Kooperationsverbund
Gesundheitliche
Chancengleichheit

GOOD PRACTICE
in der Gesundheitsförderung bei sozial Benachteiligten

BZgA
Bundeszentrale
für
gesundheitliche
Aufklärung

GERMAN COLLABORATIVE NETWORK FOR EQUITY IN HEALTH

INTRODUCTION

1. WHAT ARE THE CRITERIA FOR GOOD PRACTICE AND HOW DID THEY EMERGE?

The Criteria for Good Practice in Health Promotion Addressing Social Determinants offer a specialised framework for planning and implementing health promotion interventions. The special feature of these criteria is their focus on interventions which actively contribute to improving equity in health. Such activities aim to address health inequalities caused by social factors which can be changed (see information box: *What is health promotion addressing social determinants?*). The term 'interventions' comprises all health promotion activities ranging from individual projects and initiatives to comprehensive programmes and complex networks.

The 12 Criteria for Good Practice in Health Promotion Addressing Social Determinants were first developed by a working group of the advisory committee to the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) and the German Collaborative Network for Equity in Health. This network currently consists of 74 institutions which are active in different fields, from health care organisations and charities to those involved in social work and urban development. network members have committed to a shared goal of contributing to health equity in Germany by supporting health promotion for socially disadvantaged populations in particular. Moreover, the dissemination and continuing development of the criteria have been important aspects of the network's activities ever since. The 12 Criteria for Good Practice were first published in 2005, and in 2015 also as fact sheets in the form of a compact brochure.

The Good Practice Criteria are based on the current state of scientific discourse in the field of health promotion[1]. They are also well-suited for application in combination with more general approaches to quality improvement (e.g. *https://quint-essenz.ch*) and the improvement of health equity.

This brochure introduces the 12 Criteria for Good Practice in the form of compact fact sheets. Several levels of implementation are described for each criterion, whereby reaching the next level represents a quality gain each time. This staged approach represents the core process of quality improvement: the aim is to recognise the strengths and weaknesses of one's own work, to derive opportunities for development, and thus to autonomously improve one's own practice.

The federal German Act for the Strengthening of Health Promotion and Prevention (Prevention Act) passed in 2015 offers many new possibilities for health promotion interventions addressing social determinants, especially for the promotion of interventions at the municipal level. Many stakeholders in municipal settings are, however, not yet very familiar with health promotion approaches and interventions. Such interventions should, where possible, always be linked to programmes and funding opportunities which lie outside the health system itself (e.g. building regulations, the municipal 'Soziale Stadt' social programme, the 'Frühe Hilfen' early intervention programme, as well as state-specific legislation and programmes). The criteria also offer a good foundation for these kinds of links.

1 See e.g. Leitbegriffe der Gesundheitsförderung und Prävention (key terms used in health promotion and prevention, in German) by the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA), available at *www.leitbegriffe.bzga.de*

2. WHO IS THIS BROCHURE FOR?

This brochure is aimed at all institutions, associations and individuals who can contribute to the planning and implementation of health-promoting measures for socially disadvantaged people. It is intended to support the actors in integrating the criteria into their work and their systems of quality development.

It targets all professionals working in child care centres, schools and all other facilities which can contribute to health promotion addressing social determinants on the federal, state, municipal, and neighbourhood levels. The brochure equally targets their funders, i.e. all institutions which finance or financially support health promotion activities (e.g. health insurance funds, charitable foundations). It is also very suitable for use in professional training and development in the health care and social work fields.

Finally, the brochure is also intended for all those whose health is to be promoted. One of the principles of good practice is that health promotion interventions are always developed jointly with or by the beneficiaries themselves.

3. WHAT ARE THE AIMS OF THIS BROCHURE?

The brochure has fulfilled its purpose if it achieves the following objectives:

- It communicates the 12 Good Practice criteria in a way which is concise and illustrative.
- It sensitises its audience for the special demands on the kind of health promotion which aligns the social circumstances of those who are disadvantaged.
- It encourages readers to review their own work and adjust its objectives.
- It motivates its audience to intensify existing health promotion interventions and activities which aim for health equity and to initiate new ones.

To check whether and to what degree these objectives have been achieved, and in order to develop this brochure further, we would like to know how helpful you find it for your work and receive your suggestions for its further development. We will be pleased to receive your feedback via *good-practice@gesundheitliche-chancengleichheit.de*.

4. HOW HAVE THE CRITERIA BEEN USED TO DATE?

For many years, the Criteria for Good Practice have been firmly established as a tool to support quality improvement in health promotion. The relevance, acceptance and use of the criteria are reflected in a variety of ways:

- Strategic documents in health promotion addressing social determinants refer to the criteria for Good Practice, e.g. the guidelines published by the peak body of statutory health insurance funds regarding the implementation of Section 20 of Book V of the German Social Code (2020), and the Prevention Report (2019) of the federal government's National Prevention Assembly (Präventionskonferenz).
- The criteria also serve to guide activities at the state level, e.g. the implementation of the State Framework Agreements (Landesrahmenvereinbarungen) contained within the legal framework of the Prevention Act (Präventionsgesetz).

- In all federal states, health equity coordination centres (Koordinierungsstellen Gesundheitliche Chancengleichheit, KGC) conduct good practice workshops as part of further training for professionals from different fields of activity.
- At universities, the criteria are taught as part of the syllabus in faculties such as public health and social work, and are used e.g. for describing and assessing projects.
- Since the publication of the first edition of the criteria as a brochure at the end of 2015, orders have been received for more than 16,500 printed copies (as of summer 2021).

5. HOW ARE THE CRITERIA PRESENTED IN THE BROCHURE?

Each of the 12 criteria is presented in the form of a profile comprising these four components:

- **DEFINITION:** A brief summary of the core content of the criterion, cross-referencing with other criteria where applicable.
- **IMPLEMENTATION LEVELS:** Each level describes a more comprehensive way of implementing the criterion than the preceding one and clarifies improvement opportunities. By building on each other, the levels demonstrate that implementing the criteria is to be understood as a process. Therefore, the point is not to distinguish *criterion implemented from criterion not implemented*, but to reach a higher level of quality step by step[2].
- **EXPLANATION OF THE LEVELS:** This section of each profile contains short explanations of the individual implementation levels and illustrates them using an example. The examples used for the 12 criteria cover various fields of activity and target groups. However, the actual scope of possibilities for implementing the criteria vastly exceeds this selection.
- **FURTHER READING:** This section lists resources which are generally available online and free of charge. All online references were last checked in July 2021.

6. WHAT IS NEW ABOUT THIS EDITION?

The first edition of the Good Practice criteria brochure was published in November 2015, a second (almost unchanged) edition in 2017 and a reprint in 2019. As a working group, we have fundamentally revised this fourth edition in order to do justice to the experience and feedback accumulated over five years of applying the criteria profiles in practice. Please note the following changes:

- We have adjusted the titles of two criteria: the criterion with the combined title 'Integrated action/networking' is now simply called 'Integrated action' and the criterion 'Capturing cost-effectiveness' has been renamed 'Evidence for costs and effects'.
- To emphasise the importance of using the problems and needs of target groups as the starting point for all health promotion activities, the criterion 'Target group orientation' now tops the list.
- The language used in the text has been simplified and the content has been structured more clearly.
- Definitions and examples take greater account of the social diversity among target groups (e.g. in relation to age, background, gender attribution).
- The brochure is now supplemented by a new chapter on mutual influences between the criteria.
- An information box entitled 'What is health promotion addressing social determinants?' explains fundamental concepts.

2 It is entirely possible that current circumstances do not allow for the next higher level to be reached, making the currently reached level the highest achievable. See also Section 7: *Frequent questions and answers about working with the Good Practice criteria.*

7. FREQUENT QUESTIONS AND ANSWERS ABOUT WORKING WITH THE GOOD PRACTICE CRITERIA

Many questions can arise when working with the Good Practice criteria. We would like to take this opportunity to respond to some of those which are most frequently expressed.

▶ "Why is it not only important to convey the Criteria for Good Practice to those who carry out health promotion interventions locally, but also to those working within funding bodies?"

When the Criteria for Good Practice are used to (further) develop an intervention, this always takes place within the operational framework (the practice) of each participating organisation as a whole. These organisations may be public authorities, associations or private enterprises. In order for the criteria to be used sustainably in health promotion practice, they must also be accepted at the institutional level and coordinated with the quality management approaches applied there as well as integrated into planning, implementation and evaluation processes. An important prerequisite is that the management level also supports the implementation of the Criteria for Good Practice or even initiates it.

Implementing individual criteria should always be aligned with the organisation's operational framework. It must be checked, for example, whether the applicable legal requirements are met and whether the required resources (time, personnel, finances) are available. If this is not the case, the necessary conditions must be created before the respective criterion can be implemented in practice.

▶ "Do the criteria and their implementation levels tell me exactly what I have to do?"

Health promotion interventions – especially those intended to modify the settings of lived experience – are very complex and must be tailored to the respective operating environment. Due to the great diversity of these environments, it is not possible to articulate simple and uniform recommendations for the implementation of individual criteria. Also, not all criteria are equally relevant for all fields of activity and all types of services. It therefore remains the task of all stakeholders to adapt the content of the criteria to the respective local issues and prevailing conditions.

▶ "Can I always clearly identify my work with one of the implementation levels?"

The implementation levels illustrate in a very simplified way what the quality improvement process can look like. In practice, however, it is usually much more complex. Several levels may apply in combination; they may also blend into one another. Setting-based interventions are often particularly complex and can operate on several levels simultaneously.

▶ "Do I always have to try to reach the highest implementation level for the respective criterion?"

The implementation levels for the Good Practice criteria show the direction in which the quality of health promotion practice can be further developed. There may also be good reasons to accept a relatively low implementation level as a (currently appropriate) goal. This is the case, for example, when there is little time available or when there are limited options for action to expand an intervention. Important is that those involved discuss and document the reasons why 'only' a relatively low level of implementation can or should be achieved.It is an important aspect of quality improvment to make such decisions visible and comprehensible.

▶ "Does the development path always lead from one level to the next higher one?"

This may, but does not necessarily have to be the case. The implementation levels reflect the development process in a greatly simplified form. What is being illustrated is a logical progression of possible and desirable manifestations of the criterion concerned. In practice, however, implementation levels may be skipped or several levels may be reached simultaneously.

We wish you every success in your work with the Good Practice Criteria and we look forward to receiving your feedback and questions on the use of this brochure. Please send them by e-mail to *good-practice@gesundheitliche-chancengleichheit.de*.

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INFORMATION BOX: WHAT IS HEALTH PROMOTION ADDRESSING SOCIAL DETERMINANTS?

Health promotion addressing social determinants aims to reduce socially determined health inequalities and thus to strengthen equity in health. Why is this necessary? We know from health and social status reports that certain social groups are facing particularly strong pressures and, at the same time, lack the capacities and resources to deal with them. Attributions which are perceived as devaluing can also add stress, e.g. families receiving unemployment benefit II (colloquially known as 'Hartz IV') being referred to as 'Hartz IV families'.

How are these inequalities created?

Population groups can be distinguished by vertical and horizontal characteristics of social status. This perspective makes it possible to answer the question: 'Which subpopulation is to be reached?', whereby it is entirely possible that not every person who is thought to belong to a subpopulation also feels like they belong to it. This can be a major challenge for the target group-oriented approach.

Vertical characteristics include education level, income and occupational position, i.e. status characteristics which are socially perceived as higher or lower. Many scientific research studies show that social inequality is closely related to health disadvantage: higher social status is generally associated with better health status. Horizontal characteristics include gender, age, ethnic background, sexual identity, etc. These kinds of characteristics also impact health.

Diverse and complex interactions exist within vertical and horizontal characteristics as well as between them. For example, health conditions and impairments associated with advancing age can especially impact people who worked in physically demanding occupations. They experience additional disadvantages if they are on a low income, socially isolated and/or inexperienced in dealing with public authorities and social support systems. The technical term for this is intersectionality (↗ Target group orientation). Taking this into account is an important basis for health promotion addressing social determinants.

Health promotion addressing social determinants aims to reduce the pressures on these groups and to strengthen the capacities and resources they can draw on. Reducing stress means, above all, to modify living conditions so that they promote health as much as possible. Building capacities and strengthening resources aims to enable those who are disadvantaged to actively shape their living conditions and to live lives which are as self-determined and health-promoting as possible.

What factors have an influence on health?

The 'rainbow model', developed by Göran Dahlgren and Margret Whitehead at the beginning of the 1990s, illustrates in a simplified, schematic way the multitude of factors that can have an impact on the state of health.

Many interactions can exist between the different layers of influencing factors. The development of effective health promotion interventions addressing social determinants therefore places particularly high demands on planning and implementation. One important success factor is continuous quality improvement, a process which the 12 Criteria for Good Practice are intended to support. Important criteria in this context are e.g. ↗ Target group orientation, ↗ Setting approach, ↗ Low-threshold approach and ↗ Empowerment.These criteria emphasise that the interventions of social situation-related health promotion are always oriented towards the concrete living situations of the people, who are to be reached, involved and empowered. Interventions should, therefore, be firmly anchored in the structures of the respective living environments.

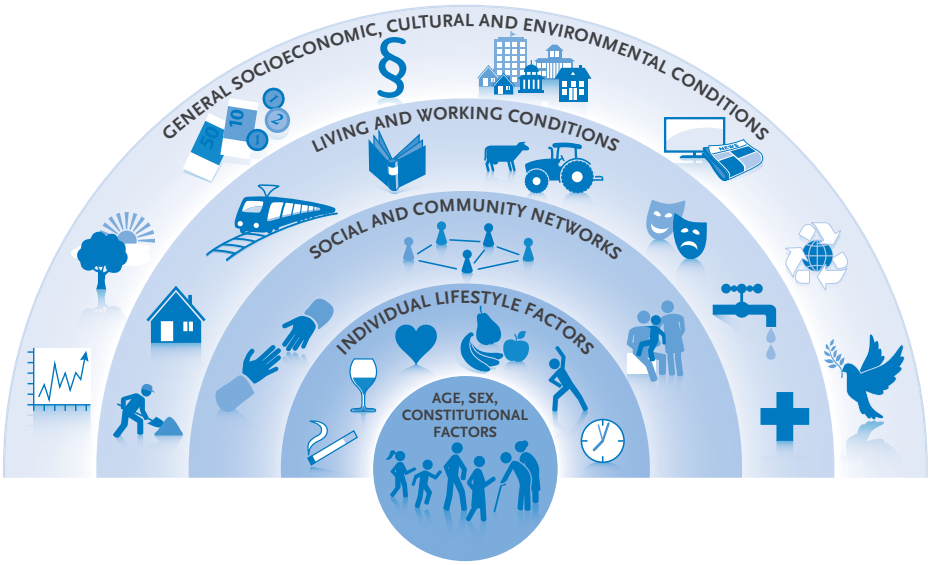


Diagram: Model of the determinants of health modified by the Robert Koch Institute according to the Austrian National Public Health Institute. Source: Dahlgren, G.; Whitehead, M. (1991): Policies and strategies to promote social equity in health. Background document to WHO – Strategy paper for Europe. Stockholm.

