLE

Teachers are to be trained as intermediaries in order to communicate drug and alcohol prevention knowledge and skills to children and their parents. Funded by a health insurance provider, a drug and alcohol service trains interested teachers and, apart from technical information, passes on important skills (e.g. on working with parents, and on gender and diversity issues). Teachers trained as intermediaries are then able to provide substantial support to drug and alcohol prevention projects.

LEVEL 3 SYSTEMATIC CAPACITY BUILDING AND SUPPORT OF INTERMEDIARIES

The intermediaries involved in the intervention are provided with regular further training and with continuous support. This ensures that materials (e.g. manuals) can be constantly revised, and that any problems occurring in the course of the work can be detected and solved quickly.

BEISPIEL

The teachers who have been trained to become intermediaries (see Level 2) have regular opportunities to exchange experiences. For this purpose, professional contact persons at the drug and alcohol service are available, i.e. they offer regular refresher courses and provide advice on any problems that may have occurred. A regular social get-together is set up across school boundaries for informal exchange among colleagues.

LEVEL 4 SYSTEMATIC EVALUATION, AND ADAPTING THE INTEGRATION OF INTERMEDIARIES

Project staff continually and systematically evaluate the work of the intermediaries. This is intended to ensure that training and support are continually adapted and improved. Feedback received as part of the evaluation also allows the project to be adapted to changes in the operating environment.

EXAMPLE

Researchers at a university of applied sciences work alongside the integration of intermediaries in drug and alcohol prevention at primary schools (see also Levels 1 - 3 above). They collate the experiences and feedback provided by the intermediaries (in this case the teachers), as well as those of the drug and alcohol service's staff, and facilitate a joint development process to update the integration of intermediaries. In addition to technical information, they discuss, above all, the demands put on the teachers and their skills as intermediaries.

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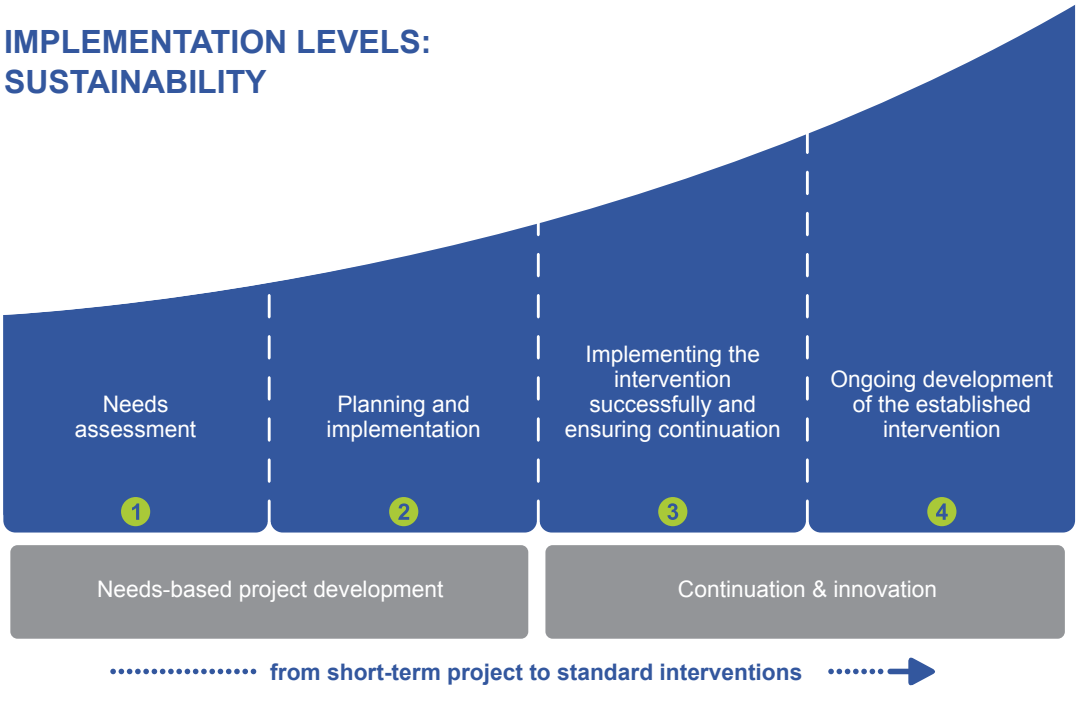
05 SUSTAINABILITY

DEFINITION

Sustainable interventions aim to produce long-term and measurable changes in the Target Groups and social settings they address. This means strengthening individual skills and resources, and creating healthy living conditions for the long term (Settings Approach). Prerequisites for sustainable effects are reliable and permanent health-promoting service structures, achieved e.g. by securing the space and personnel required, by developing collaborative partnerships, and also by linking service structures to local government strategies where possible (Integrated Action/ Networking). As part of sustainability, interventions may also be integrated into state or national-level programmes.

As part of Quality Management, providers must reflect on the approaches used to date (Concept and Project Planning) and then decide whether they are still appropriate for current problems and needs. Should these have changed, it must be decided whether new approaches and solutions – i.e. innovations – are needed. In this context, innovation is understood to mean the further development of the work and it becomes a major prerequisite for sustainable service structures beyond short-term projects, and for sustainable health benefits.

IMPLEMENTATION LEVELS: SUSTAINABILITY



EXPLANATIONS

LEVEL 1 NEEDS ASSESSMENT

Health needs and problems are established based on available information (e.g. health reports, surveys, focus groups) and the participation of, if possible, all relevant stakeholders and affected populations (→ Participation). It must then be determined which of the problems identified are to be addressed by the intervention, which existing resources are to be promoted and which options are to be pursued for long-term continuation.

EXAMPLE

In an inner city district characterised by a large percentage of low-income residents, inhabitants and experts agree that there are insufficient local counselling services regarding sexuality, health and family planning available for people with learning difficulties. They recommend establishing an innovative service and monitoring it closely during a pilot phase.

LEVEL 2 PLANNING AND IMPLEMENTATION

Objectives are determined based on the situation analysis, and suitable measures are planned to reach them and to check to what extent the objectives – particularly any health-promoting changes for the target group – have been achieved. Then, funders are approached and funding is secured to ensure implementation (e.g. as a pilot project).

EXAMPLE

The technical foundations for a specific counselling service for people with learning difficulties are developed and human resource and infrastructure requirements determined. Objectives for the project, as well as ideas for how to check whether they have been reached (→ Documentation and Evaluation), are generated as part of → Concept and Project Planning. Implementation of the pilot phase is to be carried out as part of a state-based programme that runs for 2 years.

LEVEL 3 IMPLEMETING THE INTERVENTION SUCCESSFULLY AND ENSURING CONTINUATION

As part of the project funding process (see also Level 2), activities and (intermediate) results are documented (→ Documentation and Evaluation). If there is evidence of success, efforts can be made to ensure the continuation of the work by further developing the project plan, and by looking for partners to fund and implement it. Ensuring continuity may apply to the intervention as a whole, or to some particularly important and promising components. Continuity may be ensured by integrating the service into long-term programmes, and strategic concepts at the municipal or state level, in order to secure financial support for the longer term (→ Integrated Action/Networking).

