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Health Promotion Switzerland

Best Practice

A normative framework for optimal health promotion and disease prevention

Developed by Health Promotion Switzerland

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Health Promotion Switzerland
Dufourstrasse 30
P.O. Box 311
CH-3000 Berne 6
Phone +41 (0)31 350 04 04
Fax +41 (0)31 368 17 00
office.bern@promotionsante.ch
www.healthpromotion.ch

Promotion Santé Suisse
Avenue de la Gare 52
CH-1003 Lausanne
Tél. +41 (0)21 345 15 15
Fax +41 (0)21 345 15 45
office.lausanne@promotionsante.ch
www.promotionsante.ch

Authors
Ursel Broesskamp-Stone and Günter Ackermann

With contributions by Brigitte Ruckstuhl (2004/2005), Ralph Steinmann (2006/07) and the foundation's internal Best Practice working group (Winter 2006/07)

Translation: Barbara So-Barazetti

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Editorial

Since 2003 Health Promotion Switzerland, in cooperation with national and international experts, has reassessed both foundations and existing approaches used by national professional organisations with respect to evidence, quality development and best practice in health promotion and disease prevention. These efforts were part of the further development and professionalisation of health promotion and prevention and led to a clear frame of reference for all those striving for an optimal or best practice in this field. The work was based on the Ottawa Charter as well as international studies, discussions and experiences, especially from Canada, the United States, the Netherlands and Germany.

The work also demonstrated that in order to achieve optimal, i.e. effective and sustainable decisions and actions in health promotion and disease prevention, focusing on "evidence-based" health promotion alone is insufficient. On the other hand, it emphasised the importance of considering not only the values, principles, ethical aspects, scientific and experiential knowledge, but also the context in which interventions take place.

With the best practice framework – a normative framework for action geared towards health promotion and prevention with optimal quality – Health Promotion Switzerland has adopted a position within the scientific discourse, in particular in the debate over evidence. Health Promotion Switzerland makes a point that optimal professional actions and decision-making or "best practice" in health promotion and disease prevention are knowledge-based, ethically responsible, context-sensitive and effective. This means that such health promotion is oriented towards sustainability and equal opportunity.

Health Promotion Switzerland regards the development and implementation of a normative framework for best practice as a contribution to further strengthening health promotion and disease prevention, particularly by establishing, institutionalising and networking the domain.

The best practice framework was first published in Switzerland in 2007 (version 1.0). This framework is presented here in a slightly amended version 1.1; it serves as the basis for the Swiss contribution to knowledge transfer and discussion at the 20th IUHPE World Conference for Health Promotion "Geneva 2010" in the area of best practice, quality and evidence. Health Promotion Switzerland is hoping that this broad understanding of best practice in the sense of optimal professional acting will be internationally well received in health promotion and prevention and is looking forward to further suggestions and applications.

Dr. Thomas Mattig
President

Dr. Ursel Broesskamp-Stone
Head of International Department
Senior Advisor Policy
Former Head of Department Evidence (2004–2006)

Health Promotion Switzerland, June 2010

Acknowledgement

We extend our thanks to Dr. Brigitte Ruckstuhl for her constructive collaboration and process facilitation as well as for her very valuable scientific input in the updated version of the best practice framework for Health Promotion Switzerland. Working with her was a pleasure, and we highly valued her reliability and competence. The present version 1.1 from June 2010 is a slightly amended version of the previous one (1.0) first published by Health Promotion Switzerland in 2007.

Part 1
1 Summary

Health promotion and prevention requires a clear orientation framework and appropriate guidelines. Health Promotion Switzerland has developed a normative framework from a western perspective called "best practice". This framework for best practice in health promotion and disease prevention brings together the results of discussions on evidence and quality development held in the past few years. The guidelines derived from the best practice approach support decision-makers and specialists in their challenging work of health promotion and prevention and encourage ethically responsible, scientifically based and context-sensitive action. In this sense, best practice stands for **optimal professional action.**
Best practice in health promotion and prevention is based on the three dimensions of values, knowledge and context: the implementation of the best practice framework requires systematic, recurrent reflection or critical questioning by professionals or those responsible for health promotion and disease prevention – when making decisions or when planning, implementing and evaluating activities (cf. Fig. 1).
Best practice is defined as follows:

> Best practice decisions, activities and interventions in the context of health promotion and disease prevention systematically take into account the **values** and principles of health promotion and public health, are supported by current scientific **knowledge** as well as knowledge from experts and derived from practice, observe the relevant **context factors** and achieve the intended positive effects whilst avoiding negative ones.

Best practice decisions and interventions result from applying the three dimensions of values, knowledge and context in a systematic way. In health promotion and disease prevention best practice conceptually goes beyond good practice: best practice clearly aims at highest standards of quality in respect of the three dimensions values, knowledge and context. The best practice framework describes well defined professional standards in health promotion and prevention and renders them operational via the formulation of best practice criteria. These are not defined for a particular health problem, a type of intervention or a target group, but aim more generally at supporting decision-making and action in health promotion.
Best practice is about the adequate application of existing scientific knowledge as well as experiential knowledge in the areas of health promotion and prevention, about the adequate consideration of values and principles as well as context-sensitive factors.
Best practice is a normative framework for professional activity and action and for quality development. It serves as a guideline for health promotion professionals so that their "good" or "promising" practice may become the best possible one. Optimal practice in this context does not only mean effectiveness or efficiency but also implies ethical responsibility, sensitivity to context and sustainability.
So, the notion of best practice does not represent a preconceived miracle solution nor one that is "predefined from outside". To provide a generally valid collection of "best practice interventions" in the sense of practically applicable "recipes" is impossible for most areas of health promotion and disease prevention.

2 Basis and justification

Successful professional acting and decision-making in health promotion and disease prevention require a clear frame of reference and appropriate guidelines. Interventions in health promotion and primary prevention, taking place in different contexts, are generally considered to be complex and therefore difficult to standardise. They are mainly longterm-oriented, targeting changes in health determinants as well as in behaviour patterns and contextual conditions. Requirements such as participation and empowerment add to the difficulty of standardising these interventions. Nonetheless, they need to be knowledge-based and verifiable, even under these difficult circumstances.

Best practice with its normative frame of reference for action provides answers to the current most challenging key questions:

- How can scientific knowledge be applied in practice?
- How can practical knowledge be better exploited and integrated in scientific products?
- How can greater attention be drawn to contextual factors, and how can issues of transfer be sufficiently taken into account?
- How can norms, values and ethical principles of public health and health promotion gain better visibility, how can they be stated clearly, and how can greater awareness of them be achieved?

The three dimensions of best practice include the key aspects relevant for professional decisions and actions in health promotion and disease prevention. The dimensions cover fundamental values, such as equal opportunities, social responsibility and others that are central to health promotion and new public health. They take into account the different context levels, from the structural, political and socio-cultural conditions to the level of specific contexts in which local interventions take place. The emphasis is on activities based on knowledge and on the generation of new knowledge. These activities rest upon an understanding of "evidence" adequate to health promotion, on knowledge gained from experience or from experts, including knowledge derived from integrated quality development. Evidence or evidence-base is usually conceived of as proven effectiveness and efficiency. In order to provide evidence in health promotion, methods have to fit the research object (e.g. a complex intervention). Evidence in health promotion also includes knowledge about the effects of different factors and the way they interact as well as their influence on health (determinants). As a normative reference for reflection and action, the best practice framework is meant to promote **ethically responsible**[1]**, scientifically based and also context-sensitive decisions and actions** (cf. Fig. 1).

[1] Cf. Ethisches Argumentarium (Advocacy Paper on Ethics), Health Promotion Switzerland, (www.gesundheitsfoerderung.ch)

3 Objectives and audience

The introduction and consistent implementation of the best practice framework aims to achieve the following objectives:

- Providing a clear professional standard by establishing a solid, professional and politico-strategic base
- Intensifying action that is scientifically sound, sensitive to the context in which it takes place and oriented towards systematic and continual learning
- Improving transparency, comprehensibility and coherence of decisions at all levels of professional activity
- Improving legitimisation and credibility of activities and investments in health promotion and disease prevention
- Positioning health promotion and prevention more clearly within public health and other areas of society
- Improving motivation and commitment of all involved for strengthening the evidence base in health promotion and disease prevention.

For organisations active in this field the implementation of the best practice framework means:

- Supporting and assuring optimal actions and activities
- Providing adequate and clear responses to the demands for "evidence bases" and quality development in public health
- Providing understandable reasons for the high quality standards all professionals in health promotion and disease prevention have to meet.

Best practice is intended for professionals working in the field of health promotion and disease prevention and for important decision-makers in public health. It is meant to guide and support them in their decision-making as well as in planning, implementing and evaluating their activities.

4 What is best practice?

The best practice framework for health promotion and disease prevention is a normative framework for action which is based on three **dimensions:**
– Values
– Knowledge
– Context

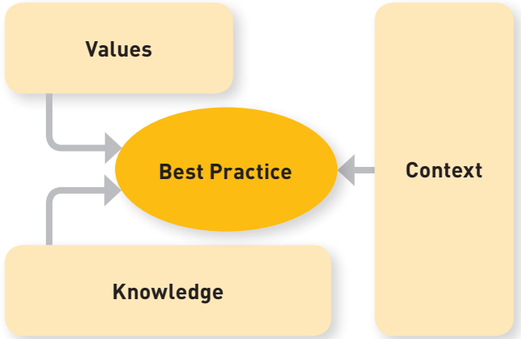


Fig. 1: The three dimensions of best practice in health promotion: values, knowledge and context

Values: As health promotion is a field of activity implemented in a social setting influenced by values and interests, rather than in a neutral and unbiased professional environment, norms and values play an important role in interventions and decision-making processes. Reflecting on norms and values and the respective context is, therefore, crucial and can be used for interventions. This requires that values be made explicit and discussed with the actors involved. Values and principles, such as participation, empowerment, equal opportunity and the consideration of social diversity which are all based on the Ottawa Charter are well known and should be systematically considered in practice.
Knowledge: With "evidence" issues debated and experiences with quality management made, there is now a growing sense of professional identity in health promotion and prevention. The time has come to formulate demands regarding knowledge bases and knowledge generation, on the levels of both policy development and implementation.
Context: The focus of "New Public Health", especially of health promotion, on the socio-cultural conditions favouring health or disease has increased the complexity of the interventions. The goal is not just to affect specific life situations and contexts, but also to achieve changes in the dynamic, political and socio-cultural environment by working together with other actors. Context factors are of extreme importance in particular when it comes to best possible actions in health promotion and disease promotion. The success of the interventions is highly dependent on how strongly the individuals and their environment can be activated and motivated. The fact that experiences can not simply be transferred to other contexts, because they are different, is another complication, which is why in a transfer of measures context factors need to be especially taken into account.
The above mentioned three dimensions of best practice can not be dealt with in isolation, since they are dependent on and influence one another.
Whenever the relevant aspects of the three dimensions are largely taken into account (cf. chapter 5) one speaks of best practice, of optimal decision-making and acting, which is to say that given the context and the existing knowledge at that time, the "best possible" is used and implemented in the best possible way, in accordance with the values and principles in health promotion.
In this respect, best practice decisions and actions in health promotion are defined as follows:

> Best practice decisions and actions systematically take the **values** and principles of health promotion and disease prevention into account, are based on current scientific **knowledge** as well on knowledge from experts and practice, pay attention to relevant **context factors** and achieve the intended positive results whilst avoiding negative effects.