Why do we speak of 'target groups'?

Health promotion interventions addressing social determinants respond to the needs of those whose health is especially at risk. Often, these groups are not only under particular pressure with regard to their health; they also have relatively few options for dealing with it. The criterion ↗ Target group orientation is therefore the starting point for planning needs-based interventions.

However, the term 'target groups' can also be misunderstood in the sense that, even if this is done with the best of intentions, people in difficult social situations are made into 'targets', i.e. objects of interventions, by professionals. Yet this contradicts the basic concept of health promotion addressing social determinants, according to which health promotion interventions are always developed and implemented jointly with their beneficiaries (↗ Participation). They should be enabled to shape and live their lives as independently as possible (↗ Empowerment).

The term 'target groups' actually carries a very positive meaning. It is intended to express that an intervention is target group-specific, i.e. it responds to the particular needs of, and the opportunities, capacities and resources available to those intended to be reached and involved. It serves to delineate it from the 'one size fits all' approach, which aims to reach different population groups with one and the same intervention. Alternative terms have been discussed in German health promotion circles, such as 'dialogue groups' ('Dialoggruppen') and 'entitlement groups' ('Anspruchsgruppen'), but these terms have their own weaknesses (not all target groups, for example, are dialogue groups at the same time).

A pragmatic solution was developed in 2019 at the Germany-wide 'Public Health Conference on Poverty and Health' under the title 'Who wants to be a target group after all?'. For intervention planning and in funding applications, it can be useful and helpful to speak of 'target groups' and to describe them in as much detail as possible. However, as soon as representatives of these groups are actively addressed and involved, the term 'target groups' should be avoided. Together with them, a term should be sought that describes the living situation of the groups as precisely as possible (e.g. single mothers in urban area X). Since the criterion ↗ Target group orientation serves conceptual development in general, the term 'target groups' has been retained in this brochure.

MUTUAL EFFECTS BETWEEN THE CRITERIA

THE GOOD PRACTICE CRITERIA AS A SYSTEM: RECOGNISING AND UTILISING MUTUAL EFFECTS

In this brochure, the 12 Good Practice criteria are introduced in 12 separate profiles to make the content as clearly structured and as easily accessible as possible. In practice, however, a multitude of overlaps and mutual effects exist between the criteria. Apart from the diagram on the title page, the links marked '↷' in the 'Definition' section of each criterion draw attention to these relationships.

The mutual effects between the criteria 'Participation' and 'Empowerment' are a good example: as a prerequisite for participating actively and meaningfully, those involved must possess the necessary capacities and resources. If these capacities and resources, such as expertise, confidence and being able to express oneself clearly, are not available, they must be developed as part of empowerment processes. Conversely, successful participatory processes build the capacity and confidence of those who are actively involved and thus contribute to their empowerment. Such mutual effects between criteria should always be considered in planning processes. However, the ways in which different aspects described in the criteria affect each other cannot be generalised. They must be considered afresh for each planning process and each intervention and monitored over the course of the project.

THE 'SATELLITE' EXERCISE: DEVELOPING A PICTURE OF THE MUTUAL EFFECTS BETWEEN CRITERIA

The following exercise taken from the 'Lernwerkstatt Good Practice' training workshop shows how the mutual effects between the Good Practice criteria can be made visible and discussed using a practical example. The message of this exercise: when implemented in practice, the criteria form a system, so that implementing one criterion affects one or more of the other criteria.

OBJECTIVE

The participants recognise and reflect on the mutual effects between the Good Practice criteria.

NOTES FOR FACILITATORS

When six or more participants take part in the exercise, it is best if they divide into small groups of three to five. The small groups then work on the exercise in parallel (in separate rooms, if possible) and come back together for discussion afterwards.
Depending on the complexity of the practice example and the relevance of the criterion, 30 to 60 minutes should be set aside for the group work component.

MATERIALS

- Sets of pictograms for the 12 Good Practice criteria (one set for each small group)
- Pinboards (covered in large sheets of blank paper), pins and marker pens in a range of colours
- Good Practice criteria brochures for easy access to the definitions

PROCESS

1. The group agrees on one practice example to be used in the exercise.
2. Participants select one criterion which will be focused on and whose mutual effects with the other criteria will be considered.
3. Group task:
   - Pin the pictogram for the selected criterion to the centre of the pinboard.
   - Then place the pictograms of all remaining criteria around it as 'satellites'.
   - Clarify the relationships between the criteria, e.g. by the distance between them, using arrows, labelling, etc.
   - Guiding questions:
     - How closely related are the criteria to each other?
     - Where and how do they reinforce each other?
     - Where is implementing one criterion a prerequisite for implementing another?
     - Where do conflicting objectives emerge in implementation?
   - Try to design your diagram in a way which makes the most important connections quick and easy to grasp. It can be helpful to make a second, cleaned-up version of the diagram for this purpose.
4. Discussion: If all participants have worked together in a single group, reflect on the insights gained for implementing the criterion used in the exercise. If there were several small groups, they convene in a plenary and present their diagrams to each other. They explain the ideas the diagrams are based on and answer questions from participants of the other groups. Finally, all participants discuss which common insights they have gained.

VARIATION

In this version of the exercise, not just one criterion is focused on in particular. Instead, participants enter all criteria in a diagram, clarifying their most important mutual effects. As in the version of the exercise described above, participants use the criteria pictograms and highlight mutual effects using arrows, labelling, etc. The depiction may be abstract or integrated into an overall illustration which provides it with a symbolic framework. This could be, for example, a house, whereby some criteria form the foundation, others the living areas, and another set the roof. There are no correct or incorrect answers. The important point is that participants engage together and creatively with the demanding task of assessing the mutual effects between the criteria and of taking them into account in their own work.

THE 12 CRITERIA – OVERVIEW

01 TARGET GROUP ORIENTATION

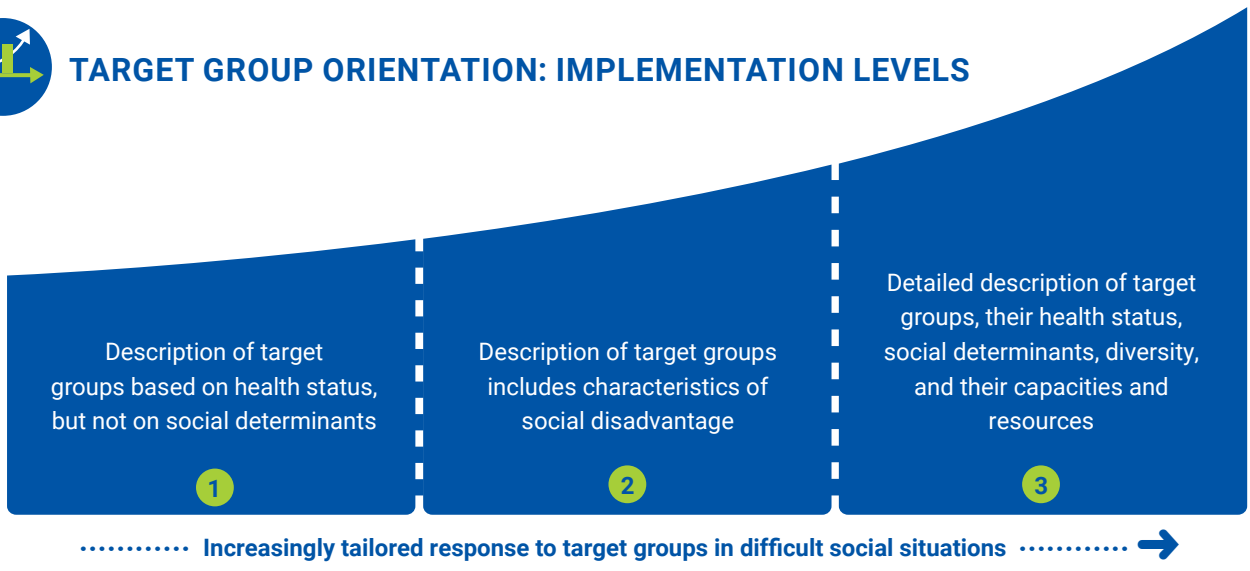
DEFINITION

In health promotion, 'target groups' are persons who are to be reached by an intervention, i.e. whose health situation is to be improved. Since they are to be involved as much as possible (→ Participation), they are active stakeholders at the same time.

The term 'target group' can be misunderstood and is therefore not unproblematic. Health promotion does not intend to turn groups of people into targets, and thus into objects, but rather – as specifically as possible – to address their socio-cultural needs together with them. The use of the term 'target group' is explained in more detail in the introduction of this brochure (see 'Why do we speak of 'target groups'?' in the information box: *What is health promotion addressing social determinants?*).

The groups to be reached and involved are defined as precisely as possible in the → Conception. Not only the pressures and problems resulting from their social situation are described there in detail, but also the capacities and resources they possess. Also taken into account in this process is the fact that large differences may exist within these groups based on additional social characteristics, such as attributions of gender or ethnic background. Moreover, care is also taken that no terms are used in describing these pressures and problems which may be perceived as stigmatising or discriminatory by the target groups.
Mainly vertical characteristics of social inequality are used to describe target groups precisely: social disadvantage may, for example, result from a lower level of education and/or income. However, characteristics of horizontal inequality must also be taken into account, i.e. a possible disadvantage on the basis of age, sex/gender, ethnic background, religion/belief system, disability, or sexual identity (see also the characteristics underlying discrimination as listed in the General Act on Equal Treatment (Allgemeines Gleichbehandlungsgesetz, AGG). The term 'diversity' is often used to cover this

TARGET GROUP ORIENTATION: IMPLEMENTATION LEVELS



wide range of social characteristics. In the majority of cases, the most accurate way to describe target groups is to combine vertical and horizontal characteristics (see also the term 'intersectionality' in the information box: *What is health promotion addressing social determinants?* in the introduction). For neighbourhood-based interventions, it is therefore important to get to know the respective problems, needs, capacities and resources pertaining to different population groups well, and to not only make distinctions by health status, but also by using characteristics such as education, income, age, gender, sexual and ethnic identity, as well as disability.

Important target groups for health promotion addressing social determinants can be found e.g. in the health equity in practice database (Praxisdatenbank Gesundheitliche Chancengleichheit, available at *www.gesundheitliche-chancengleichheit.de/praxisdatenbank/ueber-die-praxisdatenbank*).

Health promotion activities aim to sustainably improve the living conditions of target groups (↗ Setting approach) and to sustainably develop their individual coping strategies and health literacy (↗ Empowerment) and to sustainably develop their individual coping strategies and health literacy (↗ Participation) and are designed for easy access (↗ Low-threshold approach).

EXPLANATION OF THE LEVELS

LEVEL 1 DESCRIPTION OF TARGET GROUPS BASED ON HEALTH STATUS, BUT NOT ON SOCIAL DETERMINANTS

Target groups are determined according to the pressures and health issues to which they are exposed. The social factors underlying these pressures and problems, however, are hardly taken into account – or not at all – and neither the capacities nor the resources are available to the target groups.

EXAMPLE FOR LEVEL 1

A counselling centre for women is planning to offer a health promotion course with a focus on ‚Psychologically stressful aspects of unemployment'. The target group for the planned course is described as 'all unemployed women with mental health problems'. In the explanatory notes, these mental health problems are described as 'low self-esteem, depressive tendencies and anxiety'.

LEVEL 2 DESCRIPTION OF TARGET GROUPS INCLUDES CHARACTERISTICS OF SOCIAL DISADVANTAGE

Target groups are narrowed down further, based on characteristics of social disadvantage such as education, income and employment status. However, the diversity within these target groups, as well as their capacities and resources, are not closely examined.

EXAMPLE FOR LEVEL 2

The counselling centre contacts the job centre to find out more about which group of unemployed women has a particularly high need for counselling. As a result, the target group is defined as 'women who are receiving unemployment benefit II, who do not have a vocational qualification and who are experiencing particular barriers in finding employment due to mental health problems'. The workshop programme is then tailored to respond to these particular issues.

LEVEL 3 DETAILED DESCRIPTION OF TARGET GROUPS, THEIR HEALTH STATUS, SOCIAL DETERMINANTS, DIVERSITY, AND THEIR CAPACITIES AND RESOURCES

The target groups' social situation is explained in detail. This not only includes a description of vertical characteristics of social inequality (e.g. education, income), but also of horizontal characteristics of inequality and diversity, such as gender and age. The capacities and resources available to target groups, as well as the question of how these can be increased (→ Empowerment) are also considered.

EXAMPLE FOR LEVEL 3

In order to adapt the service even better to the needs of the unemployed women, the social determinants of their health status are represented in detail in the conception (including characteristics such as ethnic background, gender identity, age, and religion/belief system). In a focus group discussion with interested women from the target group, their willingness to improvise and their solidarity with each other are identified as strengths and integrated into the workshop programme.