EXAMPLE

The newly developed counselling service is implemented at a family planning centre and documented. Collected are, for example, the number and duration of counselling sessions, the main issues discussed and the level of satisfaction expressed by clients. It turns out that there is indeed a large demand for this service, that it is accepted and utilised, and that clients perceive it as helpful and supportive. The counselling service continues to be funded beyond the end of the pilot phase as part of a local government inclusion strategy.

LEVEL 4 ONGOING DEVELOPMENT OF THE ESTABLISHED INTERVENTION

Even after securing the intervention for the longer term, needs are continually assessed and reflected on together with the target groups. Should new needs emerge, or should it appear that the structure of the intervention is no longer appropriate on account of changes in the operating environment, innovative approaches are developed and integrated into the work.

EXAMPLE

During the operation of the counselling service, it emerges as part of the ↗ Quality Management process that, while clients pick up the available information material, they are not able to completely grasp or use the content. Together with service users, experts in ‘simple language’ develop information materials tailored to the target group, which are becoming a new and important component of the counselling service.

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06 LOW-THRESHOLD METHODOLOGY

DEFINITION

A low-threshold methodology is characterised by the fact that it reflects access barriers to the intervention faced by the → Target Groups. Starting with the → Concept and Project Planning, it articulates approaches to the work that avoid or lower access barriers as much as possible. A low-threshold methodology takes the following potential access barriers into account:

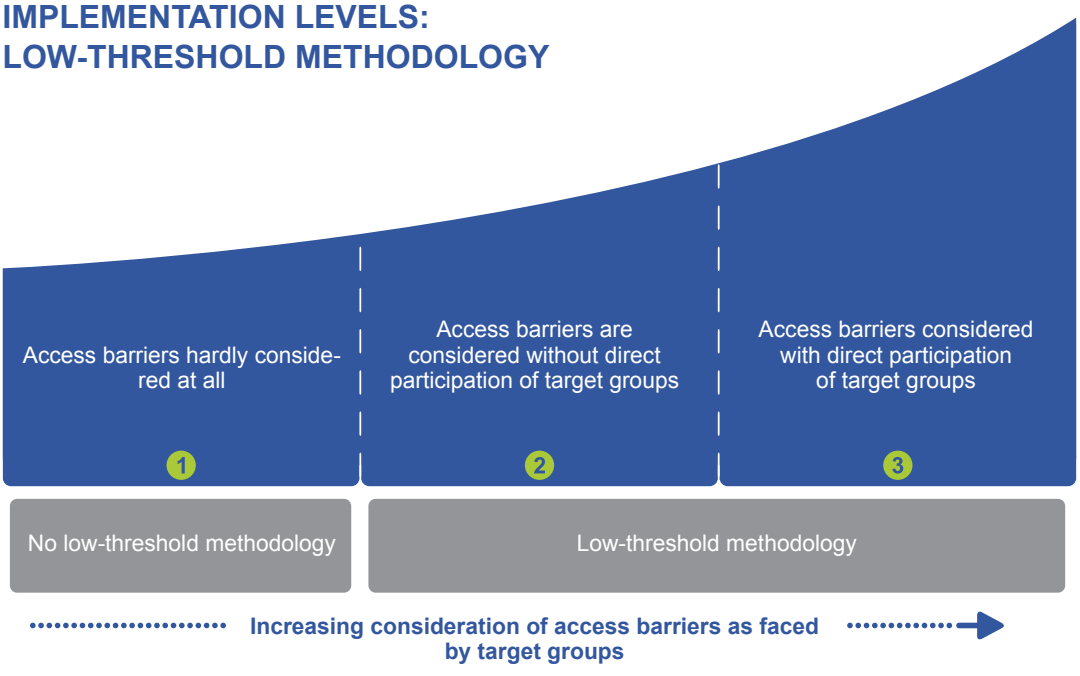
- Operational factors, such as time of day, location, costs, application and registration formalities
- Conceptual factors, such as matching needs, gender and culturally sensitive communication
- Other factors, e.g. (unintended) stigmatisation and the conditions prevailing in the local operating environment.

Typical for low-threshold methodologies are outreach and accompanying services, or combining a range of services under one roof.

Target group participation in planning and → Integrating Intermediaries can also promote a low-threshold methodology. In addition, a low-threshold methodology is one of the prerequisites for → Participation.

Knowledge and understanding of the target group's everyday life and social conditions are necessary prerequisites, as is clearly defining the target group in the first place.

IMPLEMENTATION LEVELS: LOW-THRESHOLD METHODOLOGY



EXPLANATIONS

LEVEL 1 ACCESS BARRIERS HARDLY CONSIDERED AT ALL

Based on their own experience and other information (e.g. health reporting and academic literature), the professionals involved determine the needs of the target group and design the intervention. They take guidance from relevant technical recommendations (e.g. on nutrition or exercise). Potential access barriers faced by the target group are not considered systematically.

EXAMPLE

A sports club would like to especially attract girls from a disadvantaged city district to their activities in order to strengthen their physical fitness and confidence, as well as social cohesion. Activities are conducted at fixed times in the club's sports grounds. Before the girls can participate, they or their parents must first sign up for club membership.

LEVEL 2 ACCESS BARRIERS ARE CONSIDERED WITHOUT DIRECT PARTICIPATION OF TARGET GROUPS

Based on their own experiences, professional standards and through exchange with other service providers, the professionals involved reflect on potential access barriers faced by the target group. They especially consider operational issues, e.g. opening hours, non-bureaucratic access and an outreach-oriented service structure.

EXAMPLE

A sports club is collaborating with local primary and secondary schools in order to especially reach girls from a city district under social stress. Establishing direct contact with the girls in a familiar setting is intended to increase the profile of the activities, provide information on options for participation and reduce any existing reservations. If the girls decide to participate in an activity, they must first become members of the sports club.

LEVEL 3 ACCESS BARRIERS ARE CONSIDERED WITH DIRECT PARTICIPATION OF TARGET GROUPS

Methodology and design of the intervention are guided by the setting and perspective of the target group. Being considered are not only barriers to access and participation that are based in professional standards and the experience of the professionals involved. Knowledge regarding everyday life for the target group, social conditions, needs and access barriers is also gathered through direct contact with and from the perspective of the target group, e.g. through surveys, in conversations and discussions (→ Participation).

Potential barriers to participation are avoided or kept as low as possible based on this knowledge. The target group is addressed with full consideration of its cultural and linguistic characteristics.

EXAMPLE

During the planning phase for activities for girls from a city district under social stress, a sports club contacts schools, recreational facilities, cultural associations etc. in order to reach the children and their parents. The club presents its plans for the activities and asks the children and their parents about their interests and wishes. A result may be that open-access exercise programs are developed, also jointly with collaborating partners, which will take place regularly in the afternoons in public areas of the district or in the school grounds, and won't be linked to club membership.