The best practice framework for health promotion and prevention is a basis for best possible health promotion actions and decisions. The probability of achieving systematic and coherent positive effects in the sense of health promotion and prevention[2] is thus increased.
This constantly contributes to the specific use and generation of new knowledge providing more and more accurate answers to the relevant action-guiding **questions** in health promotion and disease prevention:
– **What influences health?**
  Knowledge on health determinants
– **What is effective to improve health for whom and under which conditions?**
  Knowledge on options for interventions
– **What should we do and why?**
  Choice of intervention depending on context and based on norms and values
– **How do we do this here?**
  Context-specific implementation
– **Which changes did we achieve?**
  Knowledge about the effectiveness of interventions
– **What did we learn from this?**
  Knowledge about the implementation and its benefit and distribution

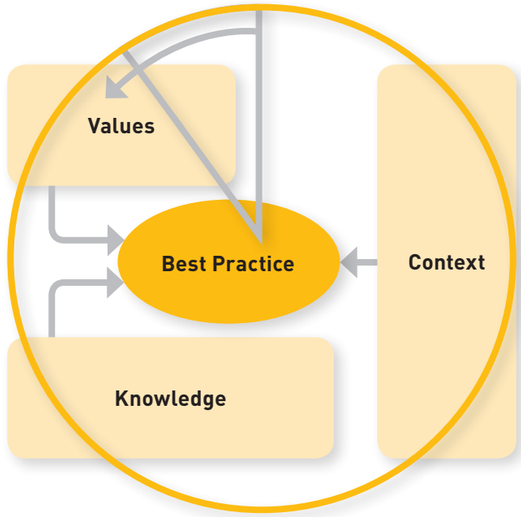


Fig. 2: Radar screen model of best practice for health promotion and prevention

The normative action framework best practice with its three dimensions is a reflection aid for everyday work. To answer the six action-guiding questions and to achieve optimal decisions and best practice, the dimensions values, knowledge and context have to be systematically thought through.
The implementation of best practice requires systematic, recurrent reflection by professionals or those responsible for health promotion and prevention when making decisions or when planning, implementing and evaluating activities to promote health (cf. Fig. 2). This is carried out throughout the three best practice dimensions and the associated criteria and indicators (cf. chapter 6) similar to a radar beam which repeatedly travels through the skies criss-crossed by aeroplanes.[3]

For planning new interventions (for example, interventions for target groups difficult to reach, or new topics) for which only few empirical findings exist, appropriate research is needed from experiences with other projects or other subject fields. In this case, best practice means not just carefully developing interventions, but also performing a research evaluation ("Praxis-Experiment"). Recording and reviewing experiences and knowledge from such innovative projects and experiments and making them available for the field of health promotion is absolutely crucial, assuring that systematic learning is possible even for individuals beyond those directly involved.

[2] Cf. also SMOC – Model for outcome classification by Health Promotion Switzerland
[3] Cf. also SMOC – Model for outcome classification by Health Promotion Switzerland

5 Best practice dimensions in detail

In health promotion and disease prevention the best practice dimensions can be illustrated as follows:

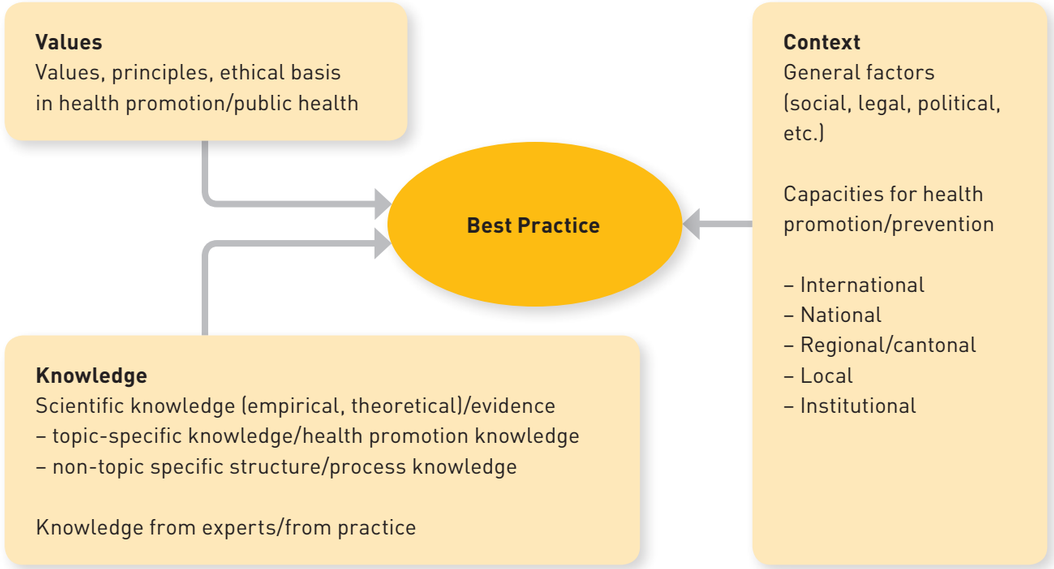


Fig. 3: The three best practice dimensions in detail

5.1 Best practice dimension "values, principles, ethical basis"

In health promotion and disease prevention, best practice or optimal practice means that decisions and actions always rest upon the basic values of public health and on the main principles of health promotion (cf. also the Ottawa Charter[4]). This includes the following in particular:

Basic values, basic principles, ethical basis in public health

- Same rights/same obligations and shared responsibility for health[5], social responsibility[6]
- Non-maleficence (avoidance of doing harm), beneficence ("doing of good"), respect for autonomy, justice[7] (the four ethical principles of public health)
- Transparency and accountability, openness[8]
- Equal opportunities in health (decisions and actions are governed by the concern about equal opportunities and fairness)[5]
- Sustainability[9]
  a) of measures and/or achieved health-promoting changes beyond the duration of the project and the initial financial aid[10]
  b) in the sense of sustainable development (Agenda21)[11]

Especially in health promotion[12]

- Orientation towards health and determinants of health (salutogenic rather than pathogenic model)[13]
- Empowerment[8]
- Participation[8]

Additionally, professional health promotion and prevention is always knowledge-based (cf. section 5.2).

If values need to be prioritised or weighted, care must be taken that decisions and actions do not contradict the basic values. It is most important that values and principles be clearly explained, justified and prioritised. Compromises as regards public health or health promotion principles are often required in situations where various parties work together. It is important to avoid major contradictions. In the event of conflict, the different positions must be carefully pondered (cf. also Advocacy Paper Ethics by Health Promotion Switzerland[14]). Interventions focussing on positive and well-intentioned goals of health promotion and disease prevention in the population, but having unwanted negative side effects, represent a particular challenge: e.g. a tendency towards increased health-related unequal opportunities, a phenomenon well known in tobacco prevention[15].

5.2 Best practice dimension "knowledge/evidence"

Programmes and projects in health promotion and disease prevention are interventions in complex social systems. In order to justify, plan, implement with a promise of success and evaluate such comprehensive processes, it is imperative that they be based on well researched and purposefully applied sound scientific statements.

Scientifically based statements are regarded as "evidence" if, by using adequate methods and study designs, there is proof that interventions are effective or efficient, or that the interplay of several health influencing factors show demonstrable effects. When evaluating "evidence" the complexity of interventions in health promotion and disease prevention must be taken into account. No type of study design or evidence can be defined as the best or the gold standard without reference to the research subject. Usually, health promotion and disease prevention resort to several types of evidence.

Actions as defined in the best practice framework are more than evidence-based activities. They are based on scientific knowledge as well as on knowledge gained from experience and from experts.

Two categories of knowledge form the bases for optimum health promotion and prevention:

The first category refers to scientific knowledge, including scientific theories and models. Depending on the field of activity and the type of interventions, various types and sources of evidence are available. In medicine, for example, the so-called "evidence pyramid" with random control studies as the highest rated evidence type is widely spread. As this study type does usually not fulfil the requirements of the complex interventions in public health, including

[4] WHO (1986)
[5] Cf. WHA (1998), World health declaration. Rootman et al. (2001). Lamprecht, Stamm (2005), p. 30. VicHealth (2006), p. 2–6: "Health is a fundamental human right. Everyone shares in the responsibility for health promotion. Everyone benefits from improved health outcomes."
[6] Tannahill (2008)
[7] Cf. Ethisches Argumentarium (Advocacy Paper Ethics) by Health Promotion Switzerland (2004), section 2.0
[8] Tennyson (w.y.); Noack (2006)
[9] Health Promotion Switzerland (2006), Long-term strategy; Noack (2006). Rootman et al. (2001).
[10] Tannahill (2008)
[11] www.un.org/esa/dsd/agenda21
[12] Rootman et al. (2001) and WHO Europe identify seven principles: four are named above; plus intersectorality, combining multiple strategies
[13] Cf. Ottawa Charter (WHO 1986); WHO (1998a); Raeburn/Rootman (1998); Green et al. (2000); Broesskamp-Stone (2004)
[14] Health Promotion Switzerland (2004)
[15] Paccaud F. (2007)

health promotion and disease prevention[16], alternative models for the weighting of evidence types are being discussed (cf. also Fig. 6).

The second category refers to **knowledge from experts and from experience gained in practice and policy**[17] and should be given appropriate consideration. Such knowledge is important as there are sometimes gaps in sufficient scientific or context-specific knowledge, particularly regarding actual implementation. These can often be filled by experts' knowledge. This category also includes knowledge from solid evaluations. In both knowledge categories a distinction can be made between topic-specific and non topic-specific knowledge. Topic-specific knowledge relates to health and health promotion and disease prevention, for example knowledge on determinants of health and health resources and on health promotion methods. Non topic-specific knowledge relates to knowledge that is applicable over a range of activities or disciplines, for example quality development, project management, advocacy processes, networking or social marketing. The knowledge cycle illustrates that current knowledge from research is needed for taking decisions and initiating actions that are based on scientific results (knowledge-based principle). On the other hand, new knowledge is also generated by solid evaluations of the health promotion and prevention practice and is incorporated in the knowledge basis of the field (knowledge generation principle). The ongoing exchange of knowledge and experience is also important and supports mutual learning.