FURTHER READING

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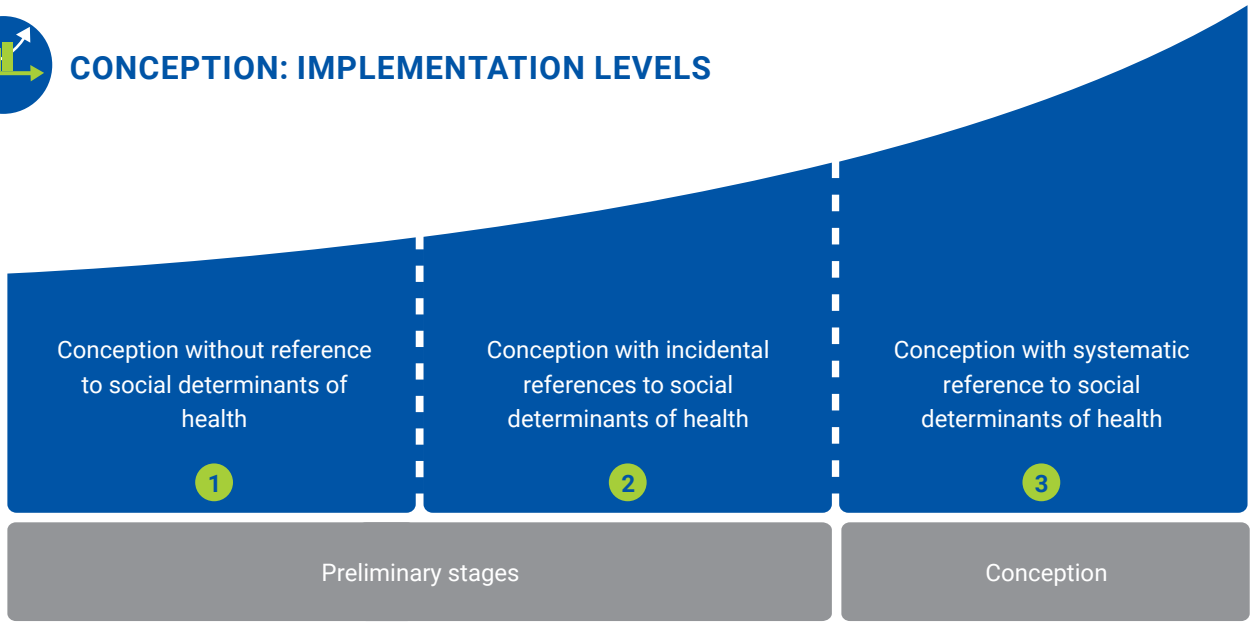
02 CONCEPTION

DEFINITION

The conception is a logically coherent description of theoretical foundations and assumptions. It justifies the selection of health promotion and prevention strategies and interventions, and lists influencing factors.
The conception describes objectives, target groups, stakeholders, interventions, and methods. It also goes into detail regarding the duration and intensity of contact with the target group and focuses on specific settings of lived experience (↗ Setting approach). A good conception, therefore, requires detailed and coherent descriptions of objectives, target groups (↗ Target group orientation) and additional stakeholders. It refers to needs analyses and considers social determinants and diversity (socioeconomic status, gender, age, ethnic attributions, etc.). The conception also describes ↗ Participation, ↗ Empowerment, (↗ Sustainability) and the project's integration into overarching programmes of action (↗ Integrated action). If possible, the conception should take all 12 Good Practice criteria into account.

The conception describes precisely which disadvantaged target groups and other stakeholders (e.g. supporters, multipliers, decision makers) the intervention aims to reach. It lists social pressures as well as opportunities for health promotion and/or prevention to influence them. For this purpose, it explains as concretely and clearly as possible how pressures faced by target groups can be reduced and how their capacities and resources can be strengthened. On this basis, the conception articulates

CONCEPTION: IMPLEMENTATION LEVELS



From a conception without reference to social determinants towards a conception with systematic reference to social determinants →

interventions and methods to promote health and health equity.

The conception makes it clear how the intervention systematically strives to reduce health disadvantage. It also demonstrates how detailed planning of the intervention considering social determinants specifically mitigates the risk of unintentionally increasing inequality. A coherent conception requires a comprehensive understanding of the factors influencing health (determinants of health, see information box: *'What is health promotion addressing social determinants?'* in the introduction). It is based on the Public Health Action Cycle and contains information on costs and timelines as well as the expected effects (↗ Evidence for costs and effects).

EXPLANATION OF THE LEVELS

Conception components	**LEVEL 1** Conception without reference to social determinants of health	**LEVEL 2** Conception with incidental references to social determinants of health	**LEVEL 3** Conception with systematic reference to social determinants of health
The conception describes ...			
(1) ... which disadvantaged target groups are to be reached.	The conception names target groups and health issues without describing social determinants.	Target groups, health issues and vertical characteristics of social status are captured.	Target groups and the relationships between their social status/diversity, health and their capacities and resources are described.
(2) ... how pressures are to be reduced and capacities and resources strengthened.	Pressures, capacities and resources for the target groups are not described.	Pressures faced by and capacities and resources available to the target groups are named only in broad and general terms.	The pressures faced by and the capacities and resources available to target groups are listed in detail and specified in relation to local conditions where relevant.
(3) ... how health inequalities are to be systematically reduced.	To reduce health inequalities is not stated as an objective at all or only indirectly.	Reducing health inequalities is an expected (side) effect, but not worked towards systematically.	The intervention is specifically geared towards modifying the determinants of health so that health inequalities are reduced. It takes the Good Practice criteria into account at every stage.
(4) ... how the intervention responds to target group needs and social determinants of health.	Target group needs and social determinants of health are not a subject of the project plan.	Target group needs and social determinants of health are referred to only incidentally and are not a central reference point for the intervention.	The conception describes in detail how the intervention responds to target group needs and social determinants of health.
(5) ... how the target groups will be actively involved in planning, implementation and evaluation.	The active participation of target groups is not envisaged in the conception.	The target groups are only involved at one of the preliminary levels of participation.	Target groups are consulted and involved in shared decision making.
(6) ... how the focus on health equity is firmly established within the funding body as well.	Improving health equity is not a core concern within the funding / auspicing organisation.	Improving health equity is supported within the funding body, but is not a component of the shared mission statement.	Improving health equity is one of the central goals of the funding body and is systematically supported at all levels (starting with the executive).

The conception makes clear reference to health equity (social determinants of health). It responds to the respective social status and needs of its target groups and takes into account the conditions prevailing in the respective social setting (→ Setting approach). The conception should consider opportunities to reduce socioeconomic pressures (education, income and employment status) and diversity-related inequalities (on the basis of gender, age, ethnic attributions, religion/belief systems, sexual identity, disability, etc.) as well as pay attention to their mutual effects (intersectionality, see information box: *What is health promotion addressing social determinants?* in the introduction). Needs, capacities and resources should be assessed in advance and, if possible, in collaboration with target groups and stakeholders (→ Participation).

The conception serves as a guideline for the design and evaluation of day-to-day work (→ Documentation and evaluation). It integrates the planned health promotion activities into the hierarchies and operations of the implementing organisation. The conception is known to all team members and defines a shared understanding of the work. Along the entire process, it is developed further based on need and in collaboration with target groups and other stakeholders.

EXPLANATION OF THE LEVELS

LEVEL 1 CONCEPTION WITHOUT REFERENCE TO SOCIAL DETERMINANTS OF HEALTH

EXAMPLE FOR LEVEL 1

In a residential district with particular development needs, a municipality is establishing a new neighbourhood park with a variety of spaces for different kinds of physical activity. The conception stipulates that the park is intended to offer all residents of this high-density neighbourhood opportunities for recreation and exercise. Future users are not named specifically, nor are they included in the design process for the neighbourhood park.

LEVEL 2 CONCEPTION WITH INCIDENTAL REFERENCES TO SOCIAL DETERMINANTS OF HEALTH

EXAMPLE FOR LEVEL 2

Apart from a sunbathing lawn and a jogging track, an area with exercise equipment for older people and a fenced ballgames court for children and adolescents are established within the neighbourhood park. The park is intended to be attractive to all generations of neighbourhood residents as well as to offer free leisure activities, mainly for people on a low income. Neighbourhood residents are included at the beginning of the planning process in the form of a survey.

LEVEL 3 CONCEPTION WITH SYSTEMATIC REFERENCE TO SOCIAL DETERMINANTS OF HEALTH

EXAMPLE FOR LEVEL 3

A skater facility is set up in the neighbourhood park, which is intended to be used primarily by young people. The initiative stems from the user advisory committee for the park, which includes representation from adolescents and their parents. Since families often include many children and live in relatively small apartments, there is a great need for leisure activities, especially for young people as they find themselves with few options for publicly accessible areas for physical activity. The young people are included in the planning and specific design of the skater facility. Following completion, the local sports club offers basic and skills-specific skateboarding classes in collaboration with a nearby youth leisure centre in order to encourage confidence and community activities among the young people. The provider of the youth centre uses the contact with the young people to make them aware of other offers, such as homework help, and to plan and implement other socially relevant activities together with them.

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03 SETTING APPROACH

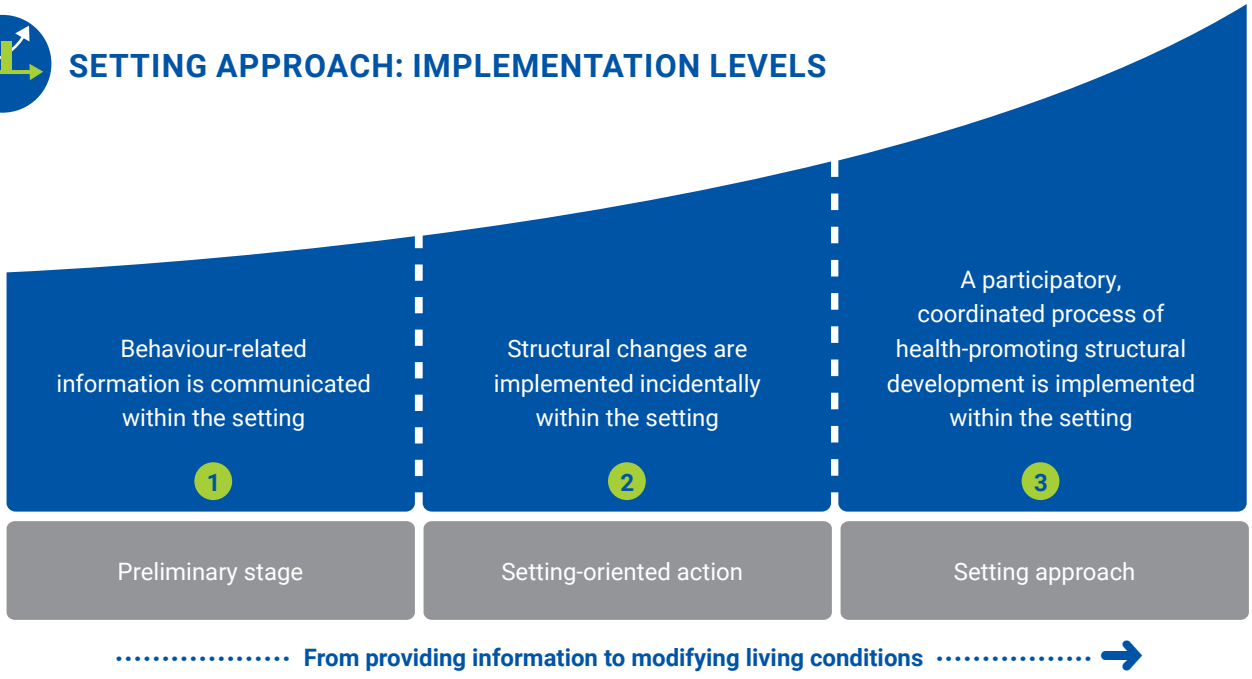
DEFINITION

As a health promotion concept, the 'setting approach' is translated in the German-speaking region as 'Lebenswelt-Ansatz' (‚life-world approach'), but the English term 'setting' is also often used. It means that 'health is created and lived by people within the settings of their everyday life; where they learn, work, play and love' (Ottawa Charter, WHO 1986). A 'setting' is a system of social spaces in which people conduct their everyday lives; it is relatively long-lived. For example, settings can be places such as nurseries, workplaces, hospitals, residential care facilities, neighbourhoods or cities.

The conditions prevailing in each setting have a substantial influence on the opportunities available to the people within them to live healthy lives. Important stakeholders for making living conditions in a setting conducive to health are e.g. decision makers as well as professionals in municipal institutions and in educational, social and health facilities.

In 2015, the Federal Prevention Act (Präventionsgesetz, PrävG) within Book V of the German Social Code introduced legal definitions for health promotion and prevention in settings. It defines settings as 'recognisably delimited social systems which are important for health, especially for housing, learning, studying, health and nursing care provision as well as for leisure activities including sports' (Section 20a (1), Clause 1 and Section 20b of Book V of the Social Code).
According to the Prevention Act, statutory health insurance funds should support the development and strengthening of health promotion at the structural level. To this end, in collaboration with all those involved in the setting, they should collect information on the health situation, including risks and opportunities, make sugges-

SETTING APPROACH: IMPLEMENTATION LEVELS



tions for health status improvement based on the information as well as support the strengthening of the health-related competencies and resources of target groups (Section 20a (1), Clauses 2 and 3 of Book V of the Social Code). The Act also describes the implementation of the setting approach as a process of continuous learning and development according to the public health action cycle.

The setting approach aims to create healthy living conditions in a participatory fashion, i.e. with the active participation of the respective target groups (→ Target group orientation), for example through a health-oriented school development programme. It aims to create a 'health promoting setting' and thus represents a more comprehensive approach than 'health promotion within the setting' in the form of individual projects, e.g. at a child care centre or school.

The setting approach follows the concepts underpinning organisational development and explicitly takes into account the practical implementation of the criteria within the framework of organisational policies and procedures (see Section 7 of the introduction: *Frequent questions and answers about working with the Good Practice criteria*).

The following four components are essential for applying the setting approach:

- Developing health-promoting living conditions (structural level, shaping social environments)
- Strengthening opportunities for action and the capacities and resources of those who e.g. live, play, go to school or work within the setting (→ Empowerment)
- Active participation of the people in the setting in all stages of planning and implementing activities (→ Participation)
- Continuous and professional coordination of all activities (→ Integrated action)

EXPLANATION OF THE LEVELS

LEVEL 1 BEHAVIOUR-RELATED INFORMATION IS COMMUNICATED WITHIN THE SETTING

The setting is used to communicate information on health-related action (behaviour), e.g. regarding nutrition, exercise or accident prevention. The permanent, health-related development of the structures present within the setting, e.g. changes to procedures or the built environment, is not the object of the intervention. This type of health promotion within the setting is a preliminary stage of the setting approach.