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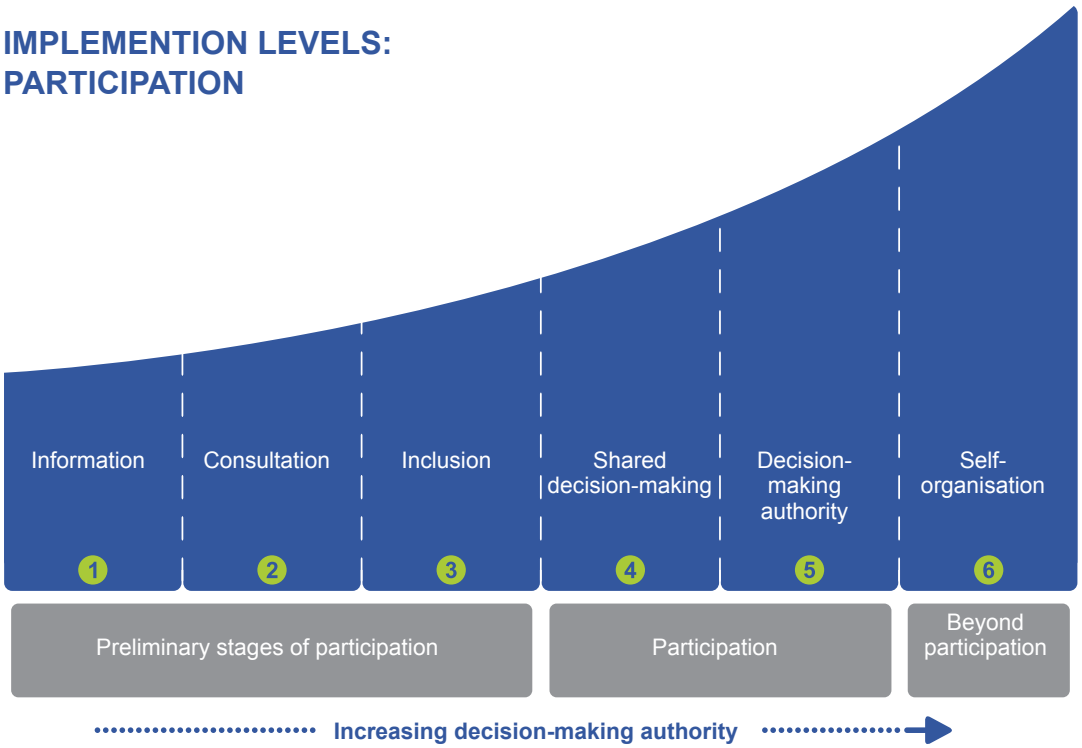
07 PARTICIPATION

DEFINITION

Participation of the → Target Groups means creating opportunities to become involved in all phases of health promotion (needs assessment, planning, implementation, evaluation), and ensuring that the participatory processes are designed according to the experience and capacity of (i.e. appropriate for) the target groups. Target groups may first have to be enabled (→ Empowerment) to articulate their own needs, and to contribute their wishes, ideas and expectations to planning, implementing and carrying out health promotion activities. Participation is a developmental process in which members of target groups increase their capacity to influence decisions more and more actively.

Those affected may demand and advocate for participation themselves, but is must also be proactively enabled and promoted in the → Concept and Project Planning. This requires detailed knowledge of social conditions as well as a respectful and empathetic attitude toward the target groups.

IMPLEMENTION LEVELS: PARTICIPATION



EXPLANATIONS

LEVEL 1 INFORMATION

Experts (e.g. nutritionists) inform the target groups about the problems that exist in their view and introduce options that may contribute to solving the problems from a professional perspective. They explain and provide technical reasons for their recommendations. The perspective of the target groups is considered – where possible – in order to increase the acceptance of the information provided and the uptake of its messages.

EXAMPLE

Using data from school entry medical examinations, local government health reporting shows that an above-average number of children from a more socially disadvantaged district are overweight or obese. On this basis, the authors recommend that those affected should eat a healthier diet and exercise more. Local government authorities react to the report by announcing more and better opportunities for exercise (e.g. through extended opening hours for sports facilities and schoolyards).

LEVEL 2 CONSULTATION

The experts would like to learn more about the target group's perspective. They interview and listen to members of the target group. However, the target groups have no influence over whether and to what extent their views are actually considered in planning health promotion interventions.

EXAMPLE

Based on the results of local government health reporting (see Level 1), the public health authority, together with local citizen's bureaus, surveys the residents of the neighbourhood regarding their exercise and dietary routines (e.g. using intercept surveys and in-depth interviews). Based on the results, training courses and information resources regarding a healthy diet and regular exercise are developed and implemented.

LEVEL 3 INCLUSION

Funders or providers of health promotion interventions consult selected individuals from the target group. These consultations, however, don't necessarily influence the decision-making process.

EXAMPLE

Based on the results from local government health reporting (see Level 1), the public health authority creates a multidisciplinary working group to develop recommendations for promoting increased exercise and a healthy diet in the district. Local residents are consulted via the citizen's bureaus about whether the proposed initiatives are helpful and expedient from their point of view. Their feedback is then included when revising the recommendations.

LEVEL 4 SHARED DECISION-MAKING

The experts consult with representatives of the target groups in order to coordinate substantial aspects of the intervention. Members of the target groups have a right to be heard, but possess no binding decision-making authority.

EXAMPLE

Based on the results from local government health reporting (see Level 1), the public health authority establishes a local government health group in collaboration with the local citizen's bureau. Apart from local government, residents as well as other stakeholders from the district (e.g. businesses and churches) are represented. The members of the health group look critically at the research questions and results of local government health reporting. They develop suggestions for a more exercise-friendly urban design of the district, e.g. by reducing traffic flow, exercise-friendly designs for public spaces (e.g. 'boules' game courts) and establishing outdoor meeting areas. However, which of these suggestions are implemented is decided by local government or the person with the political authority (e.g. the responsible city councillor).

LEVEL 5 DECISION-MAKING AUTHORITY

Involving members of the target groups in all decisions concerning the planning, implementation and evaluation of an intervention is a binding rule. This means they have decision-making authority and/or veto rights. They are informed about the extent of their decision-making options.

EXAMPLE

Based on the results from local government health reporting (see Level 1), the public health authority establishes a local government working group in collaboration with the local citizen's bureau to develop suggestions for promoting exercise and a healthy diet in the district. In addition, a budget (discretionary funding) is approved for implementing the suggestions. An advisory board in which all relevant stakeholders from the district are represented decides how the budget is used. Discussions show that the information provided and the training courses offered received little acceptance and that the district lacks a space for regular, joint activities in particular, a space that also promotes the integration of unemployed or elderly residents. The advisory board decides to use the discretionary budget to start a new community garden project and to find additional funding during the course of the project.

LEVEL 6 SELF-ORGANISATION

Members of the target group themselves initiate and carry out an intervention or project. Target group members take all decisions independently and are responsible for them. All decision makers are members of the target group. This level therefore goes beyond participation as described above.

EXAMPLE

The municipal community garden project (see Level 5) is handed over to be self-administered by the district residents. The municipality and the citizen's bureau support them with legal matters and formalities, e.g. with administrative and financial issues. A citizens' council for the district makes all relevant decisions pertaining to how the community garden project is designed and developed further.