Optimal decisions and implementation practices are based on scientifically sound impact or outcome models. When looking for evidence regarding health determinants or effectiveness of interventions, it is primarily empirical and systematically collected knowledge that is important. Other bases are provided by scientific theories and models. These are especially helpful when knowledge from various disciplines come together and need be placed in an overall context. Decision or planning processes are simplified as a result. In order to guarantee best

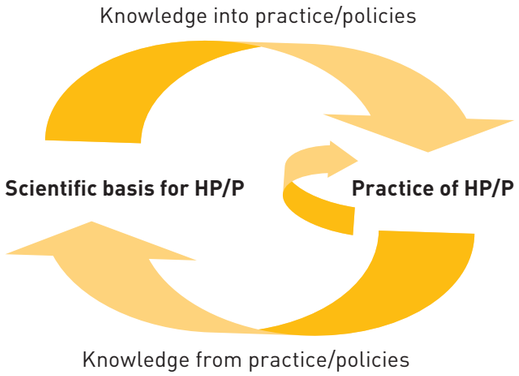


Fig. 4: Knowledge or evidence cycle: knowledge into practice and from practice

practice decision-making or interventions in health promotion and prevention, the question of current **scientific bases or evidence** must be answered **in two respects:**

- firstly with a focus on the **interaction** of the most important **determinants of health** and other important influencing factors which are relevant to the health promotion programme or health promotion interventions (e.g. the interaction of lifestyles, health literacy levels of the population, income, working and housing situation, and specific policy decisions),
- secondly with a focus on the **effectiveness** of selected measures (such as the consequences of a modified price policy on "healthy" foods for the consumption behaviour of specific population groups).

Agencies and specialist organisations responsible for health promotion and prevention may find it worthwhile to be guided by the following knowledge cycle (cf. also Annex II): Not only does it incorporate existing knowledge, but it goes beyond that by demonstrating how new knowledge can be generated from interventions and policy processes.

[16] Even in medicine the effect of most interventions is not proven via Randomised Controlled Trials (RCT's)
[17] Policy: Cf. annex III – Glossary

A. identifying, systematising and assessing, synthesising and preparing knowledge/evidence and other relevant scientific bases
B. top quality planning and implementation and very good, scientific (and where possible also comparable) evaluation of health promotion activities
C. generating knowledge/evidence and other scientific bases from scientifically evaluated practice and policy work in health promotion (through meta-evaluations and cross-border dissemination of evaluation results)
D. systematic review of results of a range of scientific studies (cf. below: evidence sources and types)

Fig. 5: Knowledge cycle in health promotion and prevention (adapted from Saan/de Haes, 2005)

Conventional practice is often restricted to the upper area of the knowledge cycle (plan–do–evaluate); the more systematic use of scientific knowledge/evidence (assessing, synthesising, applying knowledge/left-hand area) and the systematic dissemination of newly acquired knowledge such as evaluation results (sharing knowledge /right-hand area) are often neglected. The knowledge cycle helps to give adequate consideration to the best practice dimension "knowledge/evidence". This in turn contributes to reaching decisions or planning and implementing interventions based on the best practice approach. The collection and systematisation of knowledge or evidence (lower area: collection/review) is, however, one of the main tasks of research. Here, more applied research is required "for" (rather than "about") health promotion and prevention and "with" those involved in health promotion and disease[18].

The hexagonal diagram "evidence prism" (cf. Fig. 6) developed by Walach (2005) illustrates that different evidence types such as observational studies, studies with a mixed method design or qualitative studies must be chosen and weighted *depending on the topic of investigation or cognitive interest.* An overall top assessment of only one **evidence type** (type of study) *independent* of the object of investigation is rejected.

[18] Wright, M., Block, M., Unger, H. (2009). Partizipative Qualitätsentwicklung. In: Kolip, P., Müller, V. (Hrsg.), Qualität von Gesundheitsförderung und Prävention. Bern

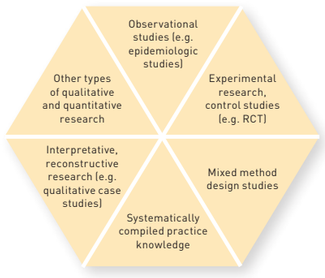
Types of knowledge (scientific knowledge)	Sources of knowledge	Objects of knowledge
1. Evidence	1. Evidence	1. Evidence
"Types of evidence"  	"Sources of evidence" – Scientific/research articles (peer reviewed) – from health, educational, social, evaluation, political, management sciences, etc. – Systematic and narrative reviews	"Objects of knowledge" – Determinants of health/health resources and their interaction – Distribution of health/determinants of health in the population – Effectiveness of interventions/ policies; effectiveness models
	Good evaluation reports; meta-analyses of evaluation reports and studies	Effectiveness of interventions/ policies
2. Scientific theories		

Fig. 6: Evidence types, sources and topics (left-hand column: evidence prism according to Walach, 2005)

Apart from systematic reviews of controlled studies, other important **sources of evidence** are other types of scientific reviews that are much more suitable for the complex health promotion interventions and respective studies. This category also comprises systematic assessments of good scientific evaluations and meta-analyses as well as scientific research reports from various disciplines. Such a broadened definition of "evidence base" is reflected in the new definition of "evidence based health promotion" (cf. also the definition of evidence based health promotion by the WHO[19]).

Objects of evidence in health promotion and disease prevention have to do with:

a) that which influences health (determinants of health and their interaction),
b) the distribution of health/health determinants in the population,
c) how health can be maintained and improved (effectiveness of interventions).

Knowledge thus be gained can provide answers to the relevant questions posed in chapter 4.

Scientific knowledge alone is an insufficient basis for the best possible, i.e. effective health promotion. Knowledge from experts and knowledge derived from practice form a necessary addition to scientific knowledge[20] and are not only important if there is (still) a lack of scientific knowledge. As mentioned before, best practice or "optimal" practice is more than "evidence-based" or "scientifically sound" practice (cf. Fig. 3).

5.3 Best practice dimension "context"

Because interventions are directed at the so-called determinants of health, i.e. at the modification of individual behavioural patterns and (politico-societal) conditions, it is highly important to take context factors into account whenever decisional processes and interventions are initiated. When analysing such context factors for interventions in health promotion and disease prevention, several levels have to be considered.

[19] Smith, Tang, Nutbeam (2006), WHO new definition: "The use of information derived from formal research and systematic investigation to identify causes and contribution factors to health needs and the most effective health promotion actions to address these in given contexts and populations".

[20] For further information to the best practice dimension knowledge/evidence cf. also: Best Practice basic document developed by Health Promotion Switzerland (Handbuch Strategie: Best Practice-Text C).

One of the levels concerns the question regarding capacities for health promotion and disease prevention. To date, there is no recognised definition for capacity for health promotion and disease prevention of groups, organisations, communities, regions or countries[21]. In the following section, the most important factors relevant for sustainable, effective and health-promoting activities are listed (cf. Fig. 7, top half).

Contextual factors concerning the capacity for health promotion/prevention[22]:

- Relevant policies, priorities and programmes (at national, cantonal and local levels) and structures and mechanisms for their development and implementation
- Information systems, monitoring and surveillance activities, networks and centres of excellence
- Research capacity, resources and mechanisms for knowledge development for health promotion and disease prevention: training and further training programmes
- Level of professionalism of those involved including problem solving capabilities, expertise for health promotion and disease prevention (national, local, public sector organisations, non-governmental organisations/NGOs)
- Organisations (such as professional associations, non-governmental organisations/NGOs) for health promotion and prevention and their roles
- Mechanisms for intersectoral collaboration in partnerships; participation mechanisms and cultures; functioning networks and exchange forums
- Leadership for health promotion and prevention
- Long-term and secure resource allocation (financial, personnel, temporal) for health promotion and disease prevention (inc. in national and cantonal public budgets); capacities for resource mobilisation[23].

A second level concerns the political, legal, social, economic and socio-cultural factors which need to be adequately considered in the processes of actual decision-making, planning and evaluation. It is about the natural and material environment on all societal levels and about other general environmental factors relevant for policy development or a particular intervention (cf. Fig. 7, lower half).

Another level concerns the narrower environment and life conditions relevant for specific interventions with target groups and in settings; it also concerns expectations and the scope of stakeholder groups. These must be borne in mind in order to achieve implementations that are sensitive to the context in which they take place.

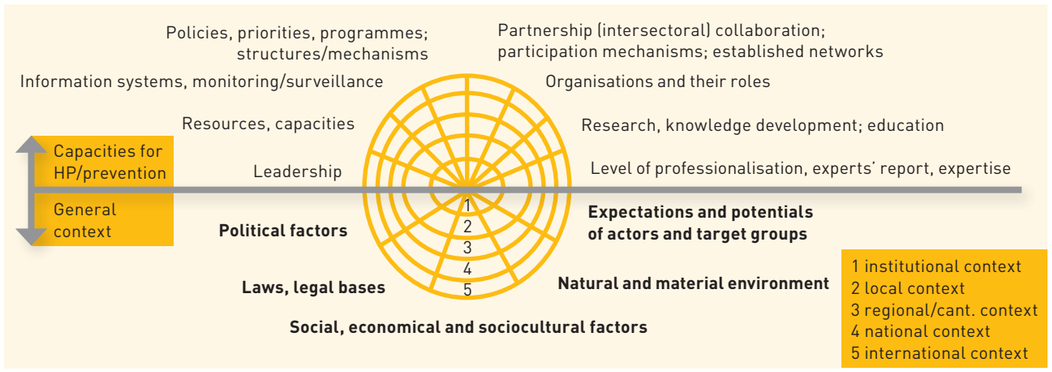


Fig. 7: Factors for the context check

[21] Cf. recent projects such as CompHP co-financed by the EU.

[22] Saan/de Haes (2006) talk here of "determinants for the effectiveness" of interventions.