EXAMPLE FOR LEVEL 1

A secondary school (year levels 5 to 10) regularly invites experts who, as part of the curriculum, inform students about the health-related topics of addiction prevention, healthy nutrition and sexuality and relationships.

LEVEL 2 STRUCTURAL CHANGES ARE IMPLEMENTED INCIDENTALLY WITHIN THE SETTING

In addition to passing on behaviour-related health information, structural changes to the prevailing conditions are implemented incidentally within the setting. For example, routines and procedures are adapted, new services are introduced or changes are made to the built environment. However, this only occurs incidentally, not in a coordinated and systematic fashion with the goal of modifying the setting to become health promoting over the long term.

EXAMPLE FOR LEVEL 2

The secondary school integrates the experts' contributions into lesson plans by systematically preparing and following up on the topics discussed. Ideas arising from dealing with health issues are translated into school-based activities: inputs regarding healthy nutrition result in an initiative to create a school kitchen, where parts of regular lessons as well as cooking workshops can take place.

LEVEL 3 A PARTICIPATORY, COORDINATED PROCESS FOR HEALTH-PROMOTING STRUCTURAL DEVELOPMENT IS IMPLEMENTED WITHIN THE SETTING

On the basis of a plan – preferably developed in a participatory way – for the health-promoting development of the setting, a coordinating unit is established and resourced appropriately. It then organises and supports the necessary processes using organisational development methods. This is intended, on the one hand, to increasingly strengthen the health-promoting and preventative aspects of the setting and, on the other hand, to systematically enable the individuals living within it. The aim is to create a health-promoting setting.

EXAMPLE FOR LEVEL 3

On the initiative of committed parents and the headmaster's office, the secondary school pursues further development towards becoming a 'Healthy School'. With funding support from a statutory health insurance fund, a steering committee is established to guide the activities. It includes representation from the headmaster's office, teaching and other personnel, students, and their parents. Using the public health action cycle, a wholeofschool plan is developed with the aim of creating a healthy setting for all groups within the school. Topics include the development of a safe teaching and learning environment, a balanced lunch menu, sufficient opportunities for physical exercise as well as bullying and violence prevention. A member of the steering committee is designated as project coordinator and released from part of their teaching duties for this purpose.

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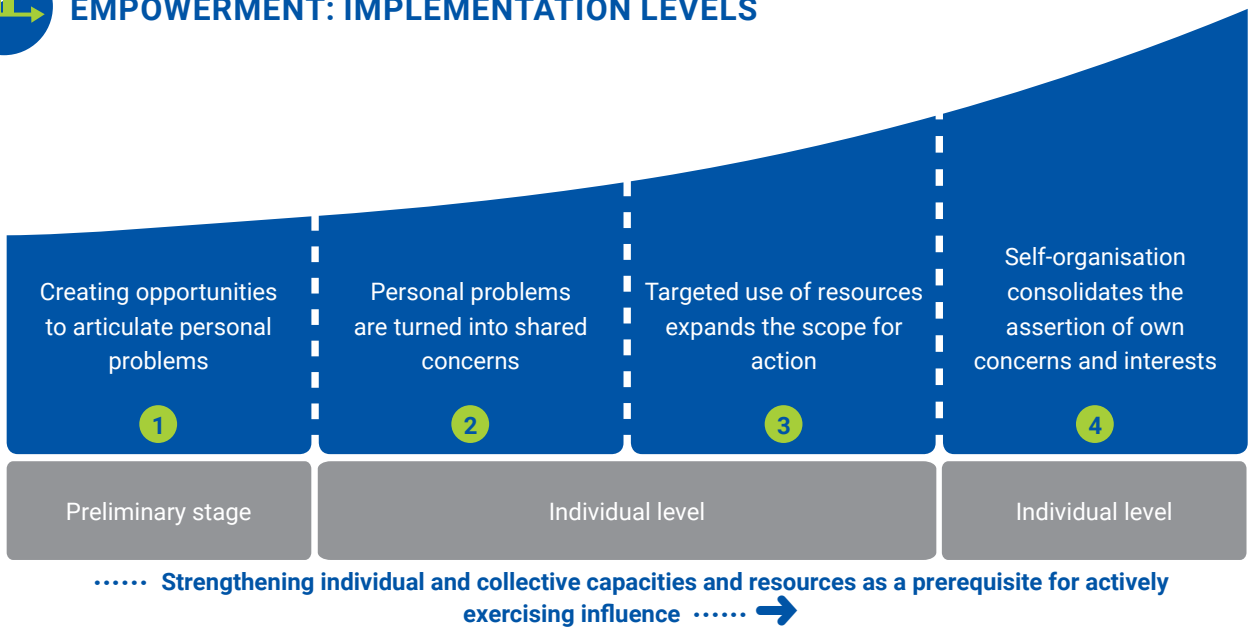
04 EMPOWERMENT

DEFINITION

Empowerment is a process which strengthens skills and increases the potential of individuals and groups of people to take action. Empowerment aims to improve the social and societal conditions in collaboration with those with limited opportunities for leading self-determined lives (↗ Participation). A prerequisite for empowerment is to acknowledge the diversity of living conditions and to offer flexible and open-ended support in response.

The starting points for empowerment as a component of health promotion interventions are the issues and problems which impact health. Empowerment addresses the individual competencies of individuals as well as the collective capacity of committed groups of people to take action (↗ Target group orientation). For those active in health promotion, empowerment means creating the necessary conditions for all those involved to discover their individual and collective capacities and resources, to develop them further and to be able to utilise them in taking practical action. This also includes concrete implementation steps in the social, geographic and political environment (↗ Setting approach), which influences the development and deployment of resources. Empowerment is closely related to successful involvement, participation and community building. The latter in turn strengthen the development of individual skills and capacity. At the same time, successful empowerment can contribute to the ↗ Sustainability of health promoting effects (↗ Evidence for costs and effects).

EMPOWERMENT: IMPLEMENTATION LEVELS



EXPLANATION OF THE LEVELS

LEVEL 1 CREATING OPPORTUNITIES TO ARTICULATE PERSONAL PROBLEMS

The factors which enable people to lead good, healthy lives as well as the changes which individuals desire and their opportunities to influence the situation are not always obvious. Individual life experiences arise in a social context which can, in principle, be shaped by individuals as well as collectively. The relationships between individual experiences and social conditions can be elucidated through joint reflective processes. This requires opportunities and spaces for an exchange on problems and opportunities to create change. Professionals can contribute to the initiation of such meetings and support them. At this level, making contact and collecting topics are at the forefront.

EXAMPLE FOR LEVEL 1

Workers at a gender-specific community health centre notice a lack of health-related services for male adolescents. The team therefore tries to design services which are attractive to boys and to make the premises accessible to this target group. In an initial, classic approach, they address the target group via a specific health issue: a counselling service for overweight boys and their parents is planned.

LEVEL 2 PERSONAL PROBLEMS ARE TURNED INTO SHARED CONCERNS

The aim is to reflect on the causal relationships underlying personal problems, to identify influencing factors and to develop options for taking action. First, the participating stakeholders agree on a shared problem or concern they want to address. Here, the role of professionals can be to initiate the process, to support it or to act in an advisory capacity only. At this level, group formation and the desire to act collectively take centre stage.

EXAMPLE FOR LEVEL 2

During the ‘weight clinic‘ for boys, it emerges that the adolescents are mainly suffering from stigmatisation on the basis of their physical appearance and that they feel severely restricted in pursuing hobbies and leisure activities. In response, the concept is extended to include group activities to jointly develop options for dealing with experiences of discrimination. Additional concerns quickly emerge: the boys want to advocate jointly for more acceptance of their physical appearance. Moreover, they would like to be offered physical activities which do not draw attention to them as a group needing special services.

LEVEL 3 TARGETED USE OF RESOURCES EXPANDS THE SCOPE FOR ACTION

Apart from creating opportunities for articulating one's own concerns (Level 1) and the goal to turn personal problems into collective concerns (Level 2), empowerment can be supported by additional resources and the scope for action can be expanded:

- Offering orientation and making information sources accessible
- Support for arriving at decisions and for the development of solutions and goals
- Mediating between different positions and perspectives.

Apart from health promotion services which strengthen competencies, socio-political advocacy is also necessary. This requires involving decision makers and pointing out opportunities for change. At this level, the focus is on building local capacity in order to introduce specific recommendations for improvements in political and social decision-making processes, thus facilitating their implementation.

EXAMPLE FOR LEVEL 3

In consultation with professionals at the community health centre, the boys design the programme of group activities and independently determine the topics to be discussed. With professional support, they organise the physical activities they would like to do. A collaboration with the local sports club ensures that exercise classes for the boys are conducted in a safe space twice per week.

LEVEL 4 SELF-ORGANISATION CONSOLIDATES THE ASSERTION OF OWN CONCERNS AND INTERESTS

Health promotion supports all forms of self-organisation, which those involved can use to independently shape their individual and collective living conditions. The aim is to gradually eliminate the need for professional assistance and support and to enable actively formative participation within existing structures and over the long term.

EXAMPLE FOR LEVEL 4

The boys actively contribute to preparing the weekly group meetings by putting topics on the agenda, preparing presentations and taking on group facilitation. The community health centre team supports them in developing ideas (e.g. for a public awareness campaign) and putting them into practice.
The boys collaborate with the sports club as part of their permanent membership status. They organise and design the exercise classes they want in consultation with club instructors. The classes take place twice per week and as a regular part of the club's schedule. The boys also involve the sports club in their public relations work to address discrimination and to promote a more sensitive approach to diversity in physical appearance across all departments.

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05 PARTICIPATION

DEFINITION

Participation of the groups involved in and addressed by the intervention (→ Target group orientation) means creating opportunities for participation which are as comprehensive as possible and thus ensuring that the processes for participation are designed to match (i.e. are tailored to) the target groups' experiences and the opportunities available to them.

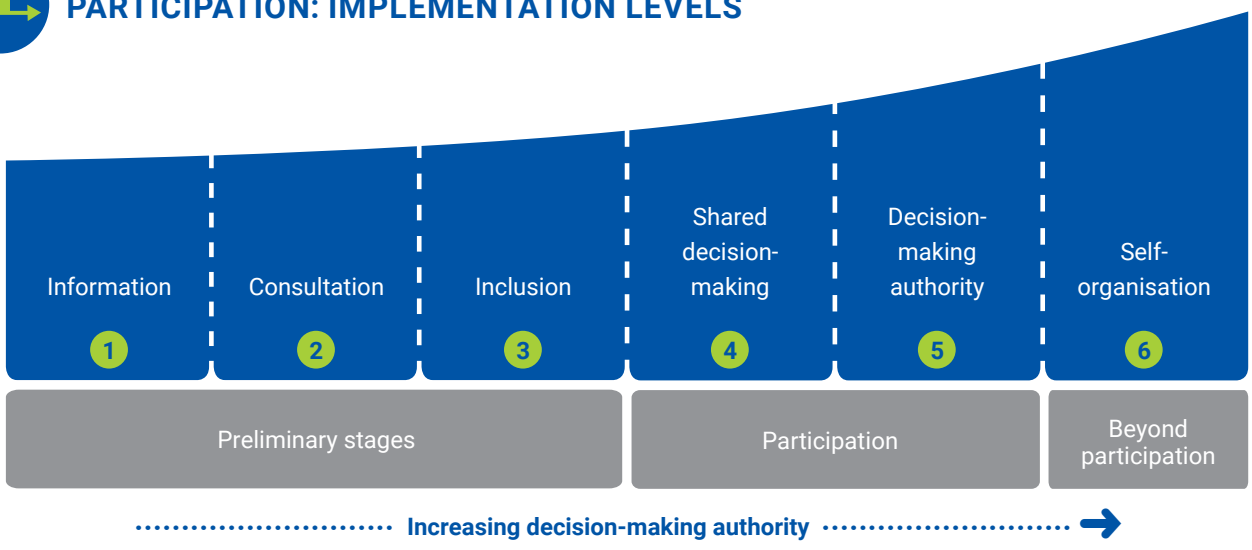
Target groups should be able to articulate their individual and collective needs as well as contribute their wishes and ideas to the planning, implementation and practice of health promotion activities. To this end, they must be enabled (→ Empowerment) and provided with opportunities for action. Participation is a development process whereby everyone involved continues to gain competencies and expands the scope of their actions in order to increasingly influence decisions.

Participation can be demanded and fought for by those affected, but it must also be enabled and promoted as part of → Conception. This requires a detailed understanding of living conditions, a joint analysis of needs and an empathetic, respectful attitude.

CONCEPT AND BACKGROUND

In health promotion, participation is a normative, i.e. an always positive and desirable value. It was already emphasised and detailed in the Ottawa Charter where it refers to people as experts in their own, everyday lived experience. This leaves us with an obligation to make participation as comprehensive as possible, pedagogically (through practising participation) as well as ethically (through self-determination). However, participation is also a functional requirement, because it causes interventions to

PARTICIPATION: IMPLEMENTATION LEVELS



become better distributed and their effects to become more sustainable.

However, there is no standardised method for measuring participation. In principle, the issue of participation presents itself differently in educational institutions – such as child care centres and schools – than when negotiating conflicting interests on the structural level, e.g. regarding the supply of energy or housing. In any case, the aim should be for the most comprehensive level of participation possible. A commonly used model is the 'Ladder of Participation'. It was initially developed by Arnstein in 1969 and later adapted multiple times, among others by Trojan at the end of the 1980s and by Wright in the 2000s. However, especially the highest level in this model, namely that of self-organisation, may not be desirable, sensible or realistic in every instance. A reason is that those involved may be unable to implement it autonomously (e.g. toddlers) or should not do so (e.g. prisoners) or because they do not want to (e.g. consumers of services).

Opportunities for participation must be actively created. It must be ensured that people who are less involved due to various access barriers are able to participate. Target group-oriented, low-threshold (→ Low-threshold approach) and tested methods should give those who are less articulate opportunities to participate. This is intended to counteract the 'prevention dilemma' inherent in health promotion and prevention. Prevention dilemma means that people with more resources, more money and better education have a greater chance to easily participate, have more influence and, thus, have more advantages than people from disadvantaged backgrounds.