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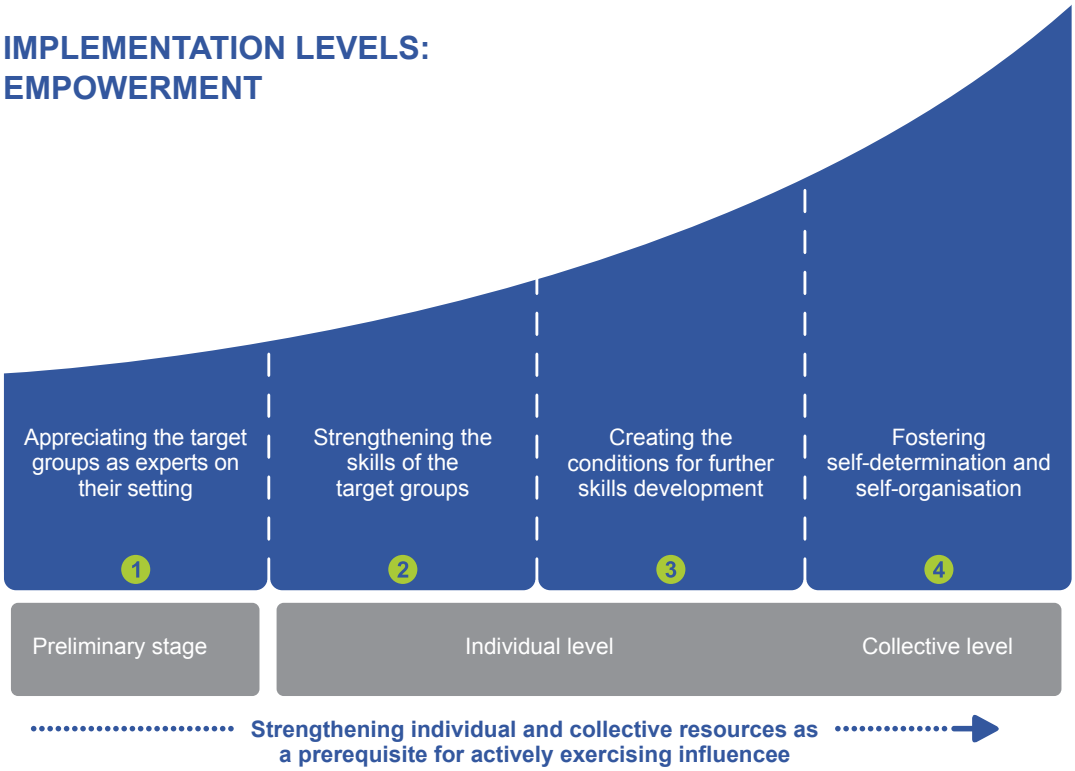
08 EMPOWERMENT

DEFINITION

Empowerment processes enable individuals or groups of people to lead self-determined lives and to shape their social environment. They build on the specific skills (resources) of individuals and the collective skills of groups of people. During the process of empowerment, health promotion stakeholders create the conditions and prerequisites that enable members of the target groups to discover their individual and collective resources, to develop them further and to convert them into practical strategies for action. An essential goal of empowerment processes is to gradually reduce dependence on support services.

Because the respective living conditions of the target groups, e.g. their social, geographic and political environment, have an influence on the development of resources, they must always be taken into account. Empowerment is often a prerequisite for successful ↗ Participation, inclusion and community building, which in turn strengthen the development of skills and capacity.

IMPLEMENTATION LEVELS: EMPOWERMENT



EXPLANATIONS

LEVEL 1 APPRECIATING THE TARGET GROUPS AS EXPERTS ON THEIR SETTING

One of the essential prerequisites or preliminary stages for all empowerment processes is for the experts to adopt an attitude of appreciating the → Target Group. This means recognising them as experts on their own lived experience and social situation who possess a range of skills and resources, which are to be strengthened and further developed as part of the empowerment process.

EXAMPLE

Staff members at a family support service in a socially disadvantaged district are thinking about the (stressful) conditions in which parents live, as well as the positive resources and commitment with which they manage their everyday life. They agree to avoid using negative and deficit-based terms such as 'families on welfare', both internally and with external contacts, and to always point out that receiving social benefits is only one aspect of their lives.

LEVEL 2 STRENGTHENING THE SKILLS OF THE TARGET GROUPS

In the course of health promotion activities, conditions are created that allow people in difficult situations to discover and strengthen their existing resources and skills.

EXAMPLE

In their interaction with family members, staff members at the family support service stress above all the skills, resources, and successes they have identified through contact with parents and children. They affirm families in continuing with positive approaches, offer them support to overcome difficulties, and refer them to additional counselling and support services where appropriate. They work alongside the families in accessing these services, in the sense of helping them to help themselves, e.g. by building their confidence in dealing with public authorities. The goal is that the families themselves will be able to find suitable services and open up perspectives for their future.

LEVEL 3 CREATING THE CONDITIONS FOR FURTHER SKILLS DEVELOPMENT

Health promotion strengthens positive approaches to skills development by promoting opportunities to link into continuing skills-building services and structures with sustained effects, as well as encouraging individual initiative.

EXAMPLE

Staff members at the family support service motivate parents to participate in a parenting course, e.g. as part of the 'ELTERN-AG' ('parents' working group') programme. In addition to discussing the demands faced by and ways of coping available to those in a parenting role, this course promotes interaction among parents in similarly stressful situations and an exchange of their current (successful) experiences with coping strategies.

LEVEL 4 FOSTERING SELF-DETERMINATION AND SELF-ORGANISATIONFÖRDERN

Health promotion supports conditions in which members of the target groups shape their own individual and collective living conditions. The goal is for 'professional' support and assistance to eventually become superfluous.

EXAMPLE

Parents are assisted to develop a longer-term vision for their future and to put it into practice, e.g. by supporting them in their search for an apprenticeship, traineeship or employment. Health promotion staff also motivate parents to maintain contact with other parents beyond the end of the programme, e.g. through self-organised meetings, and to become actively involved in support networks in their neighbourhood.

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www.gesundheitliche-chancengleichheit.de/praxisdatenbank/recherche

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09 INTEGRATED ACTION/NETWORKING

DEFINITION

Integrated action plans are important management and coordination tools for health promotion. They are generally developed in collaboration with the main stakeholder groups in the respective social setting (→ Settings Approach). A number of different levels of activity should be included in health-promoting urban and municipal development strategies across settings, ranging from national, state and local government authorities to the various local government administration departments, the local population and local stakeholders (→ Participation). Other important components are a holistic definition of health, and combining resources.