[23] Key aspects of health promotion capacity (Fosse E, Mittelmark M, Skogli K, 2005), European Capacity for Health Promotion at national level. www.HP-source.net/frontend/docs/hpsourceforwho.doc

Depending on the nature and the importance of the decision to be taken or the planned intervention, a more or less elaborate context check may be necessary: either just with a few colleagues or with the stakeholder groups; from the point of view of a local group or from that of a regional network or national organisation. It may sometimes suffice to make a rapid assessment, together with others, of the factors that appear to be particularly important on each level (institutional to global). At other times, a more in-depth analysis of the context may be required.
A systematic "context-check" can be carried out with the help of the following tool (cf. Fig. 7).
A last aspect concerns the transfer to other contexts of interventions in health promotion and disease prevention. The success of interventions depends in no small measure on the wider or narrower context. One and the same intervention may well correspond to the best practice criteria and be absolutely effective in one community, but little effective or even inappropriate in another. This underlines the known transfer problem with interventions, modules and products in public health.
The implementation of the normative action framework for health promotion and disease prevention supports the search for interventions proven to be successful elsewhere and promising enough so that they can be used in other contexts.

5.4 Weighting and prioritisation of best practice dimensions

Implementing best practice in health promotion and disease prevention means the following: Weigh up and prioritise the three best practice dimensions "values", "knowledge" and "context" and then weigh and prioritise aspects within each dimension. Considerations are systematic, well founded and comprehensible to others. There is no general rule as to which best practice dimensions are the most important for any specific decision-making process or professional intervention in health promotion and disease prevention. Therefore, the weightings are not generally performed by an individual but in agreement with the most important internal and external stakeholders. If new interventions without sufficient empirical knowledge are tried out, best practice suggests that they are carefully planned and evaluated throughout so that findings can be made available in a suitable form to health promotion and disease prevention.

6 Best practice criteria

Overriding criterion: When making strategic decisions and when planning, implementing and evaluating health promotion and prevention activities, sufficient time must be spent on reflecting and appropriately considering the three best practice dimensions (values, knowledge, context; cf. Fig. Radar screen model).
This should be done systematically, using adequate existing tools.

Values

Criterion: When making strategic decisions and when planning, implementing and evaluating health promotion and prevention activities, the fundamental (ethical) values and principles of health promotion (and public health) are given due consideration.

- The fundamental values and principles of health promotion have been communicated (cf. Fig. List of relevant values) and the most important stakeholders/target groups (sponsors, funding institutions, project team, etc.) are familiar with them.
- These are studied and discussed with the key stakeholders (e.g. by using tried and tested checklists).
- Strategic decisions and health promotion and prevention activities are in line with these fundamental values and principles. Sometimes, prioritising may be necessary. If this is the case, the order of priorities should be carefully considered and the rationale clearly explained.

Knowledge

Criterion: Decisions and activities are based on current scientific knowledge.

- Current scientific knowledge (incl. evidence) is systematically researched and reviewed in advance. The research and review process is differentiated according to the available type of knowledge (sources, types and categories of knowledge; cf. Fig. Evidence types, sources; cf. also the Swiss model of outcome classification – SMOC).
- The most important sources of knowledge are used (cf. Fig. Types, sources and objects of scientific knowledge).
- Where current knowledge is not taken into account, good reasons are provided and documented.

Criterion: Decisions and actions contribute to the strengthening scientific base or evidence base of health promotion and prevention.

- If knowledge/evidence gaps related to health promotion were found, these gaps are documented and communicated to suitable parties (federal government and cantons, Health Promotion Switzerland, research institutes, professional associations, networks).
- Work to reduce these knowledge gaps is initiated, scheduled and carried out if this is sensible, necessary and appropriate (cf. Fig. Evidence cycle).

Criterion: In addition to scientific knowledge, decisions and activities are also based on other important knowledge (expert opinions/knowledge from practice).

- This kind of knowledge is also carefully researched in advance, interpreted and reviewed, as necessary. This process, again, is differentiated according to the kind of knowledge available (types of knowledge such as expert opinion and knowledge derived from practice; sources of knowledge such as good self evaluations, project reports and experts' reports).
- Current scientific knowledge and available experiential knowledge are then carefully examined for their potential application regarding decisions and actions. When in doubt, priority is given to scientific knowledge, as long as it is appropriate and relevant in the specific context.
- Where current knowledge is not taken into account, good reasons are provided and documented.
- Important results and findings are disseminated (distributed and made usable).

Context

Criterion: When making strategic decisions and when planning, implementing and evaluating health promotion and prevention activities, the context is given appropriate consideration.

- The relevant dimensions of the narrower and broader context are studied as appropriate (cf. Fig. Context check).
- The transferability of scientific and other important findings/new knowledge to the respective context is carefully checked/studied.
- If approaches, processes and interventions from elsewhere are adapted to the specific context, these changes must be well-founded and documented.

Final overriding criterion: The intended positive effects have been achieved and negative effects have been avoided.

Part 2

Part two consists of concrete suggestions and support for practice. It includes guidelines for various areas of activity, such as "translation" of fundamental scientific texts for practice or cooperation and coordination of partnerships, alliances and networks. The guidelines take on a more concrete form and become operational with the help of indicators and can be used as a practical resource.
These are followed by two examples of interventions which have been analysed according to the best practice framework. These examples illustrate how useful systematic reflections are for this process.
The appendix contains information regarding the knowledge cycle and describes first experiences of Health Promotion Switzerland with the application of the knowledge dimension; a new model for a quality framework, a detailed glossary, a source directory and a compilation of the most important figures and tables.

7 Guidelines for implementation in selected areas of activity

This section highlights aspects which are particularly important for the implementation of the best practice approach from the point of view of Health Promotion Switzerland.

7.1 Best practice when processing the (scientific) knowledge base and literature

In health promotion and prevention, significant decisions, programmes and activities ought to be context-sensitive or value-compliant, but above all, they must be based on scientific knowledge. The actors in the field require appropriate synthesis reports on the scientific base for their work. This can be done economically by identifying and using good existing work, (scientific) knowledge and instruments already elaborated by other qualified national and international agencies and experts. Remaining knowledge gaps or insufficient access to important knowledge (such as evidence reports, outstanding intervention approaches or practical tools) should ideally be dealt with in cross-border cooperation. These could take place in a virtual environment, e.g. on www.vhpo.net or quint-essenz community[24]. National agencies with relevant expertise, competence centres and/or research institutions have a particular responsibility here.
When creating (or selecting) synthesis reports on scientific findings in health promotion and prevention (e.g. "State of knowledge", "Evidence" or "State-of-the-art" reports), best practice applies as described below:

Knowledge
- Current scientific knowledge/evidence on the subject is systematically researched and processed for practice use. The following aspects need to be extensively and clearly differentiated:
  - Distribution of health/health determinants in the population; interaction of the most important health determinants resp. health resources; effective interventions/intervention packages; (cf. also the Swiss model for outcome classification – SMOC[25]).
  - Clear differentiation between the different types of knowledge or evidence and their different sources transparent for the reader; expert and experiential knowledge is clearly marked as such (cf. also Fig. 6).
  - Use of the most important knowledge sources/databases (national/international); any possible language or cultural bias is made transparent (e.g. the predominant use of English or German literature).
- Important knowledge/evidence gaps in health promotion and prevention are well documented and communicated to suitable parties (such as the national organisation for health promotion and prevention, here Health Promotion Switzerland, other competence centres, networks, the federal government or cantons).
- When assessing and selecting scientific knowledge, the adequacy of study type and study design in relation to the object of investigation has to be considered (cf. also Fig. 6 "Evidence prism").
- Expert opinions or knowledge gained from practice (e.g. from project reports, self-evaluations) is only used if additional material is needed. It must be carefully synthesised and processed for further use.
- Where current knowledge is not taken into account, good reason is provided and this is documented.
- The synthesis or state of knowledge report is appropriate for its readership (generally experts).

Values/context
- The synthesis report of scientific findings states explicitly whether and which studies or systematic reviews have given sufficient consideration to the following aspects:
  - Equal opportunities for health (gender, socio-economic status, age, migratory background, etc.)
  - Information on assumptions made about the context or on the actual context of the analysed interventions.
- Findings from studies or reviews with appropriate information about context and/or consideration of aspects of equal opportunities for health (such as gender) are given a higher weighting.

[24] www.quint-essenz.ch/en/community
[25] www.healthpromotion.ch

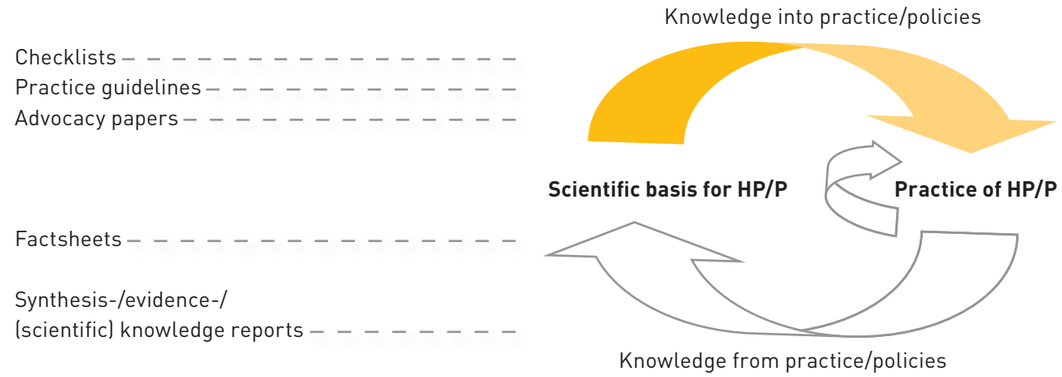


Fig. 8: Knowledge into practice/policies – the role of knowledge or evidence-based fact sheets, briefing/advocacy papers, practice guides and checklists

7.2 Best practice when creating knowledge-based or evidence-supported practice guides and briefing/advocacy papers for health promotion

In order to implement the Best Practice concept it is necessary to be aware of the latest scientific findings on the topic in question. For various reasons it is unrealistic to expect every person responsible for planning a health promotion activity to review and produce a synthesis report on the scientific knowledge base related to the topic or the selected type of intervention – whether alone or in cooperation with others. However, since decisions, programmes, projects or measures in health promotion and prevention at a local, cantonal and national level should become increasingly knowledge/evidence based, syntheses of the available **scientific knowledge base** (cf. section 7.1) must be further and systematically **"translated"** for practice use. Suitable forms include short and comprehensible fact sheets, knowledge-based or evidence-supported recommendations for action and, in particular, specific practice guides[26] and briefing/advocacy papers on priority health topics (such as healthy body weight), fundamental approaches to health promotion (such as the settings approach or advocacy campaigns) and on basic values and principles of health promotion (such as participation and equal opportunities).
When developing practice guides, briefing/advocacy papers and checklists, best practice applies as follows:

Values
- The above mentioned tools or products have been developed involving representatives of the user groups.
- They encourage and support empowerment, participation, sustainability and equal opportunities in health promotion and prevention.
- As far as the population is concerned, practice guides, briefing/advocacy papers and checklists

[26] Cf. chapter 8: Practical examples

are created, formulated and made available so as to be equally understandable and useful for groups of the population with low health literacy, low educational or socio-economic status or with a background of migration.