The 'participation paradox' should also be taken into account. It consists of the fact that the desire for participation is especially weak when the scope for influencing the outcome is especially large (e.g. in urban planning). Conversely, the desire for participation grows with decreasing possibilities of influencing the outcome, e.g. because the consequences (of construction projects, for example) tend to be understood in detail only when the undertaking is close to being realised. Participation promotion should always take into account that opportunities for participation are provided at an early stage through scenarios that are preferably as clear as possible. Furthermore, it is important that opportunities for participation are also offered in advanced planning processes.

EXPLANATION OF THE LEVELS

LEVEL 1 INFORMATION

Professionals (working e.g. in public health authorities, health insurance funds, universities, civil society associations, and independent funding bodies) provide information about the problems they see. They show possible courses of action that can contribute to solving the problem from a professional point of view, explain their recommendations and give professional reasons for them. The point of view of the target groups is taken into account as far as possible in order to promote the acceptance of the information offered and the reception of the messages.

EXAMPLE FOR LEVEL 1

Areas for children and adolescents to play, exercise and interact are planned for a high-density, inner-city neighbourhood. The municipal administration develops a conception and informs neighbourhood residents about what is envisaged.

LEVEL 2 CONSULTATION

The professionals would like to find out more about target groups' perspectives. Members of these groups are interviewed and consulted. However, there is no guarantee whether and to what extent the views of those affected are actually considered in planning health promotion interventions.

EXAMPLE FOR LEVEL 2

The plan developed by the municipal administration is presented to and discussed with citizens at a public meeting. The municipal planning staff also present the plan at neighbourhood leisure centres and schools and collect feedback from children and adolescents.

LEVEL 3 INCLUSION

Funding bodies or providers of health promotion interventions invite selected individuals from the target group to advise them. However, these consultations do not necessarily influence the decision-making process.

EXAMPLE FOR LEVEL 3

The municipal planning staff use an appeal published in schools and leisure centres to invite children and young people to participate in the planning team for the play, exercise and interactive areas. Without having decision-making authority, the planning team meets several times and discusses existing ideas.

LEVEL 4 SHARED DECISION-MAKING

The professionals involve target group representatives in the decision-making processes in order to reach agreement on substantial aspects of an intervention. Target group members have a right to be consulted, but no binding decision-making authority.

EXAMPLE FOR LEVEL 4

The mayor appeals to schools to participate in the planning process for the play, exercise and interactive areas. Students explore their neighbourhood together as part of the curriculum and develop their own suggestions. They then present these to the municipal decision-making committees of the city council. Members of the city council responsible for this area are obliged to respond to them at an event chaired by the mayor.

LEVEL 5 DECISION-MAKING AUTHORITY

Involving members of target groups in all planning, implementation and evaluation decisions regarding a particular intervention is a binding requirement. Target group members have clearly defined and transparent decision-making authority and/or veto rights.

EXAMPLE FOR LEVEL 5

When the planning and approval processes for the play, exercise and interactive areas for the inner-city neighbourhood are completed, the municipal administration establishes working groups with the participation of children and adolescents to contribute to their detailed design. As part of the existing budget, these groups take part in decisions on the design details for these spaces.

LEVEL 6 SELF-ORGANISATION

An intervention or project is initiated and implemented by the target groups themselves. Group members make decisions independently and are responsible for them. Everyone with decision-making authority is a member of the group. This level goes beyond participation as described above.

EXAMPLE FOR LEVEL 6

In the adventure playground established in the neighbourhood, children and young people are planning to build a village of huts. Taking into account accident prevention regulations, they decide themselves how and according to which rules the area is to be used and how the various existing interests can be reconciled.

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06 LOW-THRESHOLD APPROACH

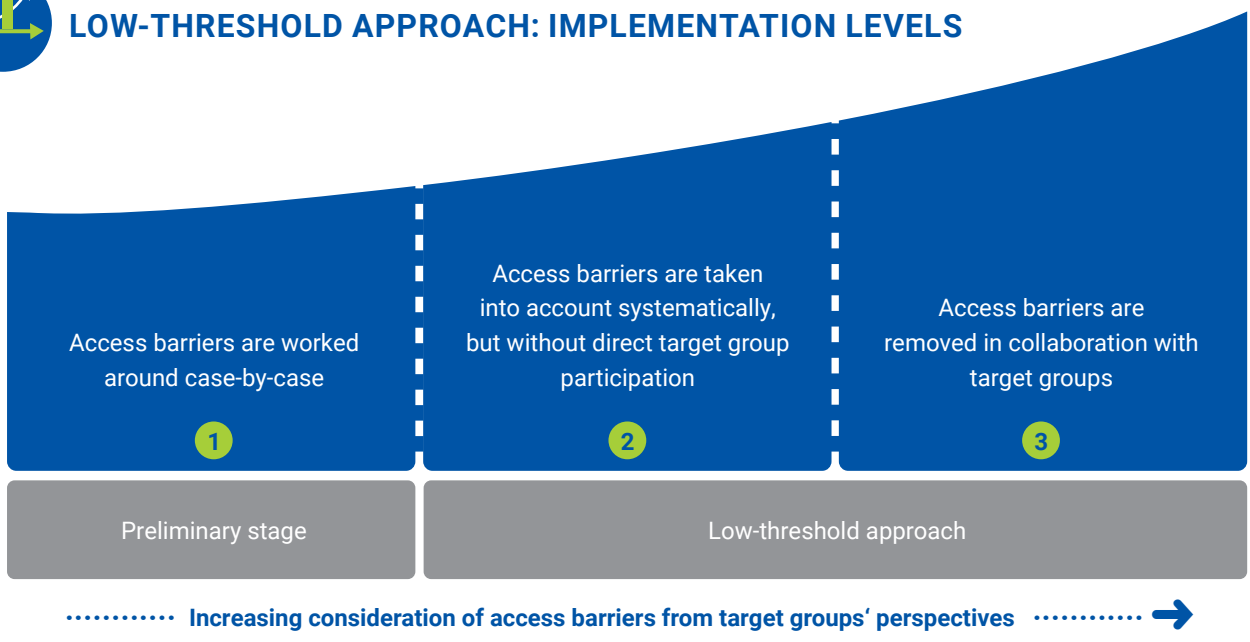
DEFINITION

Low-threshold approaches promoting health equity are characterised by the fact that they reflect on access barriers which exist from the perspectives of target groups (↗ Target group orientation) and other stakeholders. A core component of low-threshold approaches is, for example, that the ↗ Conception for the service takes accessibility into account. Accessibility means that public spaces and buildings, workplaces and housing, means of transport and commodities, services, offer of support, and leisure activities are accessible to all individuals without external assistance. Access barriers prevent people from taking advantage of health promotion services at all or to the full extent. Such barriers include, for example, complicated or incomprehensible language, the location (e.g. whether it can be reached by public transport or not) and also financial co-payments. Approaches to action are included in the conception from the outset in order to avoid access barriers or to keep them as low as possible.

Barriers to access and participation in health promotion interventions can be avoided by creating:

- organisational prerequisites, e.g. suitable times of day, locations, costs, application and registration procedures;
- conceptual prerequisites, e.g. needs-orientation, gender and cultural sensitivity, target group-specific publicity;
- additional prerequisites, e.g. avoiding stigmatisation.

LOW-THRESHOLD APPROACH: IMPLEMENTATION LEVELS



Outreach and mobile support services and combining different services under one roof while ensuring accessibility are typical examples of low-threshold methodologies. The involvement of target groups in planning (↗ Participation) as well as the integration of intermediaries (↗ Integrating intermediaries) are important prerequisites for a low-threshold approach.

An understanding and knowledge of the everyday life and living conditions of target groups are the indispensable basis for a low-threshold approach, as is a detailed stakeholder analysis which takes into account their diversity (see 'What is it exactly that these inequalities consist of?' in the information box: *What is health promotion addressing social determinants?* in the introduction).

In order to successfully pursue a low-threshold approach, it must be supported within the implementing organisation by an executive decision and guaranteed financing.

EXPLANATION OF THE LEVELS

LEVEL 1 ACCESS BARRIERS ARE WORKED AROUND CASE-BY-CASE

Guided by expert recommendations, professionals determine the needs of the target groups on the basis of their own experience and other information (e.g. health reporting and specialist literature) and design the intervention. Access barriers are worked around upon individual request, but not systematically reflected upon.

EXAMPLE FOR LEVEL 1

A sports club would like to extend its exercise classes to include older people as well as to reach people with physical limitations and those who are socially isolated. The sports and exercise classes offered at the local gymnasium, however, are mostly used by athletic and mobile, well-integrated seniors. People with physical limitations can participate if they register by phone and e.g. organise ride-sharing arrangements with other participants.

LEVEL 2 ACCESS BARRIERS ARE TAKEN INTO ACCOUNT SYSTEMATICALLY, BUT WITHOUT DIRECT TARGET GROUP PARTICIPATION

The professionals reflect on possible access barriers on the basis of their own experience, professional standards and by exchanging ideas with other service providers. They also take into account organisational prerequisites, such as location, scheduling and timeframes of the services offered. They also create the conditions for unbureaucratic participation or select an outreach mode of service provision.

EXAMPLE FOR LEVEL 2

Those responsible within the sports club reflect on the experience to date of offering the service and conclude that the (fee-based) group classes at the gymnasium are too high-threshold for older people with health-related limitations. The sports club collaborates with local government and starts offering free classes at the local community hall. It promotes this new service through the regional paper and the parish newsletter.

LEVEL 3 ACCESS BARRIERS ARE REMOVED IN COLLABORATION WITH TARGET GROUPS

Design and methodology of the intervention are adapted to the settings and perspectives of target groups. Access and participation barriers are considered on the basis of professional standards and the experiences of the specialised personnel. However, information about the everyday lives of target groups, their living conditions and needs as well as with regard to access barriers as perceived by them is also collected in direct contact with the target groups, e.g. through surveys, open conversations and group discussions. Services and interventions are tailored to target group needs or developed through a mutual exchange of ideas. In a collaborative effort, access barriers are removed, avoided or kept as low as possible. Target groups are addressed directly, taking into account cultural, linguistic and other aspects of diversity.

EXAMPLE FOR LEVEL 3

In collaboration with the town's senior citizens' advisory committee, the sports club conducts a survey on options for physical exercise for older people who are not being reached by conventional sports options. One of the findings is that short travel distances to the service are important. Another is that there shouldn't be any pressure to participate in activities lasting up to 90 minutes. As a result, the club organises free outdoor movement classes in collaboration with the seniors' committee and the municipality, which take place several times per week in parks and other open areas within residential neighbourhoods. Participation is open to anyone and at any time, not just to older people. Ride-sharing arrangements are organised so that people with limited mobility can also participate.

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07 INTEGRATING INTERMEDIARIES

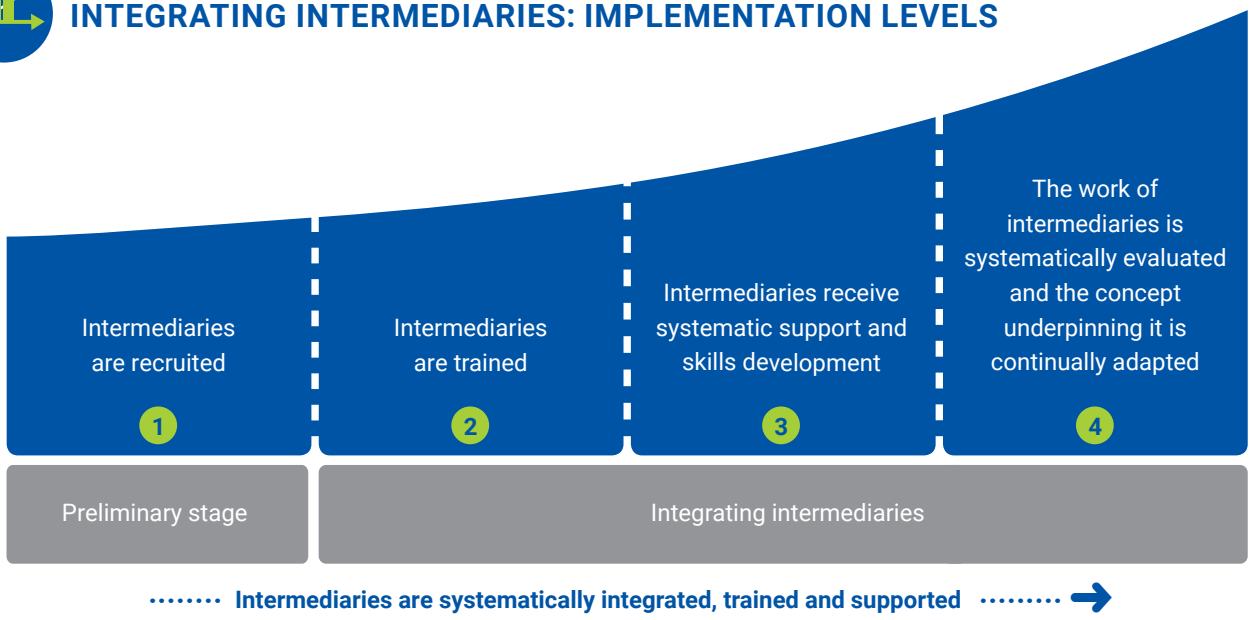
DEFINITION

As part of the intervention's ↗ Conception, integrating intermediaries describes how individuals or groups are to be systematically integrated into the implementation of an intervention and trained to perform this task. The concept is oriented on the target groups' respective living conditions and their setting (↗ Target group orientation, ↗ Setting approach). The work of intermediaries should be based within the structures already existing within the setting (e.g. a neighbourhood or child care centre). The direct reach of the respective target groups by institutions and professionals active in health promotion is usually limited. Reasons are, for instance, limited human and financial resources or limited access. In most cases, they usually rely on intermediaries. They, thus, have an important bridging function in the transfer of information and skills.

Intermediaries collaborate with stakeholders (↗ Participation) to build capacities (↗ Empowerment). The aim is to have a stronger impact on the factors influencing health in the respective setting (see also 'What are the factors influencing health' in the information box: *What is health promotion addressing social determinants?* in the introduction). They are contact persons for the needs of target groups and, after having been trained accordingly, can themselves support the creation of health-promoting settings, e.g. by organising a parents' coffee circle or by promoting networking at the municipal level.