Action plans (→ Concept and Project Planning) are generally characterised by the following core components:

- Problem and needs analysis
- Objectives
- Actions for achieving the objectives
- Timeframe, schedule and implementation plan
- Budget and funding plan

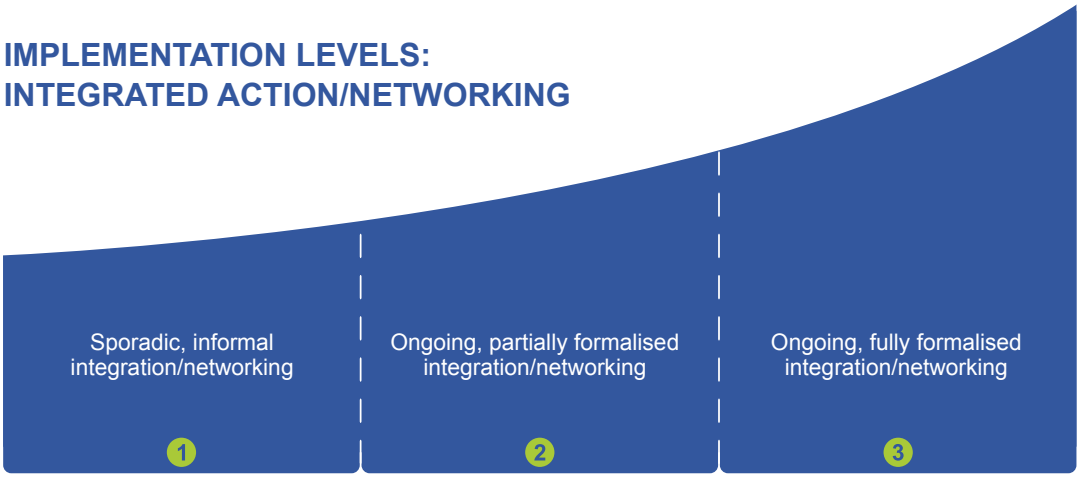
Including these basic elements is independent of whether the project plan is for an individual project of a particular provider, or a district-wide or municipal plan of a local government entity.

Integrated action plans include a number of different aspects:

- A range of professional and policy sectors (e.g. health, youth services, education, urban development/urban planning, social services, employment, environmental protection)

Continued on page 40

IMPLEMENTATION LEVELS: INTEGRATED ACTION/NETWORKING



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- A range of determinants of health, e.g. individual lifestyle, social and community networks, living and working conditions, overall environmental conditions
- A range of resources, including financial resources (e.g. the budgets of different government departments, grant funding, private funds), goods and services (e.g. premises, technical equipment) as well as human resources/technical capacity
- A range of geographic scales, e.g. neighbourhood/ward, city/town district, municipality and region
  A range of levels of government authority, e.g. local, state and national
- A range of target groups, e.g. children, adolescents, seniors, families, single parents or the unemployed.

This means that integrated action plans can possess a high degree of complexity. This makes the written form indispensable for such an action plan.

Networks are webs of interconnected relationships among stakeholders (individuals and institutions) in a particular field of action and beyond. They serve to maintain an exchange of information, to supplement resources, materials and in-kind contributions, and to adjust common goals and values. Networking is one of the central strategic actions in health promotion. Successful networking contributes to health promotion interventions becoming integrated into existing community structures according to need. In more advanced forms, collaboration leads to synergies that can become effective collective resources beyond the initial circle of partners in the network.

All networking activities should build on existing structures. One of the tasks in this context is to develop the intervention as part of local government strategies and programmes (e.g. integrated local government health strategies) – where they exist – or to promote such strategic development through joint negotiations.

Levels of intensity and commitment in collaboration can range from informal agreements, regular attendance and active contribution to formal arrangements in form of collaboration agreements or contracts.
The vision of an integrated strategy therefore reaches beyond optimising individual projects, and includes the collective, agreed design of communal health promotion structures in the sense of integrated and networked action.

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EXPLANATIONS

Aspect to be integrated	LEVEL 1 Sporadic, informal integration/networking	LEVEL 2 Ongoing, partially formalised, integration/ networking	LEVEL 3 Ongoing, fully formalised integration/networking
Professional and policy sectors	Concept development is largely under the aegis of a specific department. Other departments may be consulted and included where indicated.	A joint committee with members from various departments is responsible for strategy development. Collaboration does not depend on individuals, its continuation being backed by each department.	A collaboration agreement or a local government decision ensures that multidisciplinary collaboration is binding. This means the integrated action plan is regularly revised and updated.
Health determinants	The action plan is based on a narrow understanding of health focused on individual lifestyle; those involved address social and environmental factors only incidentally. The responsibility lies largely with one specialised department.	The stakeholders involved in the development of the plan introduce individual as well as social/community networking aspects and general social and working conditions into the planning process. Several departments assume responsibility for implementation.	The stakeholders involved in the partnership have developed a written action plan addressing the entire spectrum of health determinants, including the general socioeconomic, cultural and environmental conditions. Accordingly, interventions are planned across sectors.
Resources	Some partners contribute resources, materials and in-kind contributions to the collaboration for specific purposes.	The majority of stakeholders contribute financial and in-kind resources to the partnership. Decisions regarding amounts and allocation are made on a case-by-case basis by the respective partners.	Binding commitments and firm agreements exist about the amount of resources partners make available to the partnership. The collective jointly determines the allocation of resources.
Geographic scales	Project planning focuses on a specific neighbourhood; references to development across the municipality are incidental.	Project planning focuses on a selected city district/town area. Based on need, geographic priorities are set in specific neighbourhoods.	The strategic partnership develops a municipal plan, continuously taking into account its implications on smaller geographical scales (e.g. housing / neighbourhood / local infrastructure).
Levels of government	Project planning is carried out mainly at the national, state or local government level, or by a service provider. Integration of the different levels is absent or weak.	Project planning is carried out in negotiation with, and with the participation of several partners from various levels of government.	National, state and local government, or service providers, have come together in a strategic partnership, each having defined its own tasks for further strategic development.
Target groups	Target groups are involved in a general sense; making contributions is left to the voluntary commitment of individuals.	A range of target groups is deliberately invited to contribute, and opportunities for participation are improved. There are set processes for integration / networking.	Target groups are an integral part of the strategic partnership and participate equally in making decisions. The diversity of target group representatives reflects the heterogeneity of the population and their specific needs, which is reflected in an action plan that is detailed accordingly.

EXAMPLES FOR THE LEVELS

Assessing integration/networking as having reached any particular overall level takes into account the levels that correspond to each of the different aspects of integration. As a rule, the overall assessment follows the level attained by the majority of individual aspects.

LEVEL 1 SPORADIC, INFORMAL INTEGRATION/NETWORKING

EXAMPLE

In one area (neighbourhood) participating in the (German) 'Social Cities' urban development programme, courses on childbirth, breastfeeding, health and nutrition are offered to pregnant women. Social and financial issues are also touched on, with referral information provided about the services responsible for them. The courses are developed by a service provider, funded by the public health authority and held on its premises. A local health insurance provider is involved in the curriculum development for the health and nutrition topics.

LEVEL 2 ONGOING, PARTIALLY FORMALISED INTEGRATION/NETWORKING

EXAMPLE

In a participating 'Social Cities' neighbourhood, services are jointly developed with pregnant women – based on a written project plan – addressing questions regarding childbirth and breastfeeding, as well as health and nutrition. Social and financial issues, as well as the employment and housing situation are addressed explicitly, and support options are jointly explored with partners. This service is made available in the city district in a culturally sensitive manner by a range of providers, and in consultation with health, social, youth and housing authorities, which meet regularly as an interdepartmental working group. The costs are covered by the municipal budget and prevention funding from a local health insurance provider.