Knowledge
- The practice guides, briefing/advocacy papers and checklists correspond to the latest scientific knowledge (they are based on good synthesis reports, cf. section 7.1).
- They are also based on a good knowledge of the context in which they are to be used.
- Existing tools, products and experiences both national and international are used as far as possible and may be adapted.

Context
- The practice guides, checklists are formulated and structured to be context-sensitive and target group-specific (e.g. for experts, decision-makers in administration and politics, or specific groups of the population).
- (National) specialist agencies or competence centres for health promotion and prevention and/or actors involved in applied research each take responsibility for the development and updating of these products (possibly in a division of labour).

7.3 Best practice when setting up and implementing (intersectoral) cooperation and coordination (partnerships, alliances, networks)

Coordination generally means *mutual agreement* of various factors or processes. Cooperation refers to the process of collaboration[27] (often between the state sector and the non-governmental sector) that aims at finding *consensual solutions* to problems. To implement the best practice approach for health promotion and prevention when initiating, setting up and implementing forms of (intersectoral) cooperation and coordination the following applies:

- A clear difference is made between a) the *initiation and set-up phase* of (intersectoral) forms of cooperation or coordination and b) the *establishment or implementation* phase, e.g. the *work* in an (intersectoral) cooperation/a coordination arrangement.
- A planned (intersectoral) cooperation resp. a coordination task takes place only after careful examination and selection of a suitable form of social organisation (such as a network or an "alliance").
- The decision for or against a specific form/approach of cooperation or coordination is well-founded and based on an adequate reflection of all three best practice dimensions: values, knowledge and context. In other words, some of the following questions should be answered:

Knowledge
- To what extent was the existing *scientific* knowledge (including evaluations) on the forms of organisation of (intersectoral) coordination and collaboration (such as alliances, partnerships, networks) taken into account? Are the following aspects clear?
  - Terms such as "alliance", "partnership", "network" of organisations and their similarities and differences?
  - Success factors for *setting up* an alliance/partnership/network?
  - Success factors for *working in and using* such a form of collaboration as well as *coordinating* an alliance/partnership/network?
- To what extent was the available *experiential knowledge* on the above mentioned forms of (intersectoral) cooperation or coordination taken into account? (e.g. existing guidelines for "Public Private Partnerships" of other national and international organisations responsible for health and other relevant sectors)
- What is the balance between relevant scientific findings and relevant experiential knowledge? What are the knowledge gaps?
- To what extent can/must the knowledge gaps be filled? How can this be done efficiently?

[27] Kohout (2002), p. 40

Values
- To what extent do the various organisational forms of/approaches to (intersectoral) cooperation and coordination – such as "alliance", "partnership", "network", "forum", etc. – correspond to the values and principles of health promotion and public health? (Question of "fit" between form/approach and values/principles)

For interorganisational networks (ION) there is a good fit between the values/principles of health promotion/public health[28]; the situation is less clear for the various types of (intersectoral) cooperation such as "alliances".

Context
- What organisational types of (intersectoral) cooperation or coordination already exist in the relevant environment? Which terms/labels have a (negative/positive) connotation?
- What is the range of opinions on (intersectoral) cooperation or coordination in health promotion/public health amongst the relevant stakeholders/target groups?

7.4 Best practice in strategy development (including decision making)

For strategy development in health promotion, best practice means that all three dimensions are reflected on in each phase and given appropriate consideration – and this together with the most important target groups, i.e. key stakeholders in particular, but also colleagues, those persons affected by the implementation, professionals and target groups). Any ensuing conflicts of interest and considerations must be openly disclosed and appropriate decisions justified (if for example context factors are given more weight than evidence in a decision).

Values
- The most important stakeholders clarify their (institutional) role in society (profit-orientated and/or ethical orientation) and provide clear reasons. They check their fundamental values (stated in their vision, mission, guiding principles, etc.) and relate them to the fundamental values and principles of health promotion/public health so as to identify possible conflicts.
- They comment on the fundamental values and principles of health promotion/public health (in particular on equal opportunities, empowerment and participation), where possible agree on common values and guiding principles for strategy development and record these in appropriate written agreements.
- With this procedure, the principle of participation itself is allowed for and the most important stakeholders are integrated in the strategy development process right from the beginning.

Knowledge
- All decisions in the individual phases of strategy development (decision of general principle, formulation of mandates, selection of a strategy variant, etc.) are supported by existing scientific evidence and relevant expert and experiential knowledge and are documented accordingly. Here reflections on the state-of-the-art and generally tried and tested methods such as the SWOT and GAP analyses are used.
- Strategy variants are analysed and assessed according to firm knowledge. The consequences of not taking action and the potential negative impact on the health of the population are analysed.

Context
- Strategy development is adapted to overriding health policies.
- A systematic context analysis of the relevant context (international to local) and the most important other context factors (social, political, economic, financial, etc.) is carried out.
- Strategy development takes account of the short and long-term institutional resources and of the potential of the institution concerned.

[28] Broesskamp-Stone (2004), Assessing Networks for Health Promotion. Framework and Examples

7.5 Best practice when planning and implementing health promotion and prevention projects and programmes

When planning and implementing health promotion and prevention projects and programmes, the size and scope of the project will determine to what extent best practice dimensions can be considered. Large-scale projects and programmes should satisfy higher standards, smaller projects may ask which smaller steps in the three dimensions would already improve quality.

Values
- The most important project participants (sponsors, funders, project team) must discuss the values that guide them.
- Values and principles as set out by Health Promotion Switzerland are explicitly discussed and shared values and principles are defined. These will then be actively persued in the planning and evaluation of a project.
- Conflicting views on values and principles are discussed in full.

Knowledge
- When justifying projects it is normal practice to provide epidemiological data on the prevalence of diseases (e.g. diabetes rates) or on the extent of behaviour which is damaging to health (e.g. alcohol abuse). But, there is often a lack of findings on the effectiveness of interventions or of the interaction of effects, both in respect of health problems and approaches for solving them. The framework for optimal practice can improve this situation as it draws attention to other types and sources of knowledge.
- Findings from systematic reviews of intervention effectiveness or results from good evaluations of comparable projects and approaches as well as systematically collected knowledge from experts and from experience can contribute to the health promotion knowledge base and be used to justify the intervention or the project.
- In addition to such health-specific knowledge, findings and experiences from project management and quality development (cf. www.quint-essenz.ch) should also be used in planning.

Context
- In project and programme design, a context analysis should investigate the important factors influencing successful implementation.
- The impact of these factors can, for example, be recorded in an outcome model (cf. Health Promotion Switzerland's model for outcome classification – SMOC).
- When transferring project ideas to a new environment, the context factors of both locations should be analysed and compared, as different context factors usually lead to small or large adaptations in project design.

At present, the quality system for projects in health promotion (quint-essenz) already covers the essential aspects of the three best practice dimensions. With quint-essenz, projects are subject to repeated and systematic reflections using specifically developed quality criteria. Therefore, most of the best practice aspects are covered. In the further development of the quality system quint-essenz, best practice criteria will be integrated even more rigorously.

7.6 Best practice when assessing grant applications for health promotion and prevention projects and programmes

When assessing grant applications the best practice framework can be applied by foundations and other sponsor institutions by using the best practice criteria.

Values
- Criteria for inclusion, exclusion and quality comprise the fundamental values and principles of health promotion and prevention.
- The assessment procedure is transparent, multi-level and created in such a way that independence from a first, second or third opinion is guaranteed.

Knowledge
- When grant applications are assessed, the main criteria are the following: is there a clearly described and comprehensible objective (normative) need and/or felt need; is the currently available knowledge (evidence, expert knowledge and experiential knowledge) appropriately researched and is the planned project based on the research findings?
- The procedure for assessing applications is "state-of-the-art" in terms of assessment processes and is carried out with staff qualified to do this.

Context
- When assessing an application a check is carried out to establish to what extent the various relevant context levels (national, regional, local, etc.) and factors (social, political, financial, etc.) have been taken into consideration.
- For applications which include the acceptance of intervention approaches/projects/modules by third parties, the extent to which these are compatible with the specified context or to what extent a corresponding analysis has been carried out is investigated.
- The complexity and cost of the application procedure as well as the depth and level of detail required by the application form and given in the explanations are proportional to the demand in question, both for the funding institution and the grant applicant.

7.7 Best practice when evaluating health promotion and prevention activities

Many evaluations in health promotion and prevention do not adequately account for the three dimensions of best practice and this for a variety of reasons. The following starting points may help further:

Values
- In evaluation, values, especially the fundamental values and principles of health promotion, must be considered as transversal evaluation criteria.
- Evaluation concepts should systematically state how the value dimensions are to be dealt with and how the evaluation questions would include it in practice.
- Evaluations in the area of health promotion and prevention should explicitly take into consideration effects on health-related equal opportunities.
- Ideally, evaluations are planned and carried out in a participatory manner, i.e. involving the most important target groups. The inclusion of these groups promotes self-reflection and evaluative competence and has therefore an empowering effect on them.

Knowledge
- Evaluations, in particular external evaluations, must take empirical and theoretical knowledge much more into consideration than at present and their assessment must be based on this (so far, empirical and expert knowledge are often the only sources of knowledge taken into account).
- Impact models are a help in gaining an overview on the complexity of the research field, in structuring existing knowledge, identifying knowledge gaps and adjusting both intervention planning and the evaluation according to this knowledge base (cf. also the outcome model by Health Promotion Switzerland).
- The complexity of the research field should be taken into due account with evaluations in health promotion and prevention. In many instances, randomised control studies are not suitable for evaluating setting-oriented interventions. But in order to study evaluation problems adequately, the potentials and the combination of different social science research methods need to be investigated.
- To increase the availability of this treasure of knowledge, more attention needs to be paid to the review, distribution and valorisation of evaluation results.

Context
- A good evaluation includes an environment analysis which makes the identification of context-specific success factors and obstacles possible.
- When interpreting evaluation results, it must be clear which context factors have significantly influenced the results. Accordingly, recommendations have to be formulated in a context-sensitive manner.

- It is crucial to include the most important actors in the evaluation so that they contribute with their specific knowledge to the planning of the evaluation and the interpretation of the results.
- Results from evaluations in complex social systems are always dependent on specific contexts. Caution is required when generalising evaluation results or transferring them to other contexts!