Both certain professional groups (e.g. teachers, doctors, social workers) and people who are accepted and well-connected in the target groups' living environment can

INTEGRATING INTERMEDIARIES: IMPLEMENTATION LEVELS



be considered as intermediaries. Intermediaries often find themselves in living conditions similar to those of the intervention's target groups, e.g. older people, people with a migration background, people with a disability or people with the same sexual identity. They, therefore, function as key individuals for accessing target groups which professionals have difficulty reaching. Intermediaries have a role in mediating communication between individuals as well as in joint learning processes which form part of the development of health-promoting settings.

EXPLANATION OF THE LEVELS

LEVEL 1 INTERMEDIARIES ARE RECRUITED

The intervention team approaches potential intermediaries with the request to contribute to health promotion for the target groups and with their participation. Once they have agreed, intermediaries are asked to support the stated aims and chosen interventions as much as possible.

EXAMPLE FOR LEVEL 1

A charitable association would like to enable older Turkish-speaking individuals with dementia to continue living at home for as long as possible. Relatives providing care are also taken into consideration. Potential intermediaries are reached through noticeboards, email groups and newspaper advertisements. The project coordinators then conduct initial personal conversations with individuals interested in the role of intermediary.

LEVEL 2 INTERMEDIARIES ARE TRAINED

The conception determines that the selected intermediaries will receive skills development based on a training curriculum. The required funding has been secured. The training ensures that intermediaries are familiar with the goals, the interventions to be carried out and the problems which may be encountered so that they are able to support the work as well as possible.

EXAMPLE FOR LEVEL 2

As part of basic training on the topic of 'Migration and Dementia' (40 contact hours in total), potential intermediaries are prepared for providing in-home support to Turkish-speaking individuals with dementia. Based on an existing, proven training curriculum, training topics include the basics of the clinical presentation of dementia, cultural sensitivity and issues faced by relatives providing care. According to legal requirements, training is conducted by expert professionals. Apart from in-home support, trained intermediaries also take on tasks in organising and facilitating a care group.

LEVEL 3 INTERMEDIARIES RECEIVE SYSTEMATIC SUPPORT AND SKILLS DEVELOPMENT

The intermediaries integrated into the intervention receive continuous support and regular skills development. This ensures that potentially emerging problems with the outreach work can be recognised and solved quickly. The materials used (e.g. manuals) are also updated continuously as part of the skills development cycle.

EXAMPLE FOR LEVEL 3

A outpatient care service for people with dementia conducts reflective practice sessions with the intermediaries four times per year as well as offering needs-based skills development. These represent opportunities to reflect on personal experiences and connect learning with practice. Participants also gain insights into relevant social factors and scientific knowledge, e.g. on dementia as a health condition. Experience gained through this mutual exchange is used to continuously improve the intervention. Ongoing training and support also contribute to motivating intermediaries.

LEVEL 4 THE WORK OF INTERMEDIARIES IS SYSTEMATICALLY EVALUATED AND THE CONCEPT UNDERPINNING IS CONTINUALLY ADAPTED

The work of intermediaries is continuously and systematically evaluated in collaboration with team members. This ensures that training and support are continuously adapted and improved. The feedback received as part of the evaluation also allows the intervention to be continuously adapted to changing conditions in the operating environment.

EXAMPLE FOR LEVEL 4

Specialists from a scientific institution accompany the integration of intermediaries for the care of Turkish-speaking people with dementia. They compile the experiences and feedback of the intermediaries as well as the experts of the provider of the intervention on the basis of a scientific survey instrument. They also moderate a joint development process for updating the intermediaries concept. In addition to the technical contents, the requirements for the provider of the intervention are discussed (e.g. with regard to financing and quality).

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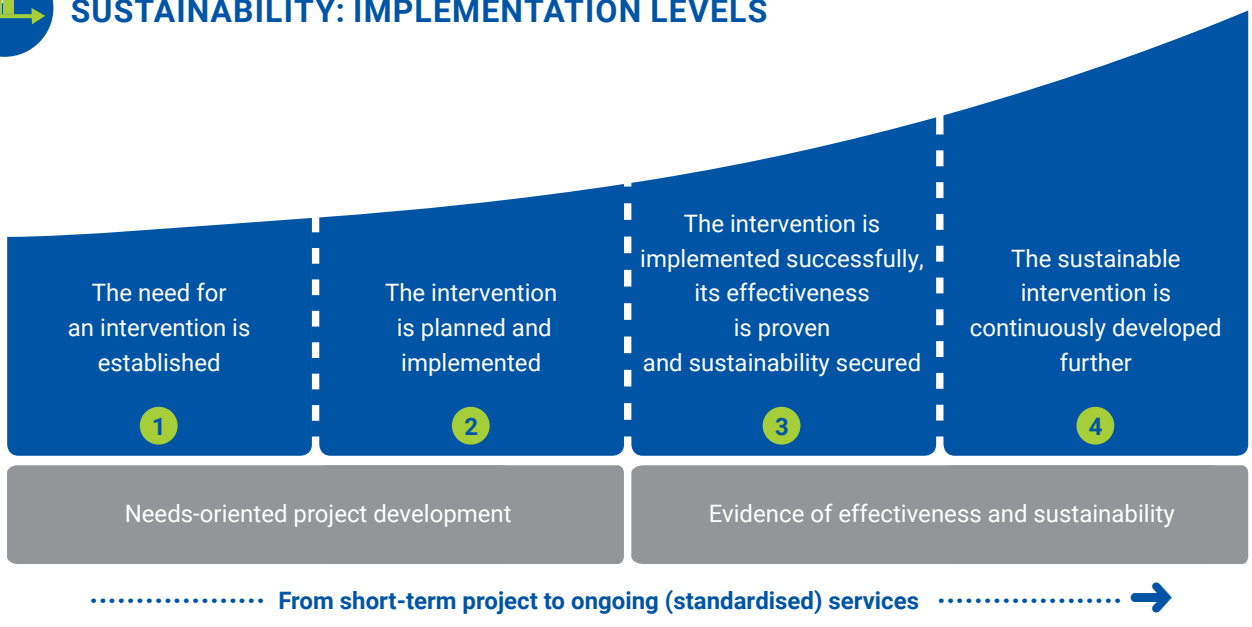
08 SUSTAINABILITY

DEFINITION

Sustainable interventions ensure that the individual competencies and resources of target groups (↗ Target group orientation) are strengthened measurably and permanently and aim to create healthy living conditions in settings (↗ Setting approach). Prerequisites for sustainability are reliable and stable, i.e. structurally integrated health promotion services. These are established e.g. by securing premises and personnel, by developing collaborations and, if possible, also by integrating them into municipal and regional strategies (↗ Integrated action). As part of making them sustainable, services may also be integrated into a programme at the state or federal level. As part of ↗ Quality management, service providers must – in some cases with target group participation (↗ Participation) – reflect on and decide whether the approaches pursued so far (↗ Conception) are still goal-oriented and appropriate for actual problems and needs. If these have changed in the meantime, providers must decide whether new solutions are required. This kind of ongoing methodological development is a prerequisite for sustainable service structures which go beyond short-term project work. In addition, it increases the likelihood of sustainable health-promoting effects.

SUSTAINABILITY: IMPLEMENTATION LEVELS



EXPLANATION OF THE LEVELS

LEVEL 1 THE NEED FOR AN INTERVENTION IS ESTABLISHED

Actual health needs and problems are established using available information sources (e.g. health and social monitoring reports, structural analyses, surveys, focus groups) and with the participation of all relevant stakeholders if possible. It is then determined which of the identified problems should be addressed as part of the intervention, which capacities and resources should be strengthened and which opportunities for sustainability pursued.

EXAMPLE FOR LEVEL 1

In a city district characterised by a high proportion of people on low incomes, residents and professionals agree that no adequate sexuality, health and family planning counselling services for people with learning difficulties exist locally. They recommend establishing an innovative service and monitoring the work intensively during a pilot phase.

LEVEL 2 THE INTERVENTION IS PLANNED AND IMPLEMENTED

On the basis of a needs assessment, objectives are determined, suitable interventions planned and the extent to which the objectives – especially health-promoting changes for the target groups – have been reached is measured. Funding bodies are approached and acquired for the project, securing implementation (e.g. as a pilot project).

EXAMPLE FOR LEVEL 2

In a sheltered workshop for people with learning difficulties, the scientific basis for a specific counselling service is developed in a participatory fashion and the staffing and structural prerequisites for establishing it are determined. Furthermore, as part of the conception, objectives are defined and ideas for health-related models are developed. Ways of checking whether the objectives have been reached are also worked out. A two-year pilot phase is implemented as part of a state-based programme.

LEVEL 3 THE INTERVENTION IS IMPLEMENTED SUCCESSFULLY, ITS EFFECTIVENESS IS PROVEN AND SUSTAINABILITY SECURED

The activities and (interim) results of the work are documented as part of funding requirements (see Level 2). If there is evidence for the success and effectiveness of the work, sustainability can be promoted. A plan is developed for this purpose and there is a search for partners in long-term funding and implementation. Either the whole of the intervention or especially important and promising components may be the subject of sustainability efforts. In order to secure long-term funding, sustainability may also consist of the service being incorporated into long-term programmes and strategic concepts at the municipal or state level.

EXAMPLE FOR LEVEL 3

The counselling service is implemented in the pilot phase, documented and assessed for effectiveness. Data on the number and duration of counselling sessions, the topics focused on during the consultations, client satisfaction, and positive effects are captured. It turns out that demand is high, the service is accepted and clients perceive it as supportive and helpful. When the pilot phase runs out, the counselling service continues to be supported as part of an inclusion strategy at the municipal level.

LEVEL 4 THE SUSTAINABLE INTERVENTION IS CONTINUOUSLY DEVELOPED FURTHER

Even for interventions which have successfully been made sustainable, current needs are continuously investigated and reflected on jointly with the target groups. If new needs emerge or if it turns out that the service structure is no longer appropriate due to changed conditions in the operating environment, innovative approaches are developed and integrated into the work.

EXAMPLE FOR LEVEL 4

As part of quality management for the counselling service it turns out that, while clients pick up the available information materials, they do not fully understand or use them. Target group-specific information materials are designed jointly with service users and plain language specialists. These become an important new component of the counselling service.

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09 INTEGRATED ACTION

DEFINITION

Health promotion at the municipal level is an interdisciplinary, cross-sectional task which can only be accomplished through integrated action. As such, it consists mainly of creating integrated action plans as well as of connecting people and institutions from a range of professional sectors, politics and civil society.

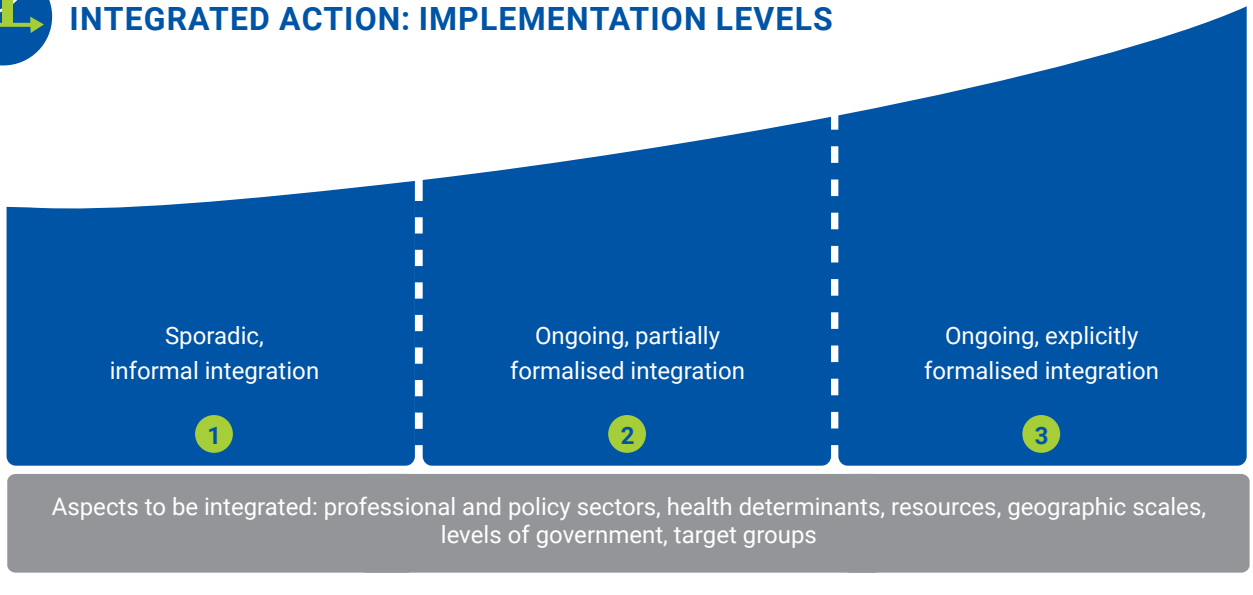
1. INTEGRATED ACTION PLANS

In health promotion, integrated action plans are important control and coordination tools. They are developed in collaboration (↗ Participation) with the central stakeholders within the respective setting (↗ Setting approach). These include the administrative departments of the municipality, charitable civil society organisations, associations and institutions, as well as the residents themselves. Integrated action plans are generally characterised by the following core components:

- Problem and needs analysis;
- Objectives;
- Actions to achieve the objectives;
- Timeframe, schedule and implementation plan;
- Quality management, documentation and evaluation;
- Budget and funding plan.

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

INTEGRATED ACTION: IMPLEMENTATION LEVELS



An integrated action plan details the activities of different areas which are to be integrated:

- a range of professional and policy sectors (‚health in all policies'), e.g. health, youth services, education, urban development, urban planning, social services, employment, environmental protection, transport;
- 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 and technical capacity;
- a range of geographic scales, e.g. neighbourhood, city / town district, municipality, region;
- a range of levels of government authority, e.g. local, state and national;
- a range of target groups (→ Target group orientation), e.g. children, adolescents, seniors, families, single parents, the unemployed, people with a migration background.