LEVEL 3 ONGOING, FULLY FORMALISED INTEGRATION/NETWORKING

EXAMPLE

The service for pregnant women, originally limited to a specific participating 'Social Cities' neighbourhood, is now – based on a local government decision – set up as a regular service in collaboration with partner organisations in all city districts. The citywide, written plan is jointly developed by the local government administration, external partners and selected members of the target group. Financial, regional and technical responsibilities are negotiated and determined. In addition, a written plan is drawn up with the goal of facilitating culturally sensitive access to health services for pregnant women in difficult social circumstances in particular, to improve their housing situation in a socially sensitive manner, to make neighbourhoods more family friendly, and to improve social infrastructure (e.g., childcare, language and education services, employment and training opportunities). This plan is based on a local government decision and is implemented by the local government administration across its departments.

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10 QUALITY MANAGEMENT

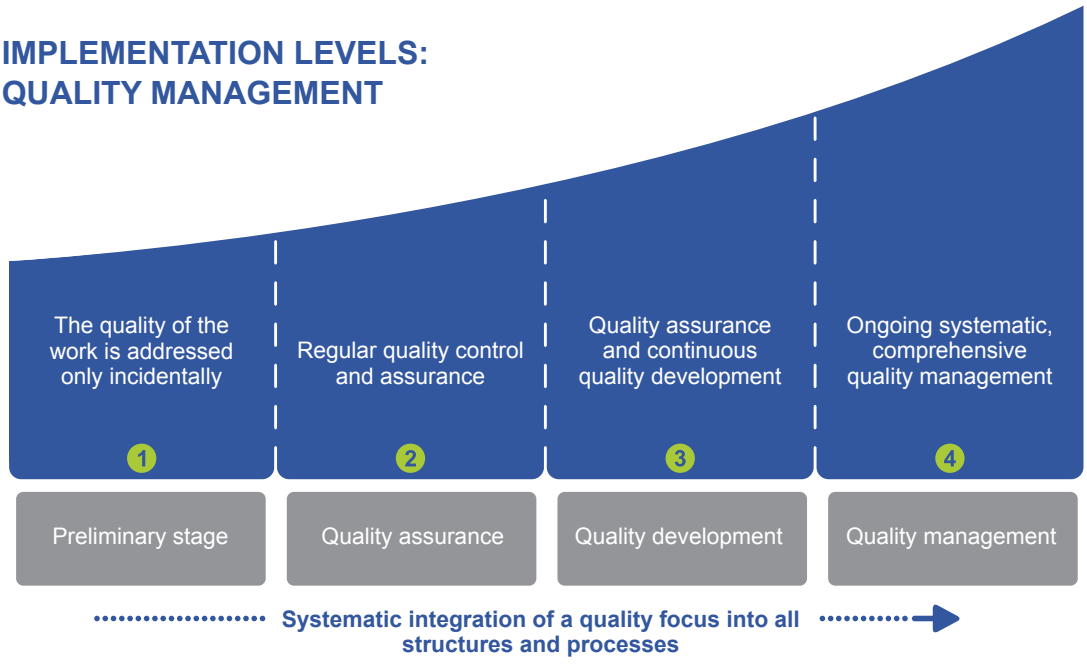
DEFINITION

Quality assurance, quality development and quality management aim to help plan, design and implement health promotion interventions according to need and based on evidence, as well as in a participatory and target group oriented manner, and to keep developing them further so they respond more and more to actual needs. While quality assurance is particularly concerned with fulfilling statutory or quality standards predetermined by the funder, quality development is an ongoing and systematic process of reflection and learning, aiming to further develop and improve the quality of services. Quality management, in turn, integrates this process into the organisation by clearly allocating responsibilities to individual staff members.

Quality assurance and quality development activities may be carried out either internally – i.e. by the employees themselves – or with external support. Opportunities for quality improvement may be found in the following areas:

- Planning: developing the → Concept and Project Plan, and planning the implementation steps involved based on a (participative) needs analysis and existing scientific evidence
- Structures: resourcing an intervention with the necessary finances, personnel, facilities and equipment
- Processes: the methods used to carry out the intervention
- Results: the effects achieved in relation to the set objectives (→ Documentation and Evaluation)

IMPLEMENTATION LEVELS: QUALITY MANAGEMENT



EXPLANATIONS

LEVEL 1 THE QUALITY OF THE WORK IS DISCUSSED ONLY INCIDENTALLY

Staff members have an implicit (i.e. undocumented), tacitly assumed awareness of what constitutes quality. They reflect on their day-to-day work individually but do not discuss it jointly. They sporadically share their thinking on potential improvements. Primarily discussed are obvious and urgent difficulties in work processes and structures that emerge spontaneously from a situation, and can be solved in the short term and with little effort.

EXAMPLE

A women's health centre offers low-threshold, anonymous psychosocial counselling. During regular opening hours, women can attend and access counselling free of charge and without the need for an appointment. The goal is that no woman leaves the counselling session without concrete suggestions for action or a referral to additional support services. Counsellors document the number of sessions, topics discussed and the results. Where urgent action is required, they discuss individual cases.

LEVEL 2 REGULAR QUALITY CONTROL AND ASSURANCE

Staff members, and potentially also others involved, meet at regular, scheduled intervals, e.g. in team and steering group meetings, to discuss how the intervention is progressing. They review the structures, processes, and results of their work using internally developed or externally prescribed indicators or checklists. The results of these reviews are documented in writing, e.g. as minutes with outstanding actions and responsibilities. Especially work processes and structures are reflected on. The main aim is to maintain the existing, 'tried and true' quality of their work.

EXAMPLE

The counsellors at the women's health centre meet at regular intervals to exchange information, reflect on the counselling services offered, and to maintain their high and consistent quality. For example, they want to ensure that there is always at least one counsellor free and available during opening hours, that native language counselling is available for migrants on a same-day basis, and that all counsellors always have access to the current contact details of external providers and relevant public authorities.

LEVEL 3 QUALITY ASSURANCE AND CONTINUOUS QUALITY DEVELOPMENT

Quality assurance and quality development tools and methods are applied continuously, e.g. in the form of reports and checklists. The quality focus is not only directed toward maintaining the levels of quality already achieved and eliminating problems, but strives

to constantly improve processes and structures. The quality of work is developed in a continuous learning process with contributions and based on feedback from those affected, in order to achieve positive and sustainable results.

EXAMPLE

The counsellors at the women's health centre jointly develop a documentation form for their low-threshold counselling sessions. The form collects personal client data (e.g. migration background), their concerns, any agreements made, as well as any questions or problems for which no solution could be found or service offered. These forms are regularly evaluated during team meetings. Based on the results, new approaches are devised to develop the low-threshold psychosocial counselling service further.

LEVEL 4 ONGOING SYSTEMATIC, COMPREHENSIVE QUALITY MANAGEMENT

Quality management continuously and systematically considers all aspects of the intervention and the organisation, as well as the perspectives of all involved. As part of clearly allocated responsibilities, conceptual and action planning as well as structures and work processes are reviewed (in relation to the objectives) and further developed. Quality assessment always compares results to stated objectives (target/actual comparison). This requires suitable indicators that can measure change and therefore make it verifiable (→ Documentation and Evaluation). A range of tools and methods are used to support quality development, some of which involve external individuals. The insights collected are then systematically incorporated into the further development of the project plan and methodology.