8 Practical examples

In this section selected examples are used to illustrate what the implementation of best practice means. The examples have been selected bearing the three best practice dimensions in mind. However, it is not intended to position the examples detailed here as "the optimum interventions or processes", but rather of highlighting important elements and steps for best practice according to the concept and of illustrating that the high demands of best practice can be achieved in health promotion and prevention. The examples include elements in which the criteria are well implemented and others that show limitations and require improvements.

Against this background it is important to mention that the selected examples have only been associated with the best practice concept with hindsight. A systematic consideration of the best practice dimensions and criteria could not be carried out while planning or implementing the activities described since at the time the concept had not yet been communicated externally and the criteria did not even exist. It is all the more encouraging that a significant part of the content of the concept was nevertheless taken into consideration, as the subsequent "Best Practice Check" has revealed here.

8.1 Development of the framework concept "Health promotion and prevention in the canton of Zug", 2003, Switzerland

Background and overview

The Health Director of the canton of Zug commissioned the local health authority with drawing up the above concept as part of the Cantonal Council's (Regierungsrat) overall policy for 2000–2010. The presentation of this practical example focuses on the development of the policy rather than on its results. The health promotion officer and his assistant, all the way from research through to "marketing" and distribution, coordinated the creation of a framework concept. As the direct superior, the chief officer provided regular feedback on the process and on the concept versions. The political authority – who was the actual client – dealt with selected points during the process.

First, values were discussed with the most important stakeholders. Due to the easily accessible scientific findings and the practical know-how of the team members data was reviewed mainly by the internal project team while at the same time, the context was reviewed together with the main stakeholders. The project team was guided by the WHO's "Agenda 21", amongst other things. Specialists/professionals or multipliers, experts, politicians and the population were identified as the main stakeholders. The population was not explicitly implicated in the process but was represented by a group of widely supported field experts that accompanied the process throughout. The multipliers approach is central to concept development, i.e. the use of the advisory group members as key people when communicating and explaining the framework concept. The advisory group followed the entire development process very closely and minutes of the regular meetings were taken. The support group was made up of 18 members who had been chosen on the basis of a survey of around 200 stakeholders in the canton of Zug. The comprehensive, health-related survey included mainly specialists and practitioners from health promotion and prevention, but also selected representatives of the local economy and political parties. In parallel, an exchange took place between health promotion officers from the cantons of Aargau and Zürich who had received the same mandate.

Analysis of the development process throughout the three best practice dimensions

Values: Intensive discussions on the **value** dimension were held with the support group. These were fundamental for the concept development. Thus help for self-help, participation and equal opportunities and the salutogenic approach (after raising awareness) were defined as general basic values or basic principles. The type, form and duration of participa-

tory options were clarified with group members. Further guiding values were developed: a common understanding of health as a process and orientation towards determinants of health.
Written agreements were not seen as necessary at this stage, although the consensus in question was recorded in the minutes of the meeting. Furthermore, the positioning of health promotion and prevention in the field of public health was agreed on. Comprehensive guidelines were the result. Only non-profit organisations were represented in the steering/advisory group, and these did not have any basic differences regarding basic values.
Particular strengths: The most important values and principles in health promotion, including the Ottawa Charter, were discussed in detail and have been taken into account in the cantonal framework concept. The members of the steering/advisory group ensured that the concept was introduced to health promotion practitioners. Most of the organisations represented in the advisory group are now active in the implementation of the main programmes in municipalities, schools and factories.
Improvement potential: A consistent participatory procedure at all stages and levels is an important success factor. The concept was not approved by the full Cantonal Council (Regierungsrat) but such approval could in retrospect have contributed to an improved political backup. It may be true that the inclusion of representatives from the local economy and from the main political parties into the expert group accompanying the project would have lengthened the process but, on the other hand, it would have increased the political acceptance of the framework concept as well as its content. Likewise, more consideration/involvement of the cantonal health department's employees and other important interfaces within the Health Directorate (e.g. of the Cantonal Chief Medical Officer) would have boosted internal acceptance and implementation.

Knowledge: The basis for analysing the actual state and for conceptual decisions was supplied by data from the 1997 national health survey, health data from central Switzerland and the cantonal survey mentioned above. Furthermore, epidemiological data available from German language sources (incomplete for the canton of Zug at the time of the development) was researched by the project team and the broad specialist **knowledge** and know-how of the experts in the accompanying group was also consulted. Great importance was placed on this since hardly any evidence could be found as regards the effectiveness of measures and projects in the time available.
The three main settings of school, workplace and community were defined as the focal points, whereby no topics or stakeholders needed to be deliberately excluded and the framework concept could be kept as open as possible. Taken up were current topics such as body weight and health in the workplace as well as other main topics pursued by Health Promotion Switzerland at the time. A preventive intervention project (home visits to elderly people) that had shown scientifically well-documented effects (Eiger study) served as a model to be implemented in the canton of Zug at municipal level.
Particular strengths: The epidemiological data currently available nationally and regionally was used primarily and was supplemented by a wide-ranging cantonal survey and relevant specialist knowledge and know-how. Knowledge gaps were identified, placed in front of expert panels and closed (Mandate to the Federal Statistical Office as regards records of representative cantonal data). They are thus available for future concept and strategy development in the canton. The opportunities for intercantonal collaboration or exchange were used.
Improvement potential: At the framework concept stage a very open approach is justified as conflicts of interest are avoided at this crucial early stage. However, such conflict is inevitable and becomes unavoidable at strategy and programme development level. Evidence sources from outside the canton and in other languages must be included in the review. The project team itself cannot rule out that the choice of the main programme themes may have been different if it had been aware of the existing evidence base or if cantonal distribution data had existed. For the purposes of sustainable and continuous development work, the analysis of the actual state could be extended into a SWOT analysis and so embrace environmental and organisational issues.

Context: The project team adapted the concept to the WHO "Agenda 21" for the European region, which was adjusted for Switzerland and enabled its 21 objectives to be prioritised as part of the survey. At cantonal level important **context** factors were analysed or taken into account. The concept was integrated into the Cantonal Council's (Regierungsrat) overall policy for 2000–2010 and adapted to the cantonal Health Care Act. At practice level a mapping of all the main partners in the canton took place. With Aargau and Zürich, a fruitful exchange was maintained beyond the cantonal borders.
In terms of organisation and resources, the tasks and roles of state institutions were clarified, the structures adapted to new priority programmes, a rough time schedule drafted for the first three years and the necessary resources for personnel estimated. Finally, public relations work and cantonal and national networking as well as quality development and evaluation was defined with reference to existing tools (www.quint-essenz.ch).
Particular strengths: The legal and political basic principles are given consideration and decisive international sources (WHO) have been used. Insufficient personnel resources are compensated by long-term service agreements with tried and tested partner organisations. The various prerequisites and needs of the target groups were taken into account through a short version of the framework concept, which is largely free of specialist terminology, and a long version for experts.
Improvement potential: The political will exists. In an institutional context, however, it must be noted that insufficient resources must be adapted so that the planned priority programmes can be implemented. Alongside the political and legal factors, social and cultural context factors also play an important role.

Summary of assessment
In the development phase of the concept the three best practice dimensions are considered in detail and given about equal importance. The framework concept has a solid base of shared values and principles. Despite lacking evidence sources from the canton, three key programmes with long-term validity were defined and integrated into the international and cantonal context. This became possible thanks to an international outlook, the availability and use of national and regional health data and widely activated specialist knowledge and know-how.
For the short version of the framework concept, cf.: www.zug.ch/gesundheitsamt.

8.2 Best practice in the "Peace Kids" peacemaker project in Schmitten, Switzerland

Background and overview
For years, the primary school teachers in the village of Schmitten (FR) have been working systematically – and against a salutogenic background – to improve the school climate. After a four-year process with teachers and structures such as break-time regulations in place, they then set about finding new ways of settling conflicts amongst pupils themselves. After intensive clarification and preliminary work, it was decided to introduce a peacemaker programme at the schools.
In conjunction with these efforts, the Schmitten school joined the Swiss Network of Health Promoting Schools and enabled one of the teachers to specialise in health promotion as part of a post-diploma course in project management. This specialist was then also put in charge of introducing and supporting the "Peace Kids" (formerly "Peace Force") peacemaker programme.

Analysis of the development process throughout the three best practice dimensions
Values: In real life, the values and principles of health promotion and prevention are not always easy to communicate. Many relevant elements underpin the project and are taken for granted without being explicitly identified. The peacemaker programme focuses on the well-being of all pupils, for example. All children in the Schmitten school should feel at ease and that their needs are being taken seriously and accepted. Thus the project implicitly adhered to the principle of equal opportunities right from the beginning. Participation and empowerment are also conceptual cornerstones of the project and the efforts of the school. These conceptual basic principles – sometimes described using other terms – have been

discussed in-depth amongst staff and strategies were adapted and developed so as to accommodate these principles.
Particular strengths: Important values and principles of health promotion and prevention have been discussed amongst staff and still form the basis of the project which has been successfully implemented for years. Thus the project is consistently oriented towards promoting the social and personal resources of the children. As a member of the municipal council, the school president was integrated in the discussions and processes from the beginning and ensured the connection with the general municipal council.
Improvement potential: The discussion about the project's guiding values and principles was mainly conducted amongst staff and an appropriate consensus was found in this group. Other target groups such as parents and pupils were not informed about the project until a later phase and were not explicitly involved in the planning or in the discussion of values. An earlier involvement of all target groups can make possible value conflicts transparent so that they can be discussed in a preventive manner so that an agreement on common basic values can be reached. In the example project above, the basic values are clearly supported by all target groups and no value conflicts occurred subsequently either.

Knowledge: In this project, the greatest needs as regards best practice dimensions are at knowledge level. The project illustrates the obstacles that practitioners are confronted with when trying to find concise, comprehensible and up-to-date knowledge on a specific topic. There is generally – and for this topic too – a lack of access to bundled scientific knowledge. There are hardly any institutions that are dedicated to collecting, carefully evaluating and processing existing scientific knowledge (evidence) on the many topics of health promotion and prevention, so that practitioners, amongst others, could really benefit from it.
This means that the knowledge basis for this project too is formed almost entirely of know-how from similar projects (e.g. Peacemaker) and topic areas (settling disputes, behavioural training, etc.). Such empirical knowledge is mainly accessible via practice-oriented articles in relevant journals and via specialised but usually not scientific books or via the Internet. Because accessibility was easier, German literature was primarily taken into consideration.
Empirical studies from Switzerland or abroad could not be found, which does not mean that these do not exist, but that these are especially hard to access.
Another important source of know-how is the personal experience of the teachers involved in settling disputes – a perpetual topic in everyday life at school.
The best practice concept goes beyond considering knowledge when planning an intervention. It is also important to recognise any knowledge gaps and to fill these as required. An important contribution was made by the Peace Kids project (formally Peace Force) – the project was evaluated together with Suchtpräventionsstelle Freiburg [Freiburg addiction prevention unit] and is available on the Peace Force Switzerland website as one of a few external evaluations[29]. In addition, there is a detailed project report that describes the project and the experiences with it (integrating the results of the third party evaluation)[30].
Particular strengths: On the knowledge dimension one particular strength is the broad consideration of available and recorded know-how and experiential knowledge, another strong point is the decision to have the project evaluated externally and then to make the results widely available. This ensures a good contribution to the evidence basis in this still new field.