The complexity of integrated action plans makes the written form indispensable. At the same time, the challenge is to reduce the complexity of the plans' concepts in such a way that they can still be implemented (feasibility). Individual interventions and existing projects should be incorporated into the integrated action plan, if possible.

2. INTEGRATION THROUGH NETWORKING

Networking is a core activity in health promotion. It describes a web of relationships between stakeholders (committed individuals, groups and institutions). Networking serves to exchange information, to supplement material and non-material resources and/or to agree on shared values and goals. Successful networking contributes to the incorporation of health promotion interventions into the existing municipal service structures. In its more mature forms, synergies emerge from collaboration, which can have a lasting effect as collective resources beyond the circle of network partners.
All networking activities should build on already existing structures. One networking task is to develop individual interventions as part of municipal strategies and programmes (e.g. integrated municipal health strategies or life-course prevention chains) or to promote such strategic or programme development through shared coordination.

Levels of intensity and commitment in collaboration can range from informal verbal agreements to regular delegate attendance or active participation and formal arrangements in the form of collaboration agreements. The reliable coordination of networking activities is an important success factor, even for informal networks. The same applies to the continuous further development of suitable network and organisational structures for joint initiatives. The different dimensions of integrated action can provide signposts for regular improvement activities.

IMPLEMENTATION LEVELS

Individual integration aspect	**LEVEL 1** Sporadic, informal integration	**LEVEL 2** Ongoing, partially formalised integration	**LEVEL 3** Ongoing, explicitly formalised integration
Professional and policy sectors	Conception is led by a single department. Other departments are consulted and involved as needed.	A joint committee of different departments is responsible for strategic development. Collaboration is independent of individuals, whereby each individual department ensures continuity.	A collaboration agreement or a local government decision ensures that multidisciplinary collaboration is binding. The integrated action plan is regularly revised and updated.
Health determinants	The action plan is based on a narrow definition of health which focuses 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 and social / community aspects as well as general living 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 socioeconomic and cultural conditions as well as the physical environment.
Resources	Some partners contribute material as well as non-material resources to the collaboration for specific purposes.	The majority of stakeholders regularly contribute physical as well as intangible resources. The respective partners themselves decide on amounts and allocations.	Binding commitments or agreements exist regarding the resources partners make available. The allocation of resources is determined jointly.
Geographic scales	Conception focuses on a specific neighbourhood; references to development across the municipality are incidental.	Conception focuses on a selected district. Based on need, priorities are set for specific neighbourhoods.	The strategic partnership develops a municipality-wide plan, continuously articulating its implications for different sectors (e.g. housing / residential environment / infrastructure).
Levels of government	Conception is carried out by individual initiatives or stakeholders at the national, state or local government level. Integration of the different levels is absent or weak.	Conception is carried out in negotiation and with the participation of several partners from various levels of government.	National, state and municipal governments 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 integrated action.	Target groups are an integral part of the strategic partnership and participate equally in decision making. The diversity of target group representatives reflects the heterogeneity of the population and their specific needs and is reflected in the details of the action plan.

EXPLANATION OF THE LEVELS

The different aspects of integration are assessed individually in order to identify the implementation level to which an action plan or a network corresponds. As a rule, the overall assessment follows the level reached by the majority of individual aspects.

LEVEL 1 SPORADIC, INFORMAL INTEGRATION

EXAMPLE FOR LEVEL 1

In a residential district participating in the federal 'Social Cohesion' urban development support programme, a discussion group for Arabic-speaking men is included as a building block of the district's action plan for the programme. The group addresses health-related topics and psychosocial issues. The group format has been developed by a service provider and is funded from the budget of the Office for Integration. Considering health and nutrition topics, a local statutory health insurance fund is invited to participate in the design process for the course.

LEVEL 2 ONGOING, PARTIALLY FORMALISED INTEGRATION

EXAMPLE FOR LEVEL 2

The group for Arabic-speaking men also addresses psychosocial concerns, parenting issues as well as the housing and working conditions of the men and their families. Support options are explored in collaboration with local partners. The costs of the service are covered by the municipality as well as by a local statutory health insurance fund as part of its prevention budget. The topics and concerns articulated by the group are incorporated into the agenda of a cross-departmental municipal working group with representation from health, social services, youth affairs, and housing.

LEVEL 3 ONGOING, EXPLICITLY FORMALISED INTEGRATION

EXAMPLE FOR LEVEL 3

The discussion group meetings for Arabic-speaking men originally held only at one particular neighbourhood centre are now conducted as a standard intervention in all city districts and in collaboration with partner organisations. This is based on a decision by the municipal government to become a 'Family-Friendly Community'. As part of this development, men's and fathers' groups are integrated into a city-wide plan for supporting families. The municipal administration, external partners as well as selected target group representatives jointly develop the plan. Binding agreements are negotiated regarding financial, governmental and departmental responsibilities. One of the objectives is to make the residential environment more family friendly and to improve social infrastructure (e.g. child care, language and educational services, employment and vocational education opportunities). Health concerns such as healthy school lunches and local spaces for physical activities also play a role.

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10 QUALITY MANAGEMENT

DEFINITION

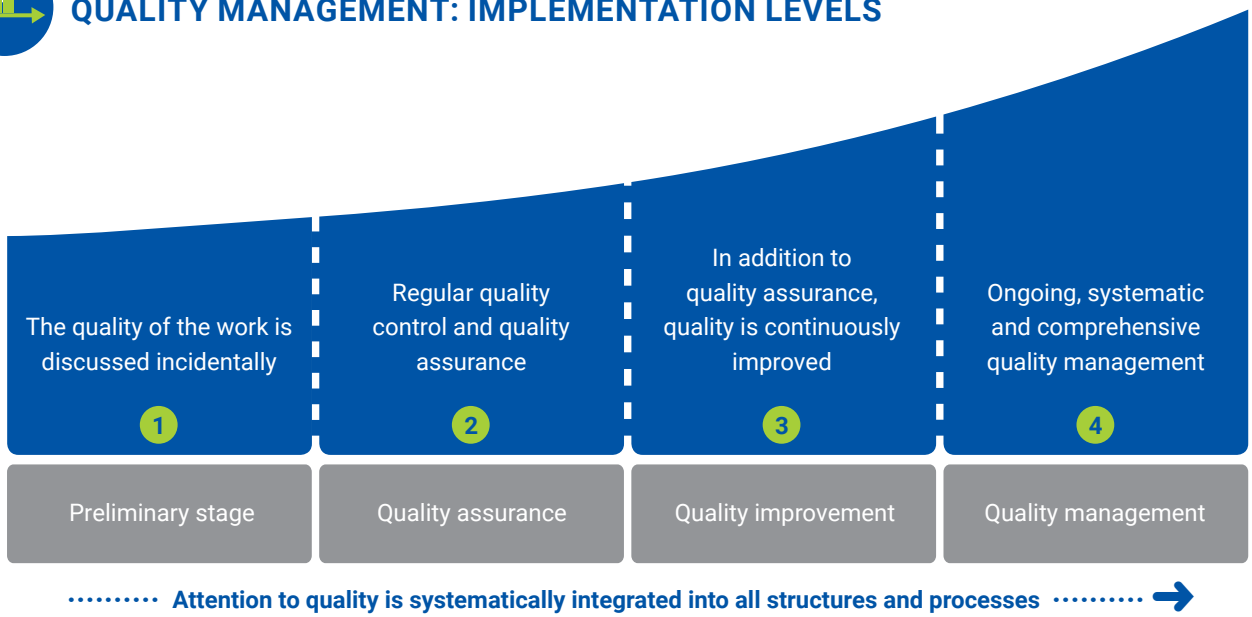
Quality management ensures that health promotion interventions are planned, designed and implemented according to need and based on evidence as well as in a participatory (→ Participation) and target group-oriented (→ Target group orientation) manner. The aim of quality management is also to continuously develop interventions and, thereby, better align them with actual needs. Quality improvement and quality assurance are components of quality management which, as an organisational control and leadership system, ensures that requirements are met.

Quality assurance mainly serves to comply with legal (external) and provider-specific (internal) quality requirements. Quality improvement, on the other hand, is a continuous and systematic reflective and learning process. To improve and further develop the service, it follows specialist expertise and the criteria for health promotion.

Quality assurance and improvement are generally supported by internal staff (mostly quality management officers) and by external experts, if required. Quality management identifies opportunities for improvement in the following areas:

- Planning quality: the development of a conception (→ Conception) and its implementation steps on the basis of a (participatory) needs assessment, scientific evidence and specialist practical experience;
- Structural quality: the resources available to an intervention, e.g. finances, personnel, facilities, equipment, etc.;

QUALITY MANAGEMENT: IMPLEMENTATION LEVELS



- Process quality: the methods used in implementation;
- Quality of results: the effects achieved with respect to the stated objectives (→ Evidence for costs and effects).

The entire process is always controlled by management. Management also ensures the continuous monitoring of results (→ Documentation and evaluation) and adjusts objectives and interventions.

EXPLANATION OF THE LEVELS

LEVEL 1 THE QUALITY OF THE WORK IS DISCUSSED INCIDENTALLY

Team members have an implicit, unwritten understanding of quality. They reflect on their own work individually, without developing a shared understanding, and share their ideas on potential improvements only sporadically. They bring up obvious and urgent difficulties with working processes and structures as well as potential solutions spontaneously and immediately, triggered by the respective situation ('incidentally').

EXAMPLE FOR LEVEL 1

A youth welfare organisation develops a programme to strengthen the health-related competencies of adolescents in open prisons and implements it jointly with a correctional facility. The programme is intended to strengthen the competencies of the young people in the areas of nutrition, exercise, coping with stress, and psychosocial health. It consists of 12 sessions with a group of 10 adolescents serving an open prison term. Team members document the number of participants using a roll call. Afterwards, team members talk informally about problems encountered during the session.

LEVEL 2 REGULAR QUALITY CONTROL AND ASSURANCE

Team members and additional stakeholders discuss the intervention's progress in a planned fashion and at regular intervals, e.g. as part of team and steering group meetings. They use internally developed or externally prescribed indicators or checklists to review the structures, processes and results of their work. They document the outcomes of these reviews as well as the resulting tasks and responsibilities in a written format. They predominantly reflect on procedures and structures in order to maintain the already existing, 'tried and true' quality of the work. In addition, team members revise the conception and adapt it to changing requirements.

EXAMPLE FOR LEVEL 2

The youth services team reflects on the project's progress at regular fortnightly meetings. Apart from the regularity of the young people's attendance, topics for discussion are their level of active participation as well as issues of session content and workers' experiences. Team members document their insights and conclusions with respect to developing the service further.

LEVEL 3 IN ADDITION TO QUALITY ASSURANCE, QUALITY IS CONTINUOUSLY IMPROVED

Quality assurance and improvement instruments and methods are applied continuously, e.g. in the form of checklists and reports. The focus of quality management is not only on securing quality levels already achieved and resolving any difficulties; it also strives for the continuous improvement of structures and processes. The quality of the work is improved in a process of continuous learning, also with the contributions of or feedback from those affected, in order to achieve long-term positive and sustainable results.

EXAMPLE FOR LEVEL 3

Youth services team members analyse their experiences with implementing the service in order to document evidence of competencies gained by the young people in the areas of nutrition, exercise, coping with stress, and psychosocial health. This is done on the basis of e.g. standardised observations and surveys of contact persons. The young people themselves are also asked about their experiences and specific suggestions for change.

LEVEL 4 ONGOING, SYSTEMATIC AND COMPREHENSIVE QUALITY MANAGEMENT

Quality management continuously and systematically investigates all aspects of the intervention and the organisation while considering the perspectives of all those involved. Within a framework of clear allocation of responsibilities, project plans as well as structures and procedures are reviewed and developed further. In this system, quality assurance always compares results to stated objectives (target <-> actual comparison). This requires suitable indicators which can measure change and render it verifiable. A range of tools and methods are used to support quality improvement, some of which involve external experts. The insights gathered are systematically incorporated into improving the conception and methodology.

EXAMPLE FOR LEVEL 4

Using a written guide, youth services staff systematically document their experiences from implementing the group programme and regularly analyse them together. Apart from technical and content-related aspects, they also discuss organisational issues. The methods to be used to measure the project's success (increased competencies among the adolescents) are also determined. These methods are applied regularly and the results are documented. They form the basis for the further development of the group work programme.

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11 DOCUMENTATION AND EVALUATION

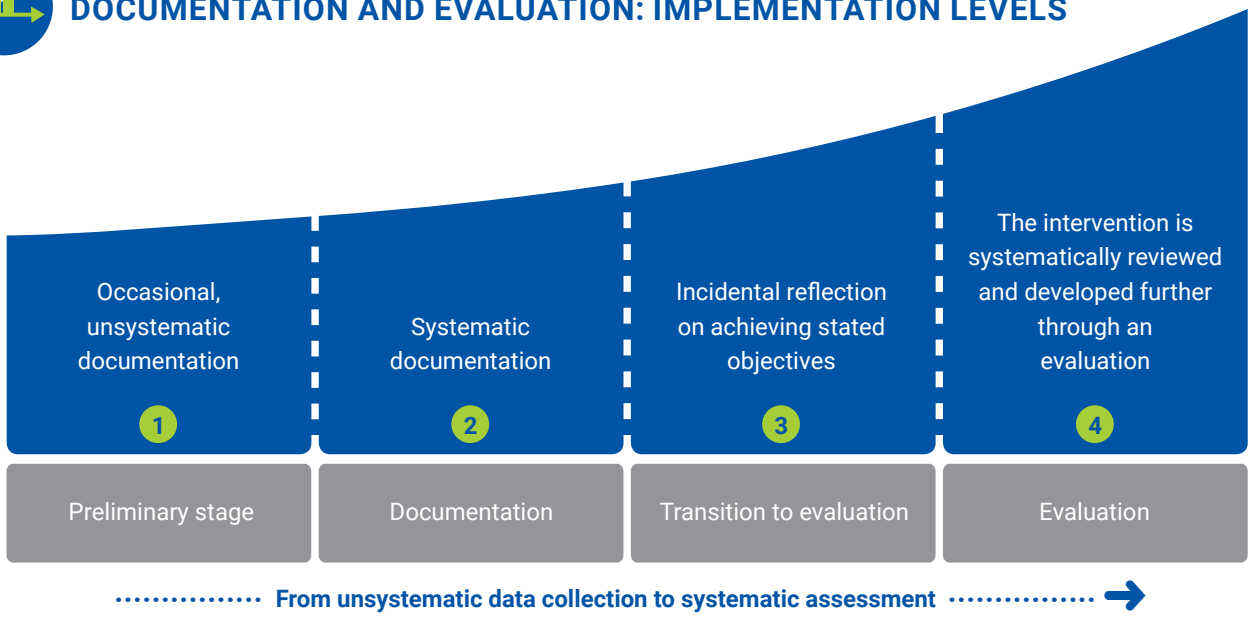
DEFINITION

Documentation and evaluation are components of → Quality management. They serve to document and assess the implementation and results of an intervention. During as well as at the end of the project, the evaluation verifies the extent to which the objectives stated in the → Conception have been achieved.