EXAMPLE

Experiences and insights from low-threshold psychosocial counselling are incorporated into the women's health centre's quality development process. The quality manager, sometimes jointly with the counsellors and selected clients, reflects on the extent to which the quantitative and qualitative objectives of the counselling service have been achieved and what improvements may look like. She also discusses how the threshold for accessing the service could be lowered further, how it could be connected to the women's health centre's other activities, and how the needs expressed in counselling sessions might be incorporated even better into the further development of the centre's other services.

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11 DOCUMENTATION AND EVALUATION

DEFINITION

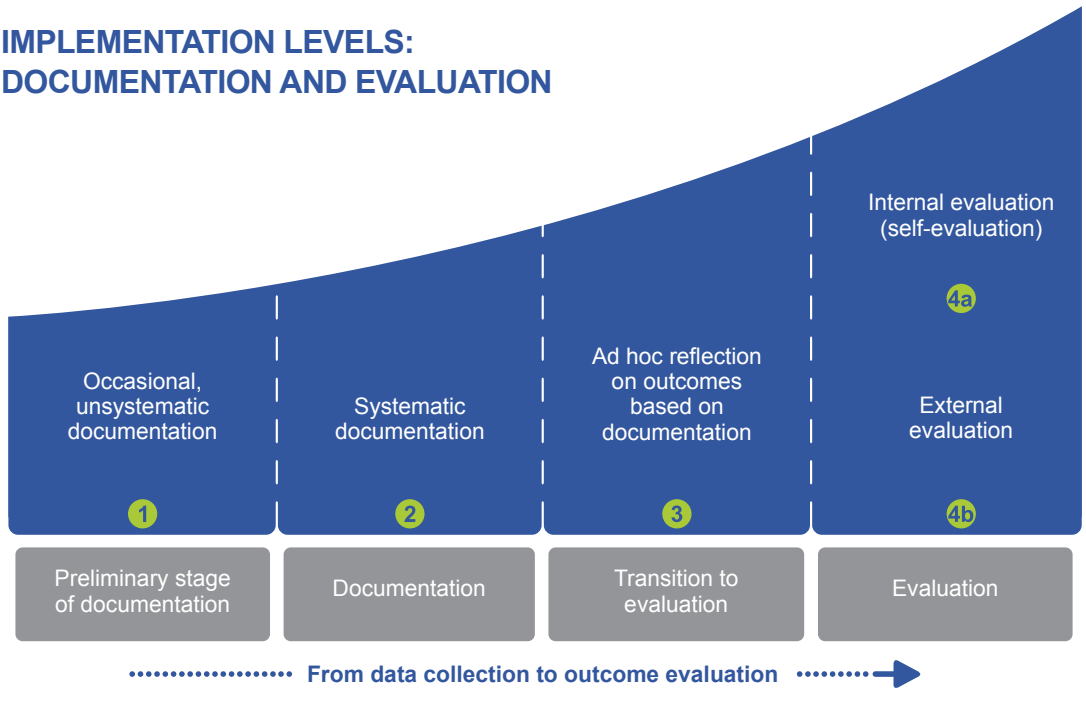
Documentation and evaluation are components of ↗ Quality Management. They serve to check that the stated objectives (↗ Concept and Project Planning) are achieved in the course of the project, and that workflow is adjusted in accordance with the results of their review.

Documentation reflects the content and results of work processes, for example in minutes of meetings, reports on the process and results of events, or by archiving the information materials developed. It ensures that project plan and implementation of an intervention can be understood and assessed even by external parties and at a later time.

Evaluation is a process for analysing and systematically assessing both documented and newly acquired information in relation to the stated objectives. Evaluation results can provide important pointers for improving work processes and results.

An evaluation may be carried out internally (self-evaluation), or by or with the support of external experts (external evaluation). Evaluation may take place concurrent with implementation, so that the results can be incorporated immediately (formative evaluation), or it makes it possible to determine in hindsight to what extend the stated objectives were achieved (summative evaluation).

IMPLEMENTATION LEVELS: DOCUMENTATION AND EVALUATION



EXPLANATIONS

LEVEL 1 OCCASIONAL, UNSYSTEMATIC DOCUMENTATION

The workflow and results are only occasionally and not systematically documented. There are no binding targets on forms of documentation, where it is stored or how the results are communicated.

EXAMPLE

Staff members of a family planning service use a shared document to record the number and duration of counselling sessions.

LEVEL 2 SYSTEMATIC DOCUMENTATION

Clear questions and rules are set for documentation. They take into account relevant privacy legislation. On this basis, information and data can be made available for internal or external evaluation (see Levels 4a and 4b).

EXAMPLE

Using a jointly maintained data input form, staff members of a family planning service regularly document their counselling sessions. They record e.g. the number of sessions per day, the main topics covered in the sessions, and socio-demographic data on clients (such as age, marital status, place of origin, social situation).

LEVEL 3 AD HOC REFLECTION ON GOAL ATTAINMENT BASED ON DOCUMENTATION

Material collected as part of documentation is considered in relation to set project goals only on an ad hoc basis.

EXAMPLE

Before meeting with their funding body, the staff members of the family planning service reflect on their systematically documented counselling sessions (see Level 2), especially in regard to the question of the extent to which the target group(s) was (were) able to be reached and provided with counselling according to their needs. On this basis they then develop ideas for how they can further develop the ways in which they approach their target group(s).

LEVEL 4a INTERNAL EVALUATION (SELF-EVALUATION)

Based on the data contained in the documented material (and additional information where applicable), staff members review and assess their work and the results of their intervention using transparent methods. As part of this self-evaluation, they discuss whether the stated objectives have been reached and look for opportunities to further develop the intervention based on their insights.

EXAMPLE

The staff members of the counselling service use the documented material to review the extent to which they were able to reach the target group(s) listed in the ↗ Concept and Project Plan with their services. Based on the result, they develop ideas to make their service better known and to increase client satisfaction with counselling and referrals.

LEVEL 4b EXTERNAL EVALUATION

An external institution (e.g. a university department) is contracted to evaluate the intervention. The evaluators agree on the evaluation questions and methods with their customer. They use the data collected as part of documentation and complement them, if necessary, with their own data collection, e.g. by surveying staff members or target group representatives. Following the evaluation, the external evaluators present their results to those involved in the intervention and make suggestions for developing the intervention further.

EXAMPLE

The counselling service contacts the social work department at a university and offers an opportunity to evaluate the intervention as part of a student thesis or dissertation. The service is particularly interested in an assessment of whether the target groups are being addressed appropriately and reached as planned, and whether the results of counselling are helpful to them.

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12 CAPTURING COST-EFFECTIVENESS

DEFINITION

An intervention is cost-effective when it is effective not only with respect to its objectives (→ Documentation and Evaluation), but when the effects are also proportionate to the costs. A prerequisite for assessing cost-effectiveness is therefore determining the effects (e.g. an improvement in health status, especially among socially disadvantaged target groups), the capacity built among the target groups (→ Empowerment), as well as the costs involved (e.g. human resources, time, goods and services) using suitable indicators. In order to determine cost-effectiveness, these parameters must be measurable and comparable. Cost-effectiveness can also be determined by comparison with interventions that had similar objectives, and either similar costs (then the more effective intervention is also the more cost-effective) or similar effects (then the less expensive intervention is the more cost-effective, and able to achieve greater health equity using the same amount of financial resources).