[29] Zimmermann, David: Peace-Force an der Primarschule Schmitten [Peace Force at the Schmitten primary school]. Evaluation report by the Suchtpräventionsstelle Freiburg [Freiburg addiction prevention unit]. January–April 2004, (www.peaceforce.ch under Schriften/Evaluationen [Publications/Evaluations])
[30] Zühlke, Sabine: "Peace-Force" an der Schule Schmitten. Einführung von Streitschlichtern und Streitschlichterinnen in der 2.–6. Klasse. ["Peace Force" at the Schmitten school. Introduction of peacemakers in the 2nd–6th classes]. May 2004 (unpublished diploma thesis for acquiring the certificate for the post-diploma course on project management in health promotion at the University of Applied Sciences Northwestern Switzerland)

Improvement potential: The main improvement potential is in considering scientific knowledge, as already described in detail above.
A statement by the project manager nicely summarises dealing with the knowledge dimension: "It works, but we don't exactly know why!"

Context: The context dimension is discussed under the aspect of transferring the project to other municipalities. What does best practice mean in such a process? For the project manager who accompanies the transfer to other municipalities the context-specific adaptation of the project is a matter of course. An adaptation process is initiated which involves the following: First, facts on the new environment are collected, such as the size of the municipality, the number of classes and pupils, etc. In the next step subjective judgements on the situation are collected, e.g. on the school climate and political situation, and subjective impressions gained from visits to schools and other observations are added to these. The facts and assessments are then compared with the context of the original municipality and the similarities and differences worked out. Based on this, an adapted implementation concept is developed and discussed with the teachers at the new school. The adaptations must, however, stay limited – as the fundamentals of the project should remain unchanged (settlement of disputes by pupils), but depending on the context the specific implementation may then vary greatly.
Particular strengths: Before transferring the project to a new municipality a careful context analysis is carried out which considers both the hard facts and the "softer" elements.
Improvement potential: Since scientific knowledge from other projects is largely unavailable, this cannot be transferred to a separate context. In addition, the relatively small size of the project did not allow for the systematic consideration of all context dimensions and it is possible that one or more of the factors that were apparent in the original concept could still be taken into consideration.

Summary of assessment
The three best practice dimensions have been considered very differently in this project. The project shows very interesting and exemplary approaches in the area of the context dimension according to the basic principle that best practice interventions are not objective and "unchangeable" parameters but can comprise context-sensitive and knowledge-based adaptations.
The presentation also showed that there is a large distance between science and practice also in this project: poor access to and the lack of well-prepared scientific knowledge makes a solid knowledge basis – which could combine empirical with scientific knowledge – difficult. The institutions responsible for the project have initiated a step towards closing up the knowledge gaps by having the project evaluated externally. The value dimension is partially taken into account. Value discussions were held but only with a restricted selection of target groups. This example also shows that in the field not every value discussion is about the basic values of public health and health promotion – but that in terms of the best practice concept the latter should have a central role for the activities of health promotion and prevention.

9 Annex I

The best practice approach and Health Promotion Switzerland – dealing with the knowledge dimension (technical knowledge management)

Health Promotion Switzerland is continually working on strengthening and improving its knowledge management both internally and externally. It processes scientifically based, action-related knowledge and other expertise according to specific target groups and then makes it available in the form of advocacy papers, fact sheets and state of knowledge reports. Updates should take place regularly or at appropriate intervals. Evaluation results and important experiences from implemented measures are systematically analysed, made explicit and made useable for stakeholders. As the foundation is part of the health system, it is particularly important that its own activities and the projects and measures it supports are selected, combined, planned and implemented as far as possible based on current *scientific* findings. For the foundation as a national organisation for health promotion, implementing the best practice general concept means using and strengthening the evidence base of health promotion even more systematically than before. Within the foundation the concept applies to the organisation itself as well as to the health promotion programmes and for all health promotion measures and projects it supports. At an international level, the foundation joins a number of other mostly national (peer) organisations for health promotion, prevention and public health. Basically, the foundation builds as far as possible on *existing* evidence and other scientific findings; and it identifies knowledge gaps and helps to close these where this is worthwhile and necessary.

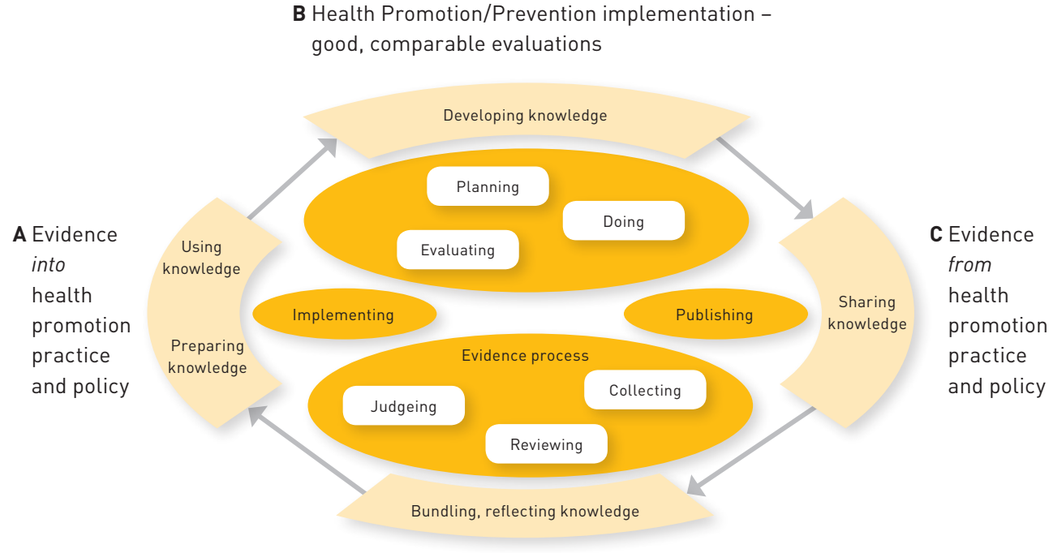
The knowledge cycle for health promotion illustrates the knowledge dimension of best practice and helps to clarify the foundation's handling of knowledge and its priorities (cf. Fig. 9).

A: Focusing on important programmes and areas of activity, the foundation identifies and systematises the available evidence and other scientific bases. It evaluates the search results critically and shows clearly where there is assured knowledge and where there is not. It processes the findings and uses them for a specific purpose (e.g. for planning programmes and other health promotion activities or for creating advocacy papers, recommendations or practice checklists). The foundation also supports the use of evidence and other scientific findings by other health promotion actors (e.g. through the provision of "state-of-the-art" reports, guidelines or fact sheets). Keeping in mind its new strategic areas, the foundation also clarifies its own existing concepts and its understanding of "evidence-based" or "evidence-informed policy" in this context.

In its priority topic areas and concerns the foundation is working towards ensuring that scientific institutions and (peer) organisations and consortiums in health promotion, in Switzerland and abroad a) have important knowledge or evidence gaps in health promotion on their agenda and b) that these are closed through targeted (research) activities geared towards implementation. It updates and uses its contacts and networks in Switzerland and abroad and exercises appropriate advocacy (observing the principle of "give and take").

B: The foundation is campaigning for good (where possible also comparable) scientific evaluations at various levels of its health promotion activities (from the health promotion projects funded through to the implementation of its long-term strategy). It ensures the accessibility and usability of evaluation results for itself and other actors in health promotion and supports relevant learning processes (see also the foundation's evaluation concept). It also supports the professionalisation of those involved in health promotion and prevention in Switzerland so that they too, may contribute more to strengthening the evidence base for health promotion through good evaluations (co-operation of the foundation, e.g. in training and further training programmes for professionals).

C: Through meta-evaluations of the above evaluation results and through the targeted dissemination of these, the foundation is contributing to improving the



A. identifying, systematising and assessing, preparing and using evidence and other relevant scientific bases
B. top quality planning and implementation and very good, scientific (and where possible also comparable) evaluation of health promotion activities
C. generating evidence and other scientific bases from scientifically evaluated practice and policy work in health promotion (through meta-evaluations and cross-border dissemination of evaluation results)
D. systematic review of results of a range of scientific studies (cf. evidence sources and types above)

Fig. 9: The foundation's fields of activity along the knowledge management cycle (Broesskamp-Stone based on the "Health Promotion Knowledge Cycle" by Saan/de Haes, 2005)

scientific bases of health promotion. The creation of evidence from practice and policy work in health promotion requires a larger number of *comparable* high-quality scientific evaluations and meta-evaluations as well as cross-border exchange and collaboration. Here, the foundation coordinates, within the realms of possibility, with other actors in health promotion or peer organisations in Switzerland and abroad. In this way, it specifically contributes to the mutually profitable international initiatives that aim at strengthening the evidence base for health promotion (e.g. as part of the Global Programme for Health Promotion Effectiveness, GPHPE).

D: The foundation does *not* carry out systematic reviews for health promotion or similar work. Its legal duty also excludes research work. However, the foundation requires good (systematic) reviews of scientific findings on important issues which are appropriate for health promotion interventions. For this reason, it carries out regular exchanges with leading (peer) organisations and scientific institutions in Switzerland and abroad which are active in this area. And it maintains and uses good working relationships in order to place its issues on their agendas where necessary.

In general, Health Promotion Switzerland concentrates on sections A, B and C of the health promotion knowledge cycle presented above. The many years of work and experience in area B (planning, implementing, evaluating) and area C (sharing knowledge) – with the outcome model and quint-essenz instruments – have been and will be more specifically extended to area A, as part of the implementation of the new long-term strategy: through more identifica-

tion, preparation and use of scientific bases/evidence (e.g. via state-of-the-art reports on strategic topics, fact sheets and practice guidelines). In this sense, it also specifically contributes to the training and further training of public health and health promotion professionals in Switzerland (e.g. through best practice-orientated contributions to the new Swiss MPH programme).