Documentation reflects the content and results of the processes used to implement the project. It includes, for example, minutes of meetings, reports of event proceedings and results, as well as a collection of the materials developed as part of the project. If it is used merely to verify that prescribed standard requirements have been met, documentation is often perceived as superfluous bureaucracy. However, documentation ensures that the planning and implementation of an intervention can be understood and assessed, not least by external parties or new team members and even after a longer period of time has passed.

Evaluation consists of methods of assessment which are based on systematic data collection, data management and analysis. Evaluations analyse documented, but also newly collected or obtained information and assess it systematically against the objectives stated in the project plan. They point out how processes, and consequently their results, can be improved. Evaluations may be carried out internally, i.e. in the form of self-assessments, or as external evaluations by or with the support of external experts.

DOCUMENTATION AND EVALUATION: IMPLEMENTATION LEVELS



The timing of the evaluation is important. If it occurs alongside the work in progress, its results can be incorporated into the ongoing implementation of activities. This is called formative evaluation and mainly consists of process evaluation. Outcome evaluation verifies retrospectively whether and to what extent the stated objectives of the intervention have been achieved and which other effects it had beyond them. This is called summative evaluation.

Evaluations can include one or more quality dimensions, in particular: planning, structural and process quality as well as the quality of the results (→ Quality management). Structural quality is rarely evaluated separately, but in most cases considered as part of the process and outcome evaluation.

It is important that the scope and methodology of the evaluation are tailored to the subject and complexity of the research question.

EXPLANATION OF THE LEVELS

LEVEL 1 OCCASIONAL, UNSYSTEMATIC DOCUMENTATION

Ways of working and results are documented only occasionally, not systematically. The value of documentation as part of quality management is not apparent. There are no binding requirements regarding content, format or storage, nor regarding the analysis and communication of results.

EXAMPLE FOR LEVEL 1

The staff of the pregnancy counselling centre note down the number and duration of counselling sessions held and file away this information individually.

LEVEL 2 SYSTEMATIC DOCUMENTATION

Rules are set for what is to be covered by the documentation of activities, and how. These rules are in compliance with the respective privacy and data protection provisions. On this basis, information and data can be supplied to internal as well as external evaluations (see also Implementation Level 4).

EXAMPLE FOR LEVEL 2

The staff of the pregnancy counselling centre document all counselling sessions using a jointly maintained data entry interface. Apart from the number of sessions and socio-demographic data (e.g. age, marital status, background, social determinants of health), they also document the main topics and content discussed during the sessions.

LEVEL 3 INCIDENTAL REFLECTION ON ACHIEVING STATED OBJECTIVES

In order to draw conclusions, staff members reflect on the content of their documented records in response to certain situations and with respect to the stated project objectives.

EXAMPLE FOR LEVEL 3

Just before a scheduled meeting with the funding body, the staff of the pregnancy counselling centre reflect on their counselling session records (see Level 2). They discuss the extent to which target groups have been reached and their needs responded to. On this basis, they develop ideas for improving communication with target groups.

LEVEL 4 THE INTERVENTION IS SYSTEMATICALLY REVIEWED AND DEVELOPED FURTHER THROUGH AN EVALUATION

The distinction between internal evaluation (self-assessment) and external evaluation made below does not represent a value judgement. Which type of evaluation is suitable and feasible in any given situation depends on the intervention, its context and the resources available.

4a INTERNAL EVALUATION (SELF-ASSESSMENT)

Starting with the data collected as part of documentation and, wherever possible, additional information sources (mixed methods approach), the outcomes of an intervention are systematically verified and assessed following the methodology selected for self-assessment. The extent to which objectives have been achieved is discussed and opportunities for the further development of the intervention are identified.

EXAMPLE FOR LEVEL 4a

Counselling service staff assess the extent to which their service was able to reach the target groups mentioned in the project plan, using their documented records as well as reflective discussions (supervision). On the basis of the results, they develop new ideas to promote the service and improve user satisfaction with counselling and referrals.

4b EXTERNAL EVALUATION

An external institution (e.g. a research institute or university) is contracted to evaluate the intervention (e.g. as part of a scientific research project working alongside the intervention or an academic qualification requirement such as an academic subject-based project or essay or an undergraduate or graduate degree thesis). Evaluators consult with the contracting organisation and the team regarding the subject matter and methods for the evaluation. They use the data collected as part of the documentation and supplement it with their own data collection, if required. They may, for example, survey staff and/or target group members.

The external evaluation process should be active before as well as during the implementation of the intervention in order to define the indicators for the achievement of stated objectives, to assess whether and to what extent implementation according to the conception has been successful and whether the methodology needs to be adjusted (process or formative evaluation). In summative evaluation, the achievement of stated objectives – and other aspects, if required (methodology, quality, etc.) – are assessed in their entirety. During or after completion of the evaluation, the external evaluators present their results and, jointly with the team, develop ideas for the further development of the intervention.

EXAMPLE FOR LEVEL 4b

The counselling service contacts a university school of social work and offers to have its work evaluated. The evaluation carried out as part of a master's thesis assesses whether the target groups have been addressed appropriately and reached as planned and to what extent they perceived counselling outcomes as helpful. In addition, the evaluation generates ideas for the improvement and further development of family planning counselling.

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12 EVIDENCE FOR COSTS AND EFFECTS

DEFINITION

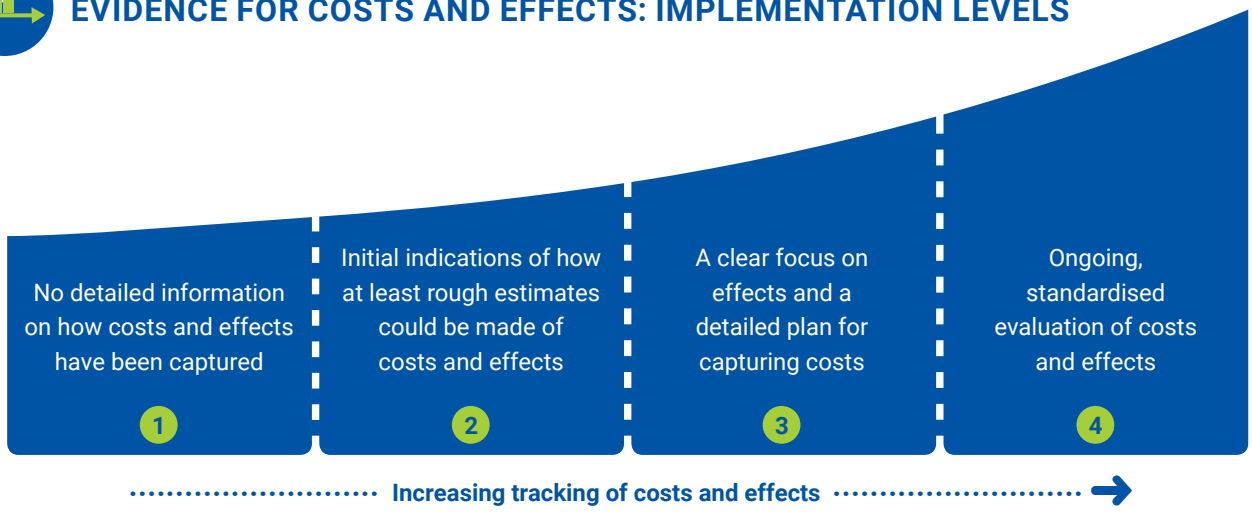
An intervention should be effective and its positive effects should be proportionate to the costs. It is, therefore, also important to capture the costs and effects of an intervention. The effects can be observed, for example, in the target groups' (↗ Target group orientation) greater ability to cope (↗ Empowerment) with health-related burdens, greater competence in shaping their living environment (↗ Setting approach) in a way that is appropriate to their health, or a strengthening of health-promoting actions.

These effects are often difficult to measure, not least because the resources required to conduct such measurements are often unavailable. However, some focus on effects is always possible: the specific effects to be achieved for target groups are clearly articulated, right from the intervention's development phase and in the ↗ Conception plan itself. Also included are explanations of how the planned activities are intended to contribute to achieving the desired changes and which indicators must be used to verify whether and to what extent the desired changes have actually been achieved.

Costs not only comprise payments for personnel, goods and rent. They also include e.g. the use of existing premises and the time contributed by volunteers. Capturing the total cost not only takes into account the resources used for the implementation of the intervention, but also the resources put into planning by all stakeholders involved. Costs in the sense of monetary or time resources can also be incurred by individuals participating in the intervention. This means that capturing costs comprehensively can require a large effort.

If it is not possible to capture costs and effects completely and accurately, it should still be considered how the effects can be described and how the costs can be estimated as accurately as possible. The more accurate this description is, the better. Even relatively general information (↗ Documentation and evaluation, ↗ Quality management) can provide important

EVIDENCE FOR COSTS AND EFFECTS: IMPLEMENTATION LEVELS



data, both for the current intervention as well as for planning future interventions.

Collecting data on costs and effects is in most cases likely to be possible only with the support of experts in the field. The required data collection instruments must be made available, whereby it is often necessary to adapt these to the respective intervention. Since each intervention has its own stated objectives, appropriate indicators are required to capture the effects. Before data collection instruments for capturing costs can be used, it must also be confirmed who is able to charge costs to whom in the first place. For this reason, data collection instruments must always be developed jointly between academia and practice, i.e. scientific suggestions must always be adapted to what is possible locally. Support from academic experts will, in most cases, also be necessary for analysing the collected data. Here, however, the role of scientific expertise remains limited to providing a service: it is not there to impose the rules of the game, but only to provide support where it is needed.

EXPLANATION OF THE LEVELS

LEVEL 1 NO DETAILED INFORMATION ON HOW COSTS AND EFFECTS HAVE BEEN CAPTURED

While the objectives of the intervention are defined, it is not possible to say whether and to what extent they are being achieved. It is not possible to discern from the conception which indicators and data collection methods are to be used to capture the effects of the intervention. There is also no evidence of a focus on effectiveness. This means that the justification for why it is expected that the objectives will be reached with the planned interventions is missing. Referring to scientific studies or comparable projects in general is insufficient for this purpose.

While specific results (e.g. the number of participants) are documented, they only provide a very rough indication of effectiveness. This is similar when it comes to costs: they are either not reported at all or the existing data are too incomplete or inaccurate to make it possible to estimate, even roughly, the actual costs.

EXAMPLE FOR LEVEL 1

As part of a programme to promote oral health at day care centres, training workshops are conducted for child care workers. The goal of the programme is defined in a very general way as ‘improving oral and dental health status‘. When it comes to costs, the only amounts mentioned are those paid to the personnel visiting the child care centres to deliver the programme.

LEVEL 2 INITIAL INDICATIONS OF HOW AT LEAST ROUGH ESTIMATES COULD BE MADE OF COSTS AND EFFECTS

The objectives are articulated clearly and linked to measurable indicators. The methodology used to achieve the stated objectives is well justified by references to scientific studies and/or practical experience. The justification includes critical reflection on whether and to what extent experiences gained from other interventions are applicable to current activities.
The costs for planning and implementing the intervention can be estimated at least roughly.

EXAMPLE FOR LEVEL 2

Specific objectives are stated as part of the programme to promote oral health in day care centres. They describe how the topic of 'oral health' can be integrated into the operational routines of the centres visited and which changes in children's dental health status are to be achieved. The organisational effort and the time spent by child care personnel are also taken into account.

LEVEL 3 A CLEAR FOCUS ON EFFECTS AND A DETAILED PLAN FOR CAPTURING COSTS

The focus on effectiveness is more clearly apparent here than at Level 2: all changes to be achieved for the target group are clearly defined. The conception comprehensively explains how the planned activities are intended to contribute to achieving the desired change. It also determines how and with which indicators and data collection methods these changes are to be measured.

There is a detailed plan for the ongoing documentation of planning and implementation costs. Captured are not only direct financial costs (e.g. for personnel, materials and rent), but also indirect costs, such as time spent and the use of existing premises.

EXAMPLE FOR LEVEL 3

The programme to promote oral health in day care centres is specified in more detail. Clearly specified are the expected specific effects, which indicators should be used to capture different levels of effects and how these indicators can help verify the extent to which the stated objectives are being achieved. The required data are partially documented by the day care centres themselves (how regularly children brush their teeth after lunch), but also collected externally (children's dental health status). The effort which goes into developing the indicators and collecting and analysing the data is also added to the itemised list of costs.

LEVEL 4 ONGOING, STANDARDISED EVALUATION OF COSTS AND EFFECTS

Using a standardised procedure also deployed in other interventions and assessed as meaningful by external experts, data are collected on effects as well as on costs. The data on costs and effects are analysed continuously and across the organisation. Where possible, this is done by external experts, not only because it requires substantial resources, but also in order to analyse costs and effects as objectively as possible.

Using a standardised method offers an opportunity to compare costs and effects, even across different interventions and programmes. The aim is to answer questions such as, 'If programme A achieves the same effects as programme B, which of the two programmes costs less?'

EXAMPLE FOR LEVEL 4

A manual exists for the programme promoting oral health in day care centres. It determines the indicators to be used to capture costs and effects and how data collection for these indicators can be integrated into operational routines. A research team works alongside the programme, advises the implementing day care facilities and summarises the results for all involved in a well-structured way.

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in der Gesundheitsförderung bei sozial Benachteiligten

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