Important aspects of determining costs and effects

When determining costs, it must be considered whether this analysis is to be applied to all processes connected with the intervention, e.g. planning, implementation, operations and scaling up.

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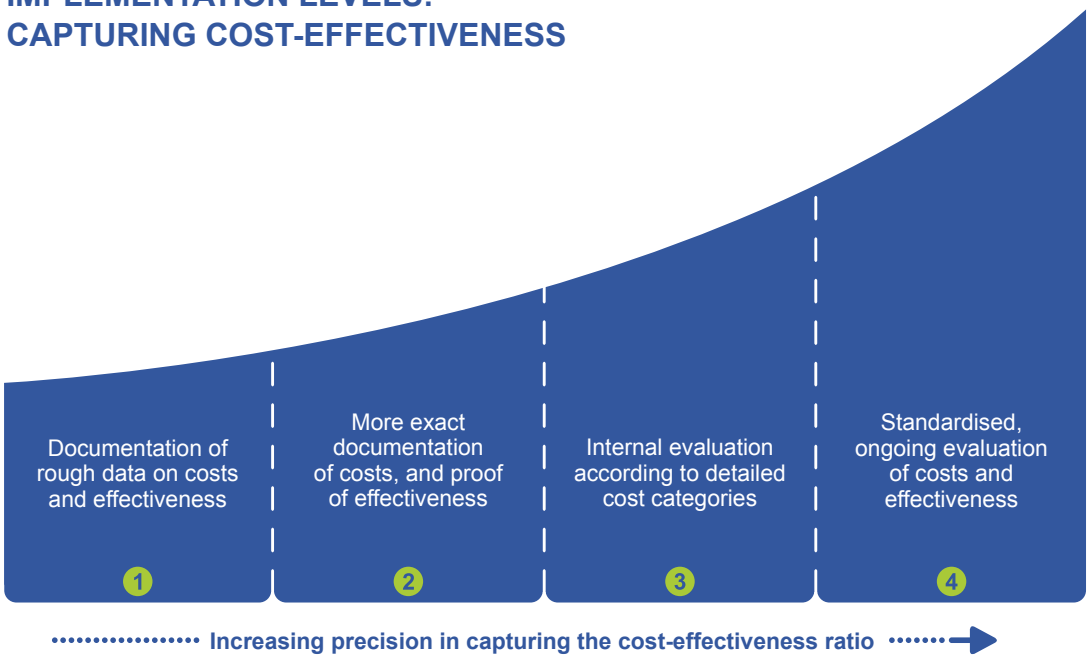
IMPLEMENTATION LEVELS: CAPTURING COST-EFFECTIVENESS



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It must also be clarified which stakeholders are involved in these processes, i.e. which costs are associated with which stakeholders. The following distinctions may be made: members of the target group (e.g. children, parents, seniors), professionals (e.g. educators, teachers, trainers, experts from health insurance providers), service providers (e.g. local municipalities, schools, sports clubs), funding bodies (e.g. federal or state ministries, local government authorities, health insurance providers) and other stakeholders (e.g. researchers, external consultants).

The perspective from which costs are calculated must also be determined. Separate perspectives may exist from the points of view of funding bodies, service providers, participants or society in general. Finally, it is important to decide whether data on costs are collected only once or regularly. All these basic points must also be taken into account when analysing effectiveness.

EXPLANATIONS

LEVEL 1 DOCUMENTATION OF ROUGH DATA ON COSTS AND EFFECTIVENESS

Only very general data are available for estimating the human resource and financial input into planning and/or implementing the intervention. Effectiveness is almost impossible to determine. While the objectives of the intervention have been defined, it is near impossible to measure whether and to what extent they are being achieved since no suitable indicators have been defined. Decisions on the methods to achieve the objectives are based on assessments that lack a rationale (e.g. references to scientific studies or model projects). Individual results are documented (e.g. the number of participants), but they only provide rough indications of actual goal attainment.

EXAMPLE

A municipality starts a programme to promote physical exercise in schools. The implementation of the programme is left to the individual schools. Only two types of data are collected: the number of additional lessons allocated to the promotion of physical exercise at the respective schools, and the number of students participating in the programme.

LEVEL 2 MORE EXACT DOCUMENTATION OF COSTS, AND PROOF OF EFFECTIVENESS

More exact data are available regarding human resource and financial input into planning and implementing the intervention. The objectives are stated clearly and backed by measurable indicators. The approach to achieving the set objectives is well founded, with references to scientific studies and/or existing practical experience as well as through critical reflection on their transferability to the target group in question.

EXAMPLE

The programme to promote physical exercise in schools is developed further: following an assessment of students' physical fitness, they are allocated to groups according to the increase in fitness that should be (or can be) achieved in a certain period of time. After this period, physical fitness is assessed again. Together with the teachers, an individual exercise programme is designed for each group of students. In order to estimate the costs, the following data are collected: time needed for planning and implementing the programme, as well as additional costs, e.g. for goods and services.

LEVEL 3 INTERNAL EVALUATION ACCORDING TO DETAILED COST CATEGORIES

Compared to Level 2, the costs are documented in greater detail in this case, i.e. human resources and financial input is itemised according to individual cost categories as much as possible (e.g. personnel, facilities, materials, other costs). As in Level 2, the effects can be documented well. Because the effects can be listed against individual cost categories, it becomes possible to compare costs and effects across different interventions, and answer questions such as: If intervention A has the same effects as intervention B, which of the two is more cost-effective with respect to facilities and/or materials?

EXAMPLE

The programme promoting physical exercise in schools is developed further as follows: During planning and implementation of the intervention, the data collected include the time individuals invested (and at which remuneration level) and the amount of money spent, e.g. on materials (sports equipment, floor mats) and on rent. Effects are then compared to the individual cost categories, albeit only internally (i.e. this information is not passed on to external parties). This comparison enables not only internal cost control; it can also support the development of additional funding sources for extending the program.

LEVEL 4 STANDARDISED, ONGOING EVALUATION OF COSTS AND EFFECTIVENESS

In contrast to Level 3, in this case the costs are detailed according to a standardised data collection process, and costs and effects are preferably evaluated by external experts (e.g. by a scientific institution or university). Also, in order to enable the continuous adaptation of the intervention to potential changes in the operating environment, the evaluation is not only performed once at the end of programme, but continually alongside operations..

EXAMPLE

The programme promoting physical exercise in schools is developed further as follows: Costs are calculated using a standardised data collection form that is also used in other, comparable programs. The evaluation performed by external experts can therefore compare the costs and effects of this programme to those of other programmes. The results of this comparison are kept confidential. They only serve internal management purposes, as well as offering important guidance for the further development of the programme.

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und Einträge in der bundesweiten Praxisdatenbank „Gesundheitliche Chancengleichheit“:
www.gesundheitliche-chancengleichheit.de/praxisdatenbank/recherche

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TO ME, THE CRITERIA FOR GOOD PRACTICE ARE

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