The above mentioned knowledge cycle also applies to *non*-scientific knowledge. Although the foundation's best practice general concept gives preference to the use of scientific knowledge, it explicitly includes the targeted use of *non*-scientific knowledge. Knowledge from experts and from practice is very important for the foundation in many areas. The scientifically based answer to the question "what should we do?" (e.g. to contribute to maintaining the healthy weight of the Swiss population) must generally be supplemented by answers that are based on experience from practice, particularly when implementation is getting closer. Only in this way can we find relevant answers to the best practice question "What should we do *here* in this our context?" The best practice general concept helps to show clearly to what extent which decisions are supported by evidence and to what extent by knowledge from experts or practice – and why that is.

Sources/instruments: review protocol of the European "Getting Evidence into Practice" project 2004–2005 (GEP)

10 Annex II

Overall framework for quality development in health promotion and disease prevention (Brigitte Ruckstuhl, 2010)

Specific quality systems for health promotion	To develop	For specific settings: *Healthy Workplace Friendly Workplace*	*quint-essenz.ch*
Quality systems	To develop	Quality management system ISO, EFQM	Quality system
Management level	Policy management	Management of organisations	Intervention-/ project management
Reference systems	Policy (higher level) ⟷	Organisation	Programmes ⟷ Projects
Models	Cyclic models: *Public Health Action Cycle, Knowledge cycle, Deming Cycle* Effect models: *SMOC – Swiss Model of Outcome Classification*		
Purpose	"Optimal Action" through Best Practice *Best Practice – A normative framework for action*		

Definition of quality
"Quality: are the actual properties of a given system, measured in terms of quality requirements generally recognised by experts".

Illustration: According to Ruckstuhl, B. (2009). Ein Gesamtrahmen für die Qualitätsentwicklung in Gesundheitsförderung und Prävention. In: Kolip P., Müller E. (Hrsg.), Qualität von Gesundheitsförderung und Prävention. Huber Verlag, Bern. p. 91.

Basis: Definition of quality
Shared understanding of quality

Purpose: Best Practice/"Optimal results"
The normative framework Best Practice defines professional standards for quality (see definition "quality") in respect of outcomes and capacity building

Models:
Cyclic models: Public Health Action Cycle and knowledge cycle
Presumes that quality is obtained through an ongoing development process
Outcome models: Outcome model SMOC

Quality system: quint-essenz
Offers comprehensive tools for achieving outcomes

11 Annex III – Glossary

Best practice
Best practice in the context of health promotion and prevention means systematically taking into account the **values** and principles of health promotion and public health, building up current scientific **knowledge** and knowledge from experts and practice, observing the relevant **context** factors and having achieved a positive **impact** in the sense intended and avoided negative impact (cf. chapter 5).

Cooperation
Cooperation (in a political system) refers to the process of collaboration (particularly between the state sector and the non-governmental sector) that aims at finding **consensual solutions** to problems.
The term cooperation is primarily used in the (political) "management debate"; thus the necessity of interaction is emphasised in particular. (Kohout, 2002)

Evidence
In health promotion and prevention, scientifically sound statements are labelled as "evidence" if they were derived from systematic analyses and syntheses of scientific findings in accordance with clear (and accepted) regulations. Various evidence types and sources are currently used to select scientific findings (cf. also the WHO's definition of evidence-based health promotion[31]).
The following definition from Canada specifies further: "Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research are the most accurate evidence. Because research is often incomplete and sometimes" inappropriate, "contradictory or unavailable, other kinds of information are necessary supplements to or stand-ins for research. The evidence base for a decision is the multiple forms of evidence combined to balance rigour with expedience – while privileging the former over the latter." (slightly adapted version from: Canadian Health Services Research Foundation (CHSRF/FCRSS) without year; drawn up after March 2005)

Evidence-based health promotion
"The use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations." (WHO 2006: cf. Smith, Tang, Nutbeam, 2006, p. 342)

Felt needs
Unlike the objective need, a felt need is a subjective "deficit" by members of specific groups of the population/organisations/systems (from an internal point of view).

Health promotion
"Health promotion is the process of enabling people to increase control over, and to improve their health." (WHO 1986 – Ottawa Charter on Health Promotion)

Intervention
"Interventions in prevention and health promotion are well thought-out, justified and systematic measures targeting people's environments in order to induce sustainable changes in behaviour and/or social conditions that aim at promoting health or avoiding illness." (adapted from www.quint-essenz.ch)
Original definition in German: "Interventionen in Prävention und Gesundheitsförderung sind fachlich begründete, systematische Eingriffe in die Lebenswelten von Menschen, mit dem Ziel, Verhalten und/oder Verhältnisse zur Förderung der Gesundheit und/oder Vermeidung von Krankheiten nachhaltig zu verändern." (adaptiert von www.quint-essenz.ch)

[31] Smith, Tang, Nutbeam (2006)

Objective need
Substantiated by specialists and generally scientifically established "deficit" in specific groups of the population/organisations/systems (from an external point of view).

Practice guidelines
Systematically developed statements to assist practitioners and people with regard to appropriate (health related) decisions. (adapted from Brown et al., 2003)

Prevention
"Prevention not only includes measures which prevent the onset of illnesses, such as the reduction of risk factors, but also measures which stop them from spreading and minimise side effects." (WHO, 1998, p. 4)

Policy
Policy cannot be equated with politics. The central characteristic of "policy" is the structure of the content of a policy: "A policy formulates the course and strategy of an institution or a country. It thus determines the content of political action.
Politics includes tracking and implementing the course or strategy." (Health Promotion Switzerland, 2000, Glossary. www.gesundheitsfoerderung.ch)

12 Annex IV – Source directory

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  WHO (2006), WHO Health Promotion Glossary: New Terms. Cf. Smith et al., 2006

13 Annex V – Overview of the main figures and tables

Radar screen model

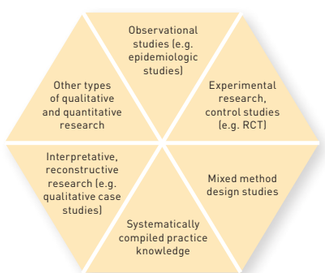
List of relevant values

Values, principles, ethical standards in public health

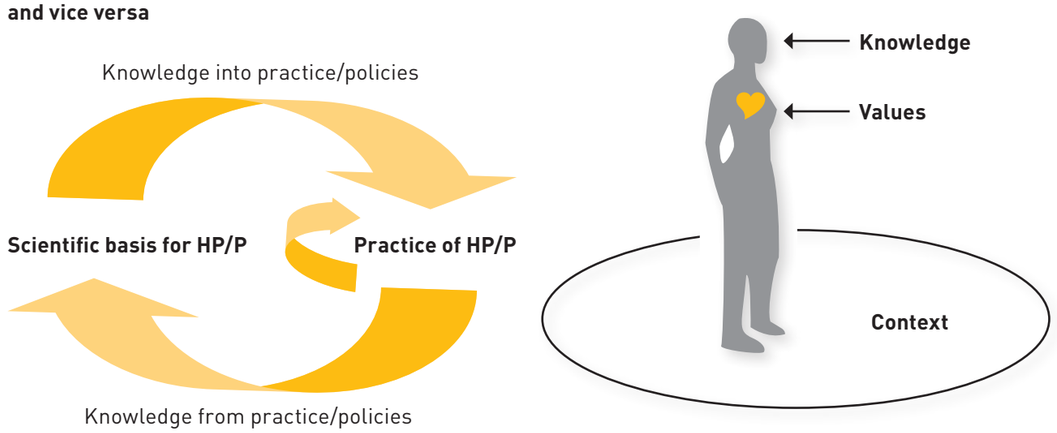
- Equal rights/equal duties and shared responsibility for health, social responsibility
- Avoidance of doing harm, beneficence ("the doing of good"), respect for autonomy, justice (the general ethical cornerstones of public health)
- Transparency and accountability, inclusiveness/openness
- Health equity (decisions and actions are guided by the principles of equal opportunity and justice)
- Sustainability: a) of measures and/or obtained health promoting changes beyond the initial financing period; b) in the sense of the concept for sustainable development

For health promotion in particular

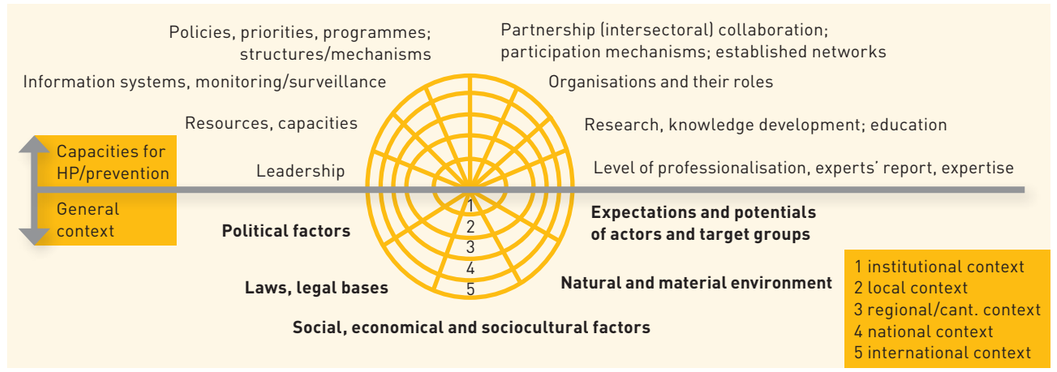
- Focused on health and health determinants (salutogenesis instead of pathogenesis)
- Empowerment
- Participation

Types of knowledge (scientific knowledge)	Sources of knowledge	Objects of knowledge
1. Evidence	1. Evidence	1. Evidence
"Types of evidence" 	"Sources of evidence" – Scientific/research articles (peer reviewed) – from health, educational, social, evaluation, political, management sciences, etc. – Systematic and narrative reviews	"Objects of knowledge" – Determinants of health/health resources and their interaction – Distribution of health/determinants of health in the population – Effectiveness of interventions/policies; effectiveness models
	Good evaluation reports; meta-analyses of evaluation reports and studies	Effectiveness of interventions/policies
2. Scientific theories		

Knowledge cycle: evidence in practice/policy and vice versa



Context check



Dufourstrasse 30, Postfach 311, CH-3000 Bern 6
Tel. +41 (0)31 350 04 04, Fax +41 (0)31 368 17 00
office.bern@promotionsante.ch

Avenue de la Gare 52, CH-1003 Lausanne
Tél. +41 (0)21 345 15 15, Fax +41 (0)21 345 15 45
office.lausanne@promotionsante.ch